IOWA | Health and Human Services

May 22, 2026

GENERAL LETTER NO. 8-I-89

ISSUED BY: Bureau of Medicaid Eligibility Policy
Division of Community Access and Eligibility

SUBJECT: Employees' Manual, Title 8, Chapter I, **Medical Institutions**, 24, 26, 28-30, 31, 32, 33, 38-41, 42, 43, 44, 46-48, 49-59, 61, 62, 66-68, 73, 75, 76, 77 and 78, 82 and 83, revised.

Summary

This chapter is revised to

- Provide the 2026 minimum monthly maintenance needs allowance (MMMNA) in the amount of $4,066.50 and update examples.
- Update the amounts that represent 125 percent of the statewide average charges for care in facilities and revise examples. Use these amounts to determine if a person with a medical assistance income trust (MAIT) qualifies for facility payment.
- Update the personal needs allowance (PNA) from $50 to $55 effective August 1, 2025.

Effective Date

January 1, 2026 for MMMNA changes; July 1, 2025 for MAIT changes.

Material Superseded

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

Page	Date
24, 26, 28-30	November 1, 2024
31	April 18, 2025
32	November 1, 2024
33, 38-41	April 18, 2025
42	November 1, 2024
43	April 18, 2025
44, 46-48	November 1, 2024
49-59	April 18, 2025
61	November 1, 2024
62, 66-68, 73, 75	April 18, 2025
76	November 1, 2024
77 and 78	April 18, 2025
82 and 83	November 1, 2024

Additional Information

Refer questions about this general letter to your area eligibility determinations manager.

Mr. M enters a nursing facility. His income consists of $870 in social security and $200 private pension. He also has an insurance policy that he purchased to pay for nursing facility care. The policy pays $70 per day when Mr. M receives nursing facility care. He also has a Medicare supplement insurance policy with an $86 premium.

The premium on his nursing facility policy is waived while he is receiving care in a nursing facility. He is applying the benefits paid by this policy to his monthly nursing facility care charges.

Mr. M applies for Medicaid payment for nursing facility care. The worker calculates the average monthly insurance benefits by taking the $70.00 per day times 30.4, for a monthly average of $2,128.00 and adds this monthly nursing facility insurance benefit to the client participation after all deductions are allowed.

Eligibility Calculation

$ 870.00	Social security
+ 200.00	Private pension
$1,070.00	Total income

Client Participation Calculation

$ 870.00	Social security
+ 200.00	Private pension
$ 1,070.00	Total income
- 55.00	Personal needs
- 86.00	Health insurance
$ 929.00	Client participation
+ 2,128.00	Insurance benefit
$ 3,057.00	Mr. M's payment to the facility

Since Mr. M's payment to the facility is greater than the maximum Medicaid rate for nursing facility care, no Medicaid payment is made.

Veterans Affairs (VA) lump-sum payments are income in the month of receipt and a resource the month following the month of receipt, except that portion due to aid and attendance and unusual medical expenses.

A VA aid and attendance payment is a third-party liability. Count the aid and attendance for the month it was intended to cover. Recalculate client participation for those months and complete a vendor adjustment or overpayment, as appropriate.

The portion of a VA payment attributable to unusual medical expenses is not considered as income in determining eligibility or client participation. See **8-E, Non-MAGI-Related Veterans Affairs Payments** for more information about aid and attendance and unusual medical expenses.

Deem parental income to a child in the month of entry to the facility using SSI income policies. See **8-E, Deeming from an Ineligible Parent to an Eligible Child**.

If the expected stay is **more than three months**, assume that SSI and State Supplementary Assistance will end.

If the expected stay is **less than three months**, phone the Social Security Administration to report this. Ask staff to let you know if payments will continue. If payment continues, do not count it in determining client participation.

If the SSI worker does not call you within five days of your telephone call, call the SSI worker again. Act on the best information available from Social Security.

If you assume that SSI or State Supplementary Assistance payments will continue but later determine that the member was not eligible for payments, redetermine client participation based on the actual income for each month.

Ms. H, an SSI recipient, enters a nursing facility on June 10, expecting to stay two months. She informs her worker June 13. The IM worker sends **form 470-0641** to the SS office informing them of the move and asking the SSI worker to notify the IM worker of the possibility of continued SSI.

On July 1, the SSI worker notifies the IM worker that the case is being developed. On July 27, the SSI worker says that the SSI will continue. The IM worker notifies Ms. H that the SSI does not count for client participation for July, August, or September. Her social security income and other income are counted.

Veterans or Surviving Spouses of Veterans

Legal reference: 441 IAC 75 (Rules in Process); 38 USC sec. 5503

Veterans Affairs (VA) “reduced/improved” pension payments are limited to $90 per month after a veteran or surviving spouse enters a medical institution unless the person has a spouse or dependent. Federal law requires that this $90 be excluded from client participation (in addition to the $55 personal needs allowance).

The VA considers a report of the changed living arrangement timely if made within 30 days of entry and gives a 60-day notice of benefit reduction. Pension recipients are not required to repay any excess assistance received between the time they report entry to a Medicaid institution and the time VA makes the change.

Mr. V has a monthly pension of $600 and gross Social Security benefit of $800. He has no wife or dependent children. He enters a nursing facility from home in January. His full pension continues until April, when it is reduced to $90. Mr. V informs the worker in April of the reduction.

Mr. V's entire VA pension and gross Social Security benefit is used to determine eligibility and client participation for January, and he is allowed expenses of his home in the month of entry (up to the current SSI benefit amount) plus the $55 personal needs allowance.

$90 of Mr. V's VA pension is excluded for eligibility and client participation effective February 1, and ongoing. The remaining $510 VA pension plus the $800 Social Security benefit is countable income until April.

For April, the IM worker removes the $510 from countable income. If the worker is unable to change April client participation by timely notice, the worker must prepare a vendor adjustment to correct the payment.

Residents of the Iowa Veterans Home

Legal reference P.L. 105-33

A person whose Veteran Affairs (VA) pension would normally be limited to $90 after entry to a medical institution will continue to receive the full pension amount upon entry to the Iowa Veterans Home (IVH). However, the person is still entitled to exclude $90 of the pension in the determination of income and client participation.

To determine whether to exempt the income of a veteran or surviving spouse of a veteran who resides in the Iowa Veterans Home (IVH), you must determine:

- The type of VA payment received and
- If the client has a spouse or dependent.

