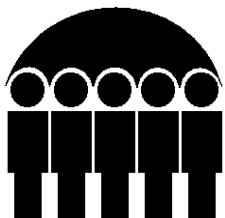


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Employees' Manual  
Title 8  
Chapter K

# PSYCHIATRIC INSTITUTIONS



Iowa  
Department  
of  
Human Services

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## **Overview**

Psychiatric institutions are medical facilities that offer psychiatric services to the resident. To be considered a psychiatric institution, the facility must provide only psychiatric services to the majority of its residents. The types of psychiatric facilities in Iowa are:

- ◆ State mental health institutes (MHIs), which provide hospital level of care.
- ◆ Nursing facilities for mental illness (NF/MIs), which provide intermediate care facility (ICF) level of care.
- ◆ Psychiatric medical institutions for children (PMICs), which provide mental health **or** substance abuse care.

Medicaid eligibility for people residing in psychiatric facilities is handled somewhat differently because of state and federal rules that apply only to these types of facilities. This chapter provides specific information about eligibility and program requirements for these facilities.

Persons who establish and maintain eligibility under most coverage groups are eligible for Medicaid payments to a psychiatric institution if the age and medical necessity requirements are met. **EXCEPTION:** The Medically Needy coverage group does not pay for psychiatric medical institution care.

Chapter 8-I, [MEDICAL INSTITUTIONS](#), describes income, resource, and nonfinancial eligibility policies for all members in medical institutions, including members in psychiatric medical institutions, and an explanation of client participation. Use this chapter in combination with 8-I to determine initial and continuing eligibility for individuals in these types of facilities.

This chapter also includes information on the workflow process for authorization of facility payment by using the Individualized Services Information System (ISIS). See 8-I, [USE OF ISIS](#), and 14-M, [ISIS USER GUIDE](#).

## **Facility Participation in Medicaid**

**Legal reference:** 441 IAC 85.1(249A), 85.21(249A), 85.41(249A); Iowa Code Section 135H.1

Psychiatric institutions participate in Iowa Medicaid as follows:

- ◆ **Mental health institutes (MHIs).** There are four state mental health institutes, at Clarinda, Cherokee, Mount Pleasant, and Independence. Medicaid can pay MHI services for Medicaid-eligible people who are:
  - Under the age of 21, or
  - Aged 65 or older, or
  - Voluntarily admitted with coverage through the Iowa Plan. (After the first month, Medicaid eligibility must be redetermined. See 8-C, [Residents of Institutions for Mental Disease](#).)
- ◆ **Nursing facility for mental illness (NF/MI s).** An NF/MI is either:
  - A nursing facility that has a special license to care for persons with mental illness, or
  - A distinct part of a hospital that is certified as a nursing facility and meets the requirements for a psychiatric hospital.

Medicaid can pay NF/MI services for Medicaid members who are aged 65 or older. Placement in an out-of-state NF/MI is not payable.

- ◆ **Psychiatric medical institution for children (PMIC).** A PMIC is a nonsecure institution that provides 24 hours of continuous care and diagnostic or long-term psychiatric services to children (under age 21).

A PMIC may provide mental health or substance abuse services. The facility must be licensed as a health care facility and must also have a license as either a foster care facility or a substance abuse treatment facility.

Mental health PMICs provide services to children who are expected to stay 14 or more days for diagnosis and evaluation, and 90 or more days for treatment.

The length of stay for PMIC substance abuse treatment averages 75 days. Medicaid PMIC substance abuse services are managed **and paid** by the Iowa Plan contractor for a Medicaid member.

The Bureau of Long-Term Care notifies local offices of PMICs that may participate in Medicaid. Currently, those facilities are:

<b>Facility</b>	<b>National Provider Identifier (NPI)</b>	<b>Type of Service</b>
Beloit Lutheran Home	1023187507	Mental health
Boys and Girls Home Residential Treatment	1063511038	Mental health
Bremwood Lutheran Home	1023187507	Mental health
Children's Square USA	1134265291	Mental health
Cornerstone Recovery	1366568065	Mental health
Four Oaks Inc	1710046255	Mental health
Hillcrest Family Services	1780880310	Mental health
Independence MHI—PMIC	1205911765	Mental health
Jackson Recovery Centers, Inc	1811994973	Substance abuse and mental health
Mercy Hospital (Council Bluffs)	1871665372	Substance abuse and mental health
Orchard Place	1245220938	Mental health
Tanager Place	1114083474	Mental health

Most of these facilities are licensed as both foster care and medical facilities. However, both foster children and non-foster children may be placed in any PMIC.

The Independence PMIC is restricted to admissions from the child and adolescent units at Independence MHI, Cherokee MHI, and the state juvenile facilities in Eldora and Toledo. Children are admitted to the Independence PMIC when no community PMIC will admit them until they exhibit a period of stable behavior.

- ◆ **Out-of-state facilities.** When no in-state facilities are available to meet the needs of a person who is enrolled in the Iowa Plan for Behavioral Care (the managed care program for mental health and behavioral services under Iowa Medicaid), the Iowa Plan contractor regulates out-of-state placement for covered services.

When the person is not enrolled with the Iowa Plan, placement in an out-of-state psychiatric hospital for acute care or other specialized psychiatric or neurobehavioral treatment facility requires prior approval through the “exception to policy” process.

Such “exception” requests are reviewed by the IME Policy Unit, which then forwards a coverage recommendation to the Director’s Office for the Director’s approval and signature. Placements are approved only if:

- The special services being sought are not available in Iowa facilities, or
- The person for whom placement is being sought presents treatment, care, or behavioral challenges not able to be addressed by any Iowa facilities.

Approval through an exception to policy requires documentation that attempts were made to place the person in at least six in-state facilities, but each facility denied the placement.

Reasons for denials typically include, but are not limited to, aggressive behavior or other problematic or unique behavioral issues or challenges exhibited by the person needing placement, which in-state facilities are not staffed to care or provide treatment for the person safely or effectively.

### **Who Is Eligible**

**Legal reference:** 42 CFR 441.151; 441 IAC 85.2 (249A), 85.3 (249A)

In order for services to be paid by Medicaid, residents of psychiatric medical institutions, including children in PMICs, must meet the income, resource, and program guidelines of a Medicaid coverage group.

EXCEPTION: The Medically Needy coverage group does not pay for psychiatric medical institution care. However, other Medicaid-covered services may be paid for a Medically Needy eligible person while in the psychiatric institution.

