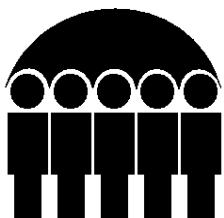


Revised September 19, 2000

Employees' Manual
Title 8
Chapter G

MEDICAID

CASE MAINTENANCE



Iowa
Department
of
Human Services

	<u>Page</u>
OVERVIEW	1
CLIENT REPORTING REQUIREMENTS	1
Supplying Information and Verification	1
Reporting Changes	3
CHANGES IN HOUSEHOLD CIRCUMSTANCES	4a
Moving and Returned Mail	5
Changes Reported From IEVS and Other Automated Sources	6
IEVS Wage Report	7
IEVS Unemployment Compensation Report	7
IEVS Bendex and State Data Exchange	8
IEVS Earnings and Pension Report (IRS)	8
IEVS Internal Revenue Service Report (IRS)	8
Iowa Central Employee Registry (ICER)	8
Child Care Assistance: CCA Warrant Report	9
Acting on IEVS Information on a Community Spouse	9
Acting on Changes Received From Other Sources	10
AWARE Hotline Referrals	10
Death of a Member	11
Report of Incarceration of a Member	11
REINSTATEMENT	12
Grace Period	12a
AUTOMATIC REDETERMINATION	12d
Additional Information for SSI-Related Redeterminations	15
Referrals to the <i>hawk-i</i> Program	18
ADDITIONAL FMAP-RELATED CASE MAINTENANCE	19
Reporting on a RRED or Quarterly Report	19
Requirements for a Complete Report	20
If a Household Fails to Return a Complete Report	21
FMAP-Related Eligibility Reviews	23
Voter Registration Procedures	24
Adding a New Member to an Existing FMAP-Related Case	25
Acting on a Client's Report of a Future Change	27
Establishing the Date of Application and Eligibility	27
Determining the Income of People Added	30

	<u>Page</u>
Other Changes in the Household	32
Returning Parent Not Eligible for Medicaid	33
Natural Father Enters the Household	33
Minor Parent Turns 18 or Marries	34
Person Becomes Ineligible for Medicaid	35
Child Goes into Foster Care	37
Budgeting for Ongoing Eligibility for FMAP-Related Households	38
Income Changes Reported on Review Forms from Other Programs	39
Acting on Changes	40
 ADDITIONAL SSI-RELATED CASE MAINTENANCE	 48
SSI-Related Eligibility Reviews	48
MEPD Case Maintenance	49
MEPD Reviews	49
Effect of Nonpayment of Premiums	50
Reinstating a Case Canceled for Failure to Pay Premium	52
Reopening a Case Canceled for Failure to Pay Premium	53
Premium Change for Current or Past System Months	54
Decrease a Premium	54
Increase a Premium	56
Refunds	57
New Members in SSI-Related Households	58
 FRAUD AND OVERUSE OF MEDICAID SERVICES	 59
Lock-In	60
Changing Primary Providers	61

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 FMAP-related and SSI-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 SSI-related or FMAP-related Medicaid.

The following sections explain requirements for:

- ◆ [Supplying information and verification](#).
- ◆ [Reporting changes](#).

Supplying Information and Verification

Legal reference: 42 CFR 435.916, 441 IAC 76.2(249A)

The client must supply complete and accurate information needed to establish ongoing eligibility. 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(b) and (c);
441 IAC 75.4(3)“c,” 75.57(1), 75.57(2), and 76.10(249A)

The client or someone acting on the client’s behalf must report the following and any other changes that affect eligibility:

- ◆ Changes in household membership.
- ◆ Medical or health insurance starting, changing, or ending.
- ◆ 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.
- ◆ 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.

FMAP-related clients must also report beginning or ending income of a client. This includes:

- ◆ The receipt of non-recurring lump sum income.
- ◆ The continuing receipt of recurring lump sum income in irregular amounts.
- ◆ Beginning to receive recurring lump sum income from a source from which another type of income is currently being received.

See 8-E, [Recurring Lump Sum](#), for more information.

Clients who are **not FMAP-related** must also report:

- ◆ Receipt of resources by a client.
- ◆ Changes in income of a client
- ◆ Receipt of a social security number.
- ◆ Becoming incapacitated or disabled or recovering from incapacity or disability.

SSI-related clients and **members eligible for Medically Needy** must also report:

- ◆ Unmet medical bills.
- ◆ A change in health insurance premium expense, including completion of buy-in.

Members receiving **home- and community-based services** must also report residency in a medical institution for other than respite care for more than 15 days.

Clients may report changes in person, by telephone, or by mail. Give clients form 470-0499, *Ten-Day Report of Change*:

- ◆ At the time of review.
- ◆ When requested by the client.
- ◆ When the client submits the form to the local office and needs a new one.

Members and people being added to the existing eligible group 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.

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.

CHANGES IN HOUSEHOLD CIRCUMSTANCES

Legal reference: 441 IAC 76.10(5); 42 CFR 435.120, 42 CFR 435.919

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](#).

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.

Mrs. R and her three children receive Medicaid under FMAP. 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 failure to return requested information. However, because the infant is in "newborn status," the newborn's Medicaid is not canceled.

See also [ADDITIONAL FMAP-RELATED CASE MAINTENANCE: Adding a New Member to an Existing FMAP-Related Case](#) and [Other Changes in the Household](#), for additional procedures specific to FMAP-related households.

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A), 75.52(4)

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

Legal reference: 42 CFR 435.945, 435.948, 435.955, 441 IAC 75.57(9) & 76.12

In addition to changes reported by the household, information that might affect eligibility is also available from reports generated through the Income and Eligibility Verification System (IEVS) and other sources. Check the description of each report that follows in this section and see [14-B\(4\)](#), [14-E](#), and [14-G](#) for more details.

When you receive IEVS information, act on the report as follows:

1. Determine if the client reported the information and if you have already acted on it. If so, note and date this on the IEVS report and file it in the case record.

Exception: Do not file the *SSA Earnings and Pension Report*, S470X425-A, or the *IRS Match Report*, S470X615-A, in the case record. If you have already acted on the information in these reports, note and date this in a narrative in the case record.

2. Act on information received from IEVS that was not previously reported by the household within 30 days from the date printed on the report. Check the description of each report 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, note this on the IEVS report, date it, and file it in the case record.

Exception: Do not file the *SSA Earnings and Pension Report*, S470X425-A, or the *IRS Match Report*, S470X615-A, in the case record. If the income on these reports does not affect past, current, or future eligibility, note and date this in a narrative in the case record.

4. If the IEVS information affects eligibility, do an automatic 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 75.57(2) & (2)“f”

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, 435.953(c), 441 IAC 75.57(1)“f”

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(a)(3), 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.

