



# Iowa Department of Human Services

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## GENERAL LETTER NO. 8-I-71

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 1), revised; and pages 2, 9, 10a, 11 through 17, 38, 40  
through 43, 49, 54, 55, 56, 59, 60, 62, 65, 66, 69, 70, 71, and 77,  
revised; and page 10b, new.

### Summary

Chapter 8-I is revised to:

- ◆ Update the Medicare deductible and coinsurance for hospital and skilled level of care for 2015.
- ◆ Provide the 2015 minimum monthly maintenance needs allowance (MMMNA) and update examples.
- ◆ Clarify the amount to use when the member has a Medical Assistance Income Trust (MAIT) and is receiving specialized care.

### Effective Date

The Medicare deductibles and coinsurance and the MMMNA are effective January 1, 2015.

### Material Superseded

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

<u>Page</u>	<u>Date</u>
Contents (page 1)	May 7, 2010
2	January 17, 2014
9, 10a	June 19, 2009
11	October 31, 2008
12	July 20, 2012
13	August 27, 2010
14-17	October 31, 2008
38, 40	January 17, 2014
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54	January 17, 2014
55, 56	July 25, 2014
59, 60, 62, 65, 66, 69-71	January 17, 2014
77	July 20, 2012

**Additional Information**

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

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

- ◆ For the first 60 days of each benefit period, full payment is made after the beneficiary pays a deductible of \$1,260.
- ◆ For days 61 through 90, beneficiaries pay a coinsurance of \$315 per day.
- ◆ After 90 days in the hospital for a single spell of illness, beneficiaries may draw on their "lifetime reserve." The lifetime reserve is 60 days and is nonrenewable. Beneficiaries must pay coinsurance of \$630.
- ◆ After 150 days (or 90 days if the lifetime reserve has been exhausted), Medicare makes no further payment.

At the **skilled** level of care, Medicare covers 100 days per spell of illness if the person has been hospitalized for at least three days within 30 days of entering skilled care. Medicare pays the full cost for days 1 through 20. For days 21 through 100, Medicare pays the full cost except for a daily coinsurance of up to \$157.50, which is paid by the beneficiary. After 100 days, Medicare skilled care payment stops until the next spell of illness begins.

Mr. B enters the hospital on January 5. After being hospitalized for four days, he returns home. He enters skilled care on February 1 and stays there until May 15. He is eligible for 100 days of Medicare skilled nursing coverage (20 days of full coverage and 80 days of coinsurance). Medicare coverage ends May 11.

On July 1, Mr. B returns to the hospital. After three days in the hospital, he reenters skilled care. Mr. B is not eligible for any more Medicare skilled nursing coverage, because he has not been outside of a hospital or skilled care long enough to begin a new spell of illness.

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

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

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

### **Medical Necessity**

**Legal reference:** 42 CFR 45, 441 IAC 78.3(249A), 81.3(249A), 81.7(249A), 82.7(249A), 82.8(249A), 85.8(1)

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

A level of care determination is required when a person enters a facility or moves to a different level of care. In most cases, the Iowa Medicaid Enterprise (IME) Medical Services Unit determines whether a person needs the level of care provided by a medical institution. In some cases, the Medicare intermediary makes the determination.

Accept a level of care determination completed for Medicare purposes for determining Medicaid eligibility. A person who has been approved for Medicare at a particular level of care is eligible for the same level of care under Medicaid. The facility should contact the Iowa Medicaid Enterprise (IME) Medical Services Unit for a level of care determination for non-Medicare covered stays or when Medicare benefits are exhausted.

To begin the process, make entries to pend the facility program in the Automatic Benefit Calculation (ABC) system. This initiates the level of care determination.

A medical professional (physician, physician's assistant, or advanced registered nurse practitioner) must complete form 470-4393, *Level of Care Certification for Facility*, to verify the need for program admission. This form is located on the IME web site at <http://dhs.iowa.gov/ime/providers/forms>. The medical provider faxes the completed form to IME Medical Services Unit at 515-725-1003 or toll-free 1-800-338-8366.

The IME Medical Services Unit nurse reviewer makes a level of care determination based on the information provided and enters the decision in ISIS. ISIS documents the level of care approval and effective date.

