Medical Institutions

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Overview

This chapter explains the eligibility, income, and resource policies that are unique for people in medical institutions. Following an explanation of how Medicare pays for people in medical institutions, there is a section on who is and is not eligible for Medicaid payment of medical institution care. Also included in this section is information about how institutionalization may affect a person's eligibility for other benefits.

Because income and resource policies are different for married people, these policies are outlined in the next section. Once the member is determined eligible, client participation is then calculated using the policies and procedures listed in the section that follows.

The balance of the chapter is devoted to administrative issues, such as billing, that are used when handling cases involving Medicaid members in medical institutions.

The section on billing and payment includes information about using the Institutional and Waiver Authorization and Narrative System (IoWANS) for authorization of facility payments.

Medicare Coverage for Institutional Care

To receive Medicare reimbursement for institutional care, a facility must be certified to provide:

- Care in an acute hospital setting,
- Care in a psychiatric hospital for patients age 65 and older, or
- Skilled nursing care.

Nursing facilities that provide the skilled level of care must also be certified to participate in the Medicare program. Because of this requirement, many Medicaid members' skilled nursing care is first paid by Medicare. (Other resources, including Medicare, must be used before any Medicaid payment is made.)

Medicare coverage limits are based on a "benefit period." Medicare defines a benefit period as beginning the day the person enters the hospital as an inpatient and ending after the person has **not** been in a hospital or skilled nursing facility for 60 days. If the person returns to the hospital or skilled care in less than 60 days, this is not a new benefit period. Any remaining days in the current benefit period are used.

Medicare coverage of **hospital care** is as follows:

- For the first 60 days of each benefit period, full payment is made after the beneficiary pays a deductible.
- For days 61 through 90, beneficiaries pay a daily coinsurance.

- After 90 days in the hospital for a single benefit period, beneficiaries may draw on their "lifetime reserve." The lifetime reserve is 60 days and is nonrenewable. Beneficiaries must pay a coinsurance.
- After 150 days (or 90 days if the lifetime reserve has been exhausted), Medicare makes no further payment.

At the **skilled** level of care, Medicare covers 100 days per benefit period if the person has been hospitalized for at least three days within 30 days of entering skilled care. Medicare pays the full cost for days 1 through 20. For days 21 through 100, Medicare pays the full cost except for a daily coinsurance, which is paid by the beneficiary. After 100 days, Medicare skilled care payment stops until the next benefit period begins.

> Mr. B enters the hospital on January 5. After being hospitalized for four days, he returns home. He enters skilled care on February 1 and stays there until May 15. He is eligible for 100 days of Medicare skilled nursing coverage (20 days of full coverage and 80 days of coinsurance). Medicare coverage ends May 11.
>
> On July 1, Mr. B returns to the hospital. After three days in the hospital, he reenters skilled care. Mr. B is not eligible for any more Medicare skilled nursing coverage, because he has not been outside of a hospital or skilled care long enough to begin a new benefit period.

Medicare coverage of care in a **psychiatric hospital** is as follows:

- There is a lifetime payment limit of 150 days for people who entered a mental health institute (MHI) before January 1, 1989, and did not have a break in their benefit period. (A patient breaks the benefit period by returning home or being placed in a hospital.)
- For a person who entered an MHI after January 1, 1989, the lifetime limit is 190 days.

Medicare does **not** cover the cost of care in a nursing facility for people with mental illness, an intermediate care facility for people with an intellectual disability (ICF/ID), or a psychiatric medical institution for children (PMIC).

Eligibility

Legal reference: 42 CFR 435.911, 441 IAC 76 (Rules in Process)

Unless otherwise specified in this chapter, application policies and general eligibility requirements are the same for people living in a medical institution as for any other applicant. Follow processing procedures described in **8-B, Application Processing** and eligibility requirements in **8-C, Nonfinancial Eligibility**, **8-D, Resources**, **8-E, Income**, and **8-F, Coverage Groups**.

A person who is not currently a Medicaid member must file an application as defined in **8-B, Which Application Form to Use**.

Residents of medical institutions must also:

- Meet specific income and resource guidelines for single and married couples.
- Need the level of care provided by the medical institution. See Medical Necessity.
- Have lived in an institution for 30 consecutive days if in the 300% eligibility group.

Reassess eligibility for a Medicaid member who enters a medical institution to determine if the member meets these additional eligibility requirements. (You do not need to reassess eligibility when a member enters an acute-care hospital unless the member expects to stay or stays more than 30 days.) A new application is not required, unless the person is at the end of a Medically Needy certification period, or the certification period will end within the 30-day stay requirement.

> Mr. W is eligible for Medically Needy with a certification period of May and June. He enters the nursing home on June 5. He is not eligible for nursing facility payment until he meets the requirements of the 300% group because he is over income. Mr. W must file an application.

Even if an application is not needed, evaluate income and resources of the client as well as the other requirements for facility payment. Entering a facility can change the household unit, deeming policies, and countable resources and income. See Effect of Institutionalization on SSI and FIP Eligibility.

A Non-MAGI member who is eligible for full Medicaid before entering the facility does not need to meet the 30-day-stay requirement for nursing facility approval in the month of entry. However, a redetermination is required before facility eligibility can be approved for ongoing months. A member, who is redetermined to the 300% group, must meet the 30-day-stay requirement before ongoing eligibility is approved.

MAGI-related members are not eligible for payment of long term care services. Exception: Children under the age of 21 who meet eligibility under the 300% group. In the month of entry, the income of the parents is counted. If the child continues to be institutionalized in the month after the month of admission, the child is considered as an individual. The income of the parents is not counted or deemed to the child.

Newborns who do not leave the hospital or who are transferred to another medical institution are considered as individuals. When a newborn is not discharged home but goes directly to another medical facility, the income of the parents is not counted or deemed to the child.

Newborns who are discharged home but return to the hospital or some other medical institution are considered part of the household in the month of admission. The income of the parents is counted or deemed in the month of entry. If the child continues to be institutionalized in the month after the month of admission, the child is considered as an individual. The income of the parents is not counted or deemed to the child.

Count resources according to **8-D, Resource Eligibility of Children**.

The 30-day stay requirement applies to people in the 300% group only. Medicaid members who are automatically redetermined to another coverage group to cover the cost of facility care do not need to meet the 30-day-stay requirement unless they are redetermined to the 300% group.

> A MEPD member enters a nursing facility on April 15. The member is eligible for nursing facility assistance in the month of entry. The IM worker redetermines eligibility for ongoing months and finds that the member meets level of care requirements, is over the 300% limit, but continues to be eligible for MEPD. The member is eligible for nursing facility assistance for ongoing months because the member meets level-of-care requirements and remains eligible for Medicaid in a full coverage group.

Assess client participation as specified in Client Participation for all members.

For ICF/ID, see **6-Appendix** for instructions on completing the required form, **ICF/ID Residential Care Agreement, form 470-0374**.

Medicaid eligibility may be established for a person who lives in a medical institution that does not participate in the Medicaid program, even though no Medicaid payment will be made to the facility. Determine income, resources, and level of care as though the institution were participating in Medicaid.

The Iowa Medicaid (IM) Medical Services Unit will do a level of care determination for a person in a facility that is not Medicaid-certified. If the person does not meet the facility's level of care, determine eligibility as if the person lived at home.

The following sections give more information on:

- Who is not eligible for Medicaid payment of institutional care
- Eligibility under the 300% coverage group
- Determination of medical necessity for institutional care
- The effect of institutionalization on SSI and FIP eligibility

Who Is Not Eligible

Legal reference: 441 IAC 75 (Rules in Process)

Eligibility under most coverage groups includes eligibility for Medicaid medical institution payment if the medical necessity requirements are met. Exceptions are as follows:

- The Medically Needy coverage group does not provide for payment for nursing care, skilled care, ICF/ID or NF/MI care, or care in psychiatric institutions.
- The qualified Medicare beneficiary (QMB) coverage group provides limited coverage for hospital and skilled nursing care and no coverage for nursing care or ICF/ID care. Only Medicare premiums, coinsurance, and deductible are covered.
- The qualified disabled and working persons (QDWP) coverage group provides Medicaid payment only for Medicare Part A premiums.
- The specified low-income Medicare beneficiary (SLMB) and the expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups provide Medicaid payment only for Medicare Part B premiums.

Examine such cases to determine if the members would be eligible for institutional care payment if in another coverage group. Obtain a new application only if a Medically Needy certification is about to end.

Eligibility for the 300% Group

Legal reference: 441 IAC 75 (Rules in Process)

The 300% group is an eligibility group used for a person in a medical institution who meets all the following requirements:

- Has countable income less than or equal to 300% of the SSI benefit amount.
- Meets level of care requirements as determined by the Iowa Medicaid (IM). See Medical Necessity.
- Receives care in a hospital, nursing facility, psychiatric medical institution, or ICF/ID for 30 consecutive days.
- The person is age 65 or older, blind, disabled, or is under the age of 21.
- Meets all SSI eligibility requirements except income. EXCEPTION: Do not consider resources for children under 21.

