

Medicaid Services

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Overview

This chapter contains an explanation of the services and programs available to Medicaid members (people who have been determined eligible for Medicaid benefits). Detailed information about coverage of specific services, conditions of provider participation, and billing and payment can be found in the Medicaid Provider Manuals.

Providers of Medical Services

Legal reference: 441 IAC 77, 79.6(249A), 80, 81, 82, 85

Participation in the Medicaid program is open to all qualified providers of medical and remedial services in the following categories:

- Noninstitutional providers:
 - Advanced registered nurse practitioners
 - Ambulance services
 - Ambulatory surgical centers
 - Area education agencies
 - Assertive community treatment providers
 - Audiologists
 - Behavioral health service providers
 - Behavioral health intervention providers
 - Birth centers
 - Case management organizations
 - Child care medical services
 - Chiropractors
 - Community-based neurobehavioral rehabilitation services
 - Community mental health centers
 - Crisis response services
 - Dentists
 - Family planning clinics
 - Federally qualified health centers
 - Indian Health Service facilities
 - Infant and toddler programs
 - Lead investigation agencies
 - Local education agencies
 - Maternal health centers
 - Medical equipment dealers
 - Occupational therapists
 - Opticians
 - Optometrists
 - Ordering and referring providers
 - Orthopedic shoe dealers
 - PACE organizations
 - Pharmacies
 - Physical therapists
 - Physician assistants
 - Physicians
 - Podiatrists
 - Psychologists

- Noninstitutional providers (Continued):
 - Health home service providers
 - Health insurance premium payment (HIPPP) providers
 - Hearing aid dealers
 - Home health agencies
 - Home- and community-based habilitation service providers
 - Home- and community-based waiver service providers
 - Hospices
 - Independent laboratories
 - Public health agencies
 - Qualified Medicare Beneficiary (QMB) providers
 - Rehabilitation agencies
 - Rural health clinics
 - Screening centers
 - Speech-language pathologists
 - Subacute mental health services
 -
- Institutional providers:
 - Acute-care hospitals
 - Critical-access hospitals (CAHs)
 - Intermediate care facilities for persons with intellectual disabilities (ICFs/ID), including the state resource centers
 - Nursing facilities for people with mental illness aged 65 and older (NFs/MI)
 - Nursing facilities, including facilities certified to provide skilled care (NFs/SNFs)
 - Psychiatric medical institutions for children (PMICs)
 - State mental health institutes (MHIs) licensed as hospitals

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

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

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

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

Requirements for Providers

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

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

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

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

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

Providers must:

- Keep records for five years from the date of service documenting the services, supplies, and care furnished to Medicaid members.
- Provide records or related information when requested by the Department or by the U.S. Department of Health and Human Services.
- Comply with Title VI of Civil Rights Act of 1964, which prohibits discrimination based on race, creed, or national origin.
- Comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on handicap.

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

Nonemergency Medical Transportation

Legal reference: 441 IAC 78.13(249A)

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

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

Managed Health Care

IA Health Link

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

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

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

- Members who qualify for the Health Insurance Premium Payment program (HIPP). See [Health Insurance Premium Payment Program \(HIPP\)](#) for more information.
- Members who qualify for the Medicare Savings Program (MSP) only.
 - Qualified Medicare Beneficiary plan (QMB)
 - Specified Low-Income Medicare Beneficiary (SLMB)
- Members who are eligible for emergency services only.
- Members who are on the Medically Needy program also known as the spenddown program.
- Presumptively eligible members (subject to change once ongoing eligibility is determined).

Some members may choose to participate in MCO enrollment:

- Members who are enrolled with the PACE program.

- American Indian or Alaskan Native members may also choose to enroll in the Managed Care program. If a member identifies as American Indian or Alaskan Native, they may contact Iowa Medicaid Member Services at 1-800-338-8366 to learn about enrolling in the IA Health Link Managed Care program.

Each MCO has a network of providers who the member may see for care. The MCOs will coordinate the care for their enrolled members.

Program for All-Inclusive Care for the Elderly (PACE)

Legal reference: 42 CFR 460; 441 IAC 88

The program for all-inclusive care for the elderly (PACE) is designed to allow enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing “managed” long-term care to Medicaid members. PACE becomes the sole source of services for Medicare and Medicaid eligible enrollees.

PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and meet nursing facility level of care in order to qualify. PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

PACE is a specialized managed care organization that receives a monthly Medicaid capitation payment for each eligible PACE enrollee. It is an optional State Plan program for members who meet its eligibility requirements. Also, applicants or members who meet PACE eligibility requirements may choose PACE as a managed care option instead of an IA Health Link MCO.

The PACE benefit package, regardless of the source of payment, must include all Medicare and Medicaid covered items and services. All other services determined necessary by the PACE IDT to improve and maintain the member’s overall health status and well-being. Common PACE services can include, but are not limited to, the following:

- Durable medical equipment
- Emergency care
- Hospital
- Nursing facility care
- Personal care
- Physical and occupational therapy and other restorative therapies
- Prescriptions
- Primary physician services
- Respite care
- Skilled nursing services
- Social work services

- Specialty care
- Therapeutic recreational services
- Transportation

Who Can Be Enrolled

Legal reference: 42 CFR 460.150; 441 IAC 88.24(249A)

In counties served by a PACE provider, Medicaid members or individuals who are eligible for Medicaid have the option to enroll in PACE to meet their long-term health care needs if they:

- Are 55 years of age or older.
- Reside in a county served by a PACE provider.
- Live in a community setting at the time of enrollment (are not institutionalized) and choose to receive PACE services.
- Are determined eligible for SSI-related Medicaid, including the 300% group but excluding the Medically Needy coverage group.
- Are determined to meet nursing facility level of care.

NOTE: PACE eligibility cannot be concurrent with any other Medicaid eligibility. Other Medicaid programs must be canceled before PACE eligibility begins.

How Medicaid Members Are Enrolled

Legal reference: 42 CFR 460.152-156; 441 IAC 88.24(249A)

The income maintenance (IM) worker, the PACE enrollment coordinator, and the Iowa Medicaid Medical Services Unit share the responsibility for determining that all PACE eligibility criteria have been met. The PACE enrollment coordinator will begin the process by notifying the IM worker of an individual who chooses to apply for the PACE program.

Application Processing

Legal reference: 441 IAC 76.2(249A), 441 IAC 88.24(1)

The IM worker determines income and resource eligibility for PACE based on a Medicaid application. A prospective PACE enrollee wanting to apply for PACE services must complete:

- An application online at <https://dhsservices.iowa.gov/apsspssp/ssp.portal>, or
- Form **470-5170** or **470-5170(S)**, **Application for Health Coverage and Help Paying Costs**.

Determine if the applicant resides in a county served by a PACE provider. All other application policies and general eligibility requirements, other than those described under [Who Can Be Enrolled](#), are the same for people applying for PACE services.

Follow the processing procedures described in [8-B, Application Processing](#), and the eligibility requirements found in the following:

- [8-C, Nonfinancial Eligibility](#),
- [8-D, Resources](#),
- [8-E, Income](#),
- [8-F, Coverage Groups](#), and
- [8-I, When Applying for or Receiving Waiver or PACE Services](#).

Provide the applicant a copy of [Comm. 316, PACE - Program of All-Inclusive Care for the Elderly](#).

Level of Care

Legal reference: 441 IAC 88.24(1)

PACE enrollees must meet the nursing facility level of care. The PACE physician completes form **470-4490, Level of Care Certification for PACE Program**. The PACE enrollment coordinator submits the level of care form along with supporting documentation to IME Medical Services.

The Medical Services nurse reviewer will review the form and the supporting documentation. The Medical Services Unit then sends a level-of-care notification through IoWANS to the IM worker and the PACE organization.