If a Medically Needy eligible person wants payment of the psychiatric institution services, you will need to complete a redetermination to determine if the person has eligibility for another coverage group, such as 300% group for those under 21 or over 65.

The person must also meet the eligibility requirements for payment for care in a medical institution. A person must:

- ◆ Need the level of care provided by the medical institution.
- ◆ Be certified for care by an independent team. (For PMICs providing substance abuse treatment services, this requirement is satisfied by the Iowa Plan's authorization process. No additional documentation is required.)
- ◆ Have lived in an institution for 30 days if the person's eligibility will be determined under the 300 percent eligibility group.
- ◆ If married, meet specific income and resource guidelines for married couples.

See 8-I, [Eligibility](#), for more information about these requirements.

The PMIC or MHI must obtain authorization for admission and continued stay for Medicaid applicants or members. The Iowa Medicaid Enterprise (IME) Medical Services Unit, Medicare, or the Iowa Plan managed care contractor authorizes the level of-care, depending on the payment source. (The Iowa Plan is the Medicaid managed care contract for mental health and substance abuse services.)

- ◆ For adults in MHIs:
  - The Iowa Plan makes the determination for a Medicaid enrollee who is voluntarily admitted.
  - Medicare makes the determination when Medicare is covering the stay. The provider will report this on the case activity report.
- ◆ For children under age 21 in MHIs, the Iowa Plan makes the determination.
- ◆ For children in PMICs:
  - The IME Medical Services Unit makes the determination for mental health services.
  - The Iowa Plan makes the determination for substance abuse services.

## **Application Processing**

**Legal reference:** 441 IAC 76.1(249A); 76.2(2)

The income maintenance (IM) worker for an MHI accepts and processes applications for MHI payment for people who live or who have lived in that facility. The MHI worker handles the ongoing case for the person entering and residing in the MHI.

The IM worker for the county where a PMIC is located accepts and processes applications for PMIC payment for people who live or have lived in the PMIC. The worker assigned to the facility processes eligibility for the child in the PMIC and enters system information.

When a person enters a PMIC, an NF/MI, or an MHI, the IM worker handling the facility case should check to see if the person is already a Medicaid member.

See [Children in Foster Care or Subsidized Adoption in PMICs](#) when processing an application for foster children in a PMIC. See [Voluntary Placement in PMICs](#) for all other children.

## **Application After Discharge**

If a child is admitted and discharged before a Medicaid determination is made, determine eligibility according to the policies earlier in this chapter. Send form 470-3924, *Request for ISIS Changes*, to DHS-ISIS-Facility. Include on the form:

- ◆ Child's name, State ID,
- ◆ Aid type
- ◆ Date of entry
- ◆ Date of discharge
- ◆ Facility national provider identifier (NPI) number
- ◆ Client participation amounts and dates. If there are different amounts for different dates, specify all.

Submit form 470-0397, *Request for Special Update*, to Quality Assurance to authorize Medicaid eligibility for specific months.

### **Person Already Receiving Medicaid**

**Legal reference:** 441 IAC 76.1(249A)

Do not require a new application when a Medicaid member enters a medical facility for psychiatric care. EXCEPTION: If the certification period for a Medically Needy member is ending within 30 days of the person's entry to the institution, a new application must be filed.

If other people are active on the case with the person in the facility, the case record stays in the county where the family lives. The facility worker opens a new case or reopens a case for the person in the institution and obtains a copy of the latest application *or* review from the local office record. The case retains the same aid type and fund code until new information is obtained (if needed to process the case for facility payments).

When the person in the facility was eligible with a family at home, the worker assigned to the facility and the worker in the county where the family lives must work together to determine continued eligibility. The family's worker processes the family's Medicaid eligibility based on the admission of a household member to the facility and the expected length of stay.

Foster children who are IV-E-eligible on entering an MHI or a PMIC must have Medicaid eligibility established under a coverage group other than IV-E, since these are not IV-E-eligible placements.

Establish a separate family budget unit (FBU) of 19 for a foster child or a child in subsidized adoption in a PMIC so that the Family And Children Services (FACS) system continues to communicate with the Automated Benefit Calculation (ABC) system.

### **Managed Health Care**

**Legal reference:** 441 IAC 88.4(4), 88.24(4); 42 CFR, Part C and Subpart D, Iowa Code Chapter 135H and 441 IAC Chapter 85

The Iowa Plan for Behavioral Health (Iowa Plan) controls placement and payment for persons:

- ◆ Under age 21 or voluntarily admitted to MHIs
- ◆ Under age 21 in PMICs for substance abuse treatment

Billing instructions for mental health PMIC providers are in 8-Appendix, [Psychiatric Medical Institutions for Children](#).

Managed health care through health maintenance organizations (HMOs) or patient management (MediPASS) also affects application processing and payment for both facility and non-facility services. See 8-M, [MANAGED HEALTH CARE](#), for more information about disenrollment when a person moves to a different county or aid type is changed to one that is not appropriate for managed care.

The member can be in two managed health care plans at the same time, in either an HMO or MediPASS and in the Iowa Plan.

- ◆ **Payment for nonfacility services.** When a Family Medical Assistance Program (FMAP)-related member who is enrolled in HMO or MediPASS enters a PMIC or MHI, the facility should contact the HMO or MediPASS provider to obtain any necessary authorization to ensure payment for services other than the facility services, until enrollment ends.

Review the Medicaid Eligibility System's SSNI screen when there is a question about whether an FMAP-related member who enters a psychiatric institution is enrolled in HMO or MediPASS. The SSNI screen identifies an enrolled person and the managed health care provider. See 14-C, [MANAGED HEALTH CARE SYSTEMS](#) and [SSNI = MEDICAID ELIGIBILITY FILE](#), for an explanation of the managed health care codes and SSNI screen information.

Any time an aid type change is made on the ABC system, it may affect the managed care enrollment. If the new aid type is excluded from managed health care coverage, the system will automatically disenroll the member. Disenrollment is prospective for the next month, subject to timely notice.

If the expected length of stay is less than 12 months, the member is considered to be temporarily absent and continues to be considered a member of the household for purposes of Medicaid eligibility.

If the member is not being removed from the family's FMAP-related case (and is not in foster care), the facility IM worker must alert the IM worker for the family and inform that worker about the length of expected placement.