IEVS Earnings and Pension Report (IRS)

Legal reference: 42 CFR 435.948, 435.952, 435.953, 435.955, 441 IAC 9.10(4)“c”

Use the information on the *SSA Earnings and Pension Report*, S470X425-A, as an indicator of the wages and pensions. Consider the information unverified. **Do not file this report in the case record.**

IEVS Internal Revenue Service Report (IRS)

Legal reference: 42 CFR 435.948(a)(2) & (4), 441 IAC 9.10(4)“c”

Use the information on the *Internal Revenue Service Report*, S470X615-A, as an indication of earned and unearned income. Consider this information unverified. **Do not file this report in the case record.**

Iowa Central Employee Registry (ICER)

Legal reference: 42 CFR 435.948(a)(6) & (e), 441 IAC 9.10(4)“a” & “b”

The ABC system runs a daily match with the ICER system. If there is a match for a person connected with a Medicaid case, a tickler message will appear on the BINC screen. See [14-B\(4\)](#) for details regarding the BINC screen.

If the tickler message indicates employment that was not reported, contact the person to verify information. Do not take any case action based solely on data taken from the ICER match.

Child Care Assistance: CCA Warrant Report

Legal reference: CFR 435.948(a)(6) and 435.952; 441 IAC 9.10(4)a, b, and c and 75.57(249A)

When a review form is due in the current month, the ABC system matches with other Departmental systems to identify state Child Care Assistance payment warrants mailed in the previous two calendar months to persons who receive Medicaid or whose income must be considered when determining the household's eligibility.

If a Child Care Assistance warrant is mailed to a Medicaid member, the member's name will appear on the report. This report is issued to the local office the first working day of each month. Consider the benefit amounts on this report verified income. Act on the information before the next month.

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, 435.955, 441 IAC 76.7(249A)

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, or the report alleges that:

- ◆ The client has a Medicaid qualifying trust.
- ◆ The information would affect eligibility for the Medicaid retroactive period.
- ◆ The client may have transferred resources to gain Medicaid eligibility.

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.

AWARE Hotline Referrals

Policy:

The Income Maintenance Customer Service Center (IMCSC) tracks fraud complaints from the Anti-Welfare Abuse Recognition Effort (AWARE) hotline.

Procedure:

When the hotline receives a fraud complaint concerning a DHS client:

1. IMCSC records the information about the complaint on form 470-4768, *Fraud Complaint Referral*.
2. IMCSC sends an electronic copy of the form to the IM worker for the case and to the worker’s supervisor and income maintenance administrator or designee.
3. The IM worker takes appropriate action on the information.

4. The IM worker documents on the form what action was taken and returns the completed form to the IMCSC.
5. IMCSC records the return date and the disposition of the complaint.
6. IMCSC maintains a record of hotline tips and compiles a monthly summary report that reports the status of hotline complaints received.

Death of a Member

Legal reference: 42 CFR 431.213

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](#).

Report of Incarceration of a Member

Procedure:

The ABC system runs a monthly match with the Social Security Administration to identify clients who are incarcerated. The match includes are Medicaid members and people whose income must be considered when determining the household's eligibility.

The *Prisoner Match Report*, S470X438-A, is available on the Mainframe Report Viewer by the 10th of the month. When a Medicaid member's name appears on the report, contact the household to verify the information on the report. Do not take any case action based solely on data taken from this match.

See 14-G, [Prisoner Match Report, S470X438-A](#), for details regarding this report. See 8-C, [Residents of Public Nonmedical Institutions](#), for information on public institutions and Medicaid eligibility.

REINSTATEMENT

Legal reference: 441 IAC 7.7(249A), 7.7(6); 75.51(249A)

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 [When Timely Notice Is Not Required](#) in 8-A.

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 Cancellation* or a *Notice of Decision* 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 75.51 (249A)

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 working 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.

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 cancellation, 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 “Remain Canceled” notice. 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.
- ◆ **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.

Comment:

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 or 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 November 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.

AUTOMATIC REDETERMINATION

Legal reference: 42 CFR 435.930(b), 441 IAC 76.11(249A)

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

Exception: Do not do an automatic redetermination 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.

When the member is eligible under a different coverage group, make system entries no later than the day before the effective date of cancellation from the previous coverage group. This will ensure the continuation of Medicaid assistance.

1. Mr. X, a 20-year-old receiving Medicaid under the CMAP coverage group, does not return requested information. He is not eligible for any other FMAP-related coverage group because he did not provide information necessary to determine Medicaid eligibility. Therefore, an automatic redetermination is not applicable. The worker sends timely notice canceling Medicaid.
2. Household composition: Ms. Q, aged 20; Mr. R, aged 27; and Baby A, newborn common child born January 6.

Ms. Q has been receiving Medicaid under the CMAP coverage group. Mr. R's income has not been considered in establishing Ms. Q's eligibility. Baby A has been receiving Medicaid on Ms. Q's case as the newborn child of a Medicaid-eligible mother.

On March 2, Ms. Q turns 21. The IM worker completes a redetermination to see if Ms. Q is eligible under another coverage group. Based on Ms. Q's income and resources, she is not eligible for Medicaid under any other coverage group unless Baby A loses newborn status and is considered in the household.

Ms. Q chooses to leave Baby A in newborn status, and Ms. Q's Medicaid benefits are canceled April 1. Baby A continues to be eligible as the newborn child of a Medicaid-eligible mother, even though Ms. Q is no longer eligible for Medicaid.

If an SSI-related person is no longer disabled, look for eligibility under FMAP-related Medicaid. If an FMAP-related person loses eligibility, check to see if the person is disabled for SSI-related Medicaid. "Disabled for SSI-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 SSI-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.

AUTOMATIC REDETERMINATION

Iowa Department of Human Services

Title 8 Medicaid

Revised December 11, 2009

Chapter G Case Maintenance

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 later than the first day of 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.

If you need additional verification before you can complete a redetermination, cancel the case using 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 Decision*.
- ◆ 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 Decision*.
- ◆ 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 Decision*, 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.

Mr. X is a 70-year-old SSI recipient. On June 5, the IM worker receives an SDX indicating Mr. X's SSI benefits would be canceled beginning July 1, because his countable resources exceed SSI eligibility limits. The worker contacts Social Security to find out the amount of Mr. X's resources. The resource information from Social Security indicates Mr. X is over resources for Medicaid.

The worker sends Mr. X the *Notice of Cancellation/Redetermination* on June 6, canceling Medicaid beginning July 1. On the notice, the worker requests that Mr. X provide verification of his resources. Mr. X has ten calendar days to return the requested verification. If Mr. X returns the requested information, the worker examines eligibility for other coverage groups.

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 SSI-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.

See the following chart for more specific information.

