STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

April 5, 2024

GENERAL LETTER NO. 8-I-86

ISSUED BY: Iowa Medicaid

SUBJECT: Employees' Manual, Title 8, Chapter I, ***Medical Institutions***, 29, 32-36, 41 and 42, 45 and 46, 48-52, 54-56, 58 and 59, revised.

Summary

This chapter is revised to

- Provide the 2024 minimum monthly maintenance needs allowance (MMMNA) in the amount of $3,853.50 and update examples.
- Update the amounts that represent 125 percent of the statewide average charges for care in facilities. Use these amounts to determine if a person with a medical assistance income trust (MAIT) qualifies for facility payment.

Effective Date

January 1, 2024.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter I, and destroy them:

Page	Date
29, 32-36, 41 and 42, 45 and 46, 48-52, 54-56, 58 and 59	April 14, 2023

Additional Information

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

- If a waiver member or programs for all-inclusive care for the elderly (PACE) enrollee moves to a nursing facility, do not recalculate client participation. Apply any client participation that was not used for waiver services or PACE to the first partial month of facility care.
- If the member was in a residential care facility (RCF) and received State Supplementary Assistance, deduct the amount paid in client participation to the RCF. Follow these same guidelines for members of in-home health-related care.
- If the member was in a RCF but did not receive State Supplementary Assistance, allow a deduction for home-maintenance living expense up to the amount of the SSI benefit for a single person.
- If the member was in a family-life home, deduct the amount paid to the home for client participation.
- If the member was in foster care, deduct the amount of the income retained by the Department to recover foster care expenses.

In April, Mr. L enters skilled care and Mrs. L enters nursing care. Their gross monthly income is $272 for Mrs. L and $430 for Mr. L. They state that they have home maintenance expenses of $1,500 and are allowed a deduction equal to a couple's SSI benefit of $1,415 for the month of entry.

The Ls' combined gross income is $702. Each spouse is allowed a $50 personal needs allowance. The personal allowances and the deduction for living expenses for the month of entry are subtracted from that gross income. ($702 – 50 – 50 – 1,415 = 0)

Personal Needs in the Month of Discharge

Legal reference: 441 IAC 75 (Rules in Process)

The member is allowed an additional personal needs deduction in the month of discharge from a medical institution to a private living arrangement, unless the member has a community spouse. A member does not need to make any declaration of expenses to get this deduction. Deduct the SSI benefit for a single person (or the SSI benefit amount for a couple if both spouses are discharged in the same month).

If member moves from a nursing facility to a HCBS waiver program or programs for all-inclusive care for the elderly (PACE), recalculate the nursing facility client participation. Allow a home maintenance deduction for the month of discharge, even if the member is going to receive waiver or PACE services during the month.

If the member is discharged and returns home and the spouse at home is an HCBS waiver member or PACE enrollee, allow a diversion to the waiver or PACE spouse at home. (See Allowance for the Community Spouse.)

Allow the deduction even if you are informed about the discharge after the member left the facility or after client participation has been paid. Complete a vendor adjustment for the month of discharge if necessary.

Minimum Monthly Maintenance Needs Allowance (MMMNA)			
Calendar Year	**Amount**	**Calendar Year**	**Amount**
2024	$3,853.50	2012	$2,841.00
2023	$3,715.50	2011	$2,739.00
2022	$3,435.00	2010	$2,739.00
2021	$3,259.50	2009	$2,739.00
2020	$3,216.00	2008	$2,610.00
2019	$3,160.50	2007	$2,541.00
2018	$3,090.00	2006	$2,488.50
2017	$3,022.50	2005	$2,377.50
2016	$2,980.50	2004	$2,319.00
2015	$2,980.50	2003	$2,266.50
2014	$2,931.00	2002	$2,232.00
2013	$2,898.00	2001	$2,175.00

Mr. B enters a nursing facility for long-term care, leaving Mrs. B at home. Mr. B has $800 per month gross income and also receives $100 in aid and attendance payments. The income available from Mr. B to meet Mrs. B's needs is determined as follows:

$ 800.00	Gross income
- 50.00	Personal needs allowance
$ 750.00	Available to meet Mrs. B's needs

If the shortfall between Mrs. B's income and the MMMNA is $750 or more, Mr. B's client participation will be $100, the amount of his aid and attendance payments.

When one spouse lives in a facility and the other lives in the community and receives HCBS waiver or programs for all-inclusive care for the elderly (PACE) services, the spouses are treated as a married couple living in separate facilities for eligibility.

However, when determining client participation of the institutionalized spouse, a diversion to the community spouse can continue even when the community spouse is receiving waiver or PACE services.

If you divert income from the institutionalized spouse to the community spouse, inform the community spouse's income maintenance and SSI workers when the community spouse or dependents receive FIP, SSI, or SSA.

Either spouse may request an appeal if the spouse believes the community spouse needs income above this level because of significant financial duress. (If the income of the institutionalized spouse does not support a greater allowance for the community spouse, explain this to the client.)