The family IM worker must take appropriate action concerning disenrollment. In a mandatory county, this involves a good cause decision so will take time to accomplish. Payment for services other than the facility care must be authorized by the managed health care provider until the person is disenrolled from the HMO or MediPASS.

- ◆ **Payment for facility services.** A Medicaid member who is under age 65 is enrolled in the Iowa Plan, managed care for behavioral health, which controls psychiatric and substance abuse placement and payment for services. Medicaid can continue when the person enters an MHI as long as the person's eligibility continues.

For a person voluntarily admitted (not court-ordered), the Iowa Plan will continue to provide managed mental health care services if the person meets the contractor's utilization management guidelines. The Iowa Plan will not manage mental health services while the person is involuntarily court-ordered to an MHI.

1. Ms. S, age 30, is an FMAP-eligible person. She voluntarily enters an MHI. Her stay is expected to be less than 12 months. Her Medicaid continues under the FMAP coverage group. The Iowa Plan will manage and pay for the cost of the MHI care.
2. Ms. T, age 30, is an FMAP-eligible person. She is court-ordered to an MHI. Her stay is expected to be less than 12 months. Her Medicaid can continue under the FMAP coverage group, but the Iowa Plan will not manage and pay for the cost of her MHI care.

### **Persons Not Receiving Medicaid**

**Legal reference:** 441 IAC 76.1(249A)

People who are not receiving Medicaid must file an application and be determined eligible before Medicaid will pay for services. See 8-B, [APPLICATION PROCESSING](#), for general application processing procedures. Follow interview procedures defined in 8-B, [Interviews](#).

Members whose Medically Needy certification is ending in the month of entry must file a new application to determine if they are eligible for a coverage group for which facility services will be paid.

If a person who applies for Medicaid after entry to a psychiatric facility is covered by the Iowa Plan, then the Iowa Plan covers services back to the date of entry (when it is the month of application). The retroactive period, if any, is covered by Medicaid.

In many cases, the coverage group for which the applicant is eligible in the retroactive period may be different from the coverage group for the month of application. Retroactive benefits are available only for up to three months preceding the month the application is filed, even if the applicant entered the facility earlier.

EXCEPTION: People gaining Medicaid eligibility after entering a substance abuse PMIC or a child or adolescent treatment unit at Cherokee MHI or Independence MHI will be covered by the Iowa Plan for all months of eligibility. Coverage begins with the month of admission and extends through the month of discharge, even when the month of admission is a retroactive month.

Examine all coverage groups, not just coverage groups for facilities, for eligibility for people between 21 and 65 years old. If the eligible group is Medically Needy with a spenddown, then that person is not Medicaid-eligible.

Sam, age 41, is court ordered to the MHI on October 18. Sam enters the MHI from his home. His wife and two minor children remain at home. He files an application on October 30. He does not meet the Social Security disability guidelines. Sam is expected to return home by December 31 so he is considered temporarily absent.

The family's income is in excess of FMAP limits. Sam qualifies for Medically Needy with a spenddown. Medicaid payments are not made to the MHI under the Medically Needy coverage group, even after spenddown has been met.

## **Nonfinancial Eligibility**

There are additional nonfinancial eligibility requirements for Medicaid payment for psychiatric institutional care:

- ◆ [Children must have a certification of their need for psychiatric institutional care.](#)
- ◆ [Each applicant and recipient must meet level of care requirements \(medical necessity\).](#)

## **Age**

**Legal reference:** 42 CFR 441.151(c); 441 IAC 85.1(249A), 85.3(2), 85.4(249A), 85.22(1), 85.43(249A)

Persons in an NF/MI must be 65 years of age or older.

To be eligible for payment of services in a PMIC, the person must be under age 21. When age has already been verified, it does not need to be verified again.

If an eligible child begins treatment in a PMIC or MHI immediately before turning 21, continue coverage until the 22nd birthday or until the last day of the last month when the person is unconditionally discharged, whichever comes earlier.

## **Certification of the Need for Care**

**Legal reference:** 42 CFR 441.152; 441 IAC 85.3(3)

Children under age 21 must have a preadmission evaluation. As a condition of eligibility for Medicaid payment of services in a PMIC or MHI, a team that is independent of the facility must certify all of the following:

- ◆ Inpatient services are expected to improve the child's condition or prevent further regression, so that ongoing inpatient services will eventually not be required.
- ◆ The child needs inpatient care under the direction of a physician.
- ◆ Outpatient services currently available in the community do not meet the treatment needs of the child.

For a child who is not Medicaid-eligible before admission, lack of a certification does not prevent the child from entering a PMIC or MHI. However, the certification must be completed before any Medicaid payment will be made. For this reason, a facility may refuse to admit a child until the certification of need is performed.

The IME Medical Services Unit will ensure that the certification has been completed for non-emergency entries to a PMIC before providing a level-of-care determination for children entering any of the PMICs that do not provide substance abuse treatment services. The Iowa Plan contractor will ensure that the certification process is completed for children admitted to a PMIC for substance abuse treatment.

### **Medical Necessity**

**Legal reference:** 42 CFR 45, 441 IAC 78.3(249A), 81.3(249A), 81.7(249A), 85.6(1)"f", 85.24(1)"f," 85.45(1)

Payment will be made to a psychiatric medical institution only if the care provided is determined to be reasonable, necessary and appropriate. This determination must be done before ABC entries are made to allow facility payments.

A determination of the medical necessity for the level of care provided is required when a person:

- ◆ Enters a psychiatric medical facility.
- ◆ Moves to a bed that is certified for a different level of care.
- ◆ Returns to the psychiatric medical facility after leave beyond reserve bed days.
- ◆ Moves to a different medical facility, even if at the same level of care.

The IME Medical Services Unit makes the determination for most people. For children entering PMIC substance abuse treatment, the Iowa Plan contractor determines medical necessity. The IME Medical Services Unit also screens all persons to determine if they are mentally ill or mentally retarded or have a related condition.

When a child in foster care is a candidate for PMIC placement, the social worker contacts the facility so the facility can request a level-of-care determination from the IME Medical Services Unit or the Iowa Plan. The IME Medical Services Unit or the Iowa Plan usually calls the facility with a determination within one working day.

The day the determination is made, the facility sends the IM worker form 470-0042, *Case Activity Report*. Review this form to verify approval for the level of care that the person is seeking. If the person meets all other eligibility requirements and the level of care is medically necessary, complete ABC system entries for an eligibility determination. See [14-B\(9\)](#) for system instructions.