Effective Date of Enrollment

Legal reference: 441 IAC 88.24(2)

If level of care is approved:

1. Process financial and nonfinancial Medicaid eligibility. A PACE enrollee is considered as an institutionalized person. Treat the applicant as an institutionalized person for attribution of resources and deeming of income and resources.

There is no retroactive eligibility for PACE.

2. The PACE organization will obtain applicant's signature on the PACE organization's **Enrollment Agreement** (a non-DHS form but required by CMS).

3. Once Medicaid eligibility has been determined and the PACE enrollment form has been signed, approve PACE eligibility on the first day of the month following the date the PACE provider receives the signed enrollment form.

NOTE: PACE enrollment cannot be concurrent with any other Medicaid eligibility. All other Medicaid programs must be canceled before PACE eligibility can begin. Timely notice is not required because the member has signed the PACE enrollment form accepting PACE services.

4. The PACE organization can view the effective date of approval and any client participation amount through Iowa Medicaid Provider Access (IMPA) in addition to IoWANS.

Client Participation for Enrollee Living at Home

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

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

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

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

The result is the client participation amount.

Mr. J, age 60, lives alone and applies for PACE services on October 2. His gross monthly income includes \$843 Social Security benefit, \$250 private pension, and \$100 VA aid and attendance. The worker determines client participation as follows:

\$843 Social Security + 250 pension = \$1,093 total gross monthly income

\$1,093 – \$2,982(300% of SSI benefit) = \$0

\$0 + \$100 VA aid and attendance = \$100 client participation

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

Members With a Medical Assistance Income Trust

To calculate client participation for PACE enrollees with a medical assistance income trust, see [8-I, Trust Payments](#).

Case Maintenance

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

In general, follow the procedures in [8-G, Case Maintenance](#).

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

If a PACE enrollee enters a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care. Do not make entries to the member's PACE case in the ABC system. All transfers to and from a medical institution are done in IoWANS. See [PACE Enrollee Enters a Medical Institution](#).

A PACE enrollee who moves out of the PACE service area will no longer be eligible for PACE services. For involuntary disenrollment, see [Disenrollment](#).

See the following sections for detailed procedures for the following:

- [PACE enrollee enters a medical institution](#)
- [PACE enrollee leaves a medical institution](#)
- [Annual recertification](#)

PACE Enrollee Enters a Medical Institution

No changes are needed when a PACE enrollee enters a **hospital**.

When a PACE enrollee enters a **nursing facility, ICF/ID**, or **NF/MI** for other than respite care, make changes through IoWANS as follows:

- Click on the "entering facility" button on the PACE program request.
- A pop-up box will appear for you to enter the date the PACE enrollee went into the facility. Enter the date of entry according to the *Case Activity Report* and click "move consumer."

- IoWANS will create a new program request with the new begin date. The program field in IoWANS will show as “PACE-NF.”
- A workflow is generated to notify the PACE provider that the member has entered a facility.

Client Participation for Enrollee Living in a Medical Institution

When a PACE enrollee enters a **nursing facility, ICF/ID, or NF/MI** for other than respite care, recalculate client participation effective the first of the month following the month of entry to a medical institution.

The following deductions from gross monthly income are allowed for people who are in a medical institution:

- Personal needs allowances, which are:
 - An ongoing personal needs allowance.
 - Personal needs in the month of entry to the institution.
 - Maintenance needs of a spouse and dependents.
 - Unmet medical needs.

See [8-I, Client Participation](#).

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

The new client participation amount will roll to IoWANS.

1. Mr. J, a PACE enrollee, enters a nursing facility from his home on May 15. His gross income is \$1,089 monthly and his PACE client participation while he is living at home is \$0.

The IM worker enters the transfer to the program request in IoWANS to move Mr. J from PACE at home to PACE-NF effective May 15.

The IM worker recalculates Mr. J's client participation effective June 1 allowing for a \$55 personal needs allowance, making his client participation \$1,034. The IM worker then enters the new client participation amount on TD05 using a positive date of June 1.

2. Ms. J, a PACE enrollee, is admitted to the hospital on April 28. On May 8 she is transferred to a nursing facility for a long-term stay. Her gross monthly income is \$1,215 and her PACE client participation while she is living at home is \$0.

The IM worker enters the transfer to the program request in IoWANS to move Ms. J from PACE at home to PACE-NF effective May 8.

The IM worker redetermines Ms. J's client participation as follows:

April: Since Ms. J was living at home in April, her client participation for April does not change.

May: The PACE provider receives the full capitation payment for May, so Ms. J's client participation continues to be \$0.

June: The \$55 personal needs allowance is subtracted from Ms. J's gross monthly income, making her client participation for June \$1,160. The IM worker enters the new client participation amount on the ABC TD05 screen using a positive date of June 1.

PACE Enrollee Leaves a Medical Institution

When a PACE enrollee is discharged from a medical institution:

- Click on the "leaving facility" button on the PACE program request in IoWANS.
- A pop-up box will appear for you to enter the date the PACE enrollee was discharged from the facility. Enter the date of discharge as recorded on the *Case Activity Report* and click "move consumer."
- IoWANS will create a new program request with the new begin date. The program field in IoWANS will show as "PACE."
- A workflow is generated to notify the PACE provider that the consumer has left a facility.
- When a PACE enrollee leaves a nursing facility, ICF/ID, or NF/MI, recalculate client participation for the month the PACE enrollee leaves the facility and goes to a private living arrangement. See [8-I, Deductions from Client Participation](#).
- Recalculate the client participation amount for ongoing months according to [Client Participation for Enrollee Living at Home](#).

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

The new client participation amount will roll to loWANS.

Mr. S, a PACE enrollee, enters a nursing facility from his home on April 16. His gross income is \$1,275 monthly and his PACE client participation while living at home is \$0.

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

\$ 1,275	Income
- 55	Personal needs allowance
\$ 1,220	Client participation

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

<u>June</u>		<u>July</u>	
\$ 1,275	Income	\$ 1,275	Income
- 994	HMA month of discharge	- 2,982	Waiver PNA
- 55	Personal needs allowance	\$ 0	Client participation
\$ 226	Client participation to NF		

Client Participation for Medicare Skilled Stays

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

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

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

1. Mr. M, a PACE enrollee, enters a nursing facility as Medicare skilled from his home on May 5. His gross monthly income is \$2,060. His PACE client participation while he is living at home is \$0.

The IM worker determines that the first 20 days of Medicare skilled is May 5 through May 24. The IM worker recalculates Mr. M's client participation effective June 1 allowing for a \$55 personal needs allowance, making his client participation \$2,005.

2. Mr. J, a PACE enrollee, is admitted to a nursing facility as Medicare skilled on May 28. His gross monthly income is \$1,093 plus \$100 VA aid and attendance. His PACE client participation while he was living at home was \$100. The per diem rate of the nursing facility is \$150.

The IM worker determines that the first 20 days of Medicare skilled is May 28 through June 16. Mr. J's client participation for May and June is as follows:

May: Mr. J entered the nursing facility on May 28. His client participation would not change until the first of the month following the month of entry. Mr. J's client participation for May would continue to be \$100.

June: Days 1 through 16 are covered by Medicare.

Determine the cost of the remaining 14 days (June 17-30):

\$ 150	Nursing facility per diem rate
x <u>14</u>	Days
\$2,100	Cost of the remaining 14 days

Calculate client participation based on Mr. J's gross monthly income:

\$1,093	Gross monthly income
- 55	Personal needs allowance
+ <u>100</u>	VA aid and attendance
\$1,138	

The 14 days per diem rate (\$2,100) is more than Mr. J's monthly client participation amount (\$1,138) so Mr. J's client participation will be \$1,138.