The facility sends form 470-0042, *Case Activity Report*, to the local office. Review the form to verify the date of the member's admission to the facility and Medicare coverage. Contact the facility if the effective date on the *Case Activity Report* does not match the date the member wants Medicaid payment to begin or if you do not receive a report.

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

### **If Level of Care Is Denied**

**Legal reference:** 441 IAC 75.1(249A), 81.3(1)

If the applicant does not need a level of medical institution care or needs a lower level than requested, the IME Medical Services Unit issues a denial letter to the applicant, the physician, the facility, and the Bureau of Long-Term Care in the Division of Medical Services. ISIS will notify you if level of care is denied.

The client may file an appeal if the client disagrees with the IME decision. Appeal requests should be sent to the Department's Appeals Section following the normal appeal procedure in 1-E, [APPEALS AND HEARINGS](#). IME staff will review the previous denial and complete an internal reconsideration in preparation for the appeal.

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

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

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

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

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

### **Approval at a Lower Level of Care**

**Legal reference:** 441 IAC 81.10(4)"g," 78.3(6)

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

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

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

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

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

## **Effect of Institutionalization on SSI and FIP Eligibility**

### **How SSI Eligibility Is Affected**

**Legal reference:** 20 CFR 416.211, 416.414; P.L. 106-360

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

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

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

Recipients who lose SSI eligibility because they enter the institution must complete form 470-2927 or 470-2927(S), *Health Services Application*. This form is for purposes of review and is not an application. Complete an automatic redetermination to see if the person meets the requirements of another Medicaid coverage group.

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

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

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

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

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

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

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

### **How FIP Eligibility Is Affected**

**Legal reference:** 441 IAC 41.3(3)

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

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

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

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

If an FMAP-related person loses eligibility under the previous coverage group, examine eligibility under another FMAP-related coverage group (such as Child Medicaid Assistance Program) or an SSI-related coverage group. Examine eligibility under the 300% group for a child under 21.

If a parent is 21 or older, determine if the family would be eligible for FIP if the person were to live at home. See [8-F, Ineligible for FMAP Due to Residence in a Medical Institution](#).

## Income and Resources of Married Persons

**Legal reference:** 441 IAC 75.5(249A)

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

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

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

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

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

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

<b>Expected stay of less than 30 days, but stay exceeds 30 days:</b>	
<b>Income:</b> Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to minimum monthly maintenance needs allowance (MMMNA).	<b>Resources:</b> Complete an attribution.
<b>In an institution on or after September 30, 1989, for 30 days or more:</b>	
<b>Income:</b> Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	<b>Resources:</b> Complete an attribution.
<b>Institutionalized spouse returns home, but community spouse enters facility and expects to stay 30 days or more:</b>	
<b>Income:</b> Count only the newly institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	<b>Resources:</b> Complete an attribution for new institutionalized spouse and new community spouse.
<b>Marries a community spouse before eligibility is established:</b>	
<b>Income:</b> Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	<b>Resources:</b> Complete an attribution for new institutionalized spouse and new community spouse as of the date of entry into the medical institution.

<b>Marries a community spouse after eligibility is established:</b>	
<b>Income:</b> Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	<b>Resources:</b> Compare the institutionalized spouse's resources to the single-person limit. Do not count community spouse's resources to institutionalized spouse. Complete an attribution for the new institutionalized spouse and new community spouse only if the institutionalized spouse's assistance is canceled and reapplication is made.
<b>Institutionalized person marries another institutionalized person:</b>	
<b>Income:</b> Treat as individuals or a couple per client request and client advantage. If treated as a couple, compare total gross income to 2 x 300%. If treated as individuals, income limit of 300% for each person.	<b>Resources:</b> Treat as individuals or a couple per client request and client advantage. If treated as a couple, add resources, compare to \$3,000 limit. If treated as individuals, resource limit is \$2,000 for each person.