Contact the facility if the effective date on the *Case Activity Report*, form 470-0042, does not match the date the person wants Medicaid payment to begin or if you do not receive a *Case Activity Report*.

If an applicant has requested retroactive eligibility to cover the cost of medical institution care, check to see if the IME Medical Services Unit or the Iowa Plan has made a retroactive determination. A person may have needed institutional care in the retroactive period even if such care is not medically necessary now.

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

**Legal reference:** 441 IAC 85.7(2), 85.46(249A), 81.10(4)“3”

If the IME Medical Services Unit determines that the person does not need the level of care or the type of facility that the person is in, it will issue a letter to:

- ◆ The applicant,
- ◆ The facility physician,
- ◆ The facility,
- ◆ The income maintenance worker, and
- ◆ The service worker, if involved.

The person may appeal to the Department if the person disagrees with the decision.

For foster children or children in subsidized adoption, notify the service worker of the initial level of care determination using form 470-2479, *PMIC Exchange of Information*.

If PMIC level of care is denied for a child in foster care, payment for the child's care is made at the foster care rate through the foster care program, instead of the Medicaid program. Cancel the Medicaid facility payment for the child effective the day of denial and refer the case to the responsible service worker to arrange for foster care payments to the PMIC.

To continue Medicaid for foster children or children in subsidized adoption without facility payment, change the aid type for all children from 37-7 to the aid type that reflects the coverage group of the child, such as Child Medical Assistance Program (CMAP), Supplemental Security Income (SSI), Family Medical Assistance Program (FMAP), IV-E, Mothers and Children (MAC), or the state-only aid type of 40-9.

### **Continued Stay Reviews**

**Legal reference:** 441 IAC 78.3(249A), 81.7(249A), 85.24(1)“f,” 85.45(1)

The IME Medical Services Unit and the Iowa Plan complete the recertification reviews. The facility is responsible for obtaining the recertification of the need for care. Assume that the level of care continues to be approved unless you receive other notice.

If the level of care is denied at the time of review for persons in a MHI, the policy is the same as in 8-I, [Medical Necessity](#). Lower level of care payments may apply. The payment to the facility is made at a reduced level.

If level of care is denied at the time of review for children in a PMIC, Medicaid will not continue payment for PMIC services.

If it is determined that a child no longer needs the level of care in the PMIC, staff at the IME Medical Services Unit or the Iowa Plan will phone the facility with the finding. On the same day, the IME Medical Services Unit or the Iowa Plan will notify the resident, the physician, and the facility, by letter. The ISIS system will notify the workers when it is determined that a person no longer meets level of care.

Charles, age 20, enters an MHI. At the continued stay review, the IME Medical Services Unit finds that Charles no longer needs MHI care, so Medicaid will not pay the MHI. Charles' MHI services are not covered while arrangements are made for a different placement. The MHI case is closed. Charles continues to be eligible for Medicaid payments of any other services. His Medicaid is reopened under another coverage group.

Reconsideration reviews and appeals follow the same process as outlined in the previous section for the initial determination.

If the person moves to another facility, the admitting facility should send a *Case Activity Report* indicating that a level of care determination has been obtained.

### **Coverage Groups**

**Legal reference:** 441 IAC 75.1(249A), 76.2(2), 85.3(4), 85.4(249A), 85.22(4), and 85.43(249A)

Persons who establish and maintain eligibility under most coverage groups are eligible for Medicaid payments to a psychiatric institution if the age and medical necessity requirements are met. EXCEPTION: The Medically Needy coverage group does not pay for psychiatric medical institution care. However, a person may be eligible for other Medicaid-covered services under Medically Needy.

Children who are not in foster care have Medicaid eligibility established under FMAP policies or SSI policies. Their FMAP-related eligibility, other than the FMAP 300% group, must be determined considering the parents when they go from home to the psychiatric medical institution and are expected to return home in less than 12 months. See 8-F, [FMAP-RELATED COVERAGE GROUPS](#).

If an FMAP-eligible child is expected to stay in the institution more than 12 months or does not enter the institution from the home, base eligibility on the child's circumstances only.

When determining eligibility under the SSI-related or FMAP-related 300% group, the parent's income is not deemed to the child when the child is in a medical facility for a full calendar month. If the child enters a medical facility after the first of the month, deeming of income stops the month after the month of entry.

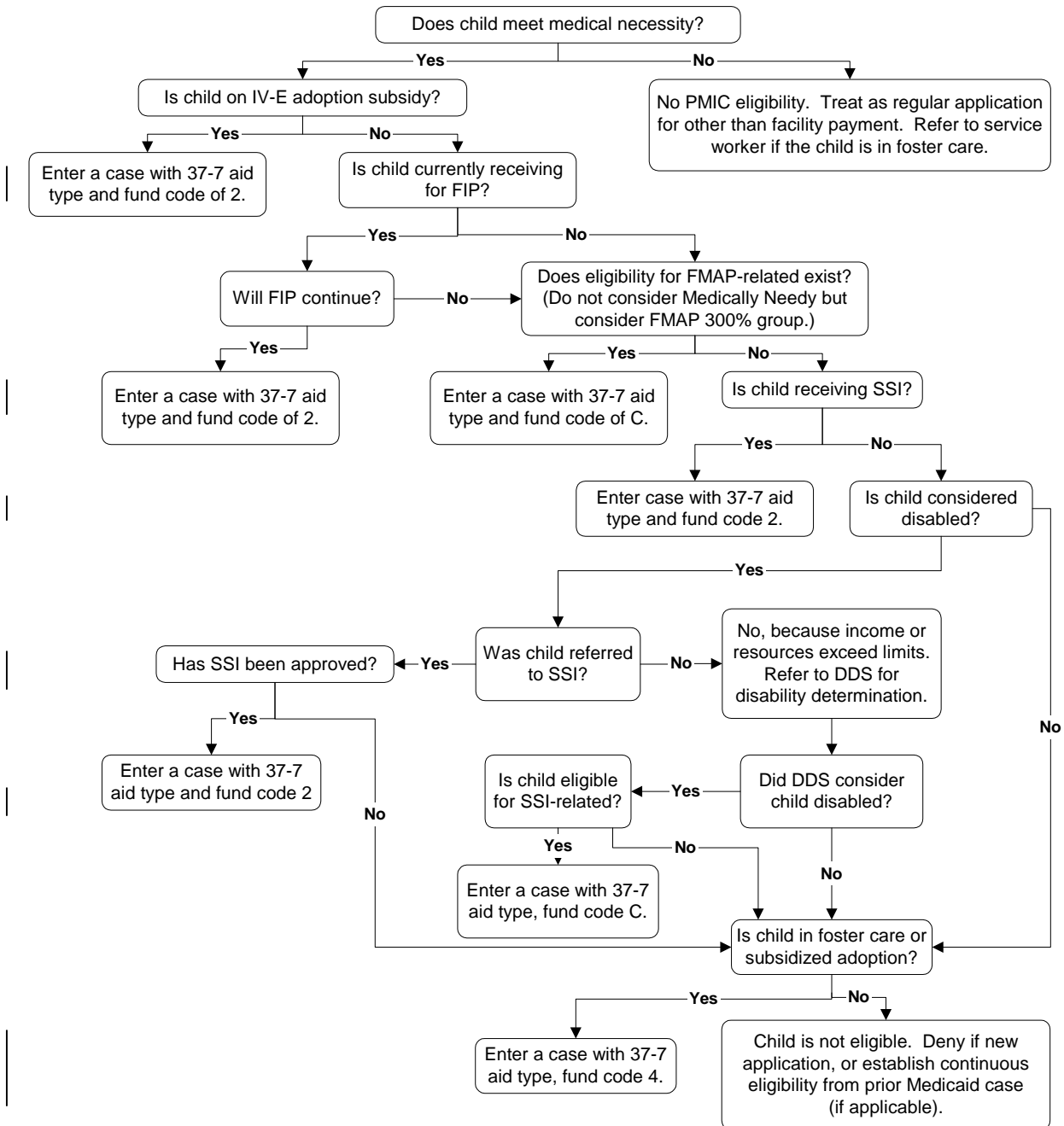
Marge, age 14, is placed in the PMIC by her parents on October 28. They file an application October 30. Marge is expected to return home by December 31. Since Marge is not a foster child, her Medicaid eligibility is determined with her family according to FMAP temporary absence policy. The parent's income is in excess of all FMAP-related Medicaid coverage groups, except Medically Needy.