For more information about the 300% group, see **8-F, People in Medical Institutions: 300% Income Level**.

Do not approve eligibility until after the applicant has lived in an institution for at least 30 **consecutive** days. Eligibility begins no earlier than the first day of the month in which the 30-day period began. The period begins at 12 a.m. on the day of admission and ends no earlier than 12 midnight of the thirtieth day following the beginning of the period.

Only one 30-day period is required to establish eligibility. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month, regardless of whether the eligibility determination was completed before discharge.

If the person dies before completing the 30-day period, consider the person to have met the 30-day requirement.

The 30-day stay requirement applies to the 300% group only. Medicaid members who are automatically redetermined to another coverage group to cover the cost of facility care do not need to meet the 30-day-stay requirement unless they are redetermined to the 300% group.

A temporary absence of not more than 14 full consecutive days does not interrupt the 30-day period if the person remains under the jurisdiction of the institution. The person must first have been physically admitted to the institution.

Do not wait until after the 30-day period is over to verify other eligibility factors such as income and resources.

1. The client enters a nursing facility at 4:00 p.m. on September 5 and remains there. An application for Medicaid is received on September 12. The 30-day period of residency is met on October 4. Eligibility can be established on October 4, effective September 1, assuming all other eligibility factors are met. There is no eligibility for a prior period under the 300% coverage group.
2. The client enters a hospital at noon on August 1, transfers to a nursing facility August 15, and remains there until October 15. An application is received September 15. Eligibility can be established effective August 1 for the 300% group, assuming all other eligibility factors are met.
3. The client enters the hospital on August 15 and leaves September 15. The client is eligible for Medicaid under the 300% group effective August 1. Eligibility for the 300% group ends September 30, providing timely notice is given.
4. The client has been a private-pay patient at a nursing facility for several years. An application for Medicaid is received August 10. Eligibility can be established retroactive to May 1, assuming all other eligibility factors are met.
5. The client enters a nursing facility on July 31 and is discharged September 10. Eligibility can be established for July, August, and September, assuming all other eligibility factors are met.

6. The client enters the hospital March 31, leaves the hospital on April 14, and returns to the hospital April 16. The client is **not** eligible, since the client was not in the hospital for 30 consecutive days. The client must establish the 30-day period in the medical institution starting April 16 up to and including May 15 to be eligible for the 300% group.

People with income in excess of 300% of the SSI benefit for one person may qualify for Medicaid payment for institutional care using a medical assistance income trust. See Members with a Medical Assistance Income Trust (MAIT).

Eligibility of Blind or Disabled Children in Medical Institutions

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

A blind or disabled child under age 18 (or under age 22 if a student) may be eligible for institutional care. The child is eligible for the month of birth if all other eligibility factors are met.

Count the income of the parents for the month the child entered the institution if the child lived with the parents for part of that month. See **8-E, Deeming SSI-Related Income** for a description of the deeming process between parents and children.

Effective with the first full calendar month of institutionalization, consider only the income and resources of the child when determining Medicaid eligibility. A child who is born in a medical institution and does not leave the institution during the month of birth is considered a resident of the institution for a full calendar month. Count only the child's income when determining eligibility.

For treatment of resources, see **8-D, Resource Eligibility of Children**.

The income and resources of the parents are not deemed to the child until the month following the month of discharge.

3-20-03 Child is born in hospital
4-10-03 Child leaves hospital for parent's home

The parents' income is not considered in determining eligibility for March and April.

Preadmission and Resident Review (PASRR)

All individuals entering a Medicaid-certified nursing facility must have a Preadmission Screening and Resident Review (PASRR) completed. PASRR is a federally required process to ensure that individuals with intellectual disabilities or mental illness are appropriately screened, evaluated, placed in nursing facilities when appropriate; and if placed in a nursing facility, are receiving all services necessary to meet the resident's needs. A PASSR must be completed prior to an individual being admitted into a nursing facility.

All nursing facilities in Iowa are required to use the PathTracker system to enter resident admissions, transfers, and discharges. PathTracker data is used to generate form **470-5386, PASRR Case Activity Report**.

Medical Necessity

Legal reference: 441 IAC 78.3(249A), 441 IAC 81.3(249A), 441 IAC 81.7(249A), 441 IAC 82.7(249A), 441 IAC 82.8(249A), 441 IAC 85.7(2)

A person is eligible for Medicaid payment for care in a long term care facility or psychiatric institution only if the level of care provided is determined to be reasonable, medically necessary, and appropriate.

A level of care determination is required when a person enters a facility or moves to a different level of care. Use the Case Activity Report to determine who will be making the level of care determination. Review the form to verify the date of the member's admission to the facility and Medicare coverage.

The Iowa Medicaid (IM) Medical Services Unit or the MCO determine whether the person needs the level of care provided by a medical institution. However, when a person is eligible for Medicare and admits into a facility using their Medicare skilled nursing benefit, the Medicare intermediary makes the determination. Accept a level of care determination completed for Medicare purposes for determining Medicaid eligibility. A person who has been approved for Medicare at a particular level of care is eligible for the same level of care under Medicaid. The facility should submit a new Case Activity Report when Medicare benefits are exhausted. To begin the process, make entries to pend the facility program in ELIAS. This initiates the level of care determination.

The Iowa Medicaid (IM) Medical Services Unit nurse reviewer or the MCO makes a level of care determination based on the information provided and enters the decision in IoWANS. IoWANS documents the level of care approval and effective date.

If a member has requested retroactive eligibility to cover cost of medical institution care, check to see if the Iowa Medicaid (IM) Medical Services Unit has made a retroactive determination. A person may have needed institutional care in the retroactive period even if such care is not medically necessary now.

If the member meets all other eligibility requirements and the level of care is medically necessary, complete ELIAS entries for an eligibility determination. For more information, see **14-M, IoWANS User Guide** for specific enrollment processes.

See If Level of Care Is Denied for procedures when the Iowa Medicaid (IM) Medical Services Unit finds that the person does not need the level of care requested.

NOTE: When a person requests Medicaid payment for skilled nursing care in an out-of-state facility, refer the facility to the Bureau of Medical and Long Term Services and Supports for approval of payment. Also discuss the waivers and programs for all-inclusive care for the elderly (PACE) with these applicants and request waiver slots if appropriate. (A person receiving Iowa Medicaid payment in an out-of-state facility is still considered an Iowa resident and can be put on waiver waiting lists.)

Continued Stay Reviews

Legal reference: 441 IAC 78.3(249A), 441 IAC 81.3(1), 441 IAC 81.7(249A), 441 IAC 82.8(249A), 441 IAC 85.7(2)

An initial medical necessity determination does not ensure continued eligibility. The Iowa Medicaid (IM) Medical Services Unit or the MCO will review the member's level of care within 90 days after admission. A member must continue to need the level of institutionalized care provided in order to ensure continued eligibility.

Assume that the level of care continues to be approved as long as the member stays at the same level of care. The Iowa Medicaid (IM) Medical Services Unit will notify you of any change in the level of care.

See If Level of Care Is Denied for procedures when the Iowa Medicaid (IM) Medical Services Unit finds that the member does not need the level of care received. If a continued-stay review denies the current level of care, but the member continues to need care in a medical institution, eligibility can continue with payment at the lower level of care. See Approval at a Lower Level of Care.

If Level of Care Is Denied

Legal reference: 441 IAC 81.3(1)

If the applicant does not need a level of medical institution care or needs a lower level than requested, the Iowa Medicaid (IM) Medical Services Unit or the MCO issues a denial letter to the applicant, the physician, the facility, and the Bureau of Medical and Long Term Services and Supports. IoWANS will notify you if level of care is denied.

The client may file an appeal if the client disagrees with the Iowa Medicaid (IM) decision. Appeal requests should be sent to the Department's Appeals Section following the normal appeal procedure in **1-E, Appeals and Hearings**. Iowa Medicaid (IM) staff will review the previous denial and complete an internal reconsideration in preparation for the appeal.

When level of care is denied, the application for payment of nursing facility care should be denied. People in the 300% group must need institutional care as a condition of eligibility. People who qualify under other coverage groups may be eligible for general Medicaid services even if they are not eligible for Medicaid payment for their institutional care.

1. Mr. P has lived in a nursing facility for four years and has gross income of $700 monthly. He applies for Medicaid March 1. Iowa Medicaid (IM) determines that Mr. P does not need care in a medical institution. He is not eligible for Medicaid payment for nursing care. Medicaid eligibility under other coverage groups is examined.
2. Mrs. W has been receiving skilled care for three months when she applies for Medicaid November 5. Iowa Medicaid (IM) determines that Mrs. W does not need skilled care, but does need nursing care. Ms. W meets all other eligibility factors. The application is approved for medical institution care at the nursing care level.

If a person files a timely appeal of a level of care denial in a continued stay review, continue assistance pending the decision.

If the appeal decision upholds the Iowa Medicaid (IM) denial, examine the case to determine if the client is eligible for another Medicaid coverage group that does not depend on institutional residence (e.g. Medically Needy or qualified Medicare beneficiary). If so, payment will be made for other services. No payment will be made for facility care. Enter the aid type the person would have if living at home.