**Determining if a Common-Law Marriage Exists**

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

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

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

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

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

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

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

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

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

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

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

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

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

**Allowance for the Community Spouse**

**Legal reference:** 441 IAC 75.16(2)“d”

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

<b>Minimum Monthly Maintenance Needs Allowance (MMMNA)</b>			
<b>Calendar Year</b>	<b>Amount</b>	<b>Calendar Year</b>	<b>Amount</b>
2015	\$2,980.50	2006	\$2,488.50
2014	\$2,931.00	2005	\$2,377.50
2013	\$2,898.00	2004	\$2,319.00
2012	\$2,841.00	2003	\$2,266.50
2011	\$2,739.00	2002	\$2,232.00
2010	\$2,739.00	2001	\$2,175.00
2009	\$2,739.00	2000	\$2,103.00
2008	\$2,610.00	1999	\$2,049.00
2007	\$2,541.00		

<p>Mr. B enters a nursing facility for long-term care, leaving Mrs. B at home. Mr. B has \$800 per month gross income and also receives \$100 in aid and attendance payments. The income available from Mr. B to meet Mrs. B’s needs is determined as follows:</p>	
\$ 800.00	Gross income
- 50.00	Personal needs allowance
\$ 750.00	Available to meet Mrs. B’s needs
<p>If the shortfall between Mrs. B’s income and the MMMNA is \$750 or more, Mr. B’s client participation will be \$100, the amount of his aid and attendance payments.</p>	

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

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

2. Mrs. G is receiving skilled care and is eligible for Medicaid in the 300% group. Mr. G is at home. He has earned income of \$3,750 per month. No diversion of Mrs. G's income can be made for Mr. G in determining her client participation, because his income exceeds the maintenance need of \$2,980.50, and no greater amount has been ordered.

3. Mr. D receives skilled care and is eligible for Medicaid under the 300% group. Mrs. D is living in an RCF and receives SSI and SSA. Mrs. D's income consists of \$300 social security, \$430 SSI, and \$276.30 SSA, for a total of \$1,006.30 per month. Mr. D has gross income of \$752. He is allowed a \$50 personal needs allowance. The diversion is determined as follows:

Mr. D:		Mrs. D:	
\$ 752.00	Gross income	\$ 2,980.50	Maintenance
- <u>50.00</u>	Personal needs	- <u>1,006.30</u>	Income
\$ 702.00	To divert	\$ 1,974.20	Deficit

Only \$702 can be diverted to Mrs. D, because Mr. D must be allowed an ongoing personal needs allowance before a diversion is made to Mrs. D. Mrs. D's income with the diversion is \$1,006.30 + \$702.00 = \$1,708.30. Mrs. D loses eligibility for State Supplementary Assistance.

4. Mr. O is in a nursing facility and eligible for Medicaid. Mrs. O and their three children are at home and receiving FIP. Mr. O has begun receiving veterans' income of \$500 per month. Mrs. O's only income is the FIP grant.

The amount of FIP to count for Mrs. O in the first month of diversion is the difference between the grant for four people and the grant for three people (\$495 - \$426 = \$69). The diversion to Mrs. O is determined as follows:

Mr. O:		Mrs. O:	
\$ 500.00	Income	\$ 2,980.50	Maintenance
- <u>50.00</u>	Personal needs	- <u>69.00</u>	FIP income
\$ 450.00	To divert	\$ 2,911.50	Deficit

Mr. O can divert a maximum of \$450 of his income to Mrs. O. With this diversion, Mrs. O and the children remain eligible for FIP.

Even though Mrs. O's income may decrease after the initial month, there will be no change in the diversion from Mr. O. He does not have enough income to meet the needs of his spouse.

5. Mrs. E is a community spouse with \$500 gross monthly income. She is estranged from Mr. E and has obtained a court order for \$3,000 per month in support. The court-ordered amount is substituted for the \$2,980.50 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:	
\$2,150.00	Gross income	\$2,980.50	Maintenance needs
- <u>50.00</u>	Personal needs	- <u>970.00</u>	Income
\$ 2,100.00	Available to divert	\$2,010.50	Deficit

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

The total need of the spouse and dependent is \$2,010.50 + \$520.66 or \$2,531.16. Mr. T does not have enough income to meet all of his mother's needs. Mr. T's client participation is determined as follows:

\$2,150.00 Gross income  
 - 50.00 Personal needs allowance  
 - 2,010.50 Diversion for spousal deficit  
 - 89.50 Diversion for mother's needs (\$2,100.00 - \$2,010.50)  
 \$ 0.00

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

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

The spousal and dependent allowances are determined as follows:

Mr. W:	Children:
\$2,980.50 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

3. Mr. P is in a nursing facility and is eligible for Medicaid. Mrs. P lives at home with her three children (Mr. P's stepchildren) who are eligible for FIP.