If the client is entitled to a full VA pension for the month of entry to the IVH; then use the entire VA pension to determine eligibility and client participation in the month of entry.

If the client **has a spouse or dependent**, continue to count the full VA pension as income when determining eligibility and client participation. This will result in the client retaining only the $55 personal needs allowance.

If the client **does not have a spouse or dependent**, exclude $90 of the VA pension income beginning the month after the month of entry to the IVH, even though the pension will not be reduced. This will result in the client retaining $90 of the VA pension in addition to the $55 personal needs allowance.

Because of living at the IVH, the member is not subject to the normal $90 VA pension limitation.

NOTE: Persons receiving VA compensation payments are not entitled to the $90 veteran's income exclusion.

VA payments for unusual medical expenses are countable income when determining client participation for residents of the IVH who do not have a spouse or dependents.

Deductions from Client Participation

Members are allowed the following deductions from their income when client participation is calculated:

- Personal needs allowances, which are:
  - An ongoing personal needs allowance
  - Personal needs in the month of entry to the institution
  - Personal needs in the month of discharge from the institution
- Deduction for the maintenance needs of a spouse and dependents.
- Deduction for unmet medical needs.

Each of these deductions is explained in more detail in the next sections.

Ongoing Personal Needs Allowance

Legal reference: 441 IAC 75 (Rules in Process)

All members who have at least $55 in countable monthly income retain $55 for a personal needs allowance. Members who have less than $55 in countable monthly income retain all of their income for a personal needs allowance.

The personal needs allowance is for the member's use for items not provided by the facility, such as magazines, cigarettes, personal care items, etc. If not used, the personal needs allowance represents a countable resource in the month following the month the income was received and is subject to resource limits.

Veteran and surviving spouses of veterans who receive the $90 reduced/improved pension receive a $55 personal needs allowance in addition to the $90 income exclusion. See Veterans or Surviving Spouses of Veterans.

State-Funded Payment

When a member who resides in a nursing facility, ICF/ID, or NF/MI has countable income of less than $55 per month, a state-funded payment for the difference between that countable income and $55 is issued so that the member will have $55 for personal needs. (This state-funded payment is not available to residents of PMICs.)

When a facility application is approved with an effective date in the previous month, issue the appropriate state-funded payment for each month in a lump-sum payment.

Do not consider the lump sum as income in the month of receipt for purposes of determining eligibility or client participation. The state-funded payment is excluded as assistance based on need.

Direct Deposit for State-Funded Payment

Medicaid facility residents or their payees who receive a state-funded payment have the option to request that their payments be deposited directly to an active account at a financial institution.

The date the money is deposited into the account depends on when the payment is authorized, as follows:

- Ongoing monthly payments are deposited into the member's account on the first working day of the month.
- Reinstatements that occur too late in the month to be included with the monthly issuances are generally deposited into the member's account three to five days after the first working day of the month.

Members who choose direct deposit will receive a notification similar to a check stub. This notification is mailed so that the member should receive it close to the date the benefits are available in the account.

Remind members that there is a risk that creditors holding past-due bills could attempt to garnish the account.

When a member requests direct deposit, have the member complete form **470-0261, Agreement for Automatic Deposit**. See **6-Appendix** for the form and instructions for its use.

Use the Automated Direct Deposit (DIRD) system to enroll members in direct deposit. See **14-B(4), DIRD-Automated Direct Deposit** for instructions in using the DIRD system. The beginning date for direct deposit is ten working days past the date you enter the direct deposit request in the DIRD, unless another, later beginning date is requested.

Benefits will continue to be credited to the account until the member requests a change and you make direct deposit stop entries in the DIRD system. Act promptly to terminate or change direct deposit when requested to do so by the member.

Remind members to report promptly if the account is closed or changed. Failure to report a closed or changed account can cause delays in getting the payment if the direct deposit is rejected.

If facility assistance is canceled and reinstated before system month end of the month of cancellation, direct deposit will continue. If the facility program is still canceled after system month end, DIRD system entries are required to start direct deposit again.

Earned Income

If the member has earned income, allow an additional $65 deduction from earned income only. The $65 deduction is intended for expenses in producing the income, like transportation, extra clothing, FICA, etc. This deduction is in addition to the $55 deduction for personal needs and the $90 VA pension income exemption for certain veterans and surviving spouses.

If the member has less than $65 of earned income, deduct only the earned amount. If the member has self-employment income, deduct the expenses of self-employment from gross self-employment income. The $65 personal needs allowance is automatically subtracted from the amount of earned income entered in the ELIAS system.

See **8-E, Projecting Income** more information.

1. Mr. B, a Medicaid member residing in an ICF/ID, has income of $596. His client participation is $546 monthly ($596 - $55 personal needs).
2. Mrs. D, a Medicaid member residing in a nursing facility, has income of $596. Her client participation is $541 monthly ($596 - $55 personal needs).

3. Mrs. G, a Medicaid member residing in a nursing facility, has income of $30 SSI. Her client participation is $0 and a state-funded payment of $25 is issued to bring her total personal needs allowance up to $55.
4. Ms. M lives in a nursing facility and occasionally works for her former employer when needed. She has $450 a month unearned income and her earned income averages $50 a month. She is allowed a total personal needs deduction of up to $65 from earned income and $55 from unearned income.
5. Mr. H, an SSI recipient living in an ICF/ID, has net self-employment earnings of $18 a month from his hobby, carving wood. He is allowed a total of $48 personal needs allowance, $18 from his earned income and $30 from the SSI income. His client participation is $0. A state-funded payment of $25 is issued to bring his total personal needs allowance to $73.

Personal Needs Expenses in the Month of Entry

Legal reference: 42 CFR 435.725, 42 CFR 435.726, 441 IAC 75 (Rules in Process)

A person entering a medical institution can be given an allowance for stated living expenses during the month of entry unless the person has a community spouse. Allow this deduction in addition to the $55 personal needs allowance.

For a single person, the limit on the deduction for living expenses or the month of entry is the amount of the SSI benefit for one person. Use the following deduction guidelines for married couples:

- If both spouses enter a medical institution in the same month and live in the same room, combine their income in determining client participation for the month of entry. Deduct any claimed expenses from this amount up to the amount of the SSI benefit for a couple.
- If both spouses enter a medical institution in the same month but live in different rooms, deduct any claimed expenses up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than the deduction, give the remainder of the allowance to the other spouse.
- If the community spouse enters a medical institution in a later month, deduct claimed expenses for the month of entry when calculating client participation, up to the amount of the SSI benefit for one person.