3. Mr. P, a PACE enrollee, enters a nursing facility as Medicare skilled on March 30. His gross monthly income is \$2,090. His PACE client participation while he is living at home is \$0. The per diem rate of the nursing facility is \$150.

The IM worker determines that the first 20 days of Medicare skilled is March 30 through April 18. Mr. P's client participation for April is as follows. Days 1 through 18 are covered by Medicare.

Determine the cost of the remaining 12 days (April 19-30):

\$ 150	Nursing facility per diem rate
x <u>12</u>	Days
\$1,800	Cost of the remaining 12 days

Calculate client participation based on Mr. P's gross monthly income:

\$2,090	Gross monthly income
- <u>55</u>	Personal needs allowance
\$2,035	Client participation

The 12 days per diem rate (\$1,800) is less than Mr. P's monthly client participation amount (\$2,035) so Mr. P's client participation for April will be \$1,800.

Annual Recertification

Legal Reference: 42 CFR 435.916; 441 IAC 76 (Rules in Process); 441 IAC 88.24(4)

The PACE provider completes a level of care determination at least annually for all PACE enrollees. The IME Medical Services Unit will determine whether nursing facility level of care continues to be met.

Review financial eligibility according to the requirements for the enrollee's particular coverage group.

Document a change in eligibility in the case record. Respond to IoWANS milestones to record cancelation of PACE services or a change in level of care or client participation. Send the appropriate notice of decision to the enrollee.

Disenrollment

Legal reference: 441 IAC 88.24(249A)

The effective date of PACE Medicaid cancellation shall be the Medicaid timely notice date. See [8-A, Notification](#). Complete an automatic redetermination to see if the member is eligible for Medicaid under another coverage group. See [8-G, Automatic Redetermination](#).

Circumstance	Policy
Enrollee death	The effective date of PACE Medicaid cancellation shall be the date of death.
Enrollee voluntary disenrollment	PACE enrollees may voluntarily disenroll at any time.
Enrollee involuntary disenrollment	A PACE enrollee may be involuntarily disenrolled for the following reasons: <ul style="list-style-type: none">▪ Failure to pay client participation, if applicable.▪ Disruptive or threatening behavior.▪ Behavior that jeopardizes the enrollee's health or safety or the safety of others.▪ Consistent refusal by the enrollee to comply with the individual plan of care or the terms of the <i>PACE Enrollment Agreement</i> (when the enrollee has decision-making capacity).▪ The enrollee moves out of the PACE service delivery area.▪ The enrollee no longer meets the nursing facility level of care requirement and is not eligible for deemed continued eligibility.▪ The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.
Provider disenrollment	A PACE provider cannot disenroll a member without prior approval from the Department.

List of Providers and Counties Served

The following PACE organizations have contracts with Iowa Medicaid and are located in the following counties:

Siouxland PACE

Counties served:

Cherokee
Monona
Plymouth
Woodbury

1200 Tri View Ave
Sioux City, IA 51103
(712) 224-7223
1-888-722-3713 (24 hours)

<http://www.unitypoint.org/siouxcity/services-pace.aspx>

**Pathways PACE – SW Iowa
*Immanuel Communities***

Counties served:

Harrison
Mills
Pottawattamie

1702 N 16th Street
Council Bluffs, IA 51501
(712) 256-7284
TTY: 1-800-537-7697

Online at:

<https://www.immanuel.com/immanuel-pathways>

**Pathways PACE – Central Iowa
*Immanuel Communities***

Counties served:

Boone
Dallas
Jasper
Madison
Marshall
Marion
Polk
Story
Warren

7700 Hickman Road
Windsor Heights, IA 50324
(515) 270-5000

Online at:

<https://www.immanuel.com/immanuel-pathways>

Medicare, VA, and Private-Pay PACE Enrollees

The Department is federally required to do level-of-care assessments for all PACE enrollees whether they apply for Medicaid or not. The following steps are taken for the enrollees who do not apply for Medicaid.

1. The PACE provider contacts the IME Medical Services Unit to do a level-of-care assessment.
2. The Medical Services Unit sends a message to either the IoWANS-Facilities inbox or the PACE policy specialist and requests to have the PACE enrollee manually entered into IoWANS.

3. A PACE program request is created with a unique case number and the enrollee information is logged on a spreadsheet. The case number represents the type of funding and the sequence number on the log.
 - For a veteran enrollee, the case number is coded as PACEVA1, PACEVA2, etc.
 - For a private-pay enrollee the case number is coded as PRIPAY1, PRIPAY2, etc.
4. The PACE workflow is started and the level of care information is recorded in loWANS.
5. Once the person is enrolled in PACE, the workflow is completed and a begin date is added to the PACE program request. The program request remains open so that loWANS can generate the annual LOC Review workflow.

NOTE: There will not be an active ABC case for these PACE enrollees and the PACE provider will not receive the monthly Medicaid capitation payment.

Care for Kids (EPSDT)

Legal reference: 42 CFR 441, Subpart B; 441 IAC 84

Federal law requires states to provide early and periodic screening, diagnosis, and treatment (EPSDT) to Medicaid members who are under age 21. In Iowa this program of preventive health screening and follow-up treatment is called “Care for Kids.”

Care for Kids provides children with regular health check-ups, continual health maintenance, and a means of early detection and treatment of disease. The program includes outreach, follow-up, and supportive services to encourage participation. All Medicaid members who are under 21 years of age are eligible for Care for Kids.

Screening Services

Legal reference: 441 IAC 84.3(249A); Section 1905(a)(4)(b) of Social Security Act

Periodic screenings or examinations allow a child’s overall health to be continually monitored. Screening services include:

- A comprehensive health and developmental history.
- Assessment of both physical and mental health development.
- An assessment of nutritional status.
- A comprehensive unclothed physical examination with physical inspection of:
 - Eyes, ears, nose, and throat.
 - Mouth and teeth.
 - All organ systems, such as pulmonary, cardiac, and gastrointestinal.

- Immunizations appropriate for the child’s age and health history.
- Health education, including anticipatory guidance.
- Vision and hearing screening.
- Direct dental referral for children over age 12 months.
- Appropriate laboratory tests, including:
 - Hematocrit or hemoglobin.
 - Rapid urine screening.
 - Blood lead testing for all children aged 12 months to 72 months.
 - Hemoglobinopathy screening.
 - Serology.
 - Tuberculin test.

Recommended Ages for Screenings

Legal reference: 441 IAC 78.18(3), 84.4(1) and 84.4(2)

Iowa recommends that children receive health, vision, and hearing screenings at the following ages:

- Two or five days if released from the hospital 24 hours or less after delivery
- 1 month, 2 months, 4 months, and 6 months
- 9 months, 12 months, 15 months, 18 months, and 24 months
- Yearly from 3 years to 20 years

An oral health exam of the oral cavity and dentation, and teaching about oral and dental health care should occur at every well child visit.

These schedules are the minimum requirements for screenings and are called “periodicity schedules” and are found in [RC-0080, EPSDT Periodicity Schedule](#).

Children may need more frequent examinations. Examinations performed more frequently are “interperiodic” screenings. Interperiodic screening, diagnosis, and treatment strengthen the preventive nature of the program. Interperiodic screenings are usually requested by the parent or guardian and may be required by foster care or for educational purposes. The screenings may also be necessary for camp or sport activities.

Screening Providers

Members may choose their screening provider. Families are encouraged to choose a permanent provider. Members enrolled in a managed care program are encouraged to obtain the services from their managed care provider.

Each county has a designated child health center under contract to the Iowa Department of Public Health (IDPH) to provide well-child services. A list of these providers can be found on the [IDPH website](#).