Once Marge has resided in the facility for 30 consecutive days, her eligibility can be determined under the FMAP-related 300% group. For the FMAP-related 300% group, Marge is considered separate from her parents starting the first month after entry to a facility. The parent's income is not considered in determining Marge's eligibility or client participation starting November 1. No Medicaid payments can be made to the PMIC facility for the days in October.

If Marge had entered the PMIC on October 1, her parent's income would not be considered in determining her eligibility or client participation starting October 1.

An FMAP-eligible child placed in foster care and in a psychiatric facility loses FMAP eligibility after the month of entry because the child is no longer considered a member of the household.

**Summary of PMIC Eligibility**



Code persons eligible for Medicaid in the coverage group for which they qualify, even though managed care may be paying for the facility care. See 14-B-Appendix, TD01: Section 1. Identification: [TD01 AID](#), [TD01 MED AID](#), and TD03 Section VII. Personal Information: [TD03 FUND](#), for proper coding.

The following coverage groups provide payment for persons in psychiatric facilities who **have not been determined eligible before the entry** or whose eligibility **must change** after entry to a psychiatric facility:

- ◆ [FMAP-related groups](#)
- ◆ [SSI-related groups](#)

### **FMAP-Related Eligibility**

**Legal reference:** 441 IAC 85.3

A person who is eligible for an FMAP-related coverage group (except Medically Needy) can qualify for psychiatric institution payments if that person meets additional eligibility requirements that apply to institutional care as listed under [Certification of the Need for Care](#) and [Medical Necessity](#).

The policies of the coverage group for which the person is eligible apply. If the person loses that eligibility, determine if continuous eligibility for children applies, or do an automatic redetermination to determine if other Medicaid eligibility exists. See 8-F, [Continuous Eligibility for Children](#), or 8-G, [AUTOMATIC REDETERMINATION](#), for additional information.

When it is determined that the income of the family at home creates ineligibility for a person, explore eligibility under the 300% group. There may be eligibility under the FMAP-related 300% group for children under age 21. For more information, see 8-F, [COVERAGE GROUPS](#).

#### **FMAP Example**

Sharon, age 17, is placed in the MHI by her parents on March 13. Sharon's doctor states she will be discharged to come home in less than 12 months. Sharon remains a member of the household at home. All of the family members are considered in determining household size and countable income. The family meets eligibility and FMAP income limits.

Sharon is included in the FMAP household for Medicaid. A second case is opened for Sharon so that payment can be made to the facility. Deemed income from Sharon's parents is counted for client participation for the partial month of admission but is not considered available for ongoing months' client participation.

#### **CMAP Example**

Henry, age 17, is placed in a PMIC by his parents on March 13. His doctor states that his stay is expected to be longer than 12 months. Henry's eligibility is determined separate from the family at home, using only his income. He is a household of one.

Henry has no income of his own, so he meets CMAP income limits. Deemed income from Henry's parents is counted for client participation for the partial month of admission but is not considered available for ongoing months' client participation.

#### **MAC Example**

Chris, age 16, and her two siblings are eligible for MAC. Her parents place Chris in the PMIC on March 13. Chris's doctor states she will be discharged to come home in less than 12 months. Chris remains a member of the MAC household for Medicaid.

A second case is opened for Chris so that payment can be made to the facility. Deemed income from Chris's parents is counted for client participation for the partial month of admission but is not considered available for ongoing months' client participation.

#### **Children Within the 300% Income Limit Example**

Sam, age 19, lived with his parents before entering the MHI. Sam's doctor states he is expected to remain in the MHI for at least 60 days. The plan is to return Sam to his parents' home after completion of treatment. Sam's eligibility is determined with the family at home. The family's income is in excess of the MAC limits.

300% group eligibility can be established after Sam has been in a medical institution for 30 consecutive days. The worker counts the income of Sam and his parents for the month of entry, but counts only Sam's income for any months following the month of entry.

Sam may not be eligible for facility coverage for the month of entry due to the deeming of parental income. If he needs help with other medical costs for that month, he may be eligible for Medically Needy.

### **FMAP-Related 300% Income Limit Example**

Ms. N enters a MHI in January. Before that, she was living with her family at home. She has social security income from her deceased spouse of \$980 per month. Ms. N's doctor does not expect her to return home in less than 12 months, so she does not meet the FMAP temporary absence policy.