Determine the prior living arrangement of the member. People living in a private living arrangement do not have to verify their living expenses unless questionable. Living alone or with friends or relatives is a “private living arrangement,” regardless of who owns the dwelling.

If the person was **not** in a private living arrangement, allow these deductions for personal needs expenses in the month of entry as follows:

- If the member enters a hospital and then enters a nursing facility in the next month, do not allow a personal needs expense deduction for the month of entry into the nursing facility. The month of entry to a medical institution was the month that the person entered the hospital, and client participation is not assessed for people in hospitals.
- 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 $1,491 for the month of entry.

The Ls' combined gross income is $702. Each spouse is allowed a $55 personal needs allowance. The personal allowances and the deduction for living expenses for the month of entry are subtracted from that gross income. ($702 – 55 – 55 – 1,491 = 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).

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 $55 personal needs, or $595 a month.

   This diversion allows a total income of only $945 a month for Mrs. B ($350 + $595). 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 $4,066.50, 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, $481 SSI, and $276.30 SSA, for a total of $1,290.30 per month. Mr. D has gross income of $752. He is allowed a $55 personal needs allowance. The diversion is determined as follows:

Mr. D:		Mrs. D:	
$ 752.00	Gross income	$ 4,066.50	Maintenance
- 55.00	Personal needs	- 1,290.30	Income
$ 697.00	To divert	$ 2,776.20	Deficit

   Only $697 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 $1,290.30 + $697.00 = $1,987.30. 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	$ 4,066.50	Maintenance
- 55.00	Personal needs	- 69.00	FIP income
$ 445.00	To divert	$ 3,997.50	Deficit

Mr. O can divert a maximum of $445 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 $4,500 per month in support. The court-ordered amount is substituted for the $4,066.50 maintenance needs. The diversion of income is determined as follows:

Mr. E:		Mrs. E:	
$1,100.00	Gross income	$ 4,500.00	Maintenance
- 55.00	Personal needs	- 500.00	Income
$1,045.00	To divert	$ 4,000.00	Deficit

Mr. E can divert only $1,045 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 $2,644.00 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	$4,066.50	Maintenance needs
- 55.00	Personal needs	- 970.00	Income
$2,095.00	Available to divert	$3,096.50	Deficit

Mr. T's mother:

$2,644.00	150% FPL for 2
- 398.00	Income
$2,246.00	Divided by 3 = $748.67maintenance for dependent

The total need of the spouse and dependent is $3,096.50 + $748.67, or $3,845.17. 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
- 55.00	Personal needs allowance
- 3,096.50	Diversion for spousal deficit
- 0.00	Diversion for mother's needs ($2,095.00 - $3,096.50)
$ 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
- 55.00	Personal needs allowance
$ 645.00	Income available to divert to spouse and dependents

The spousal and dependent allowances are determined as follows:

Mr. W:		Children:	
$4,066.50	Maintenance	$2,644.00	Poverty level
- 5,000.00	Gross	- 0.00	Income
$ 0.00	income	$2,644.00	Divided by 3 = $881.33 per child
	Unmet needs		

$881.33 x 2 children = $1,762.66

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
- 55.00	Personal needs
- 645.00	Diversion for dependents' needs ($700 – 55 = $645)
$ .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	$ 4,066.50	Maintenance
- 55.00	Personal needs	- 69.00	FIP income
$ 766.00	Available to divert	3,997.50	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
- 55.00	Personal needs	- 0.00	Income
$ 645.00	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
- 55.00	Personal needs	- 105.00	Unearned income
$ 295.00	Available to divert	$ 256.00	Deficit

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

Deduction for Unmet Medical Needs

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

Allow a deduction for expenses a person incurs for medical or remedial care that is not payable by a third party, including the following:

- The member's Medicare premiums, other health insurance premiums (including dental and vision), deductibles, and coinsurance.
  - There should be no Medicare Part A or Part B deductibles or coinsurance once Medicaid eligibility is established. The portion of the premium that remains the member's responsibility is an allowable unmet medical deduction.
  - Members who are enrolled in Part D plans or who qualify for Part D but were not enrolled may continue to be responsible for premiums, deductibles, drug costs, or coinsurance. The length of time the member remains responsible and the amount of expense varies greatly between plans.

    Allow verified expenses as an unmet medical deduction. If a deduction is allowed and expenses are later reimbursed, consider the reimbursement as income in the month of receipt and adjust the client participation accordingly.
- Health insurance premiums for coverage of other persons of the family when the insurance is a family policy that covers the member.
- Expenses for necessary medical or remedial care recognized under state law that are not covered by Medicaid and were not incurred during a transfer of assets penalty period.
- Medical bills for the month of eligibility that the member paid before being determined eligible, unless Medicaid will later pay the bill. For example, a member may have paid a medical bill incurred before eligibility was determined.

  If those bills were incurred during the period that retroactive eligibility is granted or during the month of application, allow the bills to be deducted as long as Medicaid does not later pay the bill.

- Client participation paid in another medical facility when transferring between facilities and splitting the client participation between the two facilities.
- "Private pay" payments made by residents of medical institutions.
- Client participation paid for in-home health-related care, home- and community-based waiver services, or programs for all-inclusive care for the elderly (PACE).

1. Mr. S was approved for Medicaid and nursing facility payments effective May 1. He was ineligible for Medicaid before the month of May. Mr. S did not have enough resources to pay all the private-pay charges for the month of April. He still owes the facility $900 for April charges.

   Mr. S arranges with the facility to pay off the $900 by paying $300 in June, $300 in July, and $300 in August. He provides the IM worker with verification of this agreement. An unmet medical deduction of $300 can be allowed for the months of June, July, and August when calculating the client participation for those months.

2. Mrs. A is approved for Medicaid and nursing facility payments effective May 1. She has client participation of $200 but she fails to pay the May client participation during the month of May. In June, Mrs. A pays both the May and the June client participation.

   The IM worker cannot allow an unmet medical deduction in the month of June for the $200 May client participation that was paid late, as it is not a private-pay expense.