Other providers who can do screenings include:

- Physicians
- Child health centers
- Advanced registered nurse practitioners
- Rural health centers
- Federally qualified health centers
- Clinics
- Dentists

If a member wants to choose a private provider, the member will need to find out if the provider participates in Medicaid screenings and tell the provider at the time of the appointment that the visit is for an EPSDT “Care for Kids” screening examination.

Treatment Services

Legal reference: Section 1905(a)(4)(b) of the Social Security Act

Medicaid covers services necessary to diagnose or to treat a condition identified during a health, visual, hearing, or dental screening examination when all of the following conditions exist:

- The service is required to treat the condition.
- The provider of services is a Medicaid provider.
- The service is consistent with federal and state laws that govern health care.
- The service is medically necessary, safe, and effective, and is not considered experimental.

Services not ordinarily covered under the Medicaid program can be covered under Care for Kids (EPSDT) when they meet these conditions.

If a child needs services not covered under Medicaid or beyond Medicaid limits, the child can be referred to similar child health programs, such as:

- Head Start
- 1st Five
- Special Supplemental Food Program for Women, Infants and Children (WIC)

If no other source of payment is available, request authorization for Medicaid payment from the Division of Medical Services under an exception to policy. Send the following information in with the exception to policy:

- Physician’s name and address.
- Physician’s statement of the need for service.
- Member care plan.

- Estimated cost.
- Expected outcome.

See procedures in [1-B, Exceptions to Policy](#).

Procedures for Notification and Tracking

This section explains IM procedures for the initial offer of screening and when to make system entries to send the member's name to the designated child health center.

Medicaid members are informed about the Care for Kids program by child health centers designated by the Department of Public Health. In these cases, the IM worker is responsible only for notifying members that they will be contacted by the designated agency.

ELIAS sends the K code for any person under 21 years of age in both the daily and monthly transactions. The K code indicates informing and care coordination services are provided by designated child health centers.

Medically Needy applicants with a spenddown and children in foster care remain in ABC. IM workers do have specific procedural responsibilities for these children. The report *Medicaid EPSDT Enrollees* listing these members is generated monthly for each local office.

IM responsibilities for these children involve making system entries in the SCR field on the ABC system's TD03 screen. All Medicaid members under the age of 21 must have a K code entered in this field. (See [14-B-Appendix](#) for more information.) Informing and care coordination services provided by designated child health centers will be provided for these children.

Offer of Screening

Legal reference: 441 IAC 78.18(3), 84.4(1), 84.4(2), 84.5(249A)

All families receive a computer-generated reminder, form [470-5271, Care for Kids Wellness Exam Reminder](#), which makes them aware that, as a new eligible, screening is due immediately.

Billing and Payment

Legal reference: 441 IAC 80.2(249A), 80.3(249A)

Providers participating in the Medicaid program submit claims to the Iowa Medicaid for services rendered that are not paid on a capitation basis. (See the provider manuals in [8-Appendix](#) for billing instructions for providers.)

To establish the amount of payment to be made, the IME deducts from the established cost for the service the amount of any payment made directly to the provider of care by the member, relatives, or any other source. (See [8-A, When Members Are Responsible for Payment of Medical Bills](#) for a list of member copayment requirements for various services.)

The following sections give more information on:

- [Submitting claims for payment](#)
- [“Pay and chase” provisions](#)
- [Review of trauma claims](#)
- [Medical Assistance liens](#)

Submitting Claims

Legal reference: 42 CFR 447.45(d)(4), 441 IAC 80.4(249A)

Providers may submit claims any time during the month for most services. Exceptions: Nursing facilities and home health agencies may not submit bills before the end of a calendar month. Most hospitals cannot bill until a member is discharged.

The IME will not pay claims received more than 365 days after the date of service unless the initial submission was delayed due to:

- Delays in receiving third-party payments, or
- Retroactive certification of eligibility on newly established cases.

To be payable, these claims must be submitted less than 24 months from the date of service, and the reason the claim is not timely submitted must be stated on the claim form.

Providers have 12 months from the time that the local office is notified of retroactive SSI eligibility to submit claims. Example: SSI notifies the worker by SDX on August 2, 2004, that the person is eligible for SSI back to June 1, 2002. Providers have until August 2, 2005, to submit the claim.

The IME processes claims older than 12 months when:

- Eligibility is established retroactively.
- There is a third-party liability problem.
- There is a DHS appeal decision or court decision. This may include claims for people who were originally denied for SSI eligibility but appealed and were then approved.

If you receive claims that need to be processed by the IME, return the claims to the provider with instructions to follow directions for the submission of such claims. The provider may contact the IME Provider Services Unit for assistance.

Pay and Chase

Legal reference: 441 IAC 75 (Rules in Process)

Under the normal “cost-avoidance” method of paying claims, the service provider must bill the other medical resource before submitting a claim to Medicaid. The IME approves payment only for those services or that part of the cost of a given service for which no medical resources exist, unless pay and chase provisions apply.

“Pay and chase” means that the IME pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. Pay and chase applies only to claims for:

- Prenatal care for pregnant women.
- Preventative pediatric services.
- Services provided to a person for whom there is court-ordered medical support.

If providers call for more information about the program, refer them to their provider manual or the IME Provider Services Unit. Providers should call the ELVS number (515) 323-9639 or (800) 338-7752 to obtain member insurance information.

System codes that indicate pay and chase for coverage by absent parents are located on the SSNI or MMIS screen.

The absent parent indicator is located in the second position of the medical resource code on the SSNI screen. The codes are H, K, and 8. Field 10 on the MMIS screen has an indicator of absent parent insurance for the insurance coverage that is described on the page open for viewing. Each page has information on a different health insurance policy.

Review of Trauma Claims

Legal reference: 441 IAC 75 (Rules in Process)

The IME Revenue Collection Unit screens Medicaid claims indicating an accidental injury or “trauma” in order to pursue potential third-party liability for the costs of treatment. The Unit reviews all Medicaid claims over \$250 submitted with an ICD diagnosis code indicating an accident or injury.

When additional information is needed regarding the accident or injury, the Revenue Collection Unit worker sends computer-generated form **470-0398, Accident Injury Request** to the injured person. The form asks the person to supply details of the accident or injury.

Upon receipt of the completed letter, the Revenue Collection Unit worker:

- Reviews the member's response to determine if a third party is available to pay for part or all of the medical expenses.
- Follows up with the third-party resources identified to substitute the Department's claim for that of the injured person. (This process is called "subrogation.")

Medical Assistance Lien

Legal reference: Iowa Code Section 249A.6, 441 IAC 75 (Rules in Process)

The Department has the legal right to file a lien to recover Medicaid payments made on behalf of any member if another (third) party is determined to have liability. "Third parties" include:

- Private health insurance
- Auto insurance
- Casualty insurance
- Worker's compensation insurance
- Tort liability cases

Tort liability exists when a member sues a third party and it is determined that injuries sustained were caused by the negligence of a third party.

When the Department makes Medicaid payment on behalf of a member, the IME Revenue Collection Unit files a lien for all monetary claims that the member may have against third parties, to the extent of Medicaid payments. For a lien to be effective, the Revenue Collection Unit must file a notice:

- With the clerk of the district court in the county where the member resides and
- With the member's attorney when the member's eligibility is established.

These notices serve as formal notice to the third party of the Department's interest and right to be reimbursed for the member's medical expenses. Possible liable third parties should be informed of the Department's interest at the earliest possible date, no later than 45 days from the time that the Revenue Collection Unit becomes aware of the involvement of the third party.

Medicare

Legal reference: 441 IAC 75 (Rules in Process)

This section describes general policies for Medicare (Title XVIII of the Social Security Act) including eligibility groups, available services, and the buy-in process.

