



Medicaid

*for
People in
Nursing Homes
and Other
Care Facilities*



Table of Contents

How do I choose a long-term care facility?2

Will Iowa Medicaid pay for care in an out-of-state nursing facility?2

What happens when I am admitted to a nursing facility?3

When do I become Medicaid eligible?.....4

Will my spouse at home affect my eligibility for Medicaid?.....5

What is client participation?5

What are my Medicaid benefits?7

What additional services can I get?.....7

How does Medicaid work for people who get Medicare?8

Is it possible to transfer from one facility to another?8

How are Medicaid members discharged from a facility?9

You Have the Right to Appeal.....10

Use of the Medicaid Toll-Free Hotline11

Discrimination, Harassment, Affirmative Action, and Equal Employment Opportunity Policy12

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This brochure answers some of the most commonly asked questions concerning Medicaid for people in Iowa nursing facilities and other medical facilities.

Long-term care facilities, or nursing homes, include nursing facilities (NF), intermediate care facilities for persons with an intellectual disability (ICF/ID), and certified skilled nursing facilities (SNF). Other medical facilities include general hospitals or psychiatric institutions.

The Medicaid program is sometimes referred to as the Title 19 program. This should not be confused with Medicare. The Social Security Office handles Medicare.

How do I choose a long-term care facility?

You are eligible for benefits in any Medicaid-certified facility that will accept Medicaid payment. Most Iowa facilities do participate in the Medicaid program. The fact that a long-term care facility is Medicaid certified does not guarantee entrance to the facility. Other factors, such as waiting lists, need for care, and the ability to meet your particular needs, may be considered by the facility before admitting you.

For Medicaid members, a facility must review the care needs of the member with the Iowa Medicaid Enterprise (IME) Medical Services Unit (a peer review organization) and receive approval for placement before Medicaid payments can be made.

Will Iowa Medicaid pay for care in an out-of-state nursing facility?

If you require a skilled nursing program not available in Iowa, your care in an out-of-state nursing facility or intermediate care facility for persons with an intellectual disability may be paid if it is approved in advance.

Out-of-state placement can be made only if the following conditions exist:

- ◆ The out-of-state facility participates in the Iowa nursing facility or intermediate care facility for persons with an intellectual disability program. Participating out-of-state facilities are generally found in states bordering Iowa. (Residential services are not payable out of state.)
- ◆ You are planning to return to Iowa when an appropriate placement becomes available.

Payment will be made by Iowa Medicaid for an out-of-state facility if:

- ◆ You are medically eligible; and
- ◆ Placement has been recommended by the Department.

Members who choose to move out of state should apply for Medicaid in their new state of residence.

What happens when I am admitted to a nursing facility?

A facility cannot request an advance payment or deposit from you or your family as a condition to accept you if you receive Medicaid. The deposit or advance payment made by private-pay residents, who later become Medicaid eligible, may be counted as an asset when determining your Medicaid eligibility. If you paid a deposit or advance payment when you entered the nursing facility, when you become eligible for Medicaid, these funds may be counted as an asset.

The nursing facility must make these funds available to you at your request. Upon admission, a nursing facility is required to provide you with a copy of *Residents' Rights in Nursing Facilities*.

When do I become Medicaid eligible?

You are considered a Medicaid member from the date on the *Notice of Decision*. However, the facility may charge private pay rates until your worker determines that you are Medicaid eligible. If you are currently a resident in a facility, you need to tell the facility when you apply for Medicaid.

A facility must accept Medicaid payment with your beginning date of Medicaid eligibility. Once you are Medicaid eligible, the facility must refund any payment received from you or your family member for the period of time for which you were determined to be eligible minus your client participation.

If you are not eligible for Medicaid because you have too much income or resources, you may be eligible for the "Medically Needy" program through Medicaid. However, "Medically Needy" members are not eligible for payment of services provided by nursing homes.

For factors related to eligibility, see the pamphlet "*Medicaid for SSI-Related Persons*," Comm. 28.

Will my spouse at home affect my eligibility for Medicaid?

Some eligibility factors are looked at differently when one spouse is in a medical facility and the other lives at home. A spouse living at home will not be required to contribute his or her income to the cost of your care. Also, if you are in a medical facility and are eligible for Medicaid, your income may be shared with your spouse living at home if they don't have enough to meet their needs. (See the pamphlet, *"Protection of Your Resources and Income,"* Comm. 72.)

What is client participation?

"Client participation" is that amount of your income that you must pay to the long-term care facility at the beginning of each month for your care.