The administrative law judge may substitute a higher allowance. If the appeal decision establishes a higher allowance, substitute this amount as the maintenance need. See 8-D, *If the Applicant Appeals the Attribution Amount.*

If any court orders a greater monthly income allowance against the institutionalized spouse to support the community spouse, use that amount as the minimum monthly maintenance needs allowance. Obtain from the applicant a copy of the court order to verify the amount of the court-ordered support.

If the community spouse indicates in writing that some or all of the diversion is not wanted, make the diversions in the lesser amount requested by the community spouse.

Assume that the community spouse is receiving the benefit of the income diverted from the institutionalized spouse. No further investigation is required unless there is evidence to the contrary. When the income is not made available, make a referral to the adult protective service worker at the request of the community spouse.

1. Mr. B is eligible for Medicaid payment in a nursing facility. His gross income is $650 a month, and Mrs. B's income is $350 a month. The only income that can be provided for a maintenance need for Mrs. B is $650 minus $50 personal needs, or $600 a month.

   This diversion allows a total income of only $950 a month for Mrs. B ($350 + $600). No more income can be diverted to Mrs. B, even if an appeal decision sets her maintenance needs at a higher amount.

2. Mrs. G is receiving skilled care and is eligible for Medicaid in the 300% group. Mr. G is at home. He has earned income of $4,750 per month. No diversion of Mrs. G's income can be made for Mr. G in determining her client participation, because his income exceeds the maintenance need of $3,853.50, and no greater amount has been ordered.

3. Mr. D receives skilled care and is eligible for Medicaid under the 300% group. Mrs. D is living in an RCF and receives SSI and SSA. Mrs. D's income consists of $533 social security, $430 SSI, and $276.30 SSA, for a total of $1,239.30 per month. Mr. D has gross income of $752. He is allowed a $50 personal needs allowance. The diversion is determined as follows:

Mr. D:		Mrs. D:	
$ 752.00	Gross income	$ 3,853.50	Maintenance
- 50.00	Personal needs	- 1,239.30	Income
$ 702.00	To divert	$ 2,614.20	Deficit

   Only $702 can be diverted to Mrs. D, because Mr. D must be allowed an ongoing personal needs allowance before a diversion is made to Mrs. D. Mrs. D's income with the diversion is $1,239.30 + $702.00 = $1,941.30. Mrs. D loses eligibility for State Supplementary Assistance.

4. Mr. O is in a nursing facility and eligible for Medicaid. Mrs. O and their three children are at home and receiving FIP. Mr. O has begun receiving veterans' income of $500 per month. Mrs. O's only income is the FIP grant.

   The amount of FIP to count for Mrs. O in the first month of diversion is the difference between the grant for four people and the grant for three people ($495 - $426 = $69). The diversion to Mrs. O is determined as follows:

Mr. O:		Mrs. O:	
$ 500.00	Income	$ 3,853.50	Maintenance
- 50.00	Personal needs	- 69.00	FIP income
$ 450.00	To divert	$ 3,784.50	Deficit

   Mr. O can divert a maximum of $450 of his income to Mrs. O. With this diversion, Mrs. O and the children remain eligible for FIP.

   Even though Mrs. O's income may decrease after the initial month, there will be no change in the diversion from Mr. O. He does not have enough income to meet the needs of his spouse.

5. Mrs. E is a community spouse with $500 gross monthly income. She is estranged from Mr. E and has obtained a court order for $3,900 per month in support. The court-ordered amount is substituted for the $3,853.50 maintenance needs. The diversion of income is determined as follows:

Mr. E:		Mrs. E:	
$ 1,100.00	Gross income	$ 3,900.00	Maintenance
- 50.00	Personal needs	- 500.00	Income
$ 1,050.00	To divert	$ 3,400.00	Deficit

   Mr. E can divert only $1,050 because his income supports only this amount.

Allowance for Other Dependents

Legal reference: 441 IAC 75 (Rules in Process)

Determine the maintenance needs of the other dependents by subtracting **each** person's gross income from 150% of the monthly federal poverty level for a family of two (currently $2,178 per month), and dividing the result by three. Include SSI and FIP benefits as income.

The dependent's diversion does not need to be for the benefit of the dependent. That is a requirement for the community spouse diversion only.

1. Mr. T receives Medicaid payment for nursing care. His wife and mother live at home. Diversion for Mr. T's dependents is determined as follows:

Mr. T:		Mrs. T:	
$2,150.00	Gross income	$ 3,853.50	Maintenance needs
- 50.00	Personal needs	- 970.00	Income
$ 2,100.00	Available to divert	$ 2,883.50	Deficit

Mr. T's mother:

$2,178.00	150% FPL for 2
- 398.00	Income
$1,780.00	Divided by 3 = $593.34 maintenance for dependent

The total need of the spouse and dependent is $2,883.50 + $593.34 or $3,476.84. Mr. T does not have enough income to meet all of his mother's needs. Mr. T's client participation is determined as follows:

$ 2,150.00	Gross income
- 50.00	Personal needs allowance
- 2,883.50	Diversion for spousal deficit
- 0.00	Diversion for mother's needs ($2,100.00 - $2,883.50)
$ 0.00	

2. Mrs. W lives in a nursing facility and is Medicaid-eligible. Mr. W lives at home with two children who do not receive FIP. Mr. W has earned income. Mrs. W has workers' compensation. The children have no income.