Medicare coverage is shown as a third-party resource in the eligibility systems to ensure that there is Medicare involvement in payment of any covered service. The health coverage code does not have a direct bearing on the buy-in process, but the health insurance resource should reflect Medicare coverage as soon as a member becomes eligible for Medicare, even if the buy-in has not been completed.

Medicare pays on claims for services covered by both programs before Medicaid pays. Medicaid is responsible for paying the deductible and coinsurance required by Medicare. Exceptions:

- For members eligible for the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only the Medicare premiums, deductibles, and coinsurance. See [8-F, Qualified Medicare Beneficiaries](#).
- For members eligible for the specified low-income Medicare beneficiary (SLMB) coverage group or the expanded specified low-income Medicare beneficiary (E-SLMB) coverage group, Medicaid pays only the Medicare Part B premiums. See [8-F, Specified Low-Income Medicare Beneficiaries](#) and [Expanded Specified Low-Income Medicare Beneficiaries](#).

Remember that some people are not entitled to social security benefits but are entitled to Medicare. Most people are entitled to both Part A and B. However, some people are not eligible for free Part A. In most cases, the state will pay the Part A premium for these people.

The beneficiary's *Health Insurance Card* indicates if the person is entitled to both parts. If a person was eligible for Part B but did not choose to enroll in Part B, the health insurance resource code reflects both part A and B, because the state will automatically buy-in to Part B coverage.

Refer clients who ask for more information on Medicare to the local Social Security office.

Medicare Part A

Legal reference: 42 CFR 406.10, 406.11, 406.12, 406.13, 406.20, and 409.5; OBRA 1989

Medicare Part A helps pay for the following services:

- Hospital
- Skilled nursing care
- Home health services
- Hospice programs

Part A may require a deductible or coinsurance and may limit the number of days covered during a spell of illness (benefit period).

To be eligible for Medicare Part A, an applicant must be in one of four categories:

- **Age 65 or older** and one of the following conditions is met:
 - Is entitled to social security retirement or survivor benefits.
 - Is entitled to railroad retirement benefits.
 - Would qualify for social security benefits if federal employment was treated the same for social security purposes.
- Is not a social security retirement or railroad retirement beneficiary, but had at least a minimum number of quarters of coverage under social security or railroad retirement. This was a special transition provision that expired in 1974.
- Does not have a work history that qualifies for social security or railroad retirement benefits but voluntarily enrolls in Medicare and pays a premium.
- **Under age 65** and one of the following conditions is met:
 - Has been entitled to disability benefits from Social Security or the Railroad Board for 24 consecutive months. This does not include a person receiving SSI.
 - Is insured under Social Security or Railroad Board and receives renal dialysis or has had a kidney transplant or is a spouse or dependent child of an insured or entitled person. There may be a three-month waiting period.

Persons who receive Medicare because of a permanent kidney failure are eligible for Medicare benefits for 12 months after the month in which maintenance dialysis treatment stops, or 36 months after the month in which the person receives the kidney transplant.
- Is a **widow** age 50 or over who has been severely disabled for at least 24 consecutive months but who has not filed a claim on disability because the widow receives social security checks as a mother caring for a young or disabled child.
- Has received social security disability for more than 24 months, and whose social security was terminated when the person went to work but who continues to have a disability. Medicare continues up to 36 months after the disability benefit ends.

A disabled person may be able to purchase Medicare Part A benefits if the person has exhausted the 36 months of extended Medicare benefits provided after a social security disability benefit stops. This person must meet the following conditions:

- Be under age 65.
- Be blind or continue to have the disabling physical or mental condition that was the basis of the person's social security disability insurance or to be a disabled qualified railroad retirement beneficiary.
- Have earnings that exceed the substantial gainful activity limits, resulting in termination of entitlement for social security disability insurance.

- Have worked continuously for 48 months while receiving the extended social security disability cash benefits for the first 12 months and then 36 months of extended Medicare benefits after termination of the cash benefits.
- Be entitled to Medicare benefits for disabled persons after the 36 months of extended Medicare has ended.
- Not be entitled to any other benefits under Medicare (Title XVIII).

Part A Premiums

Legal reference: 42 CFR 406.21, 406.22, and 406.32; 441 IAC 75 (Rules in Process)

In most cases, social security or railroad retirement beneficiaries do not have to pay a premium for Medicare Part A coverage. For persons not entitled to these benefits, premiums can be paid by the federal government (in the case of transitional entitlement) or the state (for qualified Medicare beneficiaries or for qualified disabled and working persons).

Part A beneficiaries who do not have a work history or who are disabled and working persons may pay their own premium for Part A because they are not automatically eligible to receive the benefit at no cost. If these persons are eligible as a qualified Medicare beneficiary or as a qualified disabled and working person, Medicaid pays the Part A premium.

The Social Security Administration assesses a penalty to a person who must pay a premium for Medicare Part A if the person enrolls 12 full months after the initial enrollment period or re-enrolls 12 full months after the last period of Medicare eligibility. The penalty is 10% of the monthly premium and is twice the number of months that the person delayed enrolling in Part A.

If the state pays the premium for QMB-eligible persons through the buy-in process, the state is not assessed a penalty. Medicaid pays the Part A premium, including penalty, if a person is eligible for the qualified disabled and working persons coverage group.

1. Mr. K, age 66, an SSI recipient, does not have a work history and is ineligible to receive social security benefits. He receives Medicare Part B. His initial enrollment period for Medicare Part A ended in January 1994. He was eligible to enroll for Part A Medicare at that time, but had to pay a premium.

Since Mr. K is eligible for QMB and currently receives Medicare Part B, the state processes the Part A enrollment and pays the Part A premium. The state is not assessed a penalty for Mr. K's late enrollment.

2. The social security disability benefits for Mrs. O (age 50) were terminated January 1996, because her income exceeded the substantial gainful activity limit. She received 12 months of extended social security disability benefits and then received 36 months of extended Medicare benefits because she was continuously employed for 48 months but still had the disabling condition.

The Social Security Administration gave her the opportunity to purchase Medicare Part A from March 2000 to August 2000. Mrs. O chose not to purchase Medicare Part A during her initial enrollment period. She waited until March 2001 (during the open enrollment period) to enroll for Medicare Part A. This is a delay of eight months. Mrs. O is assessed a 10% penalty for 16 months on the Part A premium.

Mrs. O applies for Medicaid to pay for the Part A premium and meets eligibility requirements for QDWP. Since she is considered eligible for Medicaid under the QDWP coverage group, Medicaid pays the Part A premium and 10% penalty.

Part A Enrollment Period

Legal reference: 42 CFR 406.22, P.L. 100-239

People who receive social security or railroad retirement benefits because of a qualified work history may enroll in Medicare Part A at any time.

- People who are not entitled to social security or railroad retirement benefits due to insufficient work history and disabled people who have exhausted their Medicare benefits may enroll for Part A either:
- During the initial enrollment period, which is the three months before and the three months after the person becomes eligible for Medicare.
- During the open enrollment period from January 1 through March 31 of each year. If enrolled during the open enrollment period, Part A coverage is effective the following July 1.

EXCEPTION: People who are QMB-eligible and who are already entitled to Medicare Part B are not required to wait for the open enrollment period to enroll for Medicare Part A. The state buy-in process automatically establishes Medicare Part A entitlement for people already receiving Part B.

Medicare Part B

Legal reference: 42 CFR 407.2, 407.10

Medicare Supplemental Medical Insurance, referred to as Part B, helps pay for the following types of care:

- Physician, surgeon
- Outpatient physical therapy and speech pathology
- Outpatient hospital
- Prosthetic devices, durable medical equipment, medical supplies
- X-rays, laboratories
- Ambulance
- Home health care
- Rural health clinic

Part B may require a deductible or coinsurance. Medicaid pays deductibles and coinsurance for Medicaid members.