The FIP grant for the children and Mrs. P is \$495. The amount for the children is \$426. The amount for Mrs. P is \$69 (\$495 - \$426 = \$69). Each child is credited with \$142 as income (\$426 divided by 3). The maintenance allowances are determined as follows:

Mr. P:		Mrs. P:	
\$ 821.00	Gross income	\$ 2,980.50	Maintenance
- <u>50.00</u>	Personal needs	- <u>69.00</u>	FIP income
\$ 771.00	Available to divert	2,911.50	Deficit

All of Mr. P's income is diverted to Mrs. P. There is no more income remaining for a diversion to the dependents.

If the institutionalized person does not have a spouse but does have children under age 21 at home, allow a deduction from the institutionalized person's income to meet the children's maintenance needs. Do not allow a deduction if the children receive FIP.

Count the children's income and a parent's income if living in the home in determining maintenance needs. Use gross income less disregards allowed in the FIP program. Child support is considered income of the child.

Calculate the children's maintenance needs by subtracting the children's income from the FIP standard for that number of children.

1. Mr. G is eligible for Medicaid while living in a nursing facility. He has \$700 per month gross income. He has a child aged 20 at home who has no income. The FIP payment standard for one is considered as the need. The determination of the dependent's allowance is as follows:

Mr. G:		Child G:	
\$ 700.00	Gross income	\$ 183.00	Need for one
- <u>50.00</u>	Personal needs	- <u>0.00</u>	Income
\$ 650.00	Available to divert	183.00	Deficit

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:
<b>Nursing facility</b> care and receives some type of specialized care (e.g., care in a Medicare-certified hospital-based nursing facility or a nursing facility providing care to special populations such as an Alzheimer's unit, pediatric skilled care, or skilled care for brain injury)	The cost of the type of specialized care being received. In general, use the rate charged by the facility.
<b>Skilled nursing</b> care and is eligible for <b>HCBS</b> 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

- ◆ Enter the following deductions for benefits:
  - Trust administration fee
  - Spouse and dependent needs
  - Unmet medical expenses

Mr. R is a single person in a nursing facility. His income consists of \$1,076.90 gross social security benefits and \$1,200.50 in pension, for a total of \$2,277.40 per month. He has Medicare and a supplemental health insurance. The Medicare premium of \$104.90 is withheld from his social security check. The supplemental policy premium of \$200 per month is withheld from his pension check.

Mr. R's nursing facility costs are \$3,500 per month. He contacts an attorney and establishes a medical assistance income trust. His \$972 net social security check ( $\$1,076.90 - \$104.90 = 972$ ) and \$1,000.50 net pension check ( $\$1,200.50$  less  $\$200.00$  private insurance premium) are deposited to the trust.

The total income that is deposited into the trust account is \$1,972.50. The additional \$304.90 withheld from his checks is countable income that is not deposited to the trust. Calculate the amount of income left in trust after trust administration fees by subtracting the fee from the total deposited into the trust.

\$1,972.50	Total net amount deposited into trust
- <u>10.00</u>	Trustee retains \$10 trust administrative fee
\$1,962.50	Income remaining in trust

Of the remaining \$1,962.50, the trustee makes \$50 available to Mr. R for his personal needs. The trustee pays the remaining \$1,912.50 in the trust directly to the nursing facility up to the Medicaid rate.

ABC system entries:

- \$2,199.00 (300% of the SSI benefit level) is entered on the BCW2 screen with an income indicator of "S" for eligibility.
- \$1,076.90 is entered on the BCW2 screen with an income indicator of "B," and \$1,200.50 is entered with an income indicator of "X" for benefits only. \$200 is entered in DEDUCT2 field as an unmet medical expense for benefits only. \$10 is entered in the DEDUCT PAY field as the trust administration fee.

- ◆ 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:

\$2,980.50	Minimum monthly maintenance needs allowance
- <u>210.00</u>	Mrs. G's income
\$2,770.50	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>2,770.50</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>2,199.00</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.

Amount paid from the trust:

\$2,037.00	Total amount deposited into the trust
- 10.00	Trust administration fee
- <u>50.00</u>	Personal needs allowance
\$1,977.00	Client participation

3. Mrs. D enters a nursing facility, leaving Mr. D at home. Mrs. D's income consists of \$1,233.90 in social security and \$940 in IPERS benefits. She has Medicare and a supplemental insurance policy. The monthly premium for the supplemental policy is \$64. Mr. D's income consists of \$1,300 social security.