Mrs. W:

$ 700.00	Gross income
- 50.00	Personal needs allowance
$ 650.00	Income available to divert to spouse and dependents

The spousal and dependent allowances are determined as follows:

Mr. W:		Children:	
$ 3,853.50	Maintenance	$2,178.00	Poverty level
- 4,000.00	Gross income	- 0.00	Income
$ 0.00	Unmet needs	$2,178.00	Divided by 3 = $726.00 per child

$726.00 x 2 children = $1,452.00

All of Mrs. W's income after deduction of her personal needs is diverted for the children. Mrs. W's client participation is determined as follows:

$ 700.00	Gross income
- 50.00	Personal needs
- 650.00	Diversion for dependents' needs ($700 – 50 = $650)
$ .00	Amount of client participation

3. Mr. P is in a nursing facility and is eligible for Medicaid. Mrs. P lives at home with her three children (Mr. P's stepchildren) who are eligible for FIP.

   The FIP grant for the children and Mrs. P is $495. The amount for the children is $426. The amount for Mrs. P is $69 ($495 - $426 = $69). Each child is credited with $142 as income ($426 divided by 3). The maintenance allowances are determined as follows:

Mr. P:		Mrs. P:	
$ 821.00	Gross income	$ 3,853.50	Maintenance
- 50.00	Personal needs	- 69.00	FIP income
$ 771.00	Available to divert	3,784.50	Deficit

   All of Mr. P's income is diverted to Mrs. P. There is no more income remaining for a diversion to the dependents.

If the institutionalized person does not have a spouse but does have children under age 21 at home, allow a deduction from the institutionalized person's income to meet the children's maintenance needs. Do not allow a deduction if the children receive FIP.

Count the children's income and a parent's income if living in the home in determining maintenance needs. Use gross income less disregards allowed in the FIP program. Child support is considered income of the child.

Calculate the children's maintenance needs by subtracting the children's income from the FIP standard for that number of children.

1. Mr. G is eligible for Medicaid while living in a nursing facility. He has $700 per month gross income. He has a child aged 20 at home who has no income. The FIP payment standard for one is considered as the need. The determination of the dependent's allowance is as follows:

Mr. G:		Child G:	
$ 700.00	Gross income	$ 183.00	Need for one
- 50.00	Personal needs	- 0.00	Income
$ 650.00	Available to divert	183.00	Deficit

2. Mrs. F is Medicaid-eligible in a nursing facility. She has $350 gross monthly income. She has two children at home who are under 21. One child has unearned income of $105 per month. The determination of the dependents' allowance is as follows:

Mrs. F:		Both children:	
$ 350.00	Gross income	$ 361.00	Payment standard
- 50.00	Personal needs	- 105.00	Unearned income
$ 300.00	Available to divert	$ 256.00	Deficit

   $256 can be diverted to meet the needs of the children.

The following sections explain:

- 125 Percent of the statewide average charges for care
- Trust payments
- Determination of client participation

125 Percent of the Statewide Average Charge for Care

Legal reference: 441 IAC 75.24(3)"b"

Charge for care figures are:

Type of Care	Charge for Care	
	July 1, 2022 June 30, 2023	July 1, 2023 – June 30, 2024
Nursing facility	9507.50	$10,467.50
PMIC	21,701.25	$21,477.50
Mental health institute	$30,857.50	$35,152.50
ICF/ID	$46,272.50	$54,781.25

Substitute a higher amount for 125 percent of the average statewide charge for nursing facility care in the following situations:

If the trust beneficiary meets the level of care requirements for…	Then use this amount in the income comparison:
Nursing facility care and receives some type of specialized care (e.g., care in a Medicare-certified hospital-based nursing facility or a nursing facility providing care to special populations such as an Alzheimer's unit, pediatric skilled care, or skilled care for brain injury)	The cost of the type of specialized care being received. In general, use the rate charged by the facility.
Skilled nursing care and is eligible for **HCBS** waiver or programs for all-inclusive care for the elderly (PACE) services except for income	The costs in a facility providing the type of care being received
Services in a **PMIC** and resides in a PMIC	The 125 percent of the statewide average charge to private-pay patients for PMIC care
Services in an **MHI** and resides in a state MHI	The 125 percent of the statewide average charge for state MHI care
Services in an **MHI** and is eligible for **HCBS** waiver or PACE services except for income	The 125 percent of the statewide average charge for state MHI care
Services in an **ICF/ID** and resides in an ICF/ID	The 125 percent of the maximum monthly Medicaid payment rate for services in an ICF/ID