To be eligible for Part B, the person must either:

- Have Medicare Part A, or
- Be age 65 or older and either a U.S. citizen or an alien lawfully admitted for permanent residence who has lived in the United States for five years before the month of application for Medicare Part B.

Part B Premiums

Legal reference: 42 CFR 408.6, 408.82

People enrolled in Part B pay a premium. The state pays the Part B premium for Medicaid members. See [Medicare Buy-In](#).

A penalty is assessed for a person who does not enroll in Part B as soon as the person becomes eligible. Medicaid pays the increased monthly premium when the person is eligible for the qualified Medicare beneficiary coverage group.

Part B Enrollment Period

Legal reference: 42 CFR 407.12, 407.14, 407.17

A person may enroll in Medicare Part B either at the same time social security benefits are approved or during the open enrollment period, which is January 1 through March 31 of each year.

Medicaid members do not have to wait until Medicare's next open enrollment to be eligible for buy-in of Part B. If there is a Medicare eligibility record, Medicaid automatically buys in for those members who are eligible for Part B.

Services Not Covered by Medicare

Legal reference: 42 CFR 410.10, 409.5

Neither Medicare Part A nor Part B pays for:

- Routine checkups.
- Glasses or examinations for glasses.
- Hearing aids or examination for hearing aids.
- Routine foot care (treatment of warts is covered).
- Orthopedic shoes.
- Cosmetic surgery.
- Most dental work.
- Most immunizations (flu, pneumococcal, and hepatitis B vaccinations are covered).
- Private duty nurse.
- Drugs given in an inpatient hospital stay that the government determines to be "less than effective."
- Items and services determined not to be medically necessary.
- Custodial care unless part of hospice.
- Personal comfort items for a patient's hospital room, such as telephone, radio, television.
- The first three pints of blood or packed red blood cells (applied separately under both Part A and Part B).
- Charges by immediate relatives or household members.
- Homemaker services except when part of hospice care.
- Meals delivered to the home.
- Surgical services for which a second opinion is required but not obtained.
- Items or services for which Medicare is the secondary payer. This includes situations where the beneficiary has worker's compensation or an employer group health plan, or is entitled to compensation from an automobile or liability insurance plan.

Medicare Buy-In

Legal reference: 42 CFR 431.625, 441 IAC 75 (Rules in Process)

The Department pays the Medicare Part B premium for Medicaid members. This “buy-in” transfers some medical costs from the Medicaid program, which is partially state-funded, to the Medicare program, which is funded by the federal government and premiums.

To be eligible for the buy-in, a person must be a full Medicaid member and be eligible to enroll in Medicare. People in the following “limited benefit” coverage groups are **not** eligible for buy-in:

Eligibility
Chronic care group
Concurrent eligibility under two or more limited benefit aid types (blended aid types shown on SSNI)
Family planning
Medically Needy with spenddown
Presumptive eligibility for breast and cervical cancer treatment (BCCT)
Presumptive eligibility for children
Presumptive eligibility for pregnant women
Qualified working disabled person

If requested, you can help the person apply for Medicare by calling the local Social Security office and asking that a sign-up card be sent to the person. If the person refuses to sign up for Medicare, see [8-C, Benefits from Other Sources](#).

Iowa has an agreement with the Social Security Administration to initiate buy-in for all recipients of SSI or federally administered State Supplementary Assistance who are eligible to enroll in Medicare.

People who are already enrolled in Medicare or who discontinue their Part B coverage do not have to take any action on their own to complete the buy-in process. If a person is eligible for Medicare coverage but is not participating, tell the person to contact the local Social Security office and sign up for Medicare so the buy-in process can occur.

The Buy-In Process

Legal reference: 42 CFR 407.40

To add Medicaid members to the buy-in, the Department sends the person’s claim number to the Centers for Medicare and Medicaid Services (CMS) in Baltimore.

Three types of claim numbers are used for Medicare:

- A railroad claim number, which has six to nine digits with an alphabetical prefix. You can get the railroad claim number from a health insurance card, award letter, premium notice, or from the Railroad Retirement Board. Bendex reports are not issued for persons whose claim number is a railroad number.
- The social security number of the person on whose earnings social security benefits are being paid with a suffix known as the beneficiary identification code (BIC).

The BIC is a one- or two-character code that identifies the type of social security benefits the person receives, such as wage earner's benefits, spouse's benefits, or child's benefits. The BIC has a letter in the first position and may have either a number or a letter in the second position.

You can get the social security claim number from the beneficiary's award letter or premium notice, or from the Social Security office. When the Social Security Administration changes a claim number because the benefit type changed or an incorrect number is sent, the number is automatically changed on the systems.

- The Medicare Beneficiary Identifier (MBI) is eleven characters using numbers and upper case letters. The MBI is randomly generated and does not have any hidden or special meaning. You can get the MBI from the beneficiary's health insurance card.

The Department's buy-in file is sent to CMS once a month at the system month-end cutoff, which is usually around the 21st to 23rd of the month but may be earlier or later depending on holidays and the length of the month.

CMS processes the file by comparing the claim numbers or the MBI to the CMS master file. If there is a match, the buy-in is completed. If there is no match, the name is rejected. DHS is notified in either case when CMS returns the file at the beginning of the next month.

Bendex is not immediately updated when the state buy-in is completed. But buy-in information is updated on the SSBI screen. For a buy-in history, use the PF8 key. The buy-in information is updated later on the Bendex screen.

Buy-In Effective Date

Legal reference: 42 CFR 407.47

The buy-in is effective the first month the person is eligible for Medicaid, unless the person:

- Is not eligible for Medicare in that month (for example, is not 65); or
- Is already on buy-in through another state that hasn't completed buy-out.

When the buy-in is complete, the Medicare premium is no longer deducted from the social security or railroad retirement check. If the person was being billed, the billing ends after buy-in is complete.

If the health coverage code on the ABC system is not consistent with the buy-in records, the code is automatically updated on ABC to show Medicare Part B coverage only. Verify whether this is correct and update the code to indicate both Part A and B coverage, if applicable.

Premium Refund Checks

Members who paid the Medicare premium or had it deducted from their monthly social security or railroad retirement payment will receive refunds for the months covered by the buy-in. Refunds of premiums are sent to the member in the same month that the buy-in is completed.

The buy-in file is sent to CMS at March month-end. CMS returns the file at the beginning of April. By the end of April, the Social Security Administration issues refunds to members whose buy-in was completed.

A member living in a nursing facility may owe the refund check to the facility.

A waiver member who has a medical assistance income trust (MAIT) may owe the refund check to a waiver provider.

Members living in a residential care facility are entitled to keep the retroactive refund check. No deduction is allowed for the Medicare Part B premium when computing client participation before the buy-in is complete.

Tell members at the time of approval whether they should turn over the refund check to facility when they receive it. Recalculate the client participation in the month the refund is received.

Adjust ongoing client participation to reflect the fact that buy-in is complete. The Medicare Part B premium is no longer allowed as a deduction.

Buy-Out

Legal reference: 42 CFR 407.48, 407.50

The buy-in continues until Medicaid is canceled. Entering a negative action for Medicaid on the system automatically triggers the cancellation from buy-in. Buy-out is effective the month Medicaid eligibility ends.

NOTE: If CMS accepts a buy-in for a person with more than one claim number, duplicate billing has occurred. There is no retroactive time limit when adjusting duplicate billing.

When the buy-out occurs, a member can choose to withdraw from Part B coverage. The date a person notifies the Social Security Administration of the choice to withdraw from Part B determines when Part B coverage ends.