Mrs. D applies for Medicaid payment for nursing facility care. The worker explains the income limit. The couple contacts an attorney and sets up a medical assistance income trust to receive Mrs. D's income.

Spousal diversion calculation:

\$2,980.50	Minimum monthly maintenance needs allowance
- <u>1,300.00</u>	Mr. D's income
\$1,680.50	Deficit to be diverted from Mrs. D's income to Mr. D

Income to the trust:

\$1,129.00	Net social security (Gross is \$1,233.90 less \$104.90 Medicare equals net amount of \$1,129)
+ <u>940.00</u>	Gross IPERS
\$2,069.00	Total income that is deposited into the trust

Client participation calculation:

\$2,173.90	Mrs. D's gross income
- 10.00	Trust administration fee
- <u>50.00</u>	Personal needs allowance
\$2,113.90	
- <u>1,680.50</u>	Diversion to Mr. D
433.40	
- <u>168.90</u>	Unmet medical expense (\$104.90 Medicare premium and \$64 health insurance)
\$ 264.50	Client participation

Amount paid from the trust:

\$2,069.00	Total amount deposited into trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- <u>1,680.50</u>	Diversion to Mr. D
- <u>64.00</u>	Health insurance premium
\$ 264.50	Client participation

When buy-in occurs for Mrs. D, the worker recalculates her client participation, effective for the month of buy-in.

Income to the trust:

\$1,233.00	Gross social security
314.70	Gross social security Medicare reimbursement check
+ 940.00	IPERS
\$2,487.70	Total amount that is deposited into the trust account

Client participation and amount paid from the trust:

\$2,487.70	Total amount deposited into trust
- 10.00	Trust administrative fees
- 50.00	Personal needs allowance
- 1,680.50	Diversion to Mr. D
- 64.00	Health insurance premium
\$ 683.20	Client participation in the month buy-in reimbursement is received

Ongoing client participation and amount paid from the trust:

\$1,233.00	Gross social security
+ 940.00	IPERS
2,173.00	Income going into the trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 1,680.50	Diversion to Mr. D
- 64.00	Unmet medical needs
\$ 368.50	Client participation

No recalculation is needed for members whose spousal deduction equals the income after the personal needs allowance deduction, since no Medicare deduction was given.

**Other Third-Party Payments**

Veterans Affairs (VA) aid and attendance payments are a third-party liability. They do not count as income when determining eligibility, but do count in the client participation calculation. Enter any third-party liability that is not considered income to the member as another income source in the benefit calculation (separately from the income) on the ABC system's BCW2 screen.

Spousal diversion calculation:	
\$2,980.50	Minimum monthly maintenance needs allowance
- <u>500.00</u>	Mrs. C's income
\$2,480.50	Deficit to be met by diversion from Mr. C's income to Mrs. C
Income to the trust:	
\$1,300.00	Gross Social Security
+ 242.00	IPERS pension
+ <u>731.00</u>	VA pension
\$2,273.00	Total income that is deposited into the trust
Client participation calculation:	
\$2,273.00	Mr. C's gross income
- 10.00	Trust administration fee
- <u>50.00</u>	Personal needs allowance
\$2,213.00	Income available for diversion
- <u>2,480.50</u>	Diversion to Mrs. C
\$ 0.00	
+ <u>489.00</u>	VA aid and attendance
\$ 489.00	Client participation

### **Changes in Client Participation**

**Legal reference:** 42 CFR 435.725, 441 IAC 76.12(5)

Process changes in client participation for future months within ten days after receiving information of errors in computation or changes in income or expenses. Consider all nonexempt income for client participation in the current month.

Issue timely and adequate notice when client participation increases. Client participation adjustments that cannot be made due to timely notice requirements may require vendor adjustments. The first step in completing a vendor adjustment is to determine the cause of the error or incorrect payment and calculate the correct amount of client participation.

If the income was not reported timely and Medicaid eligibility is affected, an overpayment has occurred and recoupment should be completed. (See [8-A, Recovery](#).)

### **Effect of Buy-In**

**Legal reference:** 42 CFR 435.725(c)(4), 441 IAC 75.16(2)“f”

Initially determine income for client participation based on the gross amount of social security or railroad retirement benefits. Consider any amounts withheld for overpayments as income.