AUTOMATIC REDETERMINATION
Additional Information for SSI-Related Redeterminations
 Revised September 19, 2000

Canceled Group	New Location	New Aid Type	Information Needed
RCF	Home	SSI or automatic redetermination	Information for spenddown.
300% group or waiver	Home or home with dependent	Medically Needy	Information for spenddown. May be others in home who affect eligibility.
300% group	Home with in-home health-related care	In-home health-related care	Service report must be completed with service cost. Client must file an application for State Supplementary Assistance.
Would be eligible for SSI if not living in medical institution	Home	Eligible for but not receiving SSI cash assistance	Refer to SSI for application.
Would be eligible for SSI, if not living in medical institution	Home with dependent	Eligible for but not receiving SSI cash assistance	Take dependent person application. Refer to SSI for application.
SSI	Location not changed	Automatic redetermination	<p>First check eligibility for 503, disabled children who get parental social security, or widow/widower group. Check pregnancy status for women. Then get information and application if none on file.</p> <p>If over income or resources for SSI, verify resources and income with the Social Security Administration and complete the redetermination.</p> <p>If other reasons exist to lose SSI, cancel case, unless there is continuous eligibility or eligibility for postpartum women.</p>
300%, medical institution, waiver case, or any SSI eligibility	Psychiatric institution	Existing psychiatric institution aid types or QMB	Check age. If between 21 and 65, cancel case unless eligible for QMB or enrolled in the Iowa Plan (managed behavioral health care). Transfer case record to facility worker.

Canceled Group	New Location	New Aid Type	Information Needed
In-home health-related care	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.
Medically Needy	Medical institution	Medical institution 300%	30-day stay, deductions for CP, Case Activity Report, transfers of resources. New application if certification period expired. Use medical institution aid type for the date of entry to medical institution. If a spouse, reassess resources.
RCF	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.
Dependent person	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. Only aged, blind, or disabled remain eligible. Dependent loses eligibility. If a spouse, reassess resources.
Eligible for SSI but living in medical institution (income over \$45)	RCF	Not receiving SSI cash assistance	Applications for State Supplementary Assistance and SSI.
SSI recipient living medical institution	RCF	SSI	Application for State Supplementary Assistance.
300% group	RCF	Automatic redetermination	Application for State Supplementary Assistance. If not eligible, determine eligibility for medically needy.
SSI eligible, 503, widow, widower, disabled adult child, people who could get cash	Medical institution	Medical institution	Review form for SSI cases: deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.

Referrals to the *hawk-i* Program

Legal reference: 441 IAC 86.4(4)

Refer a child member to the *hawk-i* program as part of the automatic redetermination when the child:

- ◆ Is only conditionally eligible for Medically Needy with a spenddown, or
- ◆ Has been voluntarily excluded from the Medicaid eligible group due the income or resources of the child.

Note: Make referrals even if the child is insured. The *hawk-i* program staff will work with the family to coordinate the dropping of the child's health insurance and the *hawk-i* approval to provide seamless coverage.

Do not refer a child to the *hawk-i* program if the child:

- ◆ Is 19 years of age or older, or
- ◆ Does not meet Medicaid's alien requirements (they are the same for *hawk-i*), or
- ◆ Is ineligible for Medicaid due to noncooperation (failure to provide income verification, etc.).

Within one working day of determining that a child is ineligible for Medicaid, must meet a spenddown, or has been voluntarily excluded, refer the child to the *hawk-i* program by:

- ◆ Completing an electronic referral on the Automated Benefit Calculation (ABC) system, or
- ◆ Completing form 470-3565, *Referral to the *hawk-i* Program*. A copy of the notice of decision showing the income calculation establishing Medicaid ineligibility must accompany the referral form. Fax the referral and notice of decision to 515-457-7701, or send them to:

The *hawk-i* Program
P. O. Box 71336
Des Moines, IA 50325-9958

ADDITIONAL FMAP-RELATED CASE MAINTENANCE

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

- ◆ [Reporting forms](#)
- ◆ [Eligibility reviews](#)
- ◆ [Adding a new member to an existing FMAP-related case](#)
- ◆ [Other changes in the household](#)
- ◆ [Budgeting for ongoing eligibility](#)

Reporting on a RRED or Quarterly Report

Legal reference: 42 CFR 435.916, 441 IAC 75.52(249A)

Members must complete form 470-2881 or 470-2881(S), *Review/Recertification Eligibility Document*, for an annual review. Exception: See 8-J, [Recertifications](#), for requirements for members of FMAP-related Medically Needy assistance.

Members on transitional Medicaid must complete form 470-2663 or 470-2663(S), *Transitional Medicaid Notice of Decision/Quarterly Income Report*. (For more information, see 8-F, [Transitional Medicaid: Requirements After Eligibility Is Established](#).)

The review RRED is automatically mailed to the member in the month before the review month. The form is due to be returned in the review month and is used to conduct the annual review. Members should receive it by the end of the month before the review month. For example, a review RRED sent to the member on August 30 is for an annual review in September to be effective October 1.

Also give a copy of the RRED to any member who asks for one, along with a postage-paid return envelope. When you manually issue a form, you must complete the identifying information on the top of the form before giving it to the member. You can also issue the form by making entries on the computer system.

When the Department issues the review RRED in the regular end-of-month mailing, the member must return the form by the fifth calendar day of the review month. (If this day falls on a weekend or holiday, forms must be returned by the next working day following the fifth calendar day.)

When the form is issued outside the regular end-of-month mailing, the member must return the form by the seventh day after the date the form is mailed. Day one of the seven-day period is the day after the day the RRED is mailed. (If the seventh day is a weekend or holiday, the form must be returned by the first working day following it.)

When the form is issued and a due date established, issuing a replacement form at the member's request does not change the due date.

The following sections give more information on:

- ◆ [Requirements for a complete report.](#)
- ◆ [Procedures when a household fails to return a complete report.](#)

Requirements for a Complete Report

Legal reference: 441 IAC 75.1(31)“h” and 75.52(4)

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 and date the form.
 - When both parents or a parent and stepparent are in the home, **either** may sign for the household, even if temporarily absent.
 - A member's authorized representative or someone acting responsibly for the member may sign when the member is incompetent or incapacitated and unable to do so. See 8-B, [Responsible Person](#).
 - 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.

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.

Place a copy of all verification supplied by the recipient in the case record. Return all verification to the recipient. Do not keep originals unless specifically for the Department.

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 RRED to be considered complete.

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.

A complete quarterly report is due by the 21st of the review month unless good cause exists.

If a Household Fails to Return a Complete Report

Legal reference: 441 IAC 75.1(31)“i”(1), 75.52(4)“b”

Under quarterly reporting, eligibility is dependent upon the recipient returning a complete quarterly report by the 21st of the month. If a system-generated quarterly report is received before the 21st of the month, code it on the system as received.