- If the member requests a withdrawal from Part B more than six months after buy-out occurred, Part B coverage ends at the end of the month after the month Social Security is notified.
- If the member requests a withdrawal from Part B during the last month of the buy-in coverage or during the six succeeding months, Part B ends in the month the notice was filed.
- If the member is not receiving social security or railroad benefits and is not paying the Part B premium, coverage ends at the end of the third month.

Health Insurance Premium Payment Program (HIPP)

The Health Insurance Premium Payment (HIPP) Program uses Medicaid funds to pay for health insurance coverage through an employer-related plan or an individual plan. Medicaid then becomes the secondary payer of claims.

The HIPP Unit, at the Iowa Medicaid, determines if it is cost-effective to pay for a member to get and keep group or individual health insurance coverage or for Medicaid to pay for the services. If the insurance is determined cost-effective, the HIPP program pays the premium directly to the employee, the employer, or the health insurance company on behalf of the member.

IM duties concerning HIPP include:

- Distributing Comm. 91, “The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients” upon request. This brochure contains form **470-2875, Health Insurance Premium Payment Program Application**.
- Making referrals to the HIPP Unit when insurance is available to:
 - Applicants or members at application or when new employment is reported.
 - Parents in Medicaid households with children who are Medicaid-eligible.

See [Situations Not Covered by HIPP](#) later in this chapter for a list of when not to make a referral to the HIPP Unit.

To make a referral to the HIPP Unit, have the member, applicant, or parent contact the HIPP Unit as follows:

Phone: toll-free 1-888-346-9562; local (515) 974-3282

Fax: (515) 725-0725

Interoffice mail: IME/HIPP

E-mail: HIPP@dhs.state.ia.us (DHS, HIPP Program)

U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Examples of changes that need to be reported include, but are not limited to:

Event	Why the HIPP Unit Needs to Know
Birth of a baby	Generally, a baby must be added to the health insurance within 30 days after the date of birth. Otherwise, the baby's hospital bills from birth will not be covered by the insurance plan.
The policyholder leaves the household	If the policyholder is not in the Medicaid household, the HIPP Unit will need to reevaluate whether reimbursement can continue.
Loss of employment	Usually when the employment ends the insurance ends. The HIPP Unit will need to determine if there is COBRA coverage available or if there is a new employer with health insurance available.

For more information on IM procedures and member cooperation requirements, see [8-C, Cooperation With the Health Insurance Premium Payment \(HIPP\) Unit](#).

Who Is Eligible for HIPP

Legal reference: 441 IAC 75.21(1), (2) and (4) and (249A)

Three groups of people may be eligible for HIPP:

- **Mandatory participants** are Medicaid members who have or are eligible to enroll in group health insurance through an employer. Mandatory participants are automatically evaluated for HIPP participation.

If the HIPP Unit determines that the employer group health insurance is cost-effective, a mandatory participant must keep or enroll in this health insurance as a condition of Medicaid eligibility, unless insurance is being maintained on the Medicaid member through another source (e.g., an absent parent is maintaining insurance on the member's children).

- **Voluntary participants** are Medicaid members who have health insurance from a source other than an employer, such as an individual policy. They can be eligible for HIPP if they apply and it is determined that the health insurance is cost-effective. They are not required to keep or enroll in the health insurance as a condition of Medicaid eligibility.
- **Non-Medicaid-eligible participants** are family members who are not eligible for Medicaid but who must be enrolled in the health insurance plan in order to obtain coverage for the Medicaid-eligible family members. Only the needs of the Medicaid-eligible members are considered in determining the cost-effectiveness of the plan.

1. Mr. and Mrs. M have three children who are all eligible for Medicaid under MAC. Mr. and Mrs. M are eligible only for Medically Needy with a spenddown. Mr. M's employer offers group health insurance to his employees. Mr. M states he cannot afford to pay the employee's share of the premium.

Two of the children have serious medical conditions that require frequent treatment and hospitalization. These services would be covered by the group insurance available through Mr. M's employer.

The HIPP Unit determines that it would cost less to pay Mr. M's share of the premium than to pay for these services only with Medicaid. By purchasing a family plan to cover the children, Mr. and Mrs. M will also have insurance coverage, even though they are not eligible for Medicaid.

2. Mr. and Mrs. K have two children who are eligible for Medicaid under MAC. Mr. and Mrs. K are eligible only for Medically Needy with a spenddown. Mr. K's employer offers the following options under the group health insurance plan:

Employee	\$10 per pay period
Employee + spouse	\$60 per pay period
Employee + children	\$40 per pay period
Family	\$100 per pay period

Since Mrs. K is not a Medicaid member, and the employer offers an option to cover only the employee and the children, this option is examined for cost-effectiveness. Payment is not made for the family coverage, since it is not necessary to purchase the family option to provide coverage to the Medicaid-eligible children.

When some household members are eligible for full Medicaid benefits and some only for the Medically Needy program, the premium is paid if determined cost-effective based only on the people receiving full Medicaid benefits. If the HIPP program pays the premium, the people in the Medically Needy program cannot use the premium as a deduction.

1. Household composition:

Ms. M, age 36, potentially eligible for Medically Needy
Billy, age 4, receiving Medicaid under the MAC program
Julie, age 2, receiving Medicaid under the MAC program

Ms. M's employer group health insurance is determined cost-effective when comparing its cost to the average Medicaid expenditures for the children only. Therefore, Ms. M is required to enroll in the policy as a condition of her Medicaid eligibility.

The premium is not used as a deduction when determining the remaining amount of Mrs. M's spenddown.

2. Same as Example 1, except that Ms. M is already enrolled in the health plan and the premium is being used as a deduction to spenddown when determining the remaining amount of Ms. M's spenddown for a May-June certification period.

On June 10, the HIPP worker determines the policy is cost-effective. Eligibility for the HIPP program is approved as of July 1. The premium is not used as a deduction to Ms. M's income for her July-August certification period.

3. Ms. J and her two children are eligible for Medicaid under the Transitional Medicaid coverage group. Mrs. J's employer provides insurance free to her. The cost for insuring the children is \$50 per month.

The HIPP Unit determines it would be cost-effective to pay the \$50 monthly premium to insure the children and requests that Ms. K apply for coverage. Ms. K responds that her ex-husband has insurance coverage on the children and provides verification. Ms. K is not required to add the children to her health insurance plan.

Situations Not Covered by HIPP

Legal reference: 441 IAC 75.21(5) and 75.21(14)(b)

If one of the following circumstances applies, premiums will not be paid by the HIPP program:

- On the date HIPP eligibility is determined, no one covered by the insurance is a Medicaid member.
- On the date HIPP eligibility is determined, the coverage is no longer cost-effective.
- The only Medicaid-eligible member has Medicare.
- Is eligible for Medicaid only under one or more of the following coverage groups:
 - Medicaid for Kids with Special Needs (MKSN)
 - Medically Needy

If one of the following circumstances applies, you do not need to make a referral to the HIPP program:

- Insurance is provided by the Health Insurance Plan Iowa (HIPIOWA).
- Another entity is maintaining health insurance on the Medicaid member (e.g., an absent parent is maintaining insurance on the Medicaid member's children, or when the policyholder is not in the Medicaid household).
- The insurance plan is designed to provide coverage for a temporary period.
- The insurance plan is an indemnity policy that supplements the policyholder's income or pays a predetermined amount for medical services, e.g., \$50 per day for hospital services instead of 80% of the charge.
- The insurance plan is offered on the basis of attendance or enrollment at a school.
- The policyholder is an absent parent. Child Support Services (CSS) is responsible for obtaining cash and medical support for children in households where a parent is absent.
- The health insurance premium is used as a deduction in computing the client participation.
- The policyholder or potential policyholder is an undocumented alien.

HIPP eligibility ends when:

- The policyholder leaves the household and becomes an absent parent.
- The policyholder fails to provide requested information.
- All members covered by the policy lose Iowa Medicaid eligibility.
- The insurance is no longer cost-effective.
- The insurance coverage is no longer available.

