IOWA Health and Human Services

Medicaid Member Enters a Nursing Facility

The following information is intended for employees of long-term care/nursing facilities to better understand the process when an individual on Medicaid enters long term care or nursing facility.

There are two different paths through which a Medicaid member may be eligible for nursing home coverage. The first path is for the elderly and disabled referred to as non-MAGI. The second path is for the family/individual coverage or MAGI.

Non-MAGI path:

A redetermination process is initiated when a Case Activity Report is received indicating a current Medicaid member has entered the medical facility. A new application is not needed for current Medicaid members who are receiving full Medicaid benefits. Examples of eligible coverage groups that are considered full benefits for Medicaid are SSI recipients, Medicaid for employed persons with disabilities (MEPD), Dependent person, In Home Health Care, Residential Care.

- Client must be aged, blind, or determined disabled by the Social Security Administration.
- There is no 30 days stay requirement.
- Attribution of Resources is required if member is legally married as of the date the individual went into the facility.
- A Member is required to cooperate with Third Party Liability. A member or a person acting on the member's behalf must cooperate by providing information and verification about any medical or third-party resources.
- Will need to meet the $2,000 resource limit for nursing facility Medicaid. If an individual is under 65 and was working with the intent to return to work within 6 months of when they stopped, they may be eligible through the Medicaid for Employed Persons with Disabilities (MEPD) pathway which has a higher resource limit.

Members not receiving full Medicaid (i.e., Medicare Savings Program, SSI Related Medically Needy) must meet the 30 days stay requirement in addition to the requirements above.

Members active on a Medicaid waiver program:

- When a member enters the nursing facility from waiver it is considered a transfer from one facility to another. The eligibility requirements are the same for both programs.
- HHS may request updated income or deduction information so client participation can be accurately calculated. If requested information is not provided, the member's nursing facility Medicaid case may be cancelled/denied.

- A waiver member who owns a home will also be asked to provide an intent to return home or if no intent they would need to provide proof of equity value in the home.

Members transferring to and from another facility or hospice care at a facility:

- When a member transfers from one nursing facility to another, HHS is required to have a Case Activity Report (CAR) from the discharging facility as well as the admitting facility. Workers are unable to complete the transfer until both CARs are received.

- A member who elects hospice care while residing in the facility will be transferred to the hospice provider number once the CAR and Election of Hospice benefits is received from the hospice provider and the CAR is received from the facility where the member resides. Workers are unable to complete the transfer to hospice care until all CARs and the Election of Hospice Benefits is received.

The MAGI Path:

Members whose eligibility is determined using modified adjusted gross income (MAGI methodology, such as Iowa Health and Wellness Program (IHAWP):

- A Case Activity Report must be received before an individual can be considered for Nursing Home Coverage
    - IHAWP members who are not determined to be medically exempt are eligible for 120 days of skilled nursing facility coverage only.
        - IHAWP members who have been determined to have medically exempt status by Iowa Medicaid and MAGI members can have unlimited facility coverage.
        - Members should contact Iowa Medicaid– Member Services to obtain medically exempt status,1-800-338-8366.
    - A request for information will be sent to member regarding Transfer of Asset (TOA) within the past 60 months for Medically Exempt IHAWP and MAGI members. This information is needed back to receive Nursing Home coverage. IHAWP members who do not return the information will not receive coverage beyond the 120 days of skilled care.

Please note, it is important for the member or their representative to call HHS if there will be a change in mailing address due to the facility placement.