Ms. N is considered a household of one. She does not qualify for eligibility under the 300% group unless she is disabled according to Social Security disability criteria.

### **SSI-Related Eligibility**

**Legal reference:** 441 IAC 75.1(7), 85.2(4) and 85.3(249A)

A person who is eligible for an SSI-related coverage group (except Medically Needy) can qualify for psychiatric institution payments if that person meets additional eligibility requirements that apply to institutional care as listed under [Certification of the Need for Care](#) and [Medical Necessity](#).

The policies of the coverage group for which the person is eligible apply. If the person loses that eligibility, determine if continuous eligibility for children applies, or do an automatic redetermination to determine if other Medicaid eligibility exists. See 8-F, [Continuous Eligibility for Children](#), or 8-G, [AUTOMATIC REDETERMINATION](#), for additional information.

NOTE: There may be eligibility under the SSI-related 300% group for persons who are disabled. When it is determined that income creates ineligibility for an SSI-related person, explore eligibility under the 300% group. For more information, see 8-F, [COVERAGE GROUPS](#).

When an SSI recipient enters a psychiatric institution, use form 470-0641, *Report of Change in Circumstances—SSI-Related Programs*, to notify the Social Security Administration. Admission to a psychiatric institution may affect the SSI recipient's benefits or eligibility. Verify any changes to the SSI benefits through the State Data Exchange (SDX) process.

The Social Security Administration will cancel SSI benefits for a person living in a public medical institution if Medicaid does not or is not expected to pay for at least 50% of the cost of care. EXCEPTIONS:

- ◆ If the person was eligible for SSI and Medicaid under 1619(a) or (b), then SSI will continue for two months after entry.
- ◆ If the SSI-eligible person will return home within three months, then SSI will continue for those three months.
- ◆ SSI-related Medicaid is not canceled if the person entering a public medical facility is under the age of 21 or over the age of 65.

If the person enters a non-public medical psychiatric institution and Medicaid is expected to pay at least 50% of the cost of care, the Social Security Administration does not cancel the case but reduces the SSI benefits and income level to \$30.

If an SSI-related person who is eligible under the 300% group is denied level of care, the person may be eligible under the Medically Needy program for services other than facility payments. If the person is a child in foster care, Medicaid will continue with state-only funding. See 8-F, [COVERAGE GROUPS](#).

#### **People in a Medical Institution Within the 300% Income Limit**

**Legal reference:** 42 CFR 435.236; P.L. 100-360; 441 IAC 75.1(7), 75.5(4), 75.13(2)

Medicaid is available to a person who meets all of the following requirements:

- ◆ The person receives care in a hospital, nursing facility, NF/MI, or psychiatric medical institution and has been institutionalized for 30 consecutive days.
- ◆ The person meets medical necessity requirements for the institution as established by the IME Medical Services Unit or by the managed care provider. See 8-I, [Medical Necessity](#).
- ◆ The person meets all Supplemental Security Income (SSI) eligibility requirements except income and over age 65 for NF/MI or qualifies under the FMAP 300% group.
- ◆ The person has gross monthly income that is more than the SSI standard but does not exceed 300% of the federal SSI benefit for one person living at home.

See 8-F, [People in Medical Institutions: 300% Income Level](#) (SSI-related) and 8-I, [Eligibility for the 300% Group](#), for more information.

Ms. Q enters a MHI in January. Before that, she was living with her family at home. She receives social security disability income of \$980 per month and meets all other SSI-related Medicaid eligibility criteria. Ms. Q can qualify for eligibility under the SSI-related 300% group once she stays for 30 consecutive days.

## **Client Participation**

**Legal reference:** 42 CFR 435.725; 441 IAC 75.16(249A), 85.5(249A), 85.23(249A), 85.44(249A)

Medicaid members are required to participate in the cost of payment toward psychiatric institution care. Client participation and medical payments from a third party must be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid pays the balance of the cost of care for the remainder of the month.

With a few exceptions, client participation for persons in PMICs and nursing facilities for the mentally ill (NF-MI) is calculated and assessed in the same manner as client participation for persons in other medical institutions. The same income and deductions are allowed as for persons in nursing facilities. See 8-I, [Client Participation](#).

### EXCEPTIONS:

- ◆ People in a PMIC providing substance abuse treatment under managed care are not assessed client participation.
- ◆ People in MHIs are not assessed client participation.

Do not calculate client participation or notify these members that they owe client participation to the PMIC or MHI.

People in facilities are allowed a deduction for unmet medical needs. Health insurance premiums can be allowed when children are covered under a family insurance policy. When the insurance is in the name of a parent or spouse of an institutionalized person, the premium can be allowed as an unmet medical deduction even if the policy covers other members of the family as well as the member.

Service fees charged by a bank or financial institution for handling the health insurance payments are not allowable unmet medical needs.

Mrs. A pays \$300 monthly for health insurance coverage for her family. One of Mrs. A's children, Betty, is approved for Medicaid and PMIC facility payments effective May 1. Betty is covered under the family's health insurance. Betty receives \$530 social security. She is allowed a deduction of \$300 unmet medical needs in computing her client participation.

### **Collecting Client Participation in PMICs**

**Legal reference:** 441 IAC 85.4(249A)

The consideration of unearned income in the PMIC client participation calculation is not different from other medical facilities. However, how that client participation is collected may be different, depending on whether or not the income has been assigned to the Department.

The IM worker is responsible for the calculation of the client participation, sending the notice, and making the system entries. The PMIC is responsible for collecting the client participation.

Facilities are notified of the amount of client participation through form MA-2139 (470-0371), *Facility Card*, which is authorized by the ISIS system. The facility makes arrangements directly with the member for collection of client participation.

Ted's father admitted him to a PMIC. Ted's mother receives child support of \$300 monthly for Ted and his sister. The IM worker sends Ted's father a notice explaining that Ted owes client participation. Ted's mother refuses to pay the client participation. The IM worker is not responsible for resolving this issue. Ted's father may want to seek legal counsel about the situation.

The "governmental income" of foster children who enter PMICs is assigned to the Department. The assignment continues while the child is in foster care. This assigned income cannot be considered for client participation to be paid to the facility. It is used to credit the Medicaid payment to the facility.

When a foster child in a PMIC has income such as Social Security, SSI, Veterans, Railroad Retirement, etc., the income is assigned to or collected by the Department. If the child has been in a foster care setting before entering the PMIC, this assignment will likely already be done. If not, the child's service worker should initiate this assignment and inform you when completed.