Medicaid pays any difference between the monthly client participation and the approved cost of the care in the facility. All of your monthly income is considered in order to compute the amount of client participation. The following deductions are given before the client participation is determined:

- ◆ Personal needs allowance of \$50, to be used as you wish.
- ◆ If you have earned income, up to an additional \$65 from earned income for your personal needs.
- ◆ Maintenance needs of your spouse or family at home.

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- ◆ Living expenses for partial month of nursing home care, if you are eligible for Medicaid before entering the facility and don't have a spouse or family.
 - ◆ Health insurance premiums, including the Medicare Part B and Part D premiums, deductibles, and coinsurance.
 - ◆ Necessary medical care that is recognized by state law but not covered by Medicaid.
 - ◆ Home maintenance needs for the month of discharge.

There is no client participation for hospital care.

If the facility will accept Medicaid eligibility from the date you enter the facility, pay the estimated client participation amount while you are waiting for a decision on your Medicaid application.

If your income is more than the cost of your care, you still should not pay a higher client participation than what Medicaid would pay the facility. Your DHS worker will notify you of that amount.

The Department will notify you and the facility of the amount of client participation you are to pay each month when your Medicaid application is approved.

It is your responsibility to pay the facility for your client participation. If the client participation is not paid, you may be discharged from the facility.

The amount you pay for client participation satisfies your financial obligation for nursing facility care under the Iowa Medicaid Program. A nursing facility should not charge you for any additional amount unless it is for additional goods or services that you specifically request.

What are my Medicaid benefits?

Medicaid covers the cost of care in a long-term care facility, plus other medically necessary services, such as physicians, dentists, hospitals, non-Part D covered prescribed drugs, ambulance services, and eyeglasses. *These services, plus important limits on them are covered in Comm. 20, "Your Guide to Medicaid," available at county Department offices.*

Other than client participation, no additional charges should be made to you or any family member unless it is for additional goods and services that you specifically request.

What additional services can I get?

Program of All-Inclusive Care for the Elderly (PACE) is a program designed to help you stay as healthy as possible. PACE will also provide for any other medical care that you may need such as hospitalizations, specialty care, nursing facility care, hospice, or emergency care. For more information ask for pamphlet Comm. 316, "*PACE (Program of All-Inclusive Care for the Elderly).*"

How does Medicaid work for people who get Medicare?

Once Medicaid is approved, the Department will pay your Part B Medicare premium if you are also eligible for Medicare.

It takes about three months to get this process started. In the meantime, the Part B premium may be withheld from your Social Security or Railroad Retirement check.

When the Department begins paying the premium, the Social Security Administration will refund the total amount of Part B premiums that were withheld from your check after you became eligible for Medicaid.

You must notify your DHS worker when the refund check has been received. You must pay the long-term care facility the Medicare premium amount for each month a deduction was given for the Medicare premium when calculating your client participation.

Is it possible to transfer from one facility to another?

You have a right to transfer at any time to any facility willing to admit you. If you are transferring to a facility offering the same level of care as your current facility, you must pay the cost of the transportation.

How are Medicaid members discharged from a facility?

You may be involuntarily discharged from a facility only if one of the following conditions exist:

- ◆ Discharge is necessary for medical reasons; e.g., a higher or lower level of care becomes necessary.
- ◆ Discharge is necessary for your own welfare or for the welfare of other residents.
- ◆ You do not pay the nursing home (client participation as determined by the Department) for care.

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Medicaid. To appeal in writing, do **one** of the following:

- ◆ Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- ◆ Write a letter telling us why you think a decision is wrong, **or**
- ◆ Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

You have 90 calendar days to file an appeal from the date of the decision.

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Use of the Medicaid Toll-Free Hotline

A toll-free telephone number 1-800-338-8366 is available to help you resolve unpaid bills that you think Medicaid should have covered. The worker who answers this line will take down the information about your bill and submit it for review and reconsideration.

Before you call the Medicaid hotline, you should have the following information in front of you:

- ◆ The medical bill,
- ◆ A brief description of what services were provided, and
- ◆ The Personal Identification Number listed on your *Medical Assistance Eligibility Card*.

This hotline is not to be used to ask questions about Medicaid policy or if medical procedures or equipment are covered by Medicaid. These questions should be directed to your county DHS worker or to your medical provider.

Discrimination, Harassment, Affirmative Action, and Equal Employment Opportunity Policy

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines IA 50319-0114 or via email contactdhs@dhs.state.ia.us