If a system-generated quarterly report is not coded as received, form 470-2716, *Quarterly Report Reminder*, is issued at MRTL cutoff notifying the recipient that a complete quarterly report must be received no later than the 21st of the month unless good cause exists.

If the report is received incomplete, send form 470-2721, *Quarterly Report Follow-Up*, to notify the recipient of what needs to be done to make the report complete and that a complete report must still be received by the 21st of the month. Mail the *Quarterly Report Follow-Up* as soon as you are able, allowing the recipient as much time as possible to return a complete quarterly report by the 21st.

Cancel transitional Medicaid effective the first of the seventh month, the eighth month, or the eleventh month when a recipient fails to return a completed quarterly report, as defined under [Requirements for a Complete Report](#). If a complete quarterly report is not received by the 21st of the month, an adequate notice is issued at cutoff closing the transitional Medicaid effective the first of the next month.

If the quarterly report is received between the 21st of the month and the effective date of cancellation, transitional Medicaid remains canceled unless the recipient has good cause. However, complete an automatic redetermination.

Cancel Medicaid for all household members if a recipient fails to return a completed RRED as defined under [Requirements for a Complete Report](#).

The system generates form 470-1968, *Notice of Cancellation* (NOC), whenever a RRED is not returned timely, or you do not make entries indicating a complete report was received. However, **you** must send the NOC when:

- ◆ The form is returned timely but is incomplete, or
- ◆ The recipient fails to return an out-of-cycle report form.

Return an incomplete report form along with the *Notice of Cancellation*, telling the recipient that the report form was received incomplete. Mark any incomplete sections in red. (Do not attach the form if verification is the only information needed.)

Mail the *Notice of Cancellation* within five working days after you receive the incomplete report form. Keep a copy of the report form if you return it to the client for correction.

Allow the client ten days after the date the *Notice of Cancellation* is mailed to complete and return the form. The date that the *Notice of Cancellation* was sent is day “one” of the ten days. Remember, when the tenth day falls on a weekend or legal holiday, you must allow the client until the next working day to return the form.

If the complete form is returned within ten days and eligibility is determined, reinstate the case. See [REINSTATEMENT](#) earlier in this chapter for more information.

If after receiving the *Notice of Cancellation*, the client submits an incomplete form within the time limits for reinstating assistance, return the form to the client. Attach a letter to the form indicating which sections are incomplete and explaining that Medicaid cannot be reinstated because of the incomplete form. List the manual references for the policy.

Do not send a second *Notice of Cancellation*, form 470-1968, or a *Notice of Decision*, form 470-0485 or 470-0486. Use a letter rather than a *Notice of Cancellation* or *Notice of Decision*, because the client’s appeal period begins when a notice is sent out, and a *Notice of Cancellation* was already sent when the client didn’t turn in the report form by the due date.

1. Ms. C receives a computer-issued *Notice of Cancellation* because her RRED was not received by May 5. On May 27, the worker receives the incomplete form. The worker returns the RRED to Ms. C no later than June 4, with a letter explaining that eligibility requirements are not met. Neither a second *Notice of Cancellation* nor a *Notice of Decision* is issued to Ms. C. She must reapply.
2. Mr. D receives a *Notice of Cancellation* attached to his incomplete RRED on June 8. The worker receives the RRED, still incomplete, on June 29. The worker returns the incomplete RRED to Mr. D with a letter explaining that eligibility requirements are not met. Neither a second *Notice of Cancellation* nor a *Notice of Decision* is issued to Mr. D.

FMAP-Related Eligibility Reviews

Legal reference: 42 CFR 435.916, 441 IAC 76.7(249A)

Policy:

Review each FMAP-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](#).

Schedule the annual Medicaid eligibility review to match the Food Assistance recertification date. Use form 470-2881, *Review/Recertification Eligibility Document* (RRED), for annual reviews. **Exception:** When the client has completed form 470-0462 or 470-0462(S), *Health and Financial Support Application*, for another purpose, it can be used as the review document.

An interview may be scheduled by written notice to the head of household when the client requests an interview or you believe that an interview is needed. **Note:** When there are only children in the eligible group, a review of eligibility factors is required, but an interview **cannot** be required.

Send a written request for information along with the appointment letter. If the information is not returned within ten days, you may cancel the children's Medicaid because the parents did not return the requested information required for the review.

When the adults in an eligible group that also contains children fail to attend an interview, cancel Medicaid for the adults only. Complete an automatic redetermination for the children.

Give the following information at the time of review:

- ◆ Comm. 233 or Comm. 233(S), *Rights and Responsibilities*
- ◆ Comm. 4, *Care for Kids*
- ◆ Comm. 132 or 132(S), *Family Planning Counseling*
- ◆ 470-0499 or 470-0499(S), *Ten-Day Report of Change for FIP and Medicaid*
- ◆ *Voter Registration* form

You may require an interview to discuss questionable information even if it is not time for an annual review. If the parents fail to show up for the interview, you may cancel them for not attending. Do not cancel Medicaid for the children solely for the parents' failure to appear at the interview.

Comments:

The FMAP household consists of Mr. and Mrs. D and their two children. Mr. D reports that Mrs. D has moved out of the home. Mrs. D is removed from the eligible group. However, the Ds have split up in the past and the children have always stayed with Mrs. D.

The worker finds the household composition questionable and makes an appointment for Mr. D to come into the office. Mr. D does not show up for the scheduled appointment, nor does he reschedule. The worker sends a *Notice of Decision* canceling Mr. D for failure to attend the interview. However, the children remain active under CMAP or MAC since an interview is not an eligibility factor for children.

The worker now sends a written request to determine household composition. If this information is not received by the due date, the children will remain continuously eligible until the eligibility 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 client returns an incomplete *Voter Registration* form, contact the recipient to get a completed form. If the client chooses not to check “yes” or “no,” leave the section blank and accept that the client has chosen not to register to vote. If the client chooses not to sign the form, print the client’s name and the date where indicated, and initial the form.

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

See [6-Appendix](#) for office procedures regarding processing the forms.

Adding a New Member to an Existing FMAP-Related Case

Legal reference: 441 IAC 76.1(5)

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

- ◆ New household members.
- ◆ Responsible relatives.
- ◆ People who were previously voluntarily excluded.
- ◆ 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. Ms. C’s two children are receiving Medicaid under MAC. Ms. C has asked that she be added to the Medicaid case. Income has not decreased. However, Ms. C’s 20-year-old son returns to the home and also needs medical assistance. First determine the family’s eligibility under CMAP as a household of four with Ms. C as a considered person.

