STATE OF IOWA DEPARTMENT OF
Health and Human
SERVICES

April 5, 2024

GENERAL LETTER NO. 8-M-53

ISSUED BY: Iowa Medicaid

SUBJECT: Employees' Manual, Title 8, Chapter M, ***Medicaid Services***, Contents 2, 2 and 3, 7, 10, 36, revised.

Summary

This chapter is revised to

- Update the 2024 300% of SSI benefit amount.
- Update the HMA amount for the month of discharge and the waiver personal needs allowance.
- Update the details regarding nonemergency medical transportation.
- Clarify information about skilled nursing services for IHAWP members who do not have a medically exempt status.
- Give new information about nursing facility services for MAGI members and IHAWP members who have a medically exempt status.

Effective Date

January 1, 2024.

Material Superseded

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

Page	Date
Contents 2	May 12, 2023
2 and 3, 7, 10, 36	May 12, 2023

Additional Information

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

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- Institutional providers:
  - Acute-care hospitals
  - Critical-access hospitals (CAHs)
  - Intermediate care facilities for persons with intellectual disabilities (ICFs/ID), including the state resource centers
  - Nursing facilities for people with mental illness aged 65 and older (NFs/MI)
  - Nursing facilities, including facilities certified to provide skilled care (NFs/SNFs)
  - Psychiatric medical institutions for children (PMICs)
  - State mental health institutes (MHIs) licensed as hospitals

All providers that wish to participate in the Iowa Medicaid program must apply to the Iowa Medicaid for certification as a Medicaid provider. The IME Provider Services Unit assigns a Medicaid provider number to each approved provider and issues instructions on accessing the Medicaid provider manual on the Internet and a supply of claim forms (when the claim forms are not available commercially).

Medical institutions in Iowa are licensed by the Department of Inspections and Appeals. After being licensed, the institution can ask to be certified to participate in the Medicaid program.

Nursing facilities that are certified in the Medicare program for skilled nursing care can provide and be paid either for skilled nursing care or nursing care, depending upon the needs of the member. A nursing facility that is not certified in the Medicare program may be paid only for nursing care, even if the care the member receives would be considered skilled nursing care in a Medicare-certified facility.

Direct questions about facilities participating in the Medicaid program to the IME Provider Services Unit.

Requirements for Providers

Legal reference: 441 IAC 79.2(249A), 79.3(249A), 79.5(249A), 79.6(2), 79.8(249A)

Providers cannot charge members for Medicaid services in addition to the Medicaid reimbursement the provider receives. However, they can charge members or agencies for services that are **not** covered by Medicaid.

Abortions, sterilizations, and hysterectomies have specific documentation requirements that must be included with each claim. These requirements are defined in the ***Physician Provider Manual***, among others.

Certain services require prior approval from the IME to ensure that the services are necessary. Providers must submit form 470-0829, *Request for Prior Authorization*, to the IME to obtain prior approval. Providers who are unsure if an individual or service meets the Medicaid criteria for payment can also submit a prior approval request.

Medically Needy clients who are conditionally eligible must also comply with prior approval requirements to receive Medicaid payment after spenddown is met for services or items for which prior approval is required. Prior authorization is explained further in the provider manuals.

Providers must:

- Keep records for five years from the date of service documenting the services, supplies, and care furnished to Medicaid members.

- Provide records or related information when requested by the Department or by the U.S. Department of Health and Human Services.
- Comply with Title VI of Civil Rights Act of 1964, which prohibits discrimination based on race, creed, or national origin.
- Comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on handicap.

Providers may be subject to sanctions for program violation such as filing a false claim or failure to comply with provider certification on Medicaid check endorsement. Sanctions include suspension, probation from program participation, or termination from Medicaid participation.

Nonemergency Medical Transportation

Legal reference: 441 IAC 78.13(249A)

Nonemergency medical transportation services are available to members with full Medicaid benefits and Iowa Health and Wellness Plan members who have a medically exempt status. These services provide travel reimbursement or a ride to medical or dental appointments. Hawki members are not eligible for nonemergency medical transportation services.

For any questions regarding nonemergency medical transportation, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).

Managed Health Care

IA Health Link

The IA Health Link managed care program began April 1, 2016. Most Medicaid members are enrolled in the IA Health Link managed care program. This program gives members health coverage through a Managed Care Organization (MCO). Members choose which MCO they will enroll with and will see a provider who works with the MCO they choose.

The benefits a member receives from the member's selected MCO will depend on the type of Medicaid coverage they qualify for.

There are some members who are excluded from MCO enrollment. They are listed below:

- Members who qualify for the Health Insurance Premium Payment program (HIPP). See Health Insurance Premium Payment Program (HIPP) for more information.
- Members who qualify for the Medicare Savings Program (MSP) only.
  - Qualified Medicare Beneficiary plan (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
- Members who are eligible for emergency services only.
- Members who are on the Medically Needy program also known as the spenddown program.

