



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

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ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter I, **MEDICAL INSTITUTIONS**,
Contents (page 2), revised; and pages 41, 42, 48, 49, 50, 52, 53, 55,
and 56, revised.

Summary

Chapter 8-I is revised to:

- ◆ Update the 150 percent of the monthly federal poverty level for a family of two and revise the examples. This amount is used to determine the maintenance needs of the other dependents living with the community spouse.
- ◆ Update the manual to reflect a new legislative change on Medical Assistance Income Trusts (MAITs). Before July 1, 2014, the statewide average charge to determine if a MAIT would allow the person to be income-eligible for Medicaid was used. Beginning on July 1, 2014, use 125 percent of the statewide average charge for care to determine if a person with this type of trust qualifies for facility payment.
- ◆ Update the amounts that represent 125 percent of the statewide average charges to private-pay residents and revise the examples. Use these amounts to determine the payments to be made to a beneficiary of a medical assistance income trust.

Effective Date

The allowance for other dependents is effective April 1, 2014.

The legislative change to use 125 percent of the statewide average charge for care and the amounts that represent these charges are effective July 1, 2014.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter I:

<u>Page</u>	<u>Date</u>
Contents (page 2)	July 20, 2012
41, 42	January 17, 2014
48	August 27, 2010
49	July 19, 2013
50	July 20, 2012
52	July 19, 2013
53	July 20, 2012
55, 56	January 17, 2014

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

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5. Mrs. E is a community spouse with \$500 gross monthly income. She is estranged from Mr. E and has obtained a court order for \$3,000 per month in support. The court-ordered amount is substituted for the \$2,931 maintenance needs. The diversion of income is determined as follows:

Mr. E:		Mrs. E:	
\$1,100.00	Gross income	\$ 3,000.00	Maintenance
- <u>50.00</u>	Personal needs	- <u>500.00</u>	Income
\$1,050.00	To divert	\$ 2,500.00	Deficit

Mr. E can divert only \$1,050 because his income supports only this amount.

Allowance for Other Dependents

Legal reference: 441 IAC 75.16(2) "d" and "e"

Determine the maintenance needs of the other dependents by subtracting **each** person's gross income from 150% of the monthly federal poverty level for a family of two (currently \$1,967 per month), and dividing the result by three. Include SSI and FIP benefits as income.

The dependent's diversion does not need to be for the benefit of the dependent. That is a requirement for the community spouse diversion only.

1. Mr. T receives Medicaid payment for nursing care. His wife and mother live at home. Diversion for Mr. T's dependents is determined as follows:

Mr. T:		Mrs. T:	
\$2,050.00	Gross income	\$2,931.00	Maintenance needs
- <u>50.00</u>	Personal needs	- <u>970.00</u>	Income
\$2,000.00	Available to divert	\$1,961.00	Deficit

Mr. T's mother:
 \$1,967.00 Poverty level
 - 405.00 Income
 \$1,562.00 Divided by 3 = \$520.66 maintenance for dependent

The total need of the spouse and dependent is \$1,961.00 + \$520.66 or \$2,481.66. Mr. T does not have enough income to meet all of his mother's needs. Mr. T's client participation is determined as follows:

\$2,050.00 Gross income
 - 50.00 Personal needs allowance
 - 1,961.00 Diversion for spousal deficit
 - 39.00 Diversion for mother's needs (\$2,000 - \$1,961)
 \$ 0.00

2. Mrs. W lives in a nursing facility and is Medicaid-eligible. Mr. W lives at home with two children who do not receive FIP. Mr. W has earned income. Mrs. W has workers' compensation. The children have no income.

Mrs. W:
 \$ 575.00 Gross income
 - 50.00 Personal needs allowance
 \$ 525.00 Income available to divert to spouse and dependents

The spousal and dependent allowances are determined as follows:

Mr. W:		Children:	
\$2,931.00	Maintenance	\$1,967.00	Poverty level
- <u>3,000.00</u>	Gross income	- <u>0.00</u>	Income
\$ 0.00	Unmet needs	\$1,967.00	Divided by 3 =
			\$655.66 per child
			\$655.66 x 2 children = \$1,311.32

All of Mrs. W's income after deduction of her personal needs is diverted for the children. Mrs. W's client participation is determined as follows:

\$ 575.00 Gross income
 - 50.00 Personal needs
 - 525.00 Diversion for dependents' needs (\$575 - 50 = \$525)
 \$.00 Amount of client participation

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

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

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

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

For more information on QMB eligibles, see [Client Participation for QMBs Entering Skilled Care](#).