Trust Payments

Legal reference: Iowa Code Section 633C.3

If the total income received by the beneficiary of a medical assistance income trust, including income received or generated by the trust, is **less** than 125 percent of the applicable statewide average charge for care, Iowa law allows the following deductions (trust payments) from gross income to determine client participation:

1. A reasonable amount may be paid or set aside for trust administration fee not to exceed $10 per month without court approval. This payment is not considered income to the client.
2. An amount for the needs of the beneficiary:
   - A personal needs allowance of $50 for a medical facility resident plus additional amounts for personal needs in the month of entry or discharge, as appropriate. NOTE: Exclude $90 of VA pension income per Income Exempt From Client Participation.
   - A maintenance allowance of 300% of the current SSI income limit for a waiver member or a PACE enrollee.
3. An amount for the needs of dependents:
   - An amount diverted to the community spouse to raise the spouse's income to the minimum monthly maintenance needs allowance.
   - A deduction for minor or dependent children, dependent parents, or the dependent siblings of either spouse living at home.

   Determine the deduction according to Deduction for the Maintenance Needs of Spouse and Dependents.
4. An amount for unmet medical needs, determined according to Deduction for Unmet Medical Needs.
5. Any amount of income remaining, up to the Medicaid rate, is paid directly to the medical facility, a waiver service provider, or the PACE provider. This payment is not considered income to the client.
6. At the trustee's option, payment may be paid directly to other medical providers that would otherwise be covered by Medicaid or may be paid to reimburse Medicaid. This payment is not considered income to the client.

Mr. R is a single person in a nursing facility. His income consists of $1,377.70 gross social security benefits and $2,200.00 in pension, for a total of $3,577.70 per month. He has Medicare and a supplemental health insurance. The Medicare premium of $174.70 is withheld from his social security check. The supplemental policy premium of $200 per month is withheld from his pension check.

Mr. R's nursing facility costs are $3,500 per month. He contacts an attorney and establishes a medical assistance income trust. His $1,203 net social security check ($1,377.70 - $174.70 = $1,203) and $2,000.00 net pension check ($2,200.00 less $200.00 private insurance premium) are deposited to the trust.

The total income that is deposited into the trust account is $3,203. The additional $374.70 withheld from his checks is countable income that is not deposited to the trust. Calculate the amount of income left in trust after trust administration fees by subtracting the fee from the total deposited into the trust.

$ 3,203.00	Total net amount deposited into trust
- 10.00	Trustee retains $10 trust administrative fee
$3,193.00	Income remaining in trust

Of the remaining $3,193, the trustee makes $50 available to Mr. R for his personal needs. The trustee pays the remaining $3,143 in the trust directly to the nursing facility up to the Medicaid rate.

ABC system entries:

- $2,829.00 (300% of the SSI benefit level) is entered on the BCW2 screen with an income indicator of "S" for eligibility.
- $1,377.70 is entered on the BCW2 screen with an income indicator of "B," and $2,200.00 is entered with an income indicator of "X" for benefits only. $200 is entered in DEDUCT2 field as an unmet medical expense for benefits only. $10 is entered in the DEDUCT PAY field as the trust administration fee.

- When the member's gross monthly income is **equal to** or **greater than** 125 percent of the statewide charge for the care the member receives (see 125 Percent of the Statewide Average Charge for Care):
  - Enter gross income with an income indicator of "S" for eligibility and benefits on the BCW2 screen. The income exceeds the 300% amount, so the case will be denied or canceled from facility care and Medicaid.
  - Enter any income retained by the member or withheld but continues to be counted as income on the BCW2 screen with the applicable income indicator for both eligibility and benefit.
  - Process the case for other coverage groups, including Medically Needy, to pay for other medical costs, unless the household has requested otherwise.

1. Mr. Z is a resident of a nursing facility. He has social security benefits of $2,488, a civil service pension of $4,209, and $3,000 from a private person, for a total gross monthly income of $9,697.

   Mr. Z establishes a medical assistance income trust. His income is greater than 125 percent of the statewide average charge for care. The trust pays the $10 administration fee and pays the remaining $9,687 to Mr. Z. This payment is counted as income to Mr. Z when determining Medicaid eligibility and benefits.

2. Mr. G enters a nursing facility on July 1, 2017, leaving Mrs. G at home. His income consists of $1,900 in social security and $933 in civil service pension. Mrs. G's income consists of $210 social security. Mr. G applies for Medicaid payment for nursing facility care. The worker explains the income limit and Mr. G sets up a medical assistance income trust to receive all of his income.