Do not allow a deduction for payment of:

- A bank service charge made for handling medical insurance payments.
- Insurance premiums if the benefit paid is counted as income for eligibility.
- Adult day care services from a source not certified as a Medicaid provider. This is not medical care.

If the agent is unable to tell you if the insurance is indemnity or health, ask if an established amount is paid if the member is ill or injured, regardless of the amount of the medical bill. If yes, treat it as an indemnity policy. If benefits are paid only to cover incurred expenses of illness or injury, treat it as a health insurance policy.

If Client Participation Exceeds the Facility's Medicaid Rate

Legal reference: 441 IAC 81.22(1)

The member is required to pay only the amount charged to the Medicaid program. (When the Department retroactively increases the maximum daily rate, the facility can charge the client the increased amount retroactively.) After computing client participation, if client participation exceeds the facility's Medicaid rate on IoWANS, the ELIAS system will generate a notice telling the member that the

facility can't charge client participation in excess of the approved Medicaid daily rate for the number of days the member received services in the facility. If eligibility and client participation were calculated manually, add the following words to the notice:

> "This is the most you will have to pay for your care, based on your income. The facility can charge you this amount or their daily rate whichever is less, for the days you are in the facility. If the facility rate changes for the past months, you may have to pay more based on the new rate."

When the client participation equals or exceeds the maximum Medicaid monthly reimbursement rate, no Medicaid payment is made. The member retains any difference between the Medicaid rate charged by the facility and the client participation.

This situation occurs most often when the member has veterans' aid and attendance payments but can also occur when the member has nursing facility insurance.

Mr. C is in a nursing facility. He does not have a wife or dependents. He receives:

$ 900.00	Social security
$ 400.00	Private pension
$ 500.00	VA pension
$1,000.00	VA aid and attendance allowance (disregarded for eligibility)

His income exclusive of the A & A allowance is $1,800, and he is eligible for Medicaid. The total amount available to him is $2,800. Mr. C has no unmet medical expenses or private health insurance, so his potential client participation is $2,660 ($2,800 - $55 personal needs allowance - $90 VA pension exemption).

Mr. C's client participation exceeds the maximum Medicaid reimbursement rate for the facility where he lives. Since his client participation exceeds the Department's maximum payment for nursing care, Medicaid makes no payment for Mr. C's care, although he is eligible for all other Medicaid services.

Client Participation for Skilled Care

Legal reference: 441 IAC 81.6(20)"b"

Do not split or zero out client participation just because Medicare covered some of the skilled stay at the facility. The facility provider will report Medicare-covered days on the **Case Activity Report**. In most cases, the Medicare payment amount will exceed or equal the Medicaid-allowed payment amount.

If this is the case for the skilled days, Medicare will pay the cost of care. Medicaid will not participate, and the facility will not require the member to pay client participation. Payment of any skilled care days will be handled by the facility in the way it submits the claim.

Members With a Medical Assistance Income Trust (MAIT)

Legal reference: 441 IAC 75.24(249A)

People with income in excess of 300 percent of the SSI benefit for one person may qualify for Medicaid payment for institutional care using a medical assistance income trust. A person with such a trust qualifies for facility payment only if the person's total gross monthly income does not exceed 125 percent of the statewide average charge for the type of facility or level of care the person meets.

If the person's total income is less than 125 percent of the statewide average charge for care, the trust makes payments to raise the person's countable income up to but not above the 300% limit. This allows the person to be income-eligible for Medicaid payment for facility care. See 125 Percent of the Statewide Average Charge for Care.

Unless the trust document provides otherwise, the trust is effective as of the date the document is executed and the trust is funded. If the trust document is signed but not funded, the trust becomes effective the first month that income is assigned to the trust.

For example, if the trust document is signed after the first of the month, and the income for the month is assigned to that trust, then only income that the trustee makes available to the member is counted for eligibility during that month.

See **8-D, Trusts** for more information about requirements for medical assistance income trusts. Iowa law requires certain deductions be allowed from the trust beneficiary's gross income when determining client participation.

The following sections explain:

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, 2024 June 30, 2025	July 1, 2025 – June 30, 2026
Nursing facility	$10,653.75	$11,713.75
PMIC	$26,477.50	$26,477.50
MHI	$36,416.25	$37,795.00
ICF/ID	85,026.25	$55,721.25

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 $55 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.
7. Any remaining income must be retained in the trust until the beneficiary's death, or, if the trust is abolished, must be paid to the state of Iowa.

1. Mrs. S is in a nursing facility at nursing facility level of care. She has social security benefits of $974 and a pension of $780, for total gross monthly income of $1,754. Mrs. S did not really need a medical assistance income trust but is paying all of her income to the trust.

   Mrs. S's total income is less than 125 percent of the average charge for nursing facility level of care. The trust will pay her all of the available income. Count the payment from the trust to Mrs. S as income. She is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.
2. Mr. T is in a nursing facility at the nursing facility level of care. He has social security benefits of $1,500 and a monthly pension of $1,138 per month. Only his social security check is deposited into his medical assistance income trust.

   Mr. T's total income is less than 125 percent of the average charge for nursing facility care. The trust may set aside $10 per month for administration. The trust will pay Mr. T the $55 personal needs allowance each month Mr. T is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.

3. Mr. W is in the Alzheimer's unit of a nursing facility. He meets the nursing facility level of care. He has social security benefits of $2,825, an annuity payment of $5,750, and a monthly private pension of $3,400.

   Mr. W's total income is $11,975. His total income is higher than $11,713.75, 125 percent of the average charge for nursing facility care. However, since Mr. W is receiving specialized care, the cost of his Alzheimer's care can be substituted for the average nursing facility charge.

   Mr. W provides a statement from the nursing facility that he pays $400 per day for his care. The average monthly cost would be $12,160 ($400 X 30.4 = $12,160). The cost of $12,160 can be substituted in place of 125 percent of the statewide average charge for nursing facility care. Mr. W is income-eligible for Medicaid payment of nursing care using the medical assistance income trust.

If the total income received by the beneficiary (including income received by or generated by the trust) **equals** or is **greater** than 125 percent of the applicable statewide average charge for care, Iowa law directs the trust to make the following payments, in the following order:

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. All remaining amounts paid into the trust or retained from prior months must then be paid out to the beneficiary. This payment is considered as income to the beneficiary for Medicaid eligibility purposes. (Use this income to calculate eligibility.)