Ms. A is a Medicaid member in a nursing facility. She is in the 300% group and has income of $900 per month. She is denied nursing level of care and receives the final decision June 3 that she no longer needs care in a medical institution. Her case is canceled effective July 1 for the 300% group. She is automatically determined eligible for the Medically Needy coverage group.

Approval at a Lower Level of Care

Legal reference: 441 IAC 81.10(4)“g,” 441 IAC 78.3(6), 441 IAC 78.3(14)

If the Iowa Medicaid (IM) Medical Services Unit or the MCO determines that a person needs a lower level of care, the client must seek placement in the correct level of care. The social worker at the facility is responsible for finding another placement if the current facility does not offer the lower level of care.

If an alternative placement is not available, payment may be made at the lower level if the facility agrees to accept it. When the facility agrees to accept payment at the rate for the certified lower level of care, continue to use the same aid type entered for the original level of care.

Mr. N is initially approved for nursing level of care. At the continued stay review, he is determined to need residential level of care. Payment can continue at the residential care facility rate. The case continues under the nursing facility aid type and vendor number used before the denial of level of care.

If the facility will not accept the lower payment rate, approve Medicaid in the aid type the person would be in if living at home.

NOTE: ICFs/ID and PMICs offer care that is not primarily nursing care. Iowa Medicaid (IM) does not usually certify a lower level of care for people in these facilities.

Effect of Institutionalization on SSI and FIP Eligibility

How SSI Eligibility Is Affected

Legal reference: 20 CFR 416.211, 20 CFR 416.414

Entry into a medical institution may affect SSI eligibility including the benefit amount and deeming policies. When an SSI recipient enters a medical institution, notify the Social Security Administration district office using form **470-0641, Report of Change in Circumstances - SSI-Related Programs**. This allows Social Security to review the payment.

When an SSI recipient enters a public or private medical institution in which Medicaid pays more than 50% of the cost of care, different SSI benefits rates apply. The person is entitled to the full SSI benefit rate for any month in which the person is out of the institution for part of the month.

The SSI benefit rate drops to $30 effective with the first full calendar month that the person is in the institution. For many people in institutions, this policy results in loss of SSI benefits. If SSI benefits continue, then Medicaid eligibility can continue without completing a review.

Recipients who lose SSI eligibility because they enter the institution must complete an application. This form is for purposes of review and is not an application. Complete an automatic redetermination to see if the person meets the requirements of another Medicaid coverage group.

When Medicaid is **not** paying at least 50% of the cost of **private** institutional care for an SSI recipient, the person continues to receive full SSI benefits as though the person were in an independent living arrangement. The Social Security Administration determines who is paying 50% of the cost of care. When SSI continues, the person retains Medicaid eligibility by virtue of the receipt of SSI benefits.

When an SSI recipient enters a **public** medical institution, such as a state mental health institute, SSI benefits end effective with the first full calendar month the person lives in the institution, unless Medicaid is paying at least 50% of the cost.
EXCEPTIONS:

- Full SSI benefits continue for up to three months, even if Medicaid pays 50% of the cost of care, when a doctor verifies that the stay will be less than three months.
- People who perform substantial gainful activity receive the full SSI benefit for two full months after entry to a medical institution.

When SSI recipients aged 22 through 64 enter a mental health institution, they lose SSI eligibility after being in the institution for a full calendar month.

The Social Security Administration stops deeming income and resources from ineligible parents to an eligible child effective the month after the month the child enters a medical institution.

When both members of a married couple receive SSI and one enters a medical institution, the Social Security Administration considers them a couple for the month of entry. They are considered separately the next month for SSI. Medicaid policy considers each member of the couple for attribution even though one or both members may be on SSI.

1. Mr. W, age 65, enters a mental health institute and applies for Medicaid. His income is $100 per month. He would be eligible for SSI outside the institution, but the SSI benefit level changes to $30 since Medicaid is expected to pay more than 50% of the care, and his income is in excess of that amount. He is eligible under the coverage group "eligible for SSI but for living in a medical institution."
2. Mr. J, an SSI recipient, age 32, enters a county hospital in its swing-bed unit. There is an initial level-of-care denial. Mr. J has insurance that pays the swing-bed. Since Medicaid does not pay 50% of the cost of care, Mr. J is canceled from SSI. However, Medicaid continues under the coverage group for persons ineligible for SSI because of requirements that do not apply to Medicaid, because Mr. J meets all other SSI requirements.

How FIP Eligibility Is Affected

Legal reference: 441 IAC 41.23(3)"b"

Entry into a medical institution may affect Family Investment Program (FIP) eligibility. Examine eligibility to determine if the person who enters the medical institution continues to meet the FIP definition of "living with." See **4-C, Temporary Absence in a Medical Institution**.

The person is not a part of the FIP eligible group at home if the person is not expected to return within one year from either:

- The date of application, if the person is not a current member, or
- The date of entry to a medical institution, if the person is a current member.

If the person is not "living with" the family at home, determine eligibility of the person in a medical facility separately.

If a MAGI-related person loses eligibility under the previous coverage group, examine eligibility under a Non-MAGI-related coverage group. Examine eligibility under the 300% group for a child under 21.

If a parent is 21 or older, determine if the family would be eligible for FIP if the person were to live at home.

Income and Resources of Married Persons

Legal reference: 441 IAC 75 (Rules in Process)

If a spouse in an institution is expected to stay at least 30 consecutive days, some eligibility factors are considered differently. These include:

- Determining income from property.
- Division of income for Non-MAGI-related groups.
- Attribution of resources to an institutionalized spouse and a community spouse. (There is no attribution for single persons.)
- Different income and resource policies for spouses who entered an institution before September 30, 1989, and those who entered on or after that date.

Determine the anticipated length of institutionalization for new applicants. Verify with a physician that the stay is expected to last at least 30 consecutive days if the client is unsure or the information is questionable.

Eligibility factors are also different depending upon whether one or both spouses are in an institution and whether they share a room. This section deals with the different requirements based on length of stay and living arrangements.

When one spouse is in an institution, treatment of income and resources depends upon the spouse's situation, as explained in the following chart:

WHEN ONE SPOUSE IS IN AN INSTITUTION	
Expected stay of less than 30 days:	
Income: Compare household income to SSI limit for couple when determining eligibility.	**Resources:** Compare household resources to SSI limit for a couple when determining eligibility.
Mrs. M enters skilled care after a hip injury, expecting to stay about 20 days. Mr. M, her spouse, is at home. Mr. and Mrs. M have gross income of $600 monthly and countable resources of $6,000. Mrs. M's eligibility is determined with Mr. M, since she is not expected to remain in a medical institution 30 consecutive days. They may be eligible under the Qualified Medicare Beneficiary group or Medically Needy (for services other than skilled care).	

Expected stay of less than 30 days, but stay exceeds 30 days:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to minimum monthly maintenance needs allowance (MMMNA).	**Resources:** Complete an attribution.
In an institution on or after September 30, 1989, for 30 days or more:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution.
Institutionalized spouse returns home, but community spouse enters facility and expects to stay 30 days or more:	
Income: Count only the newly institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution for new institutionalized spouse and new community spouse.
Marries a community spouse before eligibility is established:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution for new institutionalized spouse and new community spouse as of the date of entry into the medical institution.
Marries a community spouse after eligibility is established:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Compare the institutionalized spouse's resources to the single-person limit. Do not count community spouse's resources to institutionalized spouse. Complete an attribution for the new institutionalized spouse and new community spouse only if the institutionalized spouse's assistance is canceled and reapplication is made.

Institutionalized person marries another institutionalized person:	
Income: Treat as individuals or a couple per client request and client advantage. If treated as a couple, compare total gross income to 2 x 300%. If treated as individuals, income limit of 300% for each person.	**Resources:** Treat as individuals or a couple per client request and client advantage. If treated as a couple, add resources, compare to $3,000 limit. If treated as individuals, resource limit is $2,000 for each person.

Determining If a Common-Law Marriage Exists

Legal reference: Legislative Guide to Marriage Law/Iowa Legislative Services Agency at https://www.legis.iowa.gov/docs/central/guides/marriage.pdf; IowaLegalAid.org at http://www.iowalegalaid.org/resource/common-law-marriage-in-iowa

When determining if someone has a spouse, there may be situations where a common-law marriage exists or the applicant or member claims a common-law marriage exists. Accept a couple's claim that a common-law marriage exists unless you have reason to question the claim. If you question the claim, a common-law marriage exists if **both** people:

- Mutually agree they are married (they are not free to marry someone else).
- Live together continuously or lived together continuously before one member entered a medical institution.
- Publicly declare and present themselves to be married.

The following items can further indicate that a common-law marriage exists:

- Joint income tax forms
- Joint purchase of property (house, car, etc.)
- Mortgages or loans
- Insurance policies
- School records
- Employment records
- Birth records
- Joint bank accounts
- Statements to friends or relatives
- Hotel or motel registrations
- Wear wedding bands

Evidence must represent the couple as married. One item is generally not enough evidence, but several items might indicate a common-law marriage.