Members With a Medical Assistance Income Trust

Legal reference: 441 IAC 75.24(249A)

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

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

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

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

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

The following sections explain:

- ◆ [125 Percent of the statewide average charges for care](#)
- ◆ [Trust payments](#)
- ◆ [Determination of client participation](#)

125 Percent of the Statewide Average Charge for Care

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

Charge for care figures for July 1, 2014, through June 30, 2015, are:

Type of Care	Charge for Care
Nursing facility	\$5,833
PMIC	\$7,872
Mental health institute	\$25,623
ICF/ID	\$31,300

Substitute a higher amount for 125 percent of the average statewide charge for nursing facility care in the following situations:

If the trust beneficiary meets the level of care requirements for...	Then use this amount in the income comparison:
Nursing facility care and receives some type of specialized care (e.g., care in a Medicare-certified hospital-based nursing facility or a nursing facility providing care to special populations such as an Alzheimer's unit, pediatric skilled care, or skilled care for brain injury)	The cost of the type of specialized care being received
Skilled nursing care and is eligible for HCBS waiver or programs for all-inclusive care for the elderly (PACE) services except for income	The costs in a facility providing the type of care being received

If the trust beneficiary meets the level of care requirements for...	Then use this amount in the income comparison:
Services in a PMIC and resides in a PMIC	The 125 percent of the statewide average charge to private-pay patients for PMIC care
Services in an MHI and resides in a state MHI	The 125 percent of the statewide average charge to private-pay patients for state MHI care
Services in an MHI and is eligible for HCBS waiver or PACE services except for income	The 125 percent of the statewide average charge to private-pay patients for state MHI care
Services in an ICF/ID and resides in an ICF/ID	The 125 percent of the maximum monthly Medicaid payment rate for services in an ICF/ID

Trust Payments

Legal reference: Iowa Code Section 633C.3

If the total income received by the beneficiary of a medical assistance income trust, including income received or generated by the trust, is **less** than 125 percent of the applicable statewide average charge for care, Iowa law allows the following deductions (trust payments) from gross income to determine client participation:

1. A reasonable amount may be paid or set aside for trust administration fee not to exceed \$10 per month without court approval. This payment is not considered income to the client.
2. An amount for the needs of the beneficiary:
 - ◆ A personal needs allowance of \$50 for a medical facility resident plus additional amounts for personal needs in the month of entry or discharge, as appropriate. NOTE: Exclude \$90 of VA pension income per [Income Exempt From Client Participation](#).
 - ◆ A maintenance allowance of 300% of the current SSI income limit for a waiver member or a PACE enrollee.

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

Mrs. S's total income is less than 125 percent of the average charge for nursing facility level of care. The trust will pay her all of the available income. Count the payment from the trust to Mrs. S as income. She is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.

2. Mr. T is in a nursing facility at the nursing facility level of care. He has social security benefits of \$900 and a monthly pension of \$1,138 per month. Only his social security check is deposited into his medical assistance income trust.

Mr. T's total income is less than 125 percent of the average charge for nursing facility care. The trust may set aside \$10 per month for administration. The trust will pay Mr. T the \$50 personal needs allowance each month Mr. T is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.

3. Mr. W is in the Alzheimer's unit of a nursing facility. He meets the nursing facility level of care. He has social security benefits of \$2,825, an annuity payment of \$1,450, and a monthly private pension of \$2,400.

Mr. W's total income is \$6,675. His total income is higher than \$5,833, 125 percent of the average charge for nursing facility care. However, since Mr. W is receiving specialized care, the cost of his Alzheimer's care can be substituted for the average nursing facility charge.

Mr. W provides a statement from the nursing facility that he pays \$225 per day for his care. The average monthly cost would be \$6,840 ($\$225 \times 30.4 = \$6,840$). The cost of \$6,840 can be substituted in place of 125 percent of the statewide average charge for nursing facility care. Mr. W is income-eligible for Medicaid payment of nursing care using the medical assistance income trust.

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

1. A reasonable amount may be paid or set aside for trust administration fee, not to exceed \$10 per month without court approval. This payment is not considered income to the client.