When the unearned income is assigned to the Department, the worker still informs the member that income is being considered toward client participation. However, the worker should also explain that because this income is being sent to the Department, the Department will collect this portion of the client participation.

Indicate on the *Notice of Decision* that the assigned income is paid for client participation to the Department, but don't put the income on the ABC system to be paid to the facility while it is assigned. All unearned income that is not assigned will continue to be sent to the child's representative and should be used for client participation according to policies in 8-I, [Client Participation](#).

The Bureau of Purchasing, Payments and Receipts will credit the Medicaid program with the amount of the client participation accessed from income assigned to the Department and will also send the personal needs allowance to the facility for the member.

Although a member with only assigned income will technically have client participation and should be sent a notice indicating this, there will not be any client participation reflected on the ABC system or the facility's payment. Effectively, in this situation, the Department is collecting client participation instead of the PMIC.

Tim, an SSI recipient who is a foster child, enters a PMIC on July 1. Tim receives Social Security income of \$200 per month. Because Tim is a foster child, his Social Security benefit is assigned to the Department. The IM worker enters zero client participation on the ABC system. The Department will handle collecting the client participation and adjusting the Medicaid facility payment based on the amount collected.

If Tim had not been a foster child, the Social Security income would not be assigned to the Department. The IM worker would send a notice explaining that Tim must pay client participation.

If the member transfers from a foster care setting in which the member contributed income towards the cost of foster care assistance, the amount paid for foster care in the month of entry to the PMIC is not available for client participation.

Sam, a foster child, enters a PMIC on November 18. Sam's Social Security benefit of \$500 has already been assigned to the Department. For November 1 through November 17, Sam was responsible for paying \$200 towards his foster care costs. For the month of November, the amount paid for foster care is not counted for client participation.

The IM worker sends a notice explaining that Sam owes client participation and that the Department will collect this from the Social Security income the Department was already receiving. The worker enters \$0 client participation on the system. When the PMIC bills the Department, the client participation is not subtracted from the PMIC's payment. The Department sends Sam his personal needs allowance and credits the remaining income to the Medicaid program.

Child support income is assigned to the Department for a child receiving foster care cash assistance. The assigned child support paid by the noncustodial parent to CSRU is not sent to the child or the custodial parent but is instead paid to the foster care program.

When a foster care child enters a PMIC, the service worker completes entries into the FACS system. FACS communicates to CSRU that the child has entered a PMIC. The communication results in CSRU terminating the assignment of the child support to the state.

The IM worker is not responsible for billing and collection of the client participation. The PMIC is responsible for collecting any client participation. Facilities are notified of the amount of client participation through form MA-2139 (470-0371), *Facility Card*. If the facility asks for assistance in collecting child support from the noncustodial parent, tell the facility to use any collection method they would normally use to collect any other debt.

Any child support that is paid to CSRU by the noncustodial parent (other than medical support) will be sent to the child or the child's representative.

While the child support is assigned, list it on the notice as income for determining client participation, because the child support that should be paid will go to the parent upon the termination of assignment.

When determining client participation for current and future months, project the amount of child support that will be received. Project future child support payments using the child support payment history screen on Iowa Collection and Reporting System (ICAR) as a tool.

Often the payment history will reflect sporadic payments or amounts that vary from month to month. Using the payment history, project future payments as accurately as is possible. However, if the payments that the child actually receives differ from what was projected and used for client participation, adjust the client participation accordingly. Make this adjustment at least once every four months. See 8-1, [Changes in Client Participation](#).

Tim enters a PMIC. He is eligible for FMAP-related Medicaid. Tim regularly receives child support income of \$75 per month that has not been assigned to the Department. The IM worker sends Tim a notice explaining that he owes client participation.

When child support is not assigned and is being paid to the child, the full amount of the payment must be applied towards client participation. (Neither the 1/3 disregard used for SSI-related eligibility purposes nor the \$50 exemption for FMAP-related child support income is applicable for client participation.)

1. Bill enters a PMIC from foster care on December 1. Bill regularly receives child support income of \$700 per month that has been assigned to the Department. CSRU is notified on December 15 that Bill has entered a PMIC and that foster care cash assistance has been canceled beginning December 1.

Unless information is received indicating otherwise, the IM worker sends Bill a notice explaining that he owes client participation. If the assignment is not actually terminated in December and child support payments of \$700 are not received, the client participation for December should be adjusted.

2. Jan enters a PMIC from foster care on January 1. Jan receives Social Security income of \$300 and regular child support income of \$200. Jan's Social Security and child support are both assigned to the Department. However, CSRU was promptly notified of the PMIC placement and foster care assistance was canceled. The child support assignment has now been terminated.

The IM worker sends Jan a notice explaining the amount of total client participation owed. The client participation will be collected from her Social Security income, which is assigned to the Department after allowing a personal needs deduction. The notice also informs Jan that she should pay the remaining income to the PMIC from her child support.

<b>Client Participation Calculation for Facility Residents</b>			
<b>Medical institution stay will be less than 12 months (FMAP-related eligibility):</b>		<b>Medical institution stay will be more than 12 months (FMAP-related eligibility):</b>	
<b>Month of Entry</b>	<b>Subsequent Months</b>	<b>Month of Entry</b>	<b>Subsequent Months</b>
<ul style="list-style-type: none"> <li>If the family receives FIP benefits, there is no CP.</li> </ul> Otherwise: <ul style="list-style-type: none"> <li>Count the income of the institutionalized person and the family.</li> </ul>	<ul style="list-style-type: none"> <li>If the family receives FIP benefits, there is no CP.</li> </ul> Otherwise: <ul style="list-style-type: none"> <li>Count only the institutionalized person's income.</li> </ul>	<ul style="list-style-type: none"> <li>If the family receives FIP benefits, there is no CP.</li> </ul> Otherwise: <ul style="list-style-type: none"> <li>For children, count the child's income and the parents' deemed income.</li> <li>For adults, count only the income of the person in the facility.</li> </ul>	<ul style="list-style-type: none"> <li>Count the institutionalized person's income.</li> </ul>
<b>Medical institution stay will be less than 30 days (SSI-related eligibility):</b>		<b>Medical institution stay will be more than 30 days (SSI-related eligibility):</b>	
<b>Month of Entry Not Applicable</b>		<b>Month of Entry</b>	<b>Subsequent Months</b>
<ul style="list-style-type: none"> <li>For children, count the income of the institutionalized person and the family.</li> <li>For adults, count the income of the institutionalized person and the spouse.</li> </ul>		<ul style="list-style-type: none"> <li>For children, count the income of the institutionalized person and the family.</li> <li>For adults, count the income of the institutionalized person and the spouse.</li> </ul>	<ul style="list-style-type: none"> <li>Count only the institutionalized person's income.</li> </ul>