For more information on the Health Insurance Premium Payment Program, contact the HIPP Unit.

AIDS/HIV Health Insurance Premium Payment Program

Legal reference: 441 IAC 75.22(249A)

The AIDS/HIV Health Insurance Premium Payment (HIPP) Program pays for continuing health insurance coverage for people living with AIDS or HIV-related illnesses who can no longer pay the insurance premiums. This program is funded by 100% state funds with an annual capped appropriation of \$60,000.

The HIPP Unit in the Iowa Medicaid administers the program. The HIPP Unit is responsible for:

- Maintaining the application log.
- Tracking expenditures and reserving funds for future premium payments.
- Determining initial and ongoing eligibility.
- Tracking the remaining unobligated funds.
- Maintaining the waiting list.

Local office responsibility is to receive applications. Give people who ask about the program Comm. 99, "The Iowa AIDS/HIV Health Insurance Premium Payment Program," which includes the application and a business reply envelope to send the application directly to the HIPP Unit.

The Department must protect the confidentiality of people applying for or participating in the program. When contacts are made, acknowledge only that information is needed to determine eligibility for public assistance. Never acknowledge that the person is living with AIDS or an HIV-related illness without the person's express written consent.

AIDS/HIV Application Processing

Legal reference: 441 IAC 75.22(2)"a" and "b"

People applying for the program must complete form **470-2953, AIDS/HIV Health Insurance Premium Payment Application**, included in **Comm. 99**. The application must contain the applicant's name, address, and signature.

Applicants who do not use the business reply envelope in **Comm. 99** may file the application at the local office. If the local office receives an application:

- Date-stamp the application.
- Take all precautions to ensure its confidentiality.
- Send the application to the IME/HIPP Unit addressed to the HIPP supervisor by:

Fax: (515) 725-0725

Interoffice mail: IME/HIPP

U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

For more information on the Iowa AIDS/HIV Health Insurance Premium Payment Program, contact the HIPP Unit.

Money Follows the Person (MFP) Grant Services

Legal reference: P.L. 109-171, Deficit Reduction Act (DRA), Section 6071; Affordable Care Act, ACA, Section 2403

Money Follows the Person (MFP) grant services provide an opportunity for members to move out of a nursing facility (NF) or intermediate care facilities for persons with intellectual disabilities (ICF/ID) and into their own homes in the community of their choice. In some circumstances, a person placed in a hospital setting may also qualify.

Grant funds provide funding for the transition services and enhanced supports needed for the first year after they transition into the community. MFP assistance is available to members who:

- Have a diagnosis of mental retardation or brain injury,
- Have lived in a NF or ICF/ID for at least three months,
- Have expressed an interest moving from the NF or ICF/ID into the community, and
- Need home- and community-based services (HCBS) in order to reside successfully in a community-based setting.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support members in community living. Participants may be covered by the MFP program for 365 consecutive days, after which time an HBCS waiver will provide ongoing services. Members who have to return to a facility during the MFP 365 days will not have those days spent at the facility count towards the MFP 365 days. Once the member returns to the community the 365 day count will continue.

The MFP program helps members locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. The assistance of a transition specialist in coordinating transition planning, implementation, and follow-up in securing essential services are included.

The following sections give further instructions on:

- [Referrals to MFP services](#)
- [Approval of MFP services and transitioning from ICF/ID to MFP](#)
- [Discharge for the NF or ICF/ID](#)
- [Transfer to waiver at day 365 of MFP](#)
- [Case maintenance](#)

Referral to MFP Services

The facility will make a referral to a transition specialist when a resident requests MFP grant services. (The facility should not contact the IM worker to make a referral for targeted case management. If you are contacted by the facility provider, refer the provider to the transition specialist to make the MFP referral.)

The transition specialist will create an MFP program request in loWANS and start a workflow. You will receive an informational milestone in loWANS notifying you:

- When a member has applied for MFP, and
- When a member has been approved for MFP.

Members referred for MFP grant services continue to be active on a NF or ICF/ID facility case.

Mr. J has been in an ICF/ID for two years and is a Medicaid member. He requests MFP services. The ICF/ID makes a referral to the transition specialist.

The transition specialist creates an MFP program request in loWANS and starts a workflow. The IM worker receives a milestone in loWANS that MFP services have been requested. The IM worker responds to the milestone. No further action is required until Mr. J is discharged from the ICF/ID.

Approval of MFP Services and Transition Period

MFP services begin before a member is discharged from the facility. MFP funds can be used to transition the member into a community-based setting. The member continues to be active on a facility case.

You will receive an informational milestone in loWANS when a member has been approved for MFP. Do not make ABC system entries to pend or approve a waiver case until the member is discharged from the facility.

When the member is close to being discharged from the facility, the transition specialist will provide a signed statement from the member or the member's representative requesting waiver services (in lieu of an application). The transition specialist will send the statement to the IM worker by FAX or email.

Discharge from NF or ICF/ID

The transition specialist will email you with the member's date of discharge from the facility. Once you have received the **Case Activity Report** from the facility indicating a discharge from the facility, you can approve the member for MFP.

Set up the MFP case as a waiver case in the ABC system. Use the member's facility case to approve MFP by either:

- Closing the facility case first and reopening the case as a waiver. NOTE: When making these entries, the end date of the facility case and the positive date of the waiver case **must** be the same date. Or,
- Making transfer entries to move the member from facility to a waiver. See [14-B\(9\), Facility Case Actions Move, Same Day](#).

Use the aid type and waiver code applicable for the person's age and the type of disability. Most MFP cases are set up as intellectual disabilities (ID) waiver cases. However, a member may also qualify for another home- and community-based services waiver. Contact the transition specialist to determine what waiver type would be most appropriate, if questionable.

Code the INFO field on the ABC TD01 screen to indicate that the member is active for MFP.

Once the ABC entries pass to loWANS, loWANS will:

1. Add the end date on the facility program request.
2. Add a future end date on the MFP program request 365 days from the facility end date.
3. Create a new waiver program request with a future beginning date 366 days from facility end date.

The member may remain on MFP for 365 days after discharging from the facility.

Transfer to Waiver at Day 365 of MFP

Once the member has used 365 days of MFP, the member will be transitioned to an HCBS waiver.

A full waiver workflow will be started in loWANS 60 days before the end date of MFP. You may need to request case manager information from the member to assign the CM/SW role in loWANS, if unknown for fee-for-service members.

You will receive the milestone. **“The consumer has been given a choice between HCBS waiver services and institutional services. Do you want to continue with waiver eligibility?”** Respond, **“Continue, consumer has chosen HCBS.”** The signed statement choosing HCBS waiver should have already been received the previous year when the member applied for MFP.

Once the full waiver workflow is completed, the program request will be authorized for payment. The waiver case manager will issue a *Notice of Decision* to the member and the providers regarding the authorized services under the waiver program.

You will **not** need to make entries in the ABC system, since the member is already active on a waiver case. Since there is no change in Medicaid benefits, there is no need to issue a new **Notice of Decision** when the member switches from MFP to the waiver.

Case Maintenance

In general, follow the procedures in [8-G, Case Maintenance](#). If a member goes into a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care.

Occasionally, a member may need to return to the facility. If you receive a **Case Activity Report** from a facility indicating that a member has been admitted back to the facility, either:

- Close the waiver case and re-open it as a facility case, or
- Make transfer entries to move the member from waiver back to the facility. See [14-B\(9\), Facility Case Actions Move, Same Day](#).

Follow the steps under [Discharge from NF or ICF/ID](#) when the member is discharged from the facility and moves back to MFP.

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

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

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

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

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

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

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

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

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

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

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