If the household is over income for CMAP, the two younger children remain eligible for MAC, with Ms. C as a considered person. The 20-year-old can receive Medicaid under CMAP as a household of one if otherwise eligible. Medically Needy eligibility is determined for Ms. C as a household of four. The three children are considered on the MN case. A paper application is needed for the Medically Needy determination.

3. 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 and her children are determined eligible for FMAP. No paper application is necessary, because Ms. C is being added to an existing FMAP-related eligible group. 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 FMAP or FMAP-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 an NOD 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 76.1(2), 76.1(5), 76.5(2)

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.

Exception: When a household requests to add a previously voluntarily excluded person to the Medicaid-eligible group, add this person effective the first day of the month following the month that the household requests that this person be added.

Person Being Added	Date of Application	Effective Date of Eligibility
Household member who is in the home (unless voluntarily excluded)	Date of report.	Add the person effective as of the first day of the month in which eligibility is established.
	<p>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.</p> <p>2. On May 5, Ms. B reports that she got married to Mr. C on May 2. Mr. C is not the father of the FMAP child and is not a mandatory member of the eligible group.</p> <p>On June 5, Mrs. C (formerly Ms. B) reports that her husband was in an accident, and requests to add Mr. C to her case as an incapacitated stepparent. Since Mr. C is an optional household member, the date of application is June 5. The effective date is June 1.</p>	
Person who will join the household (anticipated)	Date of report.	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.
	Ms. D and her child receive FMAP. 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.	
Person who lost their Medicaid eligibility because they failed to cooperate	Date the person indicates willingness to cooperate (e.g., cooperate with Third Party Liability or HIPP).	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.

Person Being Added	Date of Application	Effective Date of Eligibility
Person previously sanctioned due to failure to cooperate with CSRU	Date the person indicates willingness to cooperate.	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.
	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.	
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 FMAP. 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 75.1(28)“a”; 75.57(249A); 75.58(249A)

The income of people added to the eligible group is counted prospectively. See [Budgeting for Ongoing Eligibility for FMAP-Related Households](#) in this chapter and also 8-E, [Budgeting for FMAP-Related Households](#), for more information.

When the person being added was a recipient for the immediately preceding month, complete a new projection of future income. Do not use the amount projected for months before the person is added to the existing eligible group.

Mrs. A receives FMAP for herself and two children. They have no income. On May 2, Mr. A, who had been a Medicaid recipient in another eligible group 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 eligible group, his income from part-time employment during the 30-day period before May 2 was \$250. This income is expected to continue at the same rate.

The worker projects \$250 monthly income for the new eligible group. The total May income is compared to the gross income level for four people. The income is under 185% of the Standard of Need test for four people. The Schedule of Basic Needs test is determined by allowing the 20% earned income deduction and the 58% work incentive deduction.

\$ 250.00	Mr. A’s income
- 50.00	20% earned income deduction
\$ 200.00	Income before work incentive deduction

\$ 84.00	Mr. A’s income after application of the 58% work incentive deduction is compared to the \$495, the schedule of basic needs for four people
----------	--

Eligibility for FMAP exists. Mr. A is added to the eligible group effective May 1.

The date of change depends on whether the new person is required to be a member of the eligible group or is an optional member of the eligible group.

Optional household members include:

- ◆ An incapacitated stepparent.
- ◆ A needy specified relative.
- ◆ A needy specified relative who acts as caretaker when the parent is in the home but unable to act as caretaker.
- ◆ A nonincapacitated stepparent required in the home to care for the dependent children while the FMAP parent works if it would be necessary to allow child care as a deduction if the stepparent were not available.

1. Mrs. A is an FMAP recipient with one child. On March 10, Mr. A, the father of the child, enters the home. Mrs. A reports the change the same day. Mr. A is disabled and receives social security benefits.

Since Mr. A's return was reported on March 10, March 1 is the effective date of assistance for Mr. A. However, because the family has difficulty in obtaining verification of Mr. A's income, the worker is not able to make a decision on the application until March 23.

Because of Mr. A's income, the family is now over income, even with Mr. A's needs included. The application to add Mr. A is denied. The worker issues timely notice to cancel the family's FMAP effective May 1 and informs the family that the child is eligible for MAC and Mr. and Mrs. A now have a spenddown under Medically Needy.

Mr. A is also conditionally eligible for Medically Needy for March and April with Mrs. A and their child as considered people, since they are already receiving Medicaid.

March is considered the month of change, since Mr. A, a mandatory member of the eligible group, returned to the home in that month. No overpayment exists for April, because the family reported the change timely and provided the information timely.

2. On March 1, Ms. B reports that Bobby, a half-brother of Ms. B's other children, entered her home on February 28. Ms. B will receive social security benefits on Bobby's behalf beginning in March.

Bobby's social security benefits do not make the household ineligible. Bobby is issued a medical assistance eligibility card for March. Retroactive eligibility is determined for the month of February.

3. On February 27, Mrs. C marries Mr. D, who enters the home the same date. There are no common children. Mr. D receives social security benefits. On March 2, the family requests to add Mr. D to the eligible group.

The social security benefits that Mr. D receives do not make the family ineligible for Medicaid. The effective date of assistance for Mr. D is March 1. Retroactive eligibility is determined for the month of February.

Since Mr. D is an optional member of the eligible group, the date the family requested to add him to the eligible group (March 2), rather than the date of entry into the household (February 27), is the date of change. March and April are Mr. D's initial two months of eligibility.

4. Ms. E receives FMAP for herself and one child. On April 5, Ms. E's son, Joe, returns to the home. She reports the change that day. Since Joe's social security benefits do not create ineligibility for the household, he is added to the eligible group effective April 1, with April and May as the initial months.

On April 18, Ms. E's daughter, Jill, enters the home and Ms. E reports the change. Jill has no income. Jill is added to the eligible group effective April 1, with April and May as the initial months.

The system will perform the first calculation for Joe. However, the system will show Joe as already on the case and, therefore, cannot perform a second calculation for both Jill and Joe for April. This calculation must be performed manually.

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 natural father enters the household but paternity has not been established.](#)
- ◆ [A minor parent turns 18 or marries.](#)
- ◆ [A person on an active case becomes ineligible.](#)
- ◆ [A child goes into foster care.](#)

Returning Parent Not Eligible for Medicaid

Legal reference: 441 IAC 75.57(249A)

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 exempted, disregarded, or deducted for work expense. Also count the returning parent in the household size. Project income of the returning parent using either:

- ◆ The 30-day period before the return, or
- ◆ A longer period of time, if the income received during that period is not a good indicator of future income, or
- ◆ Verification of future income from the income source.

See [8-E](#) for how to treat income of ineligible parents. See [Determining the Income of People Added](#) when the returning parent is added to the FMAP-eligible group.