   Spousal diversion calculation:

$ 3,853.50	Minimum monthly maintenance needs allowance
- 210.00	Mrs. G's income
$ 3,643.50	Deficit to be met by diversion from Mr. G's income to Mrs. G

   Client participation calculation:

$ 2,833.00	Total income deposited to the trust
- 10.00	Trust administrative fee
- 50.00	Personal needs allowance
$ 2,773.00	Total income available for diversion
- 3,643.50	Diversion to Mrs. G
$ .00	Client participation

3. Mrs. C applies for waiver assistance. She lives with her husband and their child, age 10. Mrs. C's income consists of $2,600 in social security and $950 in pension. Mr. C has $2,000 in gross monthly earnings. A $250 monthly health insurance premium is deducted from his earnings. This policy covers the whole family. Mrs. C meets level of care for waiver assistance and establishes a MAIT that receives all of her income.

   Spousal diversion calculation:

$ 3,853.50	Minimum Monthly Maintenance Needs Allowance
- 2,000.00	Mr. C's countable income
$ 1,853.50	Amount of Mr. C's deficit from MMMNA

   Dependent diversion calculation:

$ 2,178.00	150% FPL for 2
- 0.00	Child's income
$ 2,178.00	Divided by 3 = $726.00 maintenance for dependent

   Client participation calculation:

$ 3,550.00	Mrs. C's gross income
- 10.00	Trust administration fee
- 50.00	Mrs. C's personal needs allowance
- 2,579.50	Spouse and Dependent diversion ($1,853.50 + $726.00)
- 250.00	Unmet medical-health insurance premium
$ 660.50	Waiver client participation

1. Mr. J is a single person in a nursing facility. His income consists of $1,522.70 gross social security benefits and $2,500 in pension, for a total of $4,022.70 per month. He has Medicare and a supplemental health insurance with a premium of $123.40 per month. Mr. J's nursing facility costs are $5,500 per month. He contacts an attorney and establishes a medical assistance income trust.

   Income to the trust:

$ 1,348.00	Net social security (gross of $1,522.70 less $174.70 Medicare equals net amount of $1,358.00 rounded down)
+ 2,500.00	Gross pension check
$ 3,848.00	Total amount that is deposited into the trust

   Client participation calculation:

$ 4,022.70	Gross income
- 10.00	Trust administration fees
- 50.00	Personal needs allowance
- 174.70	Medicare premium
- 123.40	Health insurance premium
$ 3,664.60	Client participation

   Amount paid from the trust:

$ 3,848.00	Total amount deposited into trust
- 10.00	Trust administrative fees
- 50.00	Personal needs allowance
- 123.40	Health insurance premium
$ 3,664.60	Client participation

   When buy-in occurs for Mr. J's Medicare premium, the worker recalculates client participation.

   Income to the trust:

$ 1,522.00	Gross monthly social security
+ 524.10	Gross social security Medicare reimbursement check
+ 2,500.00	Gross pension check
$4,546.10	Total amount that is deposited into the trust account

   Client participation and amount paid from the trust:

$ 4,546.10	Total amount deposited into trust
- 10.00	Trust administrative fees
- 50.00	Personal needs allowance
- 123.40	Health insurance premium
$ 4,362.70	Client participation in the month buy-in reimbursement is received

   Ongoing client participation calculation:

$ 1,522.00	Gross social security
+2,500.00	Gross pension
$ 4,022.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 123.40	Health insurance premium
$ 3,838.60	Client participation

2. Mr. K is a single person in a nursing facility. His income consists of $1,543.70 gross social security benefits and $1,000.00 in pension, for a total of $2,543.70 per month. He has Medicare and a supplemental health insurance. The health insurance premium of $100 per month is withheld from his pension check. Mr. K's nursing facility costs are $5,500 per month.

   Mr. K contacts an attorney and establishes a medical assistance income trust. Income to the trust:

$ 1,369.00	Net social security (gross of $1,543.70 less $174.70 Medicare rounded down)
+ 900.00	Net pension check (gross $1,000.00 less $100 insurance premium)
$ 2,269.00	Total amount that is deposited into the trust account

   Client participation calculation:

$ 2,543.70	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 174.70	Medicare premium
- 100.00	Health insurance premium
$2,209.00	Client participation

   Amount paid from the trust:

$ 2,269.00	Total amount deposited into the trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$ 2,209.00	Client participation

3. Mrs. D enters a nursing facility, leaving Mr. D at home. Mrs. D's income consists of $1,234.70 in social security and $1,940 in IPERS benefits. She has Medicare and a supplemental insurance policy. The monthly premium for the supplemental policy is $64. Mr. D's income consists of $1,300 social security.

   Mrs. D applies for Medicaid payment for nursing facility care. The worker explains the income limit. The couple contacts an attorney and sets up a medical assistance income trust to receive Mrs. D's income.