Mr. Y is a resident of a nursing facility at nursing facility level of care. His gross monthly income consists of social security benefits of $2,877, a civil service pension of $5,000, and income from his farm (homestead) of $4,500. His total gross monthly income of $12,377 is deposited into a medical assistance income trust.

Mr. Y's total income is greater than 125 percent of the average charge for nursing facility care. The trust will take $10 in administration fees and pay the remaining as income to Mr. Y. Mr. Y is not income-eligible for Medicaid payment of nursing facility care because his income still exceeds program limits.

NOTE: Use form **470-4678, MAIT Facility Worksheet**, to calculate client participation for members who reside in a medical institution and have a MAIT. Use form **470-4679, MAIT Waiver Worksheet,** to calculate client participation for members who are eligible for a home- and community-based services (HCBS) waiver and also have a MAIT.

Determination of Client Participation

When determining client participation for a person with a medical assistance income trust, count only the income to be paid from the trust or otherwise made available to the member as income to the member. Do **not** count as income to the member:

- The gross monthly income paid into the trust.
- Direct client participation payments the trust makes to the facility or waiver service provider or programs for all-inclusive care for the elderly (PACE) provider.

When the member's gross monthly income is **less than** 125 percent of the statewide charge for the care the member receives (see 125 Percent of the Statewide Average Charge for Care):

Mr. R is a single person in a nursing facility. His income consists of $1,377.90 gross social security benefits and $2,200 in pension, for a total of $3,577.90 per month. He has Medicare and a supplemental health insurance. The Medicare premium of $202.90 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 $1,175 net social security check ($1,377.90 - $202.90 = $1,175) and $2,000 net pension check ($2,200 less $200 private insurance premium) are deposited to the trust.

The total income that is deposited into the trust account is $3,175. The additional $402.90 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.

$3,175.00	Total net amount deposited into trust
- 10.00	Trustee retains $10 trust administrative fee
$3,165.00	Income remaining in trust

Of the remaining $3,165, the trustee makes $55 available to Mr. R for his personal needs. The trustee pays the remaining $3,110 in the trust directly to the nursing facility up to the Medicaid rate.

- 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):
  - 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 $2,888, a civil service pension of $4,500, and $4,500 from a private person, for a total gross monthly income of $11,888.

   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 $11,878 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 $2,200 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:

$4,066.50	Minimum monthly maintenance needs allowance
- 210.00	Mrs. G's income
$3,856.50	Deficit to be met by diversion from Mr. G's income to Mrs. G

   Client participation calculation:

$3,133.00	Total income deposited to the trust
- 10.00	Trust administrative fee
- 55.00	Personal needs allowance
$3,068.00	Total income available for diversion
-3,856.50	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:

$ 4,066.50	Minimum Monthly Maintenance Needs Allowance
- 2,000.00	Mr. C's countable income
$ 2,066.50	Amount of Mr. C's deficit from MMMNA

   Dependent diversion calculation:

$ 2,644.00	150% FPL for 2
- 0.00	Child's income
$ 2,644.00	Divided by 3 = $881.34 maintenance for dependent

   Client participation calculation:

$ 3,550.00	Mrs. C's gross income
- 10.00	Trust administration fee
- 2,982.00	Mrs. C's maintenance allowance
- 2,947.84	Spouse and Dependent diversion ($2,066.50 + $881.34)
- 250.00	Unmet medical-health insurance premium
$ 00.00	Waiver client participation

If the institutionalized spouse's income is above 125 percent of the statewide average charge, a medical assistance income trust alone may not be sufficient to gain eligibility.

> Mr. E enters a nursing facility at the NF level of care, leaving Mrs. E at home. He does not receive specialized care. He has monthly income of $2,500 in social security, $4,500 in IPERS benefits, and $6,000 from an annuity. Mrs. E's income consists of $220 social security. After Mr. E pays for nursing facility care and other medical bills, he has only $200 a month he can give to Mrs. E to live on.
>
> Mr. E applies for Medicaid payment for nursing facility care. The worker explains the income limit and that a medical assistance income trust will not help Mr. E qualify for Medicaid. Since his income exceeds 125 percent of the statewide average charge, state law requires that all income after the $10 trust administration fee is income to Mr. E, leaving him over income for Medicaid.
>
> The worker refers the couple to their attorney to determine if a qualified domestic relations order will offer relief. Once the qualified domestic relations order is complete, the ownership of some or all of the income will be changed to Mrs. E. Mr. E should file another application at this time.
>
> The worker obtains a copy of the order to determine which income sources changed to Mrs. E's ownership. Only the income owned by Mr. E is countable to him when determining Medicaid eligibility and client participation.

Beneficiaries who have a Medicare premium deducted from their social security check are considered to have received the premium amount. This is also true for people who have other withholdings, such as union dues, taxes, and private health insurance.

When buy-in occurs, recalculate the client participation without the deduction for the Medicare premium, effective with the month of buy-in. (See Effect of Buy-In, later in this chapter.) Eliminate the Medicare premium deduction when calculating client participation for future months.

1. Mr. J is a single person in a nursing facility. His income consists of $1,522.90 gross social security benefits and $2,500 in pension, for a total of $4,022 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 $9,500 per month. He contacts an attorney and establishes a medical assistance income trust.

   Income to the trust:

$ 1,320.00	Net social security (gross of $1,522.90 less $202.90 Medicare equals net amount of $1,320 rounded down)
+ 2,500.00	Gross pension check
$ 3,820.00	Total amount that is deposited into the trust

   Client participation calculation:

$ 4,022.90	Gross income
- 10.00	Trust administration fees
- 55.00	Personal needs allowance
- 202.90	Medicare premium
- 123.40	Health insurance premium
$ 3,631.60	Client participation

   Amount paid from the trust:

$ 3,820.00	Total amount deposited into trust
- 10.00	Trust administrative fees
- 55.00	Personal needs allowance
- 123.40	Health insurance premium
$ 3,631.60	Client participation

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

   Income to the trust:

$1,522.90	Gross monthly social security
+ 608.70	Gross social security Medicare reimbursement check
+2,500.00	Gross pension check
$4,631.60	Total amount that is deposited into the trust account

   Client participation and amount paid from the trust:

$4,631.60	Total amount deposited into trust
- 10.00	Trust administrative fees
- 55.00	Personal needs allowance
- 123.40	Health insurance premium
$4,443.20	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
- 55.00	Personal needs allowance
- 123.40	Health insurance premium
$3,833.60	Client participation

2. Mr. K is a single person in a nursing facility. His income consists of $1,543.90 gross social security benefits and $2,000 in pension, for a total of $3543.90 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 $9,500 per month.