Natural Father Enters the Household

Legal reference: 441 IAC 75.14(2);76.5(249A); 76.10(5)

When a natural father enters an existing Medicaid household and paternity has not been established, request, in writing, that the client provide a signed statement from the father acknowledging paternity for a child in the eligible group.

Do not add the father to the eligible group before obtaining the statement (unless the case record already contains evidence of paternity, such as the father's signature on a previous application or a birth certificate listing the person as the child's father). The effective date of assistance is the first day of the month in which the report that the natural father entered the home was made, provided eligibility otherwise exists.

Attach a copy of the father's statement to a notarized form 470-2220, *Notarized Statement for Child Support Recovery Office*, and send both statements to CSRU. File the father's original statement and a copy of form 470-2220 in the permanent section of the case record. (See 6-Appendix for further details on form 470-2220.)

Cancel the existing case (subject to timely notice) if the requested paternity statement is not provided by the due date because the eligible group cannot be established without the statement. (Extend the due date, if applicable.) Also deny the application to add the parent, if the parent was requesting assistance.

If the statement is received in time for reinstatement, reinstate the existing case. Since the application to add the parent was denied, the date the statement is received is the new date of application to add the parent to the eligible group.

Minor Parent Turns 18 or Marries

Legal reference: 441 IAC 75.57(249A); 76.5(249A); 76.10(5)

Exempt the income of the self-supporting parents of a minor (unmarried, underage) parent who marries or turns 18 (regardless if the minor parent is in high school and expected to complete the curriculum before age 19).

The exemption is effective the first day of the month following the month that the parent turns age 18 or marries. When the parent turns age 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

1. Ms. A, an FMAP recipient and a minor parent, lives with her self-supporting parents. She turns age 18 on July 5. The income of her parents that is attributable to her becomes exempt beginning with the month of August.
2. The same situation as Example 1, except that Ms. A turns age 18 on July 1. Her parents' income becomes exempt beginning with the month of July.
3. Ms. B, aged 17, lives with her self-supporting parents. On July 3, she marries. Her parents' income becomes exempt beginning with the month of August.
4. Ms. K and her child live with her self-supporting parents. Ms. K will turn 18 on June 23. On June 4, she applies for Medicaid. Her parents' income is used to determine Ms. K's eligibility for June. Her parents' income will no longer be used beginning with the month of July.

Person Becomes Ineligible for Medicaid

Legal reference: 441 IAC 75.57(9)

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.

If the person is a parent of a child in the eligible group 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 eligible group, the person is no longer counted in the household size, even if the person continues to reside with the household.

When there is a period of proration, a nonrecurring lump sum received by a person who has left the home continues to be counted, unless the income is no longer available to the eligible group. See [8-E](#) for policies relating to lump-sum income.

1. Child A leaves the household and is removed from the eligible group effective January 1. Child A's unearned income of \$40 per month is not counted when determining eligibility for the remaining members of the eligible group beginning with the month of January.
2. The Medicaid household consists of Mr. and Mrs. B and Mrs. B's two children from a previous relationship. Mr. B is an incapacitated stepparent and a part of the FMAP eligible group of four.

At the yearly review, the worker checks on Mr. B's incapacity. The doctor has determined that Mr. B is no longer incapacitated. Mr. B's Medicaid is canceled effective the first of the next month allowing a 10-day notice. The FMAP eligible group reduces from a household size of four to a household size of three.

3. Mr. and Mrs. C and their child receive Medicaid under FMAP. In April, Mr. C receives a retroactive nonrecurring lump-sum benefit of \$8,490, which is timely reported and verified. The period of proration is ten months beginning with May ($\$8,490 \div \849 Standard of Need = ten months). Mr. and Mrs. C are conditionally eligible under Medically Needy and their child is eligible under MAC.

Mr. C moves out of the home in July. He leaves the lump sum in a bank account available to Mrs. C. The same period of proration continues. Since Mr. C did not take any portion of the lump sum with him, it is still available to the eligible group.

4. Mr. and Mrs. D receive Medicaid under FMAP 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. Therefore, Mr. D's income and needs are used in determining eligibility for Mrs. D and the children.

5. Mr. and Mrs. Q receive Medicaid under FMAP 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. Because Gary is not a parent, he cannot be a member of the eligible group. The household size is reduced to a three-member group. Gary's income and resources are not used in determining eligibility for Mr. and Mrs. Q and Bob.

Child Goes into Foster Care

Legal reference: 441 IAC 76.1(5), 76.5(2)

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 eligible group.

1. Mrs. A receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 2. Notice is issued to cancel the case effective August 1, as Mrs. A is not eligible under any other coverage group.

The worker establishes a foster care Medicaid case with an FBU of 19 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 original case is reinstated.

2. Mrs. B receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 25. Since it is too late to cancel for August, the case is canceled effective September 1.

The worker establishes a foster care Medicaid case with an FBU of 19 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 original case is reinstated.

3. Mrs. C receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 17. The case is canceled 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. Mrs. C calls the local office on August 15 and asks to be added for Medicaid. Eligibility begins August 1.

Budgeting for Ongoing Eligibility for FMAP-Related Households

Legal reference: 441 IAC 75.13(1), 75.57(249A), 75.58(249A)

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, in writing, verification of the change. 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 FMAP. 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 completes a new projection of income based on the increase in Ms. I's hourly rate. The new income projection is used beginning with the month of October.

Income Changes Reported on Review Forms from Other Programs

Some FMAP-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 FMAP-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 FMAP-related Medicaid. Allow the income used for eligibility the previous month to roll forward.

1. Mr. and Mrs. J apply for Medicaid and Food Assistance on May 3. They request Food Assistance 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 Food Assistance, 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 FMAP in addition to FIP and Food Assistance. 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 FMAP-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 FMAP-related Medicaid.

Acting on Changes

Legal reference: 42 CFR 435.911(b) & (c), 435.916(1)(c) and (2), 435.919, 435.930, 435.948, 435.952, 435.953, 441 IAC 76.10(5); 76.11 (249A), 75.52(5)

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.

Change Reported	Effect on Eligibility	Effective Date	Do a Recoupment or Adjustment?
Timely reporting for members is within ten days after the change occurred.			
Timely	Positive	The month following the month the change is reported . Timely notice is not required.	No, if the Department acted timely.
	Negative	The month following the month change is reported . Timely notice is required.	No, if the Department acted timely.

Change Reported	Effect on Eligibility	Effective Date	Do a Recoupment or Adjustment?
Timely reporting for members is within ten days after the change occurred.			
Not Timely (or not at all)	Positive	The month following the month the change is reported or became known. (Do not adjust benefits back to when the change occurred.)	No, if the Department acted timely.
	Negative	The month following the month the change occurred , regardless of when the change occurred or became known.	Yes, if benefits were received incorrectly. Redetermine eligibility beginning with the month following the month of the change. Lump-sum proration begins the month of receipt; therefore, so does recoupment.
Not Required to be Reported Until Annual Review	Positive	The month following the month the change is reported.	No, if the Department acted timely.
	Negative	The month following a timely notice.	No, if the Department acted timely.