A common-law marriage is a legal and valid marriage. When a common-law marriage exists, treat the adults the same as any other married couple.

1. Mr. Brown applies for nursing facility care. Mr. Brown and Ms. Smith have lived together for 25 years. They have purchased several properties together, including the home they live in. They have a joint bank account.

   Mr. Brown requests that an attribution be completed because he states they are common law. There is no evidence that they have publicly declared or presented themselves as married. They have always filed individual income tax returns.

   Since they have never publicly declared or presented themselves as married and never filed a joint return, evidence shows they are not common law. Do not complete an attribution.

2. Sally and John complete an application for facility care. John is listed as the spouse. Sally enters a medical institution on April 14.

   In a phone conversation with John, he states they have a common-law marriage. Sally and John have publicly declared they are husband and wife. John has Sally listed on his employment application as his wife. This creates a presumption that a common-law marriage exists.

   The worker completes an attribution of resources. When Sally is resource-eligible, John will be allowed a spousal diversion, if applicable.

When Both Spouses Are in an Institution

When both spouses are institutionalized and living in different facilities, treat each as a single individual. Do not count the income and resources of one spouse to determine the eligibility of the other spouse.

When both spouses are in the same institution, treatment of income and resources depends upon whether the spouses are living in the same room or in different rooms, as explained below.

Living in the Same Room

Legal reference: 441 IAC 75 (Rules in Process)

If spouses live in the same room in a medical institution, treat their income as a couple from the month the first spouse entered the medical institution until the last day of the sixth calendar month in which the first spouse continuously lived in the facility. The six-month period that the couple must be treated together begins with the month following the month of entry into the institution when both spouses enter in the same month. When spouses enter the same room at different times, see When a Spouse Moves into the Same Room.

To be eligible for Medicaid, the couple's combined income cannot be more than two times the 300% limit of the SSI benefit for a single person. Use the SSI resource limit for a married couple.

After Six Months

Effective the first day of the seventh calendar month, spouses can choose to be treated individually. If they chose to be separate, the income of each spouse cannot exceed 300% of the SSI benefit for one, and the resource limit is $2,000 for each person.

The couple can continue to be treated as a couple after six months if:

- They choose to be considered together, or
- One spouse would be ineligible for Medicaid or would receive reduced benefits by considering them separately.

People treated together as a couple for income and client participation must be treated as a couple for resources. People treated individually for income and client participation must be treated individually for resources.

1. Mr. and Mrs. J, a married couple, enter the same room in a nursing facility on June 13. Mr. J has gross income of $950, and Mrs. J has gross income of $675. Their combined income of $1,625 is compared to twice the 300% income limit for June through December. In January, they choose to be separate and their respective incomes are compared to the single-person gross income limit.

   They have countable resources of $3,000 in a joint checking account. For June through December, their resources are combined and compared to the couple limit. For January, half of their combined resources is compared to the single-person resource limit. (The jointly owned checking account is divided in half, since each spouse is a Medicaid member.)

2. Mr. and Mrs. Z enter the same room of a nursing facility in January. Mr. Z's income is $2,700 per month and Mrs. Z's income is $300 per month. Their combined income is $3,000; their combined resources are $2,900.

   As of July 1, eligibility for Mr. and Mrs. Z can be determined as separate individuals. Because this would make Mr. Z ineligible beginning July 1, the worker continues to determine the Zs' NF eligibility as a couple.

When a Spouse Moves Into the Same Room

Legal reference: 441 IAC 75 (Rules in Process)

If one spouse is in an institution and the second spouse later moves into the same room within six months of the first spouse's entry, the policies under Living in the Same Room apply to the eligibility of the second spouse. The eligibility and client participation of the spouse who has been in the institution does not change for the month of entry of the second spouse.

The initial eligibility of the second spouse to enter the institution is considered with the spouse already in the institution when they both live in the same room during the six-month period. In the **next month** after the second spouse's entry, combine the income of both spouses when determining each person's eligibility, until the six-month period has expired. The six-month period begins the month of entry of the first spouse.

Once the six months has elapsed, there is no second six-month period if the couple enters different rooms and then later reenters the same room. There is not a new six months' treatment for a couple's income and resources if the couple changes nursing homes. However, if both spouses return home and then reenter a medical facility, a new six months of treatment as a couple applies.

> Mr. Y entered a nursing facility in May and became eligible for Medicaid. Mrs. Y enters the same room in June. Their eligibility must be considered together from June through October 31. Her eligibility is determined by adding her income of $450 to Mr. Y's income of $575 and comparing the result of $1,025 to twice the 300% income limit. Her countable resources of $1,180 are added to his countable resources of $1,817. She is eligible.

Living in Different Rooms

Legal reference: 441 IAC 75 (Rules in Process)

If both spouses are institutionalized in the same facility but in different rooms:

- Treat their income and resources as a couple for the month of entry to the institution. Combined income may not exceed two times the 300% limit for an individual.
- Treat their income separately for eligibility purposes effective the month after the month of entry.

The spouses can be treated as a couple effective the first day of the seventh calendar month of continuous residency in the same facility if:

- One spouse would be ineligible or would receive reduced benefits if considered separately, or
- The spouses choose to be considered together.

If the spouses enter separate rooms at different times, treat income and resources as for an individual. After the spouse who entered the facility first has been in the facility for six months, the spouses may choose to be considered together for eligibility.

> Mr. W enters skilled nursing facility care and Mrs. W enters an NF care on November 7 (not in the same room). Their joint income is $897. They must remain in a medical facility 30 consecutive days for eligibility. They meet this requirement December 6.
>
> Mr. W's income is $497 monthly and Mrs. W's income is $400 monthly. Mr. W has $1,800 in a savings account and Mrs. W has $1,400 in checking.
>
> For November, the combined income of Mr. and Mrs. W is counted towards two times the 300% income limit for an individual. Their income ($897) is below this limit. The couple's joint resources ($1,800 + $1,400 = $3,200) are compared to the resource limit for a couple.
>
> Mr. and Mrs. W are both ineligible for the 300% group for November because their combined resources exceed the couple limit for the 300% group. They are conditionally eligible for Medically Needy.
>
> For December, each person's resources are compared to the resource limit for an individual. Mr. and Mrs. W each have resources below the 300% group limit, so they become eligible effective December 1.

When Applying for or Receiving Waiver or PACE Services

Legal reference: 441 IAC 83.2(1)"f," 441 IAC 83.3(5), 441 IAC 83.22(1)"c," 441 IAC 83.23(5), 441 IAC 83.42(1)"c," 441 IAC 83.43(5), 441 IAC 83.61(1)"b," 441 IAC 83.62(5), 441 IAC 83.82(1)"b," 441 IAC 83.83(4), 441 IAC 83.102(1)"e," 441 IAC 83.103(4)

hen one spouse is applying for or receiving home- and community-based service (HCBS) waiver or programs for all-inclusive care for the elderly (PACE) services and the other spouse lives in the home, treat income and resources according to policies under Income and Resources of Married Persons in the category "In an institution on or after September 30, 1989, for 30 days or more."

When both spouses are applying for or receiving HCBS waiver or PACE services, treat income and resources according to policies under When Both Spouses Are in an Institution: Living in the Same Room.

When one spouse is in a medical facility and the other spouse is applying for or receiving HCBS waiver or PACE services, treat each as an individual. Do not count the income and resources of one spouse to determine the eligibility of the other spouse.

Client Participation

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process), 441 IAC 81.4(2), 441 IAC 82.9(2)

Medicaid members (except for members in acute hospital care or QMB recipients) are required to participate in the cost of medical institution care. The amount that a resident contributes is called “client participation.” Both client participation and third party payments, such as Medicare, must be paid before any Medicaid payment.

The facility is notified of the member’s client participation amount through the Iowa Medicaid Provider Access (IMPA) portal.

The facility makes arrangements directly with the resident to collect client participation. Generally, the facility will ask the member to pay client participation at the beginning of the month from income received during the month. If income is received periodically during the month, the member may be asked to pay the facility as income is received.

This section describes:

- Countable and exempt income in determining the client participation.
- Deductions.
- How client participation is calculated.

Enter gross income into the system to determine first-month and ongoing client participation.

Review the client participation determination at the time of the eligibility review. Verify:

- The member’s income and deductions.
- The income of the community spouse and dependents.
- The cost of unmet medical needs.

Income Available for Client Participation

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

Use the member's total monthly income, including:

- The $30 benefit that SSI pays to people who remain eligible in a medical institution.
- Infrequent and irregular income disregarded during eligibility computation.
- All earned income and child support. (NOTE: The $25 annual fee paid to Child Support Services is not considered income.)
- The gross income before tax or social security withholding. (Members can write the income source to ask that federal tax not be withheld. Members should describe their living and financial circumstances in the request.)
- Veterans aid and attendance if included in the monthly VA check. Do not allow a deduction for amounts being recouped. Enter the aid and attendance amount as "income" for benefits if the system is determining client participation.
- Veterans payments for unusual medical expenses (UME) included in the monthly VA check, if the veteran or the surviving spouse of a veteran is residing in the Iowa Veterans Home (IVH) in Marshalltown **and** does not have a spouse or dependents. In these circumstances, the first $90 of the monthly VA check is not considered to be UME.