   Spousal diversion calculation:

$ 3,853.50	Minimum monthly maintenance needs allowance
- 1,300.00	Mr. D's income
$ 2,553.50	Deficit to be diverted from Mrs. D's income to Mr. D

   Income to the trust:

$ 1,060.00	Net social security (Gross is $1,234.70 less $174.70 Medicare equals net amount of $1,060.00 rounded down)
+ 1,940.00	Gross IPERS
$ 3,000.00	Total income that is deposited into the trust

Client participation calculation:

$ 3,174.70	Mrs. D's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$ 3,114.70	
- 2,553.50	Diversion to Mr. D
561.20	
- 238.70	Unmet medical expense ($174.70 Medicare premium and $64 health insurance)
$ 322.50	Client participation

Amount paid from the trust:

$ 3,000.00	Total amount deposited into trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 2,553.50	Diversion to Mr. D
- 64.00	Health insurance premium
$ 322.50	Client participation

When buy-in occurs for Mrs. D, the worker recalculates her client participation, effective for the month of buy-in.

Income to the trust:

$ 1,234.00	Gross social security
524.10	Gross social security Medicare reimbursement check
+ 1,940.00	IPERS
$ 3,698.10	Total amount that is deposited into the trust account

Client participation and amount paid from the trust:

$ 3,698.10	Total amount deposited into trust
- 10.00	Trust administrative fees
- 50.00	Personal needs allowance
- 2,553.50	Diversion to Mr. D
- 64.00	Health insurance premium
$ 1,020.60	Client participation in the month buy-in reimbursement is received

Ongoing client participation and amount paid from the trust:

$ 1,234.00	Gross social security
+ 1,940.00	IPERS
3,174.00	Income going into the trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 2,553.50	Diversion to Mr. D
- 64.00	Unmet medical needs
$ 496.50	Client participation

No recalculation is needed for members whose spousal deduction equals the income after the personal needs allowance deduction, since no Medicare deduction was given.

Other Third-Party Payments

Veterans Affairs (VA) aid and attendance payments are a third-party liability. They do not count as income when determining eligibility, but do count in the client participation calculation. Enter any third-party liability that is not considered income to the member as another income source in the benefit calculation (separately from the income) on the ABC system's BCW2 screen.

Third-party liability or other non-income sources may be included in benefit payments. For example, veterans' payments for aid and attendance, housebound allowance, or unusual medical expenses are included with veterans' pensions. These amounts should not be deposited into the trust. If the check containing both payments is deposited into the trust account, the trustee should remove the non-income portion of the payment and pay it to the beneficiary.

Mrs. V is a single person in a nursing facility. Her income consists of $2,980 in social security benefits and $1,402 VA benefits. The payment from VA consists of $782 in VA pension and $620 in aid and attendance. Mrs. V has a Medicare premium.

Mrs. V contacts an attorney and establishes a medical assistance income trust. The income deposited into the trust is the $2,980 social security benefit and $782 VA pension, for a total of $3,762. The trustee removes the $620 aid and attendance and gives it to Mrs. V to pay the third-party liability portion of the client participation.

Income to the trust:

$ 2,980.00	Gross Social Security
+ 782.00	VA pension
$ 3,762.00	Total income that is deposited into the trust

Client participation calculation:

$ 3,762.00	Mrs. V's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$ 3,702.00	
+ 620.00	VA aid and attendance
$ 4,322.00	Client participation

When there are income disregards for a community spouse as well as third-party liability, follow the same order as for a case that does not have a trust.

Mr. C enters a nursing facility. He has monthly income of $2,400 social security, $442 IPERS benefits, $731 VA pension, and $489 VA aid and attendance, none of which is attributable to unusual medical expenses. Mrs. C, at home, gets $500 in social security.

Mr. C files an application for Medicaid payment for nursing facility care. The worker explains the income limit, and Mr. C sets up a medical assistance income trust.

Spousal diversion calculation:

$ 3,853.50	Minimum monthly maintenance needs allowance
- 500.00	Mrs. C's income
$ 3,353.50	Deficit to be met by diversion from Mr. C's income to Mrs. C

Income to the trust:

$ 2,400.00	Gross Social Security
+ 442.00	IPERS pension
+ 731.00	VA pension
$ 3,573.00	Total income that is deposited into the trust

Client participation calculation:

$ 3,573.00	Mr. C's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$ 3,513.00	Income available for diversion
- 3,353.50	Diversion to Mrs. C
$ 159.50	
+ 489.00	VA aid and attendance
$ 648.50	Client participation

Changes in Client Participation

Legal reference: 42 CFR 435.725, 441 IAC 76 (Rules in Process)

Process changes in client participation for future months within ten days after receiving information of errors in computation or changes in income or expenses. Consider all nonexempt income for client participation in the current month.

Issue timely and adequate notice when client participation increases. Client participation adjustments that cannot be made due to timely notice requirements may require vendor adjustments. The first step in completing a vendor adjustment is to determine the cause of the error or incorrect payment and calculate the correct amount of client participation.

If the income was not reported timely and Medicaid eligibility is affected, an overpayment has occurred and recoupment should be completed. (See 8-A, *Recovery*.)