After the Department completes the buy-in process to pay the cost of Medicare Part A or Part B, change the social security or railroad retirement income to indicate that the member no longer pays this cost. Do not allow the Medicare premium as a deduction. The ABC system may automatically reflect this adjustment.

The member is issued a refund check for the Medicare premium costs in the same month that the buy-in occurs. The social security check increases in the next month. You will receive a Bendex form to show completion of the buy-in when the social security income changes.

The Medicare premium refund check is counted as a nonrecurring lump sum. Count the refund as income in the month received.

1. Mr. B enters a nursing facility on January 15 and is approved for Medicaid as of his date of entry. Mr. B receives \$810.90 gross Social Security before buy-in. Mrs. B remains at home and receives \$605.90 gross monthly Social Security. Mr. B's client participation before buy-in is calculated as follows:

\$ 2,980.50	Minimum monthly maintenance needs allowance
- <u>605.90</u>	Mrs. B's social security
\$ 2,374.60	Deficit to be diverted from Mr. B's income to Mrs. B
\$ 810.90	Mr. B's social security
- <u>50.00</u>	Personal needs allowance
\$ 760.90	Mr. B's income available to divert to Mrs. B
- <u>760.90</u>	Diversion to Mrs. B
\$ 0.00	Mr. B's income available for unmet medical diversion and client participation

Mr. B's gross social security is used to determine client participation, but Mr. B does not have enough income to divert the entire allowable spousal diversion to Mrs. B (\$2,374.60 allowable minus \$760.90 actual amount diverted = \$1,613.70 monthly diversion shortfall).

Buy-in occurs in April. Mr. B receives a Medicare premium refund check on April 17 for \$419.60. Since Mr. B's gross social security income was used to determine client participation and the entire allowable spousal diversion was not received, the Medicare premium refund check can be paid to Mrs. B.

- Mr. D enters a nursing facility on March 21 and is approved for Medicaid as of his date of entry. Mr. D receives \$1,550.90 gross social security before buy-in. Mrs. D remains at home and receives \$907.90 gross Social Security and a \$950 gross monthly pension. Mr. D's client participation before buy-in is calculated as follows:

\$ 2,980.50	Minimum monthly maintenance needs allowance
- 1,857.90	Mrs. D's gross income
\$ 1,122.60	Deficit to be diverted from Mr. D's income to Mrs. D

\$ 1,550.90	Mr. D's social security
- 50.00	Personal needs allowance
\$ 1,500.90	Mr. D's income available to divert to Mrs. D
- 1,122.60	Diversion to Mrs. D
\$ 378.30	Mr. D's income available for unmet medical diversion and client participation

Only \$1,122.60 of Mr. D's income is available for the spousal diversion.

Buy-in occurs in June. Mr. D receives a Medicare premium refund check on June 15 for \$419.60. Since Mr. D was able to divert enough of his income back to Mrs. D to bring her to the MMMNA amount, Mr. D will need to pay \$419.60 additional client participation to the facility.

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

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

- Calculate the correct amount of client participation for the current month that included the refund received due to buy-in. This will be the 1ST CP AMT when making ABC entries.
- Calculate the correct client participation for ongoing months. This will be the ONGO CP amount when making the ABC entries.
- Complete ABC entries according to [14-B\(9\), Changing Client Participation: Manual](#).

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

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

1. Mrs. N, who has \$850 social security income, is discharged from a nursing facility on June 5 and is approved for waiver services in the same month.

Nursing facility client participation calculation:

\$ 850.00	Social security
- 50.00	Personal needs allowance
- <u>733.00</u>	Personal needs in month of discharge
\$ 67.00	Nursing facility client participation

Waiver client participation calculation:

\$ 850.00	Social security
- <u>2,199.00</u>	Waiver maintenance allowance
\$ 0.00	Waiver client participation

2. Mr. O, who has a Miller trust and \$2,250 gross monthly income, is discharged from nursing facility on June 15 and is approved for waiver services on June 28. The nursing facility per diem rate is \$108.