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

$1,341.00	Net social security (gross of $1,543.90 less $202.90 Medicare rounded down)
+1,900.00	Net pension check (gross $2,000.00 less $100 insurance premium)
$3,241.00	Total amount that is deposited into the trust account

   Client participation calculation:

$3,543.90	Gross income
- 10.00	Trust administration fee
- 55.00	Personal needs allowance
- 202.90	Medicare premium
- 100.00	Health insurance premium
$3,176.00	Client participation

   Amount paid from the trust:

$3,241.00	Total amount deposited into the trust
- 10.00	Trust administration fee
- 55.00	Personal needs allowance
$3,176.00	Client participation

3. Mrs. D enters a nursing facility, leaving Mr. D at home. Mrs. D's income consists of $1,234.90 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:

$4,066.50	Minimum monthly maintenance needs allowance
- 1,300.00	Mr. D's income
$2,766.50	Deficit to be diverted from Mrs. D's income to Mr. D

Income to the trust:

$1,032.00	Net social security (Gross is $1,234.90 less $202.90 Medicare equals net amount of $1,032 rounded down)
+1,940.00	Gross IPERS
$2,972.00	Total income that is deposited into the trust

Client participation calculation:

$3,174.90	Mrs. D's gross income
- 10.00	Trust administration fee
- 55.00	Personal needs allowance
$3,109.90	
- 2,766.50	Diversion to Mr. D
343.40	
- 266.90	Unmet medical expense ($202.90 Medicare premium and $64 health insurance)
$ 76.50	Client participation

Amount paid from the trust:

$2,972.00	Total amount deposited into trust
- 10.00	Trust administration fee
- 55.00	Personal needs allowance
- 2,766.50	Diversion to Mr. D
- 64.00	Health insurance premium
$ 76.50	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
608.70	Gross social security Medicare reimbursement check
+1,940.00	IPERS
$3,782.70	Total amount that is deposited into the trust account

Client participation and amount paid from the trust:

$3,782.70	Total amount deposited into trust
- 10.00	Trust administrative fees
- 55.00	Personal needs allowance
- 2,766.50	Diversion to Mr. D
- 64.00	Health insurance premium
$ 887.20	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
- 55.00	Personal needs allowance
- 2,766.50	Diversion to Mr. D
- 64.00	Unmet medical needs
$ 278.50	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.

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
- 55.00	Personal needs allowance
$3,697.00	
+ 620.00	VA aid and attendance
$4,317.00	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:

$4,066.50	Minimum monthly maintenance needs allowance
- 500.00	Mrs. C's income
$3,566.50	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
- 55.00	Personal needs allowance
$3,508.00	Income available for diversion
-3,566.50	Diversion to Mrs. C
$ 00.00	
+ 489.00	VA aid and attendance
$ 489.00	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 ELIAS system; or
   - Completing and sending form **470-3924, Request for IoWANS Changes** to the DHS, IoWANS-Facilities e-mail box.
4. If the facility reports that the member refused to pay the additional client participation, reverse the client participation amount and complete a recoupment.

1. Mr. G is in a hospital at acute level of care and is eligible for Medicaid. It has just been determined that he no longer needs acute hospital care but needs skilled care. The hospital is not a skilled care provider, but provides skilled care for Mr. G until an appropriate placement is available.

   Mr. G's client participation for skilled care would normally be $695 per month but since Mr. G is receiving a lower level of care in a hospital, he does not owe any client participation.

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 $55 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 ELIAS 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:

$ 4,066.50	Minimum monthly maintenance needs allowance
- 605.00	Mrs. B's social security
$ 3,461.50	Deficit to be diverted from Mr. B's income to Mrs. B
$ 811.00	Mr. B's social security
- 55.00	Personal needs allowance
$ 756.00	Mr. B's income available to divert to Mrs. B
- 756.00	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 ($3,461.50 was the monthly shortfall but the actual amount will be $756.00, 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 $811.60. 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 gross social security before buy-in. Mrs. D remains at home and receives $908 gross Social Security and a $1,500 gross monthly pension. Mr. D's client participation before buy-in is calculated as follows:

$ 4,066.50	Minimum monthly maintenance needs allowance
- 2,408.00	Mrs. D's gross income
$ 1,658.50	Deficit to be diverted from Mr. D's income to Mrs. D
$ 1,951.00	Mr. D's social security
- 55.00	Personal needs allowance
$ 1,896.00	Mr. D's income available to divert to Mrs. D
- 1,658.50	Diversion to Mrs. D
$ 237.50	Mr. D's income available for unmet medical diversion and client participation

   Only $1,658.50 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 $811.60. 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 $811.60 additional client participation to the facility.

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 $1,100 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:

$	1,100.00	Social security
-	55.00	Personal needs allowance
-	994.00	Personal needs in month of discharge
$	51.00	Nursing facility client participation

   Waiver client participation calculation:

$	1,100.00	Social security
-	2,982.00	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
-	55.00	Personal needs allowance
-	994.00	Personal needs in month of discharge
$	1,941.00	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
- 2,982.00	Waiver maintenance allowance
8.00	Remaining income
- 1,941.00	Unmet medical deduction for nursing facility client
$ 0.00	participation paid
	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
- 55.00	Personal needs allowance
- 994.00	Personal needs in month of discharge
$ 1,941.00	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
- 2,982.00	Waiver maintenance allowance
8.00	Remaining income
- 175.00	Unmet medical deduction for nursing facility client
$ 00.00	participation paid
	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
- 55.00	Personal needs allowance
$ 2,935.00	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
- 55.00	Personal needs allowance
- 994.00	Personal needs in month of discharge
$ 1,941.00	Recalculated PACE client participation for July

August PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	2,982.00	Maintenance allowance
$	8.00	PACE client participation for August (no adjustment is made in the month of institutionalization)

Qualified Medicare Beneficiaries in Skilled Care

Legal reference: P.L. 100-360, 441 IAC 75 (Rules in Process), 441 IAC 76.13(1)“a”

For people whose only Medicaid eligibility is under the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only for the Medicare Part A and Part B premiums, coinsurance and deductibles. If a person is receiving skilled care or hospital care, Medicare pays the cost of care within certain limits. (See Medicare Coverage for Institutional Care for payment limits.)