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](#).

- ◆ When a lump sum is not timely reported, the recoupment begins the month when the lump sum was received, because the proration begins with the month of receipt. See 8-E, [Period of Proration](#).
- ◆ 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 FMAP 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 FMAP. 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 FMAP until the annual review. If the children are no longer eligible at the annual review due to income, they are referred to *hawk-i*.

3. Negative Change Timely Reported:

Ms. G and her children receive Medicaid under FMAP. 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 FMAP 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 referred to *hawk-i*.

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

Mr. F's children receive Medicaid under MAC. 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 FMAP. 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. The children's case is changed to CMAP with Mr. F as a considered person.

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 and for the retroactive period of May, June, and July. Mr. F is not eligible for Medicaid for February, March, and April because he requested Medicaid in August.

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

Ms. C and her children receive Medicaid under FMAP. 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 FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

6. Required to Be Reported Only at Annual Review But Reported Earlier:

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.

Although the change was not required to be reported until the annual review, since it was reported, 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, although a TM notice is issued.

No claim is established, since Mr. G was not required to report the increase in income until the annual review.

7. Reported at the Annual Review as Required:

Mr. J and his children are approved for Medicaid under FMAP in November. In December, Mr. J goes from part-time employment to full-time employment at the same company. Mr. J reports this at his annual review in October.

The increase in income makes the family over income for FMAP. They are eligible for transitional Medicaid (TM) beginning November 1.

No claim is established, since this was not a new job but an increase in income and it was not required to be reported between annual reviews.

Had Mr. J changed employers, he would have been required to report the new job since it is stopping and starting income.

8. 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 FMAP. 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.

If Mr. K wants retroactive coverage, his eligibility would have to be determined under another coverage group because he did not live with Ms. K and the children.

9. 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 FMAP. 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 FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

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.

10. **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 FMAP. 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 FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

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.

Exception: When a lump sum is not timely reported, the recoupment will begin the month the lump sum was received. See 8-E, [Period of Proration](#).

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 though 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 June 1.

ADDITIONAL SSI-RELATED CASE MAINTENANCE

This section contains information for SSI-related cases on:

- ◆ [Eligibility review](#)
- ◆ [MEPD case maintenance](#)
- ◆ [New members in SSI-related households](#)

SSI-Related Eligibility Reviews

Legal reference: 441 IAC 76.7(249A)

Policy:

Eligibility shall be reviewed at least once every 12 months for all SSI-related cases when:

- ◆ No member receives SSI or only a blind or mandatory State Supplementary Assistance payment, or
- ◆ The member who receives SSI or a blind or mandatory State Supplementary Assistance payment has a trust in which income and resources are treated differently for Medicaid eligibility than for SSI eligibility.

The member shall complete form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS), *Medicaid Review*, for the annual review.

Procedure:

Evaluate the information on the *Medicaid 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. Do not require an interview for cases on which only children receive Medicaid.

MEPD Case Maintenance

Legal reference: 441 IAC 75.1(39)“b”(1)

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 Automated Benefit Calculation (ABC) system issues a *Medicaid Review*, form 470-3118 or 470-3118(S) to the member at the end of the eleventh month of the premium period. After the *Medicaid Review* is returned, use the *MEPD Income Worksheet*, form 470-3686, to determine income eligibility and the premium. Keep a copy of the worksheet in the case file.

If the income calculation on the *MEPD Income Worksheet* shows the household is ineligible because its income is over 250% of the federal poverty level, then cancel the MEPD case.

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 ABC 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 ABC system after cutoff require MEPC entries to revise the premium for the next month.

Specific MEPD review entries must be made in order for the premium to be correctly assessed. The entry in the LAST REV field on ABC's TD05 screen must be the first month of the new 12-month enrollment period, and the entry in the NEXT REV field must be the twelfth month. For example: LAST REV of 07/09 and NEXT REV of 06/10. For entry instructions, see 14-B(9), [MEPD Annual Review](#).

Verify that the premium amount shown on the *MEPD Income Worksheet* is the same as the premium amount shown on the review *Notice of Decision (NOD)*. If the premium amount is not the same, resolve the discrepancy before approving the NOD.

Comment:

Ms. T is approved for MEPD with a zero premium. A *Medicaid Review* form was issued to her in the eleventh month of her 12-month enrollment period. Ms. T does not return the *Medicaid Review* form, so the ABC system cancels her MEPD case with timely notice at the end of the twelfth month.

The worker receives the *Medicaid Review* form on the last day of the twelfth month. The worker enters the income in the *MEPD Income Worksheet* and determines that Ms. T is still under the MEPD income limits and her premium is \$25.

The worker uses entries of ENTRY RSN "C" and STATUS "C" to reopen the case. The ABC system does not allow an increase in the premium amount with reopening entries, so the premium stays at zero. The worker notes the premium discrepancy and chooses not to issue the NOD. Instead, the worker changes the reopening RSN1 code to 000.

After the reopening entries update, the worker makes the MEPD annual review entries and issues an NOD showing the correct premium amount for the next 12-month enrollment period.

Effect of Nonpayment of Premiums

Legal reference: 441 IAC 75.1(39)"b"(2) and (3)

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, standard procedures are as follows:

- ◆ When a payment is not recorded in the MEPD billing system by the 14th of the month, an e-mail “Warnings, Informational, Fatal and Summary” (WIFS) message is issued to the worker as notification that the MEPD case should be canceled.
- ◆ When payments are recorded after the due date, a WIFS message 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. A WIFS message is issued to his worker. The worker 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 a WIFS message 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, so a WIFS message is issued to the worker, and the worker 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. A WIFS message 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 due date.

Reinstating a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75.1(39)“b”(5)

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.

Procedure:

To reinstate an MEPD case, see entries in 14-B(9), [Reinstatement for Payment of MEPD Premium](#). Reinstatement entries must be entered correctly or the MEPD premium will not be correctly calculated.

A WIFS is issued to the worker because Mr. J didn't pay his June premium on time. The worker cancels Mr. J's MEPD case with timely notice effective July 1.

Mr. J makes a premium payment after the *Notice of Decision* is issued, but before June 30th. The premium payment is applied to the unpaid calendar month of June.

The worker receives a WIFS stating that an MEPD payment has been received and the worker reinstates the MEPD case.

The worker does not need to enter any changes in the MEPD billing system.

Reopening a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75.1(39)“b”(5)

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.