Nursing facility client participation calculation:

\$ 2,250.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- <u>733.00</u>	Personal needs in month of discharge
\$ 1,457.00	Nursing facility client participation (Actual cost of care is \$1,512 (\$108.00 per diem x 14 days))

Waiver client participation calculation:

\$ 2,250.00	Gross income
- 10.00	Trust administration fee
- <u>2,199.00</u>	Waiver maintenance allowance
41.00	Remaining income
- <u>1,457.00</u>	Unmet medical deduction for nursing facility client participation paid
\$ 0.00	Waiver client participation

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

Nursing facility client participation calculation:

\$ 2,250.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- <u>733.00</u>	Personal needs in month of discharge
\$ 1,457.00	Nursing facility client participation (Actual cost of care is \$108 (\$108.00 per diem x 1 day))

Waiver client participation calculation:

\$ 2,250.00	Gross income
- 10.00	Trust administration fee
- <u>2,199.00</u>	Waiver maintenance allowance
41.00	Remaining income
- <u>108.00</u>	Unmet medical deduction for nursing facility client participation paid
\$ 0.00	Waiver client participation

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

July PACE client participation:

\$ 3,000.00	Gross trust income
- 10.00	Trust administration fee
- <u>50.00</u>	Personal needs allowance
\$ 2,940.00	PACE client participation for institutionalized enrollee

Adjusted PACE client participation for the month of ICF/ID discharge

\$ 3,000.00	Gross trust income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- <u>733.00</u>	Personal needs in month of discharge
\$ 2,207.00	Recalculated PACE client participation for July

August PACE client participation:

\$ 3,000.00	Gross trust income
- 10.00	Trust administration fee
- <u>2,199.00</u>	Maintenance allowance
\$ 791.00	PACE client participation for August (no adjustment is made in the month of institutionalization)

### **Qualified Medicare Beneficiaries in Skilled Care**

**Legal reference:** P.L. 100-360, 441 IAC 75.1(29), 75.2(249A), 76.2(2)

For people whose only Medicaid eligibility is under the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only for the Medicare Part A and Part B premiums, coinsurance and deductibles. If a person is receiving skilled care or hospital care, Medicare pays the cost of care within certain limits. (See [Medicare Coverage for Institutional Care](#) for payment limits.)

Eligibility for QMB applicants begins the month **after** the month of decision. The person is not eligible for Medicaid payment until the month following the month of decision unless the worker determined Medicaid eligibility under another coverage group.

Some members may be concurrently eligible for QMB and another Medicaid coverage group. Examples of these members include:

- ◆ SSI recipients with Medicare
- ◆ People in the 300% group with Medicare
- ◆ FIP recipients with Medicare

When a person is concurrently eligible both for skilled care payments under a nursing facility aid type and for QMB benefits on the date of entry, the person has no client participation until Medicare is exhausted. Medicaid payment for skilled care stops for a person who is **only** QMB-eligible when the Medicare is exhausted.

A member who is eligible for SSI, FIP, or FMAP and has Medicare Part A has already been determined eligible as a QMB member. No QMB application is needed.

If the beginning Medicaid eligibility date is a future month, the facility must accept the Medicaid rate effective the first of that future month.

NOTE: When a resident enters skilled care in a facility outside the state of Iowa, refer the facility to the Bureau of Long-Term Care to obtain approval of out-of-state skilled payments.

A claim that is over two years old can't be paid under normal claims processing. The provider must submit the claim with a request for an exception to policy to the DHS Appeals Unit. You can assist in this process by providing the facility with any information showing that approval for facility payment was made retroactively.

| See [6-Appendix](#) for instructions on completing the required form, *ICF/ID Resident Care Agreement, Form 470-0374*.

Nursing facility services can be paid for many Medicaid members who are nonfacility aid types in the month of entry into the facility and for short stays. A "short stay" means less than 30 days. Also, people in nursing facilities may go back and forth between facilities. If the worker is not informed of these changes, payment may be delayed or not made at all.

In both instances, an ISIS file must be created or updated and transferred to the Iowa Medicaid Enterprise (IME) before payment for the appropriate facility care can be made.

When a Medicaid member in a nonfacility aid-type is admitted to a medical institution and continues care at the medical facility the month following the month of admission, and you are informed **before** the discharge, close the regular Medicaid case. (Enter code 401 in the MED RSN2 field on the ABC TD05 screen.) Complete an automatic redetermination and reopen the case beginning the date of admission under the applicable facility aid type.

When a Medicaid member in a nonfacility aid type is admitted to a medical institution and continues care the month following the month of admission, but you are informed **after** the discharge, do not close the regular Medicaid case. Complete an automatic redetermination for the applicable facility aid type.