  Payments for UME are not considered as income in determining eligibility or client participation for veterans residing in other medical facilities or those residing at the IVH who have a spouse or other dependents.
- Deemed income from the parent for any month when a child spends part of the month in the parents' household (i.e., the child enters the facility on a day other than the first of the month).
- Benefits from insurance policies for institutional care that are paid to the policyholder but excluded as income for eligibility purposes. (See **8-E, What Is Not Considered Income** and **Types of SSI Related Income: Insurance and Third-Party Payments** for a description of this type of income.)
- Interest and dividends that are excluded during the eligibility computation.

See **8-E, Projecting Income** for instructions on calculating client participation correctly.

Do not allow the earned income deduction of $65 and 1/2 or the $20 disregard in computing gross income. See Ongoing Personal Needs Allowance regarding earned income.

Ms. J. has a gross monthly pension of $50.00. $5.80 is deducted from the pension for federal income tax. Also, she has infrequent interest income that prorates to $6.00 monthly. The $50.00 gross pension and $6.00 interest are counted as income in computing client participation.

If a client enters skilled care, check with the facility to determine if Medicare will share in the cost of care. Calculate client participation as if Medicare were not paying. The facility will refund any excess client participation to the client.

EXCEPTION: Client participation is not accessed when the combination of Medicare payments and Medicaid benefits available to qualified Medicare beneficiaries covers the cost of skilled care. For more information on client participation in skilled care, see Client Participation for QMBs Entering Skilled Care.

If there is a community spouse, consider only the institutionalized spouse's income when determining client participation.

If both spouses are in the same room and they chose to be considered as a couple, use the couple's combined income to determine eligibility. Determine client participation for each spouse based on half of the combined income.

If spouses are living in different rooms of the same medical institution or in different medical institutions, they are considered separately for eligibility. Consider each person's income separately for client participation.

Benefits insurance policies that are paid to the policyholder are considered available to pay for facility care. Add them to the client participation for the benefit calculation. These payments are not considered income for eligibility as long as they are applied to the member's cost of care. Any insurance payment retained by the member is considered income in the month of receipt and must be included in the eligibility determination.

When an insurance payment is based on a flat rate per day, convert the daily amount to a monthly amount by multiplying by 30.4. Add the monthly amount to the client participation after giving all allowable deductions. Do not complete form **470-2826, Insurance Questionnaire** when the insurance payments are added to the client participation. (See **8-E, Third-Party Payments**.)

If the client participation plus the additional insurance benefits exceeds the maximum monthly Medicaid rate, follow policies under If Client Participation Exceeds the Facility's Medicaid Rate.

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**.

Income Exempt from Client Participation

Legal reference: P.L. 99-643, 441 IAC 75 (Rules in Process)

For FIP recipients, do not calculate client participation using the income of the member or the family if the member has a parent, stepparent, or child at home who receives FIP and the family's income is considered together in determining FIP eligibility.

> Sam, age 17, enters a facility and is expected to stay less than 12 months. His Medicaid eligibility is determined under the 300% group. The family's income is below the FIP guidelines for their household size.
>
> Sam will need to meet the 30-day stay requirement for the 300% group. The family at home is approved for FIP and neither the family's income nor Sam's income is used to calculate client participation.

For State Supplementary Assistance recipients, exempt the State Supplementary Assistance payment and exempt any client participation that the member paid while in a State Supplementary Assistance living arrangement for the month of entry to the medical institution.

If the member enters a medical institution from foster care, do not count the amount of income paid for foster care when calculating client participation for that month. Check with the service worker for the amount of the member's income that was spent on the foster care maintenance payment, and use the remaining balance as income.

Non-MAGI-Related Members

Legal reference: 441 IAC 75 (Rules in Process)

For Non-MAGI-related members who are substantially gainfully employed, as determined by the Social Security Administration, exempt any SSI and mandatory State Supplementary Assistance payments for the first two full months after the resident enters the institution.

For Non-MAGI-related members expecting to return home within three months, exempt SSI or federally administered State Supplementary Assistance payments for the three months after entry to the institution if the Social Security Administration continues these payments.

To determine whether to exempt the income of an SSI or federally administered SSA recipient, ask how long the person expects to remain in the facility. Record the answer under "Comments" on form **470-0641, Report of Change of Circumstances, SSI-Related Programs** and send the form to the Social Security Administration district office.

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.

To determine whether to exempt the income of a veteran or surviving spouse of a veteran, you must:

- Determine the type of VA payment being received. Other types of VA benefits, such as compensation payments, aid and attendance, and unmet medical expenses are not subject to the reduction and do not qualify for the $90 income exclusion.
- Determine whether the person has a spouse or dependents. If the person **has** a spouse or dependent, the pension will not be reduced, and the person does not qualify for the $90 income exclusion.

Based on the person's situation:

- Use the entire VA pension amount to determine eligibility and client participation for the month of entry if the veteran or surviving spouse is entitled to full benefits for that month.
- If the VA pension has already been reduced because the person came from another institutional placement, exclude $90 pension as income when determining eligibility and client participation.
- If the client **does not have** a spouse or dependent, assume that the VA pension will be reduced to $90. Exclude $90 pension income when determining income and client participation beginning with the month after the month of entry to the institution.
- If the VA continues to pay full benefits to a member whose pension will be changed to $90:
  - Consider any pension or aid and attendance amount over $90 for eligibility and client participation,
  - Tell the member to report when the pension is reduced, and
  - Use the reduced amount to calculate client participation for the month of the reduction, even if the change is reported later.

NOTE: VA pension payments of certain residents of the Iowa Veterans Home are not subject to the $90 limitation but still qualify for the $90 income exclusion. See Residents of the Iowa Veterans Home.

When an application for a VA pension is approved, a lump sum is sent to the member. Exclude the portion of this lump sum that represents the $90 reduced/improved pension, based on federal requirements for eligibility and benefits. Consider any remaining amount of the lump sum as income in the month of receipt. Any amount of the lump sum retained in the following month is a countable resource.

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).

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

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

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

1. Ms. M enters skilled care in February and returns home in October. She is allowed a deduction for expenses in October equal to the SSI benefit for one person.
2. Mr. and Mrs. P enter a nursing facility together and return home in the same month. They are given the SSI benefit for two as a deduction in the month of discharge.

Deduction for the Maintenance Needs of Spouse and Dependents

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

Allow a deduction for the maintenance needs for:

- A community spouse and dependents living with the community spouse, including:
  - Children, regardless of age,
  - Parents and in-laws, and
  - Siblings of either spouse.

  NOTE: Consider children under age 22 who are away attending school but are under the control of the parents as living with the community spouse.
- Children under the age of 21 living at home when there is no community spouse.

If the institutionalized spouse has a community spouse with income less than the minimum monthly maintenance needs allowance (MMMNA), allow a deduction to provide an ongoing allowance for the maintenance needs of the community spouse. Also allow a deduction for minor or dependent children, stepchildren, dependent parents, or the dependent siblings of either spouse who live with the community spouse.

The community spouse and dependents must apply for every income benefit for which they are eligible, except they are not required to accept Supplemental Security Income (SSI), Family Investment Program (FIP), or State Supplementary Assistance (SSA) in place of the maintenance needs allowance.

Issue form **470-0383, Notice Regarding Acceptance of Other Benefits** to the community spouse and dependents. The community spouse and dependents must indicate whether the member or spouse intends to apply for the identified benefits.

If the community spouse or dependents refuse to apply for benefits, contact the benefit agency to determine benefit amounts for a person in the same financial circumstances as the spouse or dependent. Count the anticipated amount as income as if the spouse or dependents received the benefits. Reduce the maintenance needs allowance by the amount of the anticipated income from each income source.

Consider income prospectively. See **8-E, Projecting Future Income**. If there is a change in income, consider the change when determining prospective income.

Use the verified gross income of the spouse and dependents when determining maintenance needs. Include all monthly earned and unearned income and assistance from the FIP, SSI, and SSA. Gross income also includes the proceeds of any annuity or contract for sale of real property. See **8-D, Specific Non-MAGI-Related Resources: Annuities** on how to count annuities.

Consider income the same way the SSI program considers income. Do not allow the community spouse or dependents the earned income disregard or the general income disregard. Do not count any other income disregarded by policy.

If the community spouse is receiving FIP, the community spouse's share of the grant is based on whether the children for whom the FIP benefit is received are the children or the stepchildren of the institutionalized spouse.

- If the children receiving FIP are all stepchildren of the institutionalized spouse, use the standard of need for one as the portion of the FIP benefit to count as income for the community spouse.
- If the children receiving FIP are all children of the institutionalized spouse, consider the FIP grant as income to the community spouse. Divide the grant by the number of people in the household and count the result as income to each person when calculating deficits.
- If the institutionalized spouse has both stepchildren and legal children at home receiving FIP, use the procedure in **4-E, Excluded Parent** to determine the FIP income of the community spouse.