Eligibility for QMB applicants begins the month **after** the month of decision. The person is not eligible for Medicaid payment until the month following the month of decision unless the worker determined Medicaid eligibility under another coverage group.

Some members may be concurrently eligible for QMB and another Medicaid coverage group. Examples of these members include:

- SSI recipients with Medicare
- People in the 300% group with Medicare
- FIP recipients with Medicare

When a person is concurrently eligible both for skilled care payments under a nursing facility aid type and for QMB benefits on the date of entry, the person has no client participation until Medicare is exhausted. Medicaid payment for skilled care stops for a person who is **only** QMB-eligible when the Medicare is exhausted.

A member who is eligible for SSI, FIP, or FMAP and has Medicare Part A has already been determined eligible as a QMB member. No QMB application is needed.

In order for Medicare to make skilled care payments, the member must be hospitalized for three days and enter skilled care within 30 days of leaving the hospital. If this requirement is not met, Medicare does not pay for skilled care and QMB also does not pay, because there is no coinsurance. Determine eligibility under another coverage group. The member does have client participation under the other coverage group.

Billing and Payment

Legal reference: 441 IAC 79.1(249A), 441 IAC 80.2(249A), 441 IAC 80.3(249A), 441 IAC 81.9, 441 IAC 81.11(1), 441 IAC 81.22(2), 441 IAC 82.14(4), 441 IAC 82.15(1)

When a resident becomes eligible for Medicaid payment for facility care, the facility must accept Medicaid or MCO contracted rates effective with the date the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

If the beginning Medicaid eligibility date is a future month, the facility must accept the Medicaid rate effective the first of that future month.

NOTE: When a resident enters skilled care in a facility outside the state of Iowa, refer the facility to the Bureau of Medical and Long Term Services and Supports to obtain approval of out-of-state skilled payments.

Nursing facility services can be paid for many Medicaid members who are nonfacility aid types in the month of entry into the facility and for short stays. A "short stay" means less than 30 days. Also, people in nursing facilities may go back and forth between facilities. If the worker is not informed of these changes, payment may be delayed or not made at all.

In both instances, an IoWANS file must be created or updated and transferred to the Iowa Medicaid (IM) before payment for the appropriate facility care can be made.

When a Medicaid member in a nonfacility aid-type is admitted to a medical institution and continues care at the medical facility the month following the month of admission, and you are informed **before** the discharge, close the regular Medicaid case. Complete an automatic redetermination and reopen the case beginning the date of admission under the applicable facility aid type.

When a Medicaid member in a nonfacility aid type is admitted to a medical institution and continues care the month following the month of admission, but you are informed **after** the discharge, do not close the regular Medicaid case. Complete an automatic redetermination for the applicable facility aid type.

Billing Process

Legal reference: 441 IAC 81.9(249A), 441 IAC 82.12(249A)

The facility can view a member's client participation through Iowa Medicaid Provider Access (IMPA). IMPA allows the facility to view client participation that a member residing in their facility is required to pay.

Fee-for-service claims for medical institution care are submitted to the Iowa Medicaid (IM). The claims can be submitted any time after the end of the month of service. The facility is responsible for billing other payers before filing a Medicaid claim. Payments are mailed from the Iowa Medicaid (IM) after the claims are approved. Medicaid is the payer of last resort.

For members enrolled in managed care, providers submit claims to the appropriate MCO.

Payment is made only for those services or for the part of the cost of a service for which no other payer exists. Any health insurance, Medicare, client participation, or other payments made to the facility by the member, relatives, or other source is deducted before payment is made.

Payment for Reserve Bed Days

Legal reference: 441 IAC 81.88(3), 441 IAC 82.11(2)

Different limits apply to payments to reserve a bed in a nursing facility or an ICF/ID during a member's absence. No reserve-bed payments are allowed for nursing facilities, hospitals or MHIs.

Nursing Facilities

Legal reference: 441 IAC 81.8(3)"f"

Effective December 1, 2009, Medicaid no longer pays for reserved bed days in nursing facility for persons at the NF/ICF level of care.

Skilled care is a level of care received by residents of a nursing facility. The number of bed-hold days is the same when a resident is receiving skilled care. The resident is not required to receive skilled care for 90 days before the bed-hold days can be paid.

Reserve bed days stop when:

- The resident enters a different long-term care facility (whether for skilled care, nursing care, or ICF/ID care).
- The facility will not accept the client back from hospitalization due to care needs.

Payment for reserve bed days is at 42% of the facility's rate. No worker entries are required to stop or lower payments to a nursing facility for bed hold. Payments are adjusted based on claims submitted by the facility.

Facilities use the **Case Activity Report**, to notify you if the resident is discharged, including reserve bed information from the month of discharge. If reserve bed days run out before the person is discharged, remaining days are noncovered days, and are not paid by Medicaid.

Use the information from the **Case Activity Report** to recalculate client participation between facilities. When calculating the payment for reserved bed days, use the facility per diem listed on the IoWANS My Reports screen.

Mr. N leaves a nursing facility and goes to the hospital August 10. He stays 15 days in the hospital and is placed in skilled care. His total client participation is $1,500. The portion computed for each facility is as follows:

NF Medicaid per diem is $90.00
42% of $90.00 = $37.80
$37.80 x 10 days = $378.00

$ 810.00	$90.00 x 9 resident days
+ 378.00	$37.80 x 10 bed hold days
$1,188.00	CP owed for nursing care
$1,500.00	Total CP
- 1,188.00	CP paid for nursing care
$ 312.00	CP owed for skilled care beginning August 20

ICFs/ID

Legal reference: 441 IAC 82.11(2)

Payment will be made to reserve a bed in an ICF/ID as follows:

- For visits home, payment is made up to a maximum of 30 days annually.

  Additional days may be approved for special programs of evaluation, treatment, or habilitation outside the facility. A physician or qualified intellectual disability professional must sign documentation indicating the appropriateness and therapeutic value of the resident's visits and programming days.

  Visit days may be taken at any time. There is no restriction on the number of days taken in any month or any visit as long as the maximum number is not exceeded.

- For hospitalization, payment is made up to a maximum of ten days in any calendar month.

Reserve bed days stop if the resident enters a different long-term care facility, whether for skilled care, nursing care, or ICF/ID care.