Procedure:

See 14-B(9), [Reopening Due to Payment of MEPD Premium](#), for entry instructions to reopen an MEPD case.

Ms. Z doesn't pay her June premium of \$29 on time, so the worker cancels her MEPD case effective July 1. An *MEPD Billing Statement* is issued on July 15 showing \$29 due for both June and July, and a zero premium for August.

Ms. Z makes a \$58 premium payment on July 16. The payment is applied to the unpaid month of June for \$29 and \$29 is held in CREDIT.

After receiving a WIFS stating that a payment had been received, the worker reopens the MEPD case. After the MEPD eligibility for July is reopened, the \$29 credit is applied to July.

The worker enters a request to create a statement on the CREATE STMT field on the MEPD system's STMT screen. The due date on that bill for a \$29 premium for August is August 14.

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 75.1(39)“b”

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 on the ABC system’s TD05 screen, or
- ◆ How income was determined.

Decrease a Premium

Procedure:

Reduce MEPD premiums effective the month following the month the lower income is reported. See 14-B(9), [Change to MEPD Premium](#). Send a *Notice of Decision* 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 on the TD05 screen **before** ABC 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 on the TD05 screen **after** ABC 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 the ABC system 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 *Medical Review* form that her earned income has decreased.

On March 30, the worker makes MEPD review entries on the ABC system TD05 screen 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. The worker follows the instructions in 14-B(9), [Change to MEPD Premium: Decrease](#), to use notice reason code 487.

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 on the ABC system TD05 screen, 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.

Increase a Premium

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 Decision* 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](#).
4. The billing system will issue a revised *MEPD Billing Statement* for the months corrected.
5. Contact the DHS SPIRS Help Desk to request the change to the higher ongoing premium. You cannot make entries on the ABC system to assess a higher premium during an enrollment period.

Ms. Z applies for MEPD. The worker enters gross income in the *MEPD Income Worksheet* with a resulting premium calculation below 150% of the federal poverty level. Ms. Z is approved for MEPD with a zero premium.

Two months later, it is discovered that disability pension income was reported on the application, but not entered on the ABC system's TD05 screen by the worker.

When the additional income is included with the other income on the *MEPD Income Worksheet*, Ms. Z remains under the 250% of the federal poverty level for eligibility, but she should have been assessed a monthly premium of \$29 when MEPD was originally approved.

Ms. Z is given the choice to have the premiums for the prior months recouped or to sign a statement that she agrees to accept the assessed premiums for the prior months. Ms. Z agrees to accept the higher premiums, signs a statement, and returns it to her worker.

The worker:

- ◆ Contacts the SPIRS Help Desk to request the higher premium amount for ongoing months. (The worker cannot increase the premium amount by entries on the ABC system for ongoing months in the 12-month enrollment period.)
- ◆ Follows the MEPC instructions to increase the premium for the current and past months.
- ◆ Manually-issues a new *Notice of Decision* stating the higher premium amount and the months involved.

After the MEPC entries update, a revised *MEPD Billing Statement* is issued.

Refunds

Legal reference: 441 IAC 75.1(39)“b”(6)“5”

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 SSI-Related Households

Legal reference: 441 IAC 76.1

For SSI-related Medicaid purposes, the “eligible group” concept and “adding a new member to an eligible group” do not apply in the same way as for FMAP-related cases. Rather, except for eligible married couples, SSI-related cases are based on an individual’s eligibility.

SSI-related Medicaid eligibility for unmarried persons is determined individually rather than as an “eligible group.” Therefore, a new member may not be added to an unmarried person’s SSI-related Medicaid case. **Note:** A newborn child of an SSI-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.

SSI-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 SSI-related Medicaid. When two SSI-related members marry, determine their ongoing eligibility as a couple in the month following the month of marriage.

When an SSI-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 SSI-related Medicaid.

When an SSI-related member is living with a spouse who turns 65 or becomes blind or disabled, the spouse must file an application to begin receiving SSI-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 an SSI-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 76.9(7) and (8)

The Iowa Medicaid Enterprise (IME) Medical Services Unit reviews health care provided to Medicaid members and determines overuse or misuse of medical services. “Overuse of medical services” is defined as receipt of treatments, drugs, medical supplies, or other Medicaid benefits from one or multiple providers in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the member.

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, report the situation to the IME Medical Services Unit at 1-800-383-1173 or in Des Moines at 515-256-4623. Ask for the person who handles lock-in issues. You will need the member’s name and state identification number.

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.

Lock-In

Legal reference: 441 IAC 76.9(2), (4)

The IME Medical Services Unit reviews referrals from DHS workers and data gathered through the Surveillance and Utilization Review System (SURS) to search for records indicating overuse of Medicaid services.

If the IME Medical Services Unit determines that a member is overusing services, the member may be restricted or “locked in” to receive services from designated providers for at least 24 months. The purpose of the lock-in program is to:

- ◆ Promote high quality health care.
- ◆ Prevent harmful practices such as duplication of services, drug abuse, and possible drug interaction.

Once a member has been identified as overusing medical services, a nurse reviewer from the IME Medical Services Unit sends an educational letter to the member outlining appropriate ways to use medical services. The letter also includes the contact numbers (1-800-383-1173 or in Des Moines at 515-256-4623) the member may call to discuss concerns or questions about health care services with a nurse review coordinator.

If it is determined that the member had duplicated medications or services, that member’s claims are reviewed again in six months. A physician reviewer makes the final determination that the member is overusing or misusing Medicaid medical services and that the member would benefit from the restrictions of the lock-in program.

After the lock-in determination, an IME Medical Services Unit nurse reviewer notifies the member of the lock-in restrictions. The member then has the opportunity to choose a primary provider, pharmacy, hospital, and special physicians to meet the member’s needs. If the member does not select providers, the IME Medical Services Unit will select the restricted providers.

The lock-in program is not intended to limit the member’s free choice of a provider or to apply to situations where the primary physician refers the member to a specialist requiring office visits, such as a surgeon, internist, or obstetrician. When the member has reason to receive regular care from more than one physician, more than one physician can be designated as primary.

Providers must check the Eligibility Verification System to determine lock-in status. If you have any questions about lock-in or member health education (MHEP), contact the IME Medical Services Unit at 1-800-383-1173 or in Des Moines at 515-256-4623.

Changing Primary Providers

Legal reference: 441 IAC 76.9(249A)

Members in the lock-in program can change their primary provider only if:

- ◆ The provider or member moves.
- ◆ The provider no longer participates.
- ◆ The provider refuses to see the member.

See 6-Appendix for instructions on how to change a member's provider using form 470-1945, *Change of Primary Provider*. A change in provider can be effective only at the beginning of a month. When care is needed and the former primary provider is not available, the change is effective the date the member makes the request and is approved.