If the community spouse or dependents receive SSI or federally administered SSA, use the State Data Exchange (SDX) amount labeled “SSI gross” or “SSA gross.”

If the community spouse or dependents receive SSA benefits for in-home health-related care, count all the SSA benefit for the spouse or dependent receiving this care. If both spouses receive in-home health-related care in the month of entry, ask the service worker the amount of the community spouse’s SSA benefit.

Allowance for the Community Spouse

Legal reference: 441 IAC 75 (Rules in Process)

To determine the maintenance needs of the community spouse, subtract the spouse’s gross income from the minimum monthly maintenance needs (MMMNA) allowance shown below. The allowance is indexed annually for inflation.

Minimum Monthly Maintenance Needs Allowance (MMMNA)			
Calendar Year	**Amount**	**Calendar Year**	**Amount**
2026	$4,066.50	2013	$2,898.00
2025	$3,948.00	2012	$2,841.00
2024	$3,853.50	2011	$2,739.00
2023	$3,715.50	2010	$2,739.00
2022	$3,435.00	2009	$2,739.00
2021	$3,259.50	2008	$2,610.00
2020	$3,216.00	2007	$2,541.00
2019	$3,160.50	2006	$2,488.50
2018	$3,090.00	2005	$2,377.50
2017	$3,022.50	2004	$2,319.00
2016	$2,980.50	2003	$2,266.50
2015	$2,980.50	2002	$2,232.00
2014	$2,931.00	2001	$2,175.00

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

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

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

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

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

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

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

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

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

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

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

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

Facility providers have received an informational letter explaining the procedure for these claims.

Providers are to submit a Medicare claim for the Medicare-covered days. The provider should also submit one Medicaid care claim for the full month, even when the resident's status changes to a Medicare-payable level of care during the month. The Medicare days are to be shown on the Medicaid claim as noncovered days to avoid duplicate payment by Medicare and Medicaid.

> A Medicaid member was in a nursing facility from May 1 to May 7. She was in the hospital on May 7 through May 12 and then returned to the nursing facility with Medicare coverage from May 13 through May 16. Medicare coverage ended May 17. The member's care was covered only by Medicaid from May 17 to May 31.
>
> The worker determines one client participation amount for the entire month. The facility bills Medicare for the four Medicare-covered days of May 13 to May 16. The facility submits a Medicaid claim for May 1 through May 31 (the entire month) showing four noncovered days (the four days that Medicare covered).
>
> The claim for May 1 through May 31 is processed and the facility receives Medicaid payment for 27 of the 31 days. The Medicaid payment is reduced by the amount of the full monthly client participation. The four Medicare-covered days are not paid on this claim. If Medicare does not pay at 100%, a crossover claim is received and processed. Medicaid payment is made only when the rate for Medicare didn't equal or exceed the Medicaid rate.

When the Medicare rate equals or exceeds the Medicaid rate, no Medicaid payment is made to the facility for the Medicare-covered days. Most of these situations, there is no Medicaid payment on the Medicare crossover claim. In a rare case where the Medicaid rate is higher, you will need to adjust the client participation.

If a facility reports that the client participation has been used twice, once on the crossover claim and once on the long-term care claim, then the stay will need to be split in IoWANS to correct the doubled client participation.

If the facility reports that the client participation has been used twice and the client is a qualified Medicare beneficiary (QMB), then the stay will need to be split in IoWANS to show that client participation was zero for the Medicare-covered days. Change the client participation to zero during Medicare-covered days when:

- A QMB-eligible facility client is receiving skilled care, and
- The Medicaid rate is higher than the Medicare rate for this stay.

For more information on QMB eligibles, see Client Participation for QMBs Entering Skilled Care.

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 charges for care
- Trust payments
- Determination of client participation

125 Percent of the Statewide Average Charge for Care

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

Charge for care figures are:

Type of Care	Charge for Care	
	July 1, 2025 June 30, 2026	July 1, 2026 – June 30, 2027
Nursing facility	$11,713.75	$12,002.50
PMIC	$26,477.50	$25,275.00
MHI	$37,795.00	$37,795.00
ICF/ID	$55,721.25	$61,526.25

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.

On March 24, Mr. W, a nursing facility member, receives a retroactive veterans payment of $2,000 and an award of $600 monthly veterans income. He reports this April 2. The worker changes client participation on the system for May. Mr. W also owes **extra** client participation for March and April, but no more than the state would pay for the care.

For computation of March client participation, the worker adds $2,000 to March's income. For April, the worker adds the monthly veterans income ($600) to April's income. The worker notifies Mr. W and the facility of adjusted client participation for March and April. When Mr. W pays the facility, the worker corrects the amount on IoWANS for March and April.

When the member has paid too much client participation, prepare an adjustment to return the money to the medical institution. The member collects the excess client participation from the facility.

If Lower Level of Care Is Needed

Legal reference: 441 IAC 75 (Rules in Process), 441 IAC 78.3(6), 441 IAC 78.3(14), 441 IAC 81.10(4)"g"

As described in Medical Necessity, the Iowa Medicaid (IM) Medical Services Unit or the MCO may decide that a member needs a lower level of medical care than the level provided by the facility where the member lives. If the facility agrees to accept payment at the lower level, the member may stay in the facility temporarily until placement at the correct lower level is found.

Assess client participation based on the type of facility in which the member lives. For members in a hospital, do not assess client participation if the hospital is providing SNF or NF care in an acute-care bed. If the hospital is a swing-bed hospital, the member is considered to be in a skilled facility as long as the member needs skilled care. When the member does not need skilled care, the bed "swings" back to an acute-care bed.

If a member is eligible or potentially eligible for Medicaid only under the Medically Needy coverage group, there is no client participation, since Medicaid does not pay for institutional care under Medically Needy.

See Payment for Inpatient Hospitals Who Require a Lower Level of Care for how to handle payments to facilities when a member needs a lower level of care but an alternative placement cannot be found.

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.

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

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

1. Calculate the correct amount of client participation for the current month that included the refund received due to buy-in.
2. Calculate the correct client participation for ongoing months.
3. Complete ELIAS entries according to **NJA0116 LTC – Medical Institutions.**
4. Send a manually prepared **Notice of Action, form 470-0485(M) or 470-0485(MS)**. Use the comments section of the notice to explain that member owes additional client participation for the current month due to receipt of the refund.
5. If a member does not pay the facility the additional client participation for the current month, complete form **470-3924, Request for IoWANS Changes**, to reduce the client participation back to the original amount.

If the Member Receives a Lump Sum

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

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

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

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

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

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

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

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

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

2. Mrs. A receives a retroactive VA payment in December for $8,700. $2,500 is for VA aid and attendance for August through December. The remainder of this, $6,200, is pension.

   Mrs. A's client participation is $800 per month. The worker considers $6,200 pension and $500 VA aid and attendance when determining client participation for December. The maximum Medicaid reimbursement rate for the facility is $1,922. The worker sends a notice to Mrs. A to pay $1,122 to the facility to bring her total client participation for the month of December to the maximum Medicaid reimbursement rate.

   The worker completes a Request for IoWANS Changes for December.

   The worker recalculates client participation for the months of August through November using the VA aid and attendance, which equals $500 per month. The worker sends a notice to Mrs. A to pay $500 per month for each month August through November. The worker completes a Request for IoWANS Changes for August through November.

If the Member Leaves or Transfers Facilities

Legal reference: 42 CFR 435.725, 441 IAC 81.5(1), 441 IAC 81.13(6)“a,” 441 IAC 82.10(1), 441 IAC 85.6(249A)

A member who transfers from one medical institution to another in the same month must pay any unused client participation to the new institution.

If the member transfers from a medical institution to a residential care facility (RCF), the member pays unused client participation computed for the medical institution to the RCF.

If a member transfers from an RCF to a medical institution in the same month, the member pays the unused client participation computed for the RCF to the medical institution.

To determine the amount of unused client participation:

1. Find the per diem rate of the facility in which the member lived during the first part of the month. Multiple the rate times the number of days in that facility. Do not include the day of discharge, because Medicaid does not pay for the discharge day.
2. Subtract this amount from the member’s previously calculated total client participation. If any amount remains, this is the unused client participation and must be paid to the second facility.

If a member transfers from an RCF to a medical institution, do **not** make an adjustment to client participation to allow for the decreased personal needs allowance in a medical institution. The member is allowed to retain the higher personal needs allowance for the month of transfer, but client participation must be recomputed for the month following the month of transfer.

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

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

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

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

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

1. Mrs. N has $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 participation paid
$	0.00	Waiver client participation

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

   Nursing facility client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	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 participation paid
$	00.00	Waiver client participation

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

   July PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	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.

If you are examining eligibility under both QMB and the 300% group for a person who is not a QMB member when the person enters skilled level of care, determine whether the 30-day stay or QMB eligibility happened first.