Client Participation for Enrollee Living at Home

Legal reference: 42 CFR 460.152-156; 42 CFR 435.725; 441 IAC 88.28(2)

Client participation is the amount a PACE enrollee is required to contribute to the cost of PACE services. The PACE provider arranges directly with the enrollee to collect client participation.

To calculate client participation for PACE enrollees who are receiving services in their homes:

1. Determine the total gross monthly income of the enrollee only, according to 8-I, *Income Available for Client Participation*.
2. Subtract 300% of the SSI benefit for one person. See 8-E, *SSI-Related Income Limits*.
3. Add in the following:
   - Veteran's aid and attendance,
   - Veteran's housebound allowance, and
   - Third-party medical payments.

The result is the client participation amount.

> Mr. J, age 60, lives alone and applies for PACE services on October 2. His gross monthly income includes $843 Social Security benefit, $250 private pension, and $100 VA aid and attendance. The worker determines client participation as follows:
>
> $843 Social Security + 250 pension = $1,093 total gross monthly income
>
> $1,093 – $2,829(300% of SSI benefit) = $0
>
> $0 + $100 VA aid and attendance = $100 client participation

See 14-B(9), *SSI–Related Medicaid And Facility Case Actions* for the necessary case actions for the ABC system. IoWANS will notify the PACE provider of the amount of client participation to be paid, if any.

Members With a Medical Assistance Income Trust

To calculate client participation for PACE enrollees with a medical assistance income trust, see 8-I, *Trust Payments*.

Case Maintenance

Legal reference: 42 CFR 460.160; 441 IAC 88.24(249A)

In general, follow the procedures in 8-G, *Case Maintenance*.

Once a member is enrolled to PACE, the PACE provider will provide all of the member's medical needs and services. A PACE enrollee can continue to be enrolled in PACE even if the enrollee enters a medical institution.

- When a PACE enrollee leaves a nursing facility, ICF/ID, or NF/MI, recalculate client participation for the month the PACE enrollee leaves the facility and goes to a private living arrangement. See 8-I, *Deductions From Client Participation*.
- Recalculate the client participation amount for ongoing months according to Client Participation for Enrollee Living at Home.

  Enter the new client participation amount on the ABC TD05 screen effective the first day of the month following the month of discharge from a medical institution.

  The new client participation amount will roll to IoWANS.

Mr. S, a PACE enrollee, enters a nursing facility from his home on April 16. His gross income is $1075 monthly and his PACE client participation while living at home is $0.

The IM worker recalculates his client participation effective May 1 as follows:

$	1075	Income
-	50	Personal needs allowance
$	1025	Client participation

Mr. S is discharged from the nursing facility and returns to his home on June 5. The worker recalculates his client participation for June and July as follows:

June

$	1075	Income
-	943	HMA month of discharge
-	50	Personal needs allowance
$	82	Client participation to NF

July

$	1075	Income
-	2,829	Waiver PNA
$	0	Client participation

Client Participation for Medicare Skilled Stays

When a PACE enrollee enters a medical institution as skilled and Medicare will be participating in the cost of care, do not assess client participation until after the first 20 days.

Determine if client participation for a Medicare skilled stay should be split by following these steps:

1. Determine the number of days remaining for the month after the first 20 days of a Medicare skilled stay.
2. Multiply the days remaining by the nursing facility's per diem rate.
3. Determine the monthly client participation based on gross monthly income and allowing the deductions.
4. Compare the calculation in #2 with the calculation in #3. The client participation will be the lesser of the two amounts.
5. For the month following the month the enrollee entered a nursing facility as Medicare skilled, determine client participation based on the enrollee's gross monthly income.

The MFP program manager and transition specialist will determine the number of days the member was on MFP and will manually adjust the dates in IoWANS.

NOTE: The MFP days do not start over at 365 days.

Skilled Nursing Services Available for IHAWP Members Who Do Not Have a Medically Exempt Status

The Iowa Wellness Plan offers up to 120 days of facility based skilled nursing services per year for members that meet the level of care determination. Skilled nursing services include:

- necessary therapy,
- medications,
- wound care,
- stoma care,
- ventilator,
- tracheostomy care, or
- tube feedings.

Skilled services are payable when provided in nursing facilities, skilled nursing facilities and hospital swing beds.

For any questions regarding skilled care coverage for IHAWP, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).

Nursing Facility Services Available for MAGI Members and IHAWP Members Who Have a Medically Exempt Status

Nursing facility services are a state plan benefit and are a covered service for all Medicaid members who have full coverage. This includes IHAWP members who have a Medically Exempt (ME) status.

Nursing facility services are also covered under the Hawki benefit plan (not including Hawki Dental Only coverage).

For any questions regarding nursing facility coverage for MAGI members and IHAWP who have a medically exempt status, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).