An ICF/ID with 16 or more beds receives 80% of its actual per diem for reserve bed days. An ICF/ID with 15 or less beds receives 95% of its actual per diem for reserve bed days. No worker activity is required to correct reserve bed day payment.

When Reserve Bed Days Are Paid Privately

Legal reference: 441 IAC 81.8(4), 441 IAC 82.11(3)

The resident, family, or friends may choose to pay reserve bed days when the resident has exhausted reserve bed days. If the resident is not discharged, the payment made by the resident must be consistent with the Department payment. These days paid by family or friends are not covered days for Medicaid.

If the facility plans to discharge a resident after Medicaid payment stops, the resident or the family may make an arrangement to hold the bed when the resident is discharged. The facility must follow normal discharge procedures (e.g., clothing and possession are returned to the family, the personal needs account is closed and all resident records are closed), and send a **Case Activity Report** to the local office.

No Supplementation of Payment Allowed

Legal reference: 441 IAC 80.3 (249A), 441 IAC 81.8(4), 441 IAC 82.11(3)

Only client participation can be billed to the member. The facility cannot require supplementation of a Medicaid payment. The facility must accept reimbursement based on the Department's methodology as payment in full. There are two exceptions:

- The member, family, or friends may pay to hold a bed when the member is absent over the limit for reserve bed days. See When Reserve Bed Days Are Paid Privately.
- Payment of the cost of care by the resident or resident's family is not supplementation when it is included in the calculation of client participation and does not exceed the payment made by the state.

Use form **470-0373, Voluntary Contribution Agreement**, to document a voluntary contribution so that all parties are aware of the contribution and its effect on the Medicaid payment.

Voluntary contribution amounts should be entered in the ELIAS system as "Other" income benefits only.

Payment for items that the facility does not have to provide, such as a telephone or cable television, is not considered supplementation.

Payment for items or care required to be provided by the facility is supplementation. A family member may pay directly to a facility to have the member in a private room but are not obligated to and this would not affect client participation. The facility cannot require the payment and if the family does not pay the difference for a private room, the facility cannot charge the difference to the member in addition to the client participation.

Payment for Inpatient Hospitals Who Require a Lower Level of Care

Legal reference: 441 IAC 78.3, 441 IAC 78.3(13) and (14), 441 IAC 81.10(4)“g”

When the Iowa Medicaid (IM) Medical Services Unit or the MCO determine that a resident needs a lower level of care, the facility’s social worker is responsible for finding alternative placement. When an alternative placement cannot be found, and the facility and the Department agree to this, Medicaid payment may continue.

Payment for Transferring a Resident by Ambulance

Legal reference: 441 IAC 78.11(249A)

Payment for transporting a resident by ambulance will be approved if medically necessary and the resident is:

- Transferred to the nearest hospital with appropriate facilities.
- Transferred to a hospital in the same locality.
- Transferred from one hospital to another.
- Transferred from a hospital to a nursing facility.

The Iowa Medicaid Enterprise or the MCO will deny a claim for ambulance transportation from a medical institution to a hospital if the transportation was not medically necessary.

When a nursing facility resident is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility in which the recipient lives, even if it is not the nearest nursing care facility.

If a resident needs to move to another facility because a facility is closing, the requirements regarding medical necessity and distance do not apply. Nor do these requirements apply to a resident moving from a nursing home to a residential care facility because the resident no longer required nursing care.

- Is covered by Medicare for skilled level of care.
- Is no longer covered by Medicare for skilled level of care.

Transfers and Discharges

Legal reference: 441 IAC 81.4(249A), 441 IAC 82.9

The facility is not allowed to transfer or discharge the resident unless:

- A transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
- The resident's health improves so that the resident no longer needs the facility's services.
- The safety of other residents in the facility is endangered.
- The health of other residents in the facility would be endangered.
- The resident has failed, after reasonable and appropriate notice, to pay for stay at the facility. If the resident became eligible for Medicaid after admission, the facility may charge only for those items allowed by Medicaid.
- The facility ceases operation.

If a facility plans to discharge a resident, facility staff must provide advance written notice and explain appeal rights. The facility must also send you form **470-0042, Case Activity Report** when the discharge is made.

A resident may be transferred or discharged from a facility upon the request of the resident or the resident's family, guardian or physician. The facility's social worker may help the resident by:

- Planning the move.
- Referring the resident to other resources for help.
- Coordinating the services of public health nursing, homemaker services and other agencies, and work with the resident's family.
- Performing follow-up visits.
- Involving family and friends in decision-making, planning, and the work of transfer or discharge.

Resident Trust Account

Legal reference: 441 IAC 81.3(2), 441 IAC 82.8(3)

As described in Ongoing Personal Needs Allowance, residents may keep a portion of their monthly income for personal needs, to spend as the resident wishes. Resident trust accounts are set up by the facility to manage the personal needs funds for residents.

If the resident dies, the facility must release the balance in the account to the resident's guardian or next of kin to pay funeral expenses. The facility must get a receipt when it releases funds.

If there are no relatives, funds in the account revert to the Department. The facility should turn the funds over to the Facility and Waiver Eligibility Team (FWET) Forward the funds to the Department's Bureau of Accounting Services. If an estate is opened, the Department will turn the funds over to the estate. The estate is responsible for paying claims to the Department under the estate recovery program.

If a Facility Closes

Legal reference: 441 IAC 81.10(249A), 441 IAC 82.13(249A)

If a facility plans to close, facility staff must notify the Department 60 days in advance. (In an emergency, this time may be shortened.) If the contract between the Department and a facility is terminated, the local office must help residents who wish to transfer to a certified facility.

If the Department terminates the Medicaid contract with a facility, the Iowa Medicaid (IM) sends a notice of cancellation to the facility by certified mail. Copies are sent to the local office, the service area manager or the MCO, the Division of Fiscal Management, and the Department of Inspection and Appeals.

Local office staff and the administrator of the facility must immediately notify the residents and their families of the closing, then plan for an orderly transfer of residents. Alternative placements must be investigated. The facility may make transfer plans independently with the residents and their families.

In certain cases the federal government will continue participation of Medicaid funds for residents of facilities that have lost certification. The extension cannot exceed 30 days beyond the date of contract cancellation, and is allowed **only** to cover the time necessary to ensure the orderly transfer of residents.