When the member remains eligible, the member is still obligated to pay the increased client participation amount for the month that the client participation increases but timely notice could not be given. Complete the following steps:

1. Recalculate client participation, taking into consideration the additional income in the month received.
2. Manually issue a notice of decision telling the member to pay the additional client participation to the facility.
3. Complete changes to the client participation in IoWANS, either by:
   - Using the IoWANS Change Tool after completing the change for the current month in the ABC system; or
   - Completing and sending form 470-3924, *Request for IoWANS Changes*, to the DHS, IoWANS-Facilities e-mail box.

2. Ms. F is Medicaid member in a nursing facility with $250 monthly income. The IM Medical Services Unit determines that she does not need care in a medical facility. She is seeking appropriate placement. She remains eligible for Medicaid nursing facility payment. Her client participation is determined by subtracting $50 personal needs and her $30 medical insurance payment from her gross income.
3. The IM Medical Services Unit determines that Mrs. M no longer needs nursing care but she does need residential care. The facility agrees to keep her at the lower level of care and accept the RCF rate. The Department agrees to pay the lower level of care amount while Mrs. M is looking for another placement. The worker keeps the case under the nursing facility aid type, with the nursing care MED CP code and the nursing facility vendor number.

Effect of Buy-In

Legal reference: 42 CFR 435.725(c)(4), 441 IAC 75 (Rules in Process)

Initially determine income for client participation based on the gross amount of social security or railroad retirement benefits. Consider any amounts withheld for overpayments as income.

After the Department completes the buy-in process to pay the cost of Medicare Part A or Part B, change the social security or railroad retirement income to indicate that the member no longer pays this cost. Do not allow the Medicare premium as a deduction. The ABC system may automatically reflect this adjustment.

The member is issued a refund check for the Medicare premium costs in the same month that the buy-in occurs. The social security check increases in the next month. You will receive a Bendex form to show completion of the buy-in when the social security income changes.

The Medicare premium refund check is counted as a nonrecurring lump sum. Count the refund as income in the month received.

1. Mr. B enters a nursing facility on January 15 and is approved for Medicaid as of his date of entry. Mr. B receives $811.00 gross Social Security before buy-in. Mrs. B remains at home and receives $605.00 gross monthly Social Security. Mr. B's client participation before buy-in is calculated as follows:

$	3,853.50	Minimum monthly maintenance needs allowance
-	605.00	Mrs. B's social security
$	3,248.50	Deficit to be diverted from Mr. B's income to Mrs. B
$	811.00	Mr. B's social security
-	50.00	Personal needs allowance
$	761.00	Mr. B's income available to divert to Mrs. B
-	761.00	Diversion to Mrs. B
$	0.00	Mr. B's income available for unmet medical diversion and client participation

Mr. B's gross social security is used to determine client participation, but Mr. B does not have enough income to divert the entire allowable spousal diversion to Mrs. B ($3,248.50 was the monthly shortfall but the actual amount will be $761.00, or all of Mr. B's income after deductions).

Buy-in occurs in April. Mr. B receives a Medicare premium refund check on April 17 for $698.80. Since Mr. B's gross social security income was used to determine client participation and the entire allowable spousal diversion was not received, the Medicare premium refund check can be paid to Mrs. B.

2. Mr. D enters a nursing facility on March 21 and is approved for Medicaid as of his date of entry. Mr. D receives $1,951.00 gross social security before buy-in. Mrs. D remains at home and receives $908.00 gross Social Security and a $1,250 gross monthly pension. Mr. D's client participation before buy-in is calculated as follows:

$	3,853.50	Minimum monthly maintenance needs allowance
-	2,158.00	Mrs. D's gross income
$	1,695.50	Deficit to be diverted from Mr. D's income to Mrs. D
$	1,951.00	Mr. D's social security
-	50.00	Personal needs allowance
$	1,901.00	Mr. D's income available to divert to Mrs. D
-	1,695.50	Diversion to Mrs. D
$	205.50	Mr. D's income available for unmet medical diversion and client participation

Only $1,695.50 of Mr. D's income is available for the spousal diversion.

Buy-in occurs in June. Mr. D receives a Medicare premium refund check on June 15 for $698.80. Since Mr. D was able to divert enough of his income back to Mrs. D to bring her to the MMMNA amount, Mr. D will need to pay $698.80 additional client participation to the facility.

Timely and adequate notice must be given when client participation increases. The member is still obligated to pay the increased client participation amount for the month that the payment was received.

Although the ABC system has been designed to complete buy-in automatically, there may be cases that the system cannot handle. To manually complete buy-in, please follow the steps below:

1. Calculate the correct amount of client participation for the current month that included the refund received due to buy-in. This will be the 1ST CP AMT when making ABC entries.
2. Calculate the correct client participation for ongoing months. This will be the ONGO CP amount when making the ABC entries.
3. Complete ABC entries according to 14-B(9), *Changing Client Participation: Manual*.
4. Send a manually prepared *Notice of Decision: Medical Assistance or State Supplementary Assistance*, form 470-0490. Use the comments section of the notice to explain that member owes additional client participation for the current month due to receipt of the refund.

5. If a member does not pay the facility the additional client participation for the current month, complete form 470-3924, *Request for IoWANS Changes*, to reduce the client participation back to the original amount and establish an overpayment for the amount owed.