Initially approve eligibility for the coverage group under the eligibility that occurred first. If a client is eligible for QMB and the 300% group, approve eligibility for the 300% aid type and enter the percent of poverty in the poverty level indicator field. If the member wants QMB assistance only, do not approve 300% group coverage.

1. Mr. and Mrs. P are QMB-eligible in July. Mr. P enters a nursing facility (not receiving skilled level of care) where he is expecting to stay indefinitely. Mr. P is considered a single person for QMB eligibility for the month of July, or is evaluated under the program of his choice. Eligibility for Mrs. P must be reexamined after the resource determination is made for Mr. P.
2. Mr. C, age 83, enters a hospital February 1 and then enters a nursing facility at the skilled level of care and applies for Medicaid on February 4. He receives $385 monthly in social security benefits. He is eligible for and receiving Medicare benefits. Mr. C's countable resources are $3,800 as of February 1. He is not resource-eligible for any SSI-related coverage group except for QMB and Medically Needy.

   The IM worker explains that due to the amount of his countable resources, the only Medicaid coverage group for which he may be eligible that would pay for his cost of care is QMB. Mr. C is also eligible for Medically Needy. The Medically Needy program will pay for services other than the cost of facility care.

   The worker approves eligibility on February 28, with the Medically Needy program effective February 1 and a QMB effective date of March 1. The worker enters the approval with the Medically Needy aid type (37-E).

   The ELIAS system establishes QMB eligibility for March based on the coding and poverty level indicator and the date of entry. No client participation or any other facility entries are made on the ELIAS system, because they do not apply under QMB or under Medically Needy.

   Mr. C is responsible for paying the coinsurance for February 24-28, which is before the QMB effective date. If Mr. C's resources still remain in excess of Medicaid limits after Medicare pays for the 100 days, he is totally responsible for paying his own cost of care.
3. Mr. W, age 68, enters a hospital on February 1, and then enters a nursing facility at the skilled level of care on February 5. He applies for QMB on the same day. He is approved for QMB March 1, with an effective date of April 1.

   If Mr. W needs help with the cost of skilled care for February and March, he must be determined eligible under the 300% group or as a person who would be eligible for SSI or SSA, if not in a medical institution.

Client Participation for QMBs Entering Skilled Care

Legal reference: 441 IAC 75 (Rules in Process)

When an application is for QMB and skilled care payment, assess client participation until QMB eligibility becomes effective. When the person becomes QMB eligible, access zero client participation while Medicare is paying for the cost of the skilled care and Medicaid pays the copayment.

If Medicare coverage has not been exhausted, you may need to enter zeros in the first-month client participation and ongoing client participation fields. This prevents the facility from overcharging the member and provides the Iowa Medicaid (IM) with the correct payment amount. See Client Participation for Skilled Care.

You may contact the Medicare intermediary to verify the number of days to be paid by Medicare. You need a signed release of information to contact the intermediary.

The facility will complete the **Case Activity Report** to verify the number of days to be paid by Medicare.

Manually issue a notice to notify the applicant of the client participation amount for days 21 through 100 and to tell the applicant that client participation will not be charged until Medicare coverage is exhausted. Include the following wording:

> "Medicare and Medicaid will pay for the cost of care in the facility until Medicare coverage ends. If you remain at this level of care after Medicare coverage ends, you will be charged for part of the cost of care. The client participation amount on this notice is the amount you will be responsible for paying the facility each month after the Medicare payments end."

When the Medicare coverage has been exhausted and the client is concurrently eligible for payment at the skilled level of care under a facility aid type, enter client participation into the ELIAS system. Allow deductions, including personal needs in the month of entry to the facility.

Enter the first month and ongoing client participation on the ELIAS system effective the day after Medicare coverage ends. For this purpose, "first month" means the first month that the member has to pay client participation. This usually is not the month that the member entered the facility.

1. Ms. P, age 78, applies for Medicaid on March 5. She reports that she entered the hospital on March 1 and transferred to skilled care on March 5. The worker verifies that Ms. P began a new spell of illness as of March 1.

   The worker processes the application under the 300% group. The worker approves eligibility for QMB on March 22, effective April 1, and for the 300% group on April 4, effective March 1. The worker calculates client participation for March 5 (first month) and the ongoing months.

   Ms. P is issued a notice informing her of the client participation for March and ongoing months, and that she will not be responsible for paying client participation after March until Medicare is no longer paying the facility. On the 101st day, she must pay client participation.

2. Mr. B, a QMB Medicaid member, enters skilled level of care on January 15. Mr. B asks that the worker determine whether another coverage group would be more advantageous for his situation. Since Mr. B is still receiving skilled care on February 15, the IM worker determines that eligibility also could exist under the 300% group. He chooses the 300% group.

   Since Mr. B is QMB-eligible and was hospitalized for a week before entering skilled level of care, he has Medicare coverage for 100 days of skilled care. Medicaid pays the Medicare coinsurance for days 21 through 100.

   If the Medicaid rate is higher than the Medicare rate, the IM worker computes client participation for the first month and ongoing client participation. The poverty level indicator is also entered. The ongoing client participation amount is entered on the notice of decision.

   If Mr. B still lives in a nursing facility receiving skilled care after the 100-day period covered by Medicare, no change in aid type is required. **NOTE**: If this were a new applicant, there would be client participation charged for January.

3. Ms. L is currently receiving Medicaid as a Medically Needy member and is QMB eligible. There is no spenddown. On March 5, Ms. L reports that she entered the hospital on February 15 and entered a skilled level of care on March 1. Ms. L continues to be QMB-eligible.

   Eligibility can be established under the 300% group after the 30-day residency requirement is met. No facility entries are made until there is eligibility in a 300% aid type. After eligibility for the 300% group has been met on March 16, the IM worker closes the Medically Needy case on the ABC system and reopens the case with a 300% aid type.

   Zeros are entered for the first month and ongoing client participation fields **if** Medicare is paying for the cost of care and the Medicaid rate is higher than the Medicare rate.

   The IM worker computes client participation for the ongoing months and informs Ms. L on the notice when she will be required to pay client participation to the facility and the amount she will be charged.

4. Mrs. N is eligible for Medicaid as part of the 300% group and also has QMB eligibility. The nursing facility reports that Mrs. N no longer needs skilled level of care on June 4. On July 4, she again meets skilled level of care after having been hospitalized for three days. A new benefit period has not started for Mrs. N. The facility reports that Mrs. N has used all but ten days of Medicare entitlement for skilled level of care.

   No changes are needed unless the Medicaid rate is higher than the Medicare rate. In August, Mrs. N is required to pay the facility $350 in client participation per month.

5. Mr. G, age 79, enters a hospital on May 27, then transfers to a nursing facility on May 30 receiving skilled care. He applies for Medicaid for help to pay for the cost of care. On July 1, the IM worker determines that he is both eligible under the 300% group and QMB-eligible.

   Medicare pays for the cost of care from May 30 through June 18. Since QMB cannot be effective until August 1, Mr. G is responsible for paying client participation from June 1 through July 31. Medicaid will pay the Medicare coinsurance beginning August 1. If the Medicaid rate is higher than the Medicare rate, change the client participation to zero effective August 1.

   The IM worker enters the amount of client participation for May, June, and July, because these months are before QMB eligibility.

   The worker issues a manual notice to inform Mr. G that he is responsible for paying client participation for May, June, and July, and that he will be responsible for client participation when Medicare is no longer paying the facility after the 100th day.

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.

Follow these steps to get authorization into IoWANS:

1. Complete a manual notice of decision showing the approval and the cancellation on the same notice.
2. Complete form **470-3924, Request for IoWANS Changes**, and e-mail it to HHS, IoWANS-Facilities. The form must include:
   - The member's name, case number, and state identification number.
   - The facility name and vendor number.
   - The dates of service (admission and discharge dates).
   - The client participation amount (for each vendor and stay).

Remember that the 30 day stay requirement is for a person in the 300% group. Many Medicaid members in nonfacility aid types do not need to meet this requirement, unless they are redetermined to the 300% group.

When you are informed that a nursing facility member moved to a different facility (and is still there), complete an automatic redetermination for the new, appropriate aid type.

When a nursing facility member is admitted to a different facility but returns to the original facility, and you are informed of the moves after the member has returned, do not close the current case. Complete an automatic redetermination for the care the member received in the other facility.

If a significant amount of time has passed and you are unable to update ELIAS all the way back to the original admission date, follow these steps to get authorization into IoWANS:

1. Complete a manual notice of decision showing the approval and the cancellation to any facility stays that are in the past.
2. Complete form **470-3924, Request for IoWANS Changes** and e-mail it to HHS IoWANS-Facilities. The form must include:
   - The member's name, case number, and state ID number.
   - The facility name and vendor number.
   - The dates of service (admission and discharge dates).
   - The client participation amount (for each vendor and stay).

Provider Rates

Facilities have an established rate based on their cost report. The fee-for-service rate for each facility provider can be found by viewing the IoWANS My Reports screen. For client participation purposes, use the rate on IoWANS My Reports screen for the facility in which the member resides.