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

Mr. Y is a resident of a nursing facility at nursing facility level of care. His gross monthly income consists of social security benefits of \$1,277, a civil service pension of \$3,500, and income from his farm (homestead) of \$1,180. His total gross monthly income of \$5,957 is deposited into a medical assistance income trust.

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

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

Determination of Client Participation

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

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

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

- ◆ Enter 300% of the SSI limit on the ABC system's BCW2 screen with an income indicator of "S" for eligibility.
- ◆ Enter social security on the ABC system's BCW2 screen with an income indicator of "B" and the total of all other income with an income indicator of "X" for benefits.

- ◆ When the member's gross monthly income is **equal to or greater than** 125 percent of the statewide charge for the care the member receives (see [125 Percent of the Statewide Average Charge for Care](#)):
 - Enter gross income with an income indicator of "S" for eligibility and benefits on the BCW2 screen. The income exceeds the 300% amount, so the case will be denied or canceled from facility care and Medicaid.
 - Enter any income retained by the member or withheld but continues to be counted as income on the BCW2 screen with the applicable income indicator for both eligibility and benefit.
 - Process the case for other coverage groups, including Medically Needy, for other medical costs, unless the household has requested otherwise.

1. Mr. Z is a resident of a nursing facility. He has social security benefits of \$1,488, a civil service pension of \$3,209, and \$2,000 from a private person, for a total gross monthly income of \$6,697.

Mr. Z establishes a medical assistance income trust. His income is greater than 125 percent of the statewide average charge for care. The trust pays the \$10 administration fee and pays the remaining \$6,687 to Mr. Z. This payment is counted as income to Mr. Z when determining Medicaid eligibility and benefits.

2. Mr. G enters a nursing facility on July 1, 2014, leaving Mrs. G at home. His income consists of \$1,600 in social security and \$833 in civil service pension. Mrs. G's income consists of \$210 social security. Mr. G applies for Medicaid payment for nursing facility care. The worker explains the income limit and Mr. G sets up a medical assistance income trust to receive all of his income.

Spousal diversion calculation:

\$2,931.00	Minimum monthly maintenance needs allowance
- <u>210.00</u>	Mrs. G's income
\$2,721.00	Deficit to be met by diversion from Mr. G's income to Mrs. G

Client participation calculation:

\$2,433.00	Total income deposited to the trust
- 10.00	Trust administrative fee
- <u>50.00</u>	Personal needs allowance
\$2,373.00	Total income available for diversion
- <u>2,721.00</u>	Diversion to Mrs. G
\$.00	Client participation

3. Mrs. C applies for waiver assistance. She lives with her husband and their two children, ages 10 and 12. Mrs. C's income consists of \$1,282 in social security and \$950 in pension. Mr. C has \$2,000 in gross monthly earnings. A \$250 monthly health insurance premium is deducted from his earnings. This policy covers the whole family. Mrs. C meets level of care for waiver assistance and establishes a Miller trust that receives all of her income.

Spousal/dependent diversion calculation:

\$ 566.00	MNIL for three-person household
- <u>2,000.00</u>	Mr. C's countable earnings
\$.00	

Client participation calculation:

\$ 2,232.00	Mrs. C's gross income
- 10.00	Trust administration fee
- <u>2,163.00</u>	Mrs. C's maintenance needs
- <u>250.00</u>	Unmet medical-health insurance premium
\$ 0.00	Waiver client participation

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

Mr. E enters a nursing facility at the NF level of care, leaving Mrs. E at home. He does not receive specialized care. He has monthly income of \$1,000 in social security, \$2,640 in IPERS benefits, and \$3,000 from an annuity. Mrs. E's income consists of \$220 social security. After Mr. E pays for nursing facility care and other medical bills, he has only \$200 a month he can give to Mrs. E to live on.

Mr. E applies for Medicaid payment for nursing facility care. The worker explains the income limit and that a medical assistance income trust will not help Mr. E qualify for Medicaid. Since his income exceeds 125 percent of the statewide average charge, state law requires that all income after the \$10 trust administration fee is income to Mr. E, leaving him over income for Medicaid.

The worker refers the couple to their attorney to determine if a qualified domestic relations order will offer relief. Once the qualified domestic relations order is complete, the ownership of some or all of the income will be changed to Mrs. E. Mr. E should file another application at this time.