If the Member Receives a Lump Sum

Count a nonrecurring lump-sum payment in the month the payment is received. Send a notice telling the member to pay the difference between the client participation already assessed and either the redetermined client participation or the maximum Medicaid reimbursement rate to the facility, whichever is less.

Prorate a recurring lump-sum payment over the period it is intended to cover. Do not count any lump-sum income received before the month Medicaid eligibility is granted.

If a member receives a lump-sum VA check, divide the check into pension and aid and attendance. The pension portion is income in the month of receipt, regardless of the months it is intended to cover. The aid and attendance portion is a medical payment for the months the lump-sum payment is intended to cover.

Send a notice showing the new client participation for ongoing months and the additional payment for the back months. The member pays the difference between the assessed client participation and either the Medicaid payment or the redetermined client participation, whichever is less.

Complete vendor adjustments for the pension portion and the VA aid and attendance after the member repays the facility.

Determine the maximum Medicaid reimbursement rate by multiplying the per diem rate of the facility (from the MMIS screen) by the number of days in the month. Adjust the per diem rate for any reserved bed days or days that Medicaid would not pay due to the member's absence from the facility exceeding reserved bed days.

When the payment is made to the facility, completes form 470-3924, Request for IoWANS Changes for each of the months involved.

1. In October, Mrs. Z receives a retroactive VA payment for $2,500. This amount is all pension money; no VA aid and attendance is included. Mrs. Z's client participation is $300 and she has paid this for the month of October. The maximum Medicaid reimbursement rate for the facility for October is $1,900.

   The worker considers the VA amount a lump sum in October and notifies Mrs. Z to pay $1,600 to bring the total payments by Mrs. Z to the maximum Medicaid reimbursement rate to the facility for the month of October. The worker completes a Request for IoWANS Changes for October.

1. Mrs. M transfers January 6 from skilled care to regular nursing care. Her client participation is $540. Her client participation for each type of care is computed as follows:

   Per diem for skilled care = $90
   $90 x 5 = $450 owed for skilled care

$ 540.00	Ms. M's client participation
- 450.00	Owed for the skilled care
$ 90.00	Available to pay for the nursing care

2. Mrs. Q transfers from an RCF to a nursing facility on July 5. Her client participation at the RCF is $500. The RCF rate is $19 per day. She owes $76 to the RCF for the month of July ($19 x 4 days). Her client participation to the nursing facility is $424 ($500 client participation - $76 for the RCF = $424).

If a member goes home and is approved for either Programs for All-Inclusive Care for the Elderly (PACE) or waiver services in the month of discharge from the facility, adjust the facility client participation to allow for the increased personal needs allowance in the month of discharge. Calculate waiver client participation according to 8-N, *Client Participation* and allow a deduction for client participation paid to the medical facility in the month of discharge.

1. Mrs. N has $900 social security income, is discharged from a nursing facility on June 5, and is approved for waiver services the same month.

   Nursing facility client participation calculation:

$ 900.00	Social security
- 50.00	Personal needs allowance
- 841.00	Personal needs in month of discharge
$ 9.00	Nursing facility client participation

   Waiver client participation calculation:

$ 900.00	Social security
- 2,829.00	Waiver maintenance allowance
$ 0.00	Waiver client participation

2. Mr. O, who has a MAIT and $3,000 gross monthly income, is discharged from nursing facility on June 15 and is approved for waiver services on June 28. The nursing facility per diem rate is $175.

   Nursing facility client participation calculation:

$ 3,000.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 943.00	Personal needs in month of discharge
$ 1,997.00	Nursing facility client participation (Actual cost of care is $2,450 ($175.00 per diem x 14 days))

Waiver client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	2,829.00	Waiver maintenance allowance
	161.00	Remaining income
-	1,997.00	Unmet medical deduction for nursing facility client participation paid
$	0.00	Waiver client participation

3. Same as Example 2, except that Mr. O's discharge date is June 2.

Nursing facility client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
-	943.00	Personal needs in month of discharge
$	1,997.00	Nursing facility client participation (Actual cost of care is $175 ($175.00 per diem x 1 day))

Waiver client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	2,829.00	Waiver maintenance allowance
	161.00	Remaining income
-	175.00	Unmet medical deduction for nursing facility client participation paid
$	00.00	Waiver client participation

4. Mr. P is a PACE enrollee residing in an ICF/ID. He has $3,000 in gross monthly income which is deposited into a MAIT. He is discharged from the ICF/ID on July 10. He re-enters ICF/ID on August 25.

July PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
$	2,940.00	PACE client participation for institutionalized enrollee

Adjusted PACE client participation for the month of ICF/ID discharge

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
-	943.00	Personal needs in month of discharge
$	1,997.00	Recalculated PACE client participation for July

August PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	2,829.00	Maintenance allowance
$	161.00	PACE client participation for August (no adjustment is made in the month of institutionalization)