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.

Billing and Payment for Hospice Members

Legal reference: 441 IAC 78.36(3)

Before providing hospice service to a Medicaid member in a nursing facility, the hospice agency must notify the member's IM worker that the member has chosen to receive hospice services, and to verify the amount of client participation. Determine eligibility and client participation as for other nursing facility member.

When a hospice member enters a nursing facility, the hospice is responsible for paying for the nursing facility care. Medicaid will pay the hospice for the care, and the hospice reimburses the nursing facility. The hospice collects client participation, unless the hospice and nursing facility jointly agree that the nursing facility will collect the client participation.

The hospice is responsible for obtaining the signature of the member or the member's representative on form **470-2618, Election of Medicaid Hospice Benefit** or a similar form as defined in the hospice provider manual.

The hospice is also responsible for entering into a written agreement with the nursing facility under which the hospice program takes responsibility for the professional management of the member's hospice care and the facility agrees to provide room and board to the member.

Use of IoWANS

IoWANS is the Iowa Department of Human Services' Institutional and Waiver Authorization and Narrative System. IoWANS (previously Individualized Services Information System (ISIS)) started supporting the facility programs in October of 2004. The purpose of IoWANS is to assist workers in both processing and tracking requests starting with entry from the ELIAS system through approval or denial.

Upon application, the consumer will be tracked through the eligibility determination process. Once the application is approved, IoWANS will provide the Iowa Medicaid Enterprise or the MCO with information and authority to make payments to or on behalf of a member. The member is tracked in IoWANS until that member is no longer accessing a facility or waiver program.

A case normally starts with the income maintenance (IM) worker entering information into the ELIAS system. Pertinent information is then passed to IoWANS. IoWANS identifies key tasks (called "milestones") for the IM worker and for other entities involved to complete approval of the member. The milestones form a workflow, taking a request for facility payment to denial or final approval.

For details on IoWANS work flows for facilities and on using IoWANS, see **14-M, IoWANS User Guide**.

Different IoWANS work flows (sequences of key tasks presented on milestone screens) have been established for medical facility enrollment processes:

- NF, skilled, PMIC, MHI, and hospice
- ICF/ID

Important Facts About IoWANS for Facility Programs

While **14-M, IoWANS User Guide** is a rich source of information about IoWANS, some of the important facts from that guide are repeated here for emphasis and convenience:

- IoWANS milestone screens present a question, instruction, or statement followed by choices for a response on two to five response buttons. Reaching a choice may take activity outside of IoWANS. Remember that while IoWANS tends to speed the process, it does not replace all the work that must be done, such as collection of verification.
- All milestones in the process of approving a facility case must be completed before the Iowa Medicaid Enterprise or the MCO can be authorized to start making payments.
- If you receive an IoWANS milestone and do not immediately know how to respond, clicking on the **CANCEL** button will leave the milestone task on the workload page so it can be postponed for a later response. You will be able to access the milestone screen again whenever you are ready to respond.
- If the person responsible for a milestone responds prematurely with insufficient or erroneous information, it may be possible to "undo" the milestone.

  To see if that is possible, navigate to the STATUS screen for the member by clicking on the **STATUS** subtab while the member is selected. If it is possible to undo the milestone, a **TRASH CAN** icon will be present in the last column of the milestone's record.

  If the "undo" is not permitted because "downstream" milestones have been accomplished, it will be necessary to contact people who have performed the downstream milestones to arrange for a series of "undo" actions or to contact the IoWANS Facilities Help Desk for assistance.
- The LOC (level of care) and LOC EFFECTIVE DATE fields (on the PROGRAM REQUEST screen) will be blank or show "unknown" when the pending application is first passed to IoWANS. During the workflow process, an LOC milestone is generated. Once the level of care is formally entered, the program request will display the correct level of care and the effective date.

- When entries are completed in the ELIAS system to move a consumer to a different facility, IoWANS will start a new program request. All of the workflow associated to a new member must be repeated before for the new facility can receive payment.
- IoWANS provides a screen that displays the current program request. This screen will eventually show three years of program request history. Information for programs older than three years will be archived. Reports will be available through the SPIRS Help Desk.

A request for facility payment is processed through the IoWANS workflow that ends with the milestone for the IM worker to give final approval. When you give a positive response to this milestone, it will authorize the Iowa Medicaid (IM) or the MCO to make payments to the provider.

IMPORTANT: Make sure that all actions necessary to establish eligibility, including those outside of IoWANS are complete and accurate before you respond to the final milestone and enter the approval on ELIAS.

Once the program request is authorized and a beginning date is passed from ELIAS, a facility provider can view the member's client participation amount using Iowa Medicaid Provider Access (IMPA).

For enrollment process details, see **14-M, IoWANS User Guide**.

Facility Administrative Information

This section contains a brief overview of selected facility responsibilities. The facility provider manuals explain more fully all the responsibilities of facilities that participate in the Medicaid program. Included in this section are procedures relating to:

- Reporting changes in a resident's status
- Transfers and discharges
- How personal needs accounts are handled
- What happens when a facility closes
- What happens when ownership of a facility changes

Reporting Changes in a Resident's Status

Legal reference: 441 IAC 81.5(2), 441 IAC 82.10(2), 441 IAC 85.6(2), 441 IAC 85.24 (2), 441 IAC 85.45(2)

Medical institutions, except hospitals, are required to send the **Case Activity Report** to the office responsible for the placement when a Medicaid applicant or member:

- Enters the facility.
- Dies or is discharged.

- 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.

If a resident is transported by ambulance due to a facility closing, contact the Bureau of Medical and Long Term Services and Supports before the date of service with the following information:

- Name and case number of resident to be transferred.
- Date of transfer.
- The vendor used in the transfer.
- The facility from which the resident is being moved and the facility to which the resident is being moved.

This information is used to process the claim and authorize the Iowa Medicaid Enterprise to make payment.

If Facility Ownership Changes

If ownership of a facility changes, the facility is given a different provider number for the new owner. Payments will not be made until the provider number is changed from the old owner's number to the new owner's number. This change occurs in IoWANS through the following steps:

1. Department of Inspections, Appeals, and Licensing (DIAL) notifies the Iowa Medicaid (IM) Provider Services Unit of the ownership change.
2. The new facility owner submits an enrollment application to Iowa Medicaid (IM) Provider Services Unit.
3. The Iowa Medicaid (IM) Provider Services Unit:
    - Issues the facility a new provider number.
    - Enters the number into MMIS.
    - Verifies the reimbursement rate for the old provider number in MMIS.
    - Verifies that the new provider number is active in MMIS.
    - Sends a memo to Iowa Medicaid (IM) Data Warehouse to initiate the automatic change in IoWANS.
    - Sends a letter to inform the facility of the change, with copies to DIAL Health Facilities and Audits, the IM supervisor, and other Iowa Medicaid (IM) units.
4. The Iowa Medicaid (IM) Data Warehouse implements the "change of ownership" (CHOW) process for all members who are identified as receiving services from the old provider. Any member whose record has an open program request with the old provider number or has been closed with an end date that is later than the effective date of the new provider number will be processed as follows:
    - The program request is ended for the old provider on the date the new provider number is effective.
    - A new program request is started for the same date with the new provider number.

- The aid type, level of care, assessment date, county of residence, county of responsibility, program, case number, and “app date” fields on the newly created program request are the same as the program request that was closed.
- The change of ownership reason code of 077 will show on the new program request on IoWANS.

5. Review the program request to ensure that the change was processed correctly. If the change is effective the first day of the month, the approval is set. If the change is any day other than the first, you will receive a workflow notification that the change has been made in IoWANS, and you must respond to the workflow to set the approval.

   Check the calculation of client participation. If there were bed hold or hospital days, the CP 1ST MONTH entry should be lower and you need to send a request to DHS, SPIRS to correct this. Check the calculation of the CP 1ST MONTH entry as follows:

   - Determine the reimbursement rate of the facility in which the member lived during the first part of the month.
   - Multiply that rate by the number of days in the facility. This is the amount to be applied to the last partial month at the old vendor number, before the change of ownership. Do not include the last day, because Medicaid does not pay for that day. The last day will be paid under the new provider number.
   - Subtract this amount from the member’s previously calculated total client participation (found in the CP ONGOING field on the program request that is being closed).
   - The remainder is to be applied to the new vendor number for the remaining days in the month and should be entered in the CP 1ST MONTH field.

   The CP ONGOING entry should be the same as in the previous program request.

   Any subsequent program requests with **this same provider** number must also have the provider number changed. If there are subsequent program request with a different provider number, you must process the ownership change manually.

6. You will also be notified through IoWANS workflow to make ELIAS entries to change to the new provider number and effective date. If you don’t make the correct entries in ELIAS, this could cause errors or an incorrect vendor number to be passed with the next ELIAS activity.
7. Once approval is set on the new program request, the provider can submit claims to Iowa Medicaid (IM) CORE using the new provider number. The provider will need to check Iowa Medicaid Provider Access (IMPA) to determine if the approval to the new provider number has been completed.