**Case Maintenance**

The following sections explain how to treat persons in psychiatric institutions with respect to:

- ◆ [Review and redetermination of Medicaid eligibility](#)
- ◆ [Discharge from the facility](#)
- ◆ [Payment for reserved beds during absence from the facility](#)
- ◆ [Voluntary placements](#)

**Reviews and Redeterminations**

**Legal reference:** 441 IAC 76.7(249A)

Review eligibility according to the policies for the coverage group under which the member is eligible. The following chart shows by coverage group when reviews are required. For any coverage group, when there is a change in the person's circumstances that might affect eligibility, complete a desk review to determine the effect of the change.

<b>Medicaid Coverage Group</b>	<b>Review Due</b>	<b>Review Form</b>
SSI-related	Annually	<i>Health and Financial Support Application</i> , form 470-0462 and 470-0466(S)
FMAP-related, including CMAP and MAC	Annually	<i>Review/Recertification Eligibility Document</i> , form 470-2881
Foster care children Subsidized adoption children State-only medical assistance Unaccompanied refugee minors	Annually	<i>Foster Care and Subsidized Adoption Medicaid Review</i> , form 470-2914

Send the applicable review form to the person who signed the application. For children in foster care, use form 470-2914, *Foster Care and Subsidized Adoption Medicaid Review*. When the review form is returned, complete the review and request needed verification.

If the necessary review form is not returned or the requested information is not provided, contact the service worker or juvenile court officer for assistance.

If this person does not know the financial circumstances of the family, and the family income and resources must be considered or eligibility cannot be determined, cancel Medicaid eligibility and reopen the case as state-only with a FUND code of "4." However, continue to request this information from the service worker or juvenile court officer.

See 8-G, [ADDITIONAL FMAP-RELATED CASE MAINTENANCE: Eligibility Reviews](#) and [ADDITIONAL SSI-RELATED CASE MAINTENANCE: Eligibility Review](#).

### **Payment for Reserving a Bed in a Psychiatric Medical Institution**

**Legal reference:** 441 IAC 85.7(3), 85.25(2), 85.46(249A)

People in NF/MIs have ten hospital days per month and 30 visit days per year.

People in MHIs do not have hospitalization leave but do have 30 visit days per calendar year.

For children in a mental health PMIC, payment will be approved for a maximum of ten days per calendar month during which the child is confined in an acute-care general hospital. Payment will not be authorized for over ten days per month for any continuous hospital stay.

Payment for a child in a mental health PMIC may also be approved for 30 days per year during which the child is out of the PMIC at the time of a nightly census for the purpose of a visit. The 30 days can be extended with a service plan approved by the service area administrator or designee.

The facility should contact the service worker before any absence of the foster child or child in subsidized adoption, unless an emergency exists. The absence for the visit may also be for detention, shelter care, or because the child ran away.

Send a copy of the *Case Activity Report* to the service worker to inform the worker about visit days for foster children and children in subsidized adoption. If an absence for detention, shelter care, or runaway is reported on the *Case Activity Report* contact the service worker to find out whether payment for reserve bed days should be made to the facility.

If the plan is for the child to return to the facility, visit days are approved and payment made. If not, visit days are denied, and no payment is made for the time that the child was out of the institution.

The mental health PMIC receives full payment when the resident has an approved absence. Other psychiatric institutions receive reserve bed day payments depending on the level of care. See 8-I, [Payment for Reserve Bed Days](#).

### **Discharge From a Psychiatric Facility**

**Legal reference:** 441 IAC 85.5(1)“k”

When you receive a *Case Activity Report* from the facility indicating that the member has been discharged, send a copy of the *Case Activity Report* to the service worker for a child in foster care. The service worker will then send back the form indicating the child’s new living arrangement.

Determine if continuous eligibility applies or complete an automatic redetermination for another coverage group when form 470-0042, *Case Activity Report*, from the facility shows that a person has been discharged.

- ◆ If a person is eligible for SSI, the IM worker for the facility case must immediately assign the SSI aid type to the person’s case, because it is up to the Social Security Administration to complete any redetermination of SSI eligibility.
- ◆ For people discharged from an MHI, the worker in the county where the person is being relocated determines if continuous eligibility for children applies or completes the automatic redetermination.

The case record must be transferred to the county, unless there is a family at home where the person is going to live and the family already has a case record. Then the case record stays with the MHI. All medical information gathered at the MHI stays at the MHI, except for information that is used to establish a disability.

- ◆ If a child runs away from a PMIC, contact the service worker regarding a discharge date. Cancel the PMIC case effective the discharge date. If the child is also being discharged from foster care, issue a *Notice of Decision* saying that we cannot locate the child and cancel Medicaid.

**Voluntary Placement in PMICs**

When a child is voluntarily placed in a PMIC, the IM worker processes the application. The following chart summarizes the responsibility for processing the case.

<b>Summary of Responsibility for Processing PMIC Voluntary Placement</b>	
<b>Duties of Service Staff</b>	<b>Duties of IM and Others</b>
<p>Service workers are not normally involved with voluntary placements.</p>	<ol style="list-style-type: none"> <li>1. Professional (doctor, counselor, etc.) recommends PMIC care. Parents contact facility. PMIC collects general information and, if admitted, refers the family to apply for Medicaid.</li> <li>2. Each PMIC has a designated IM worker in the service area where the PMIC is located, who is responsible for processing the PMIC entries. The PMIC IM worker pends the application in the ABC system. The person also meets FMAP temporary absence.                      The person may also be on a case in the county where the family lives. The family IM worker will need to work with the PMIC IM worker in sharing information and copies of forms needed to determine eligibility.</li> <li>3. The PMIC IM worker responds to ISIS workflow. When the placement is in a PMIC that provides substance abuse treatment services, the worker responds that managed care will complete level of care. Otherwise, the worker responds that the IME Medical Services Unit will complete the determination.</li> <li>4. Once the level of care decision and Medicaid eligibility determination are complete, the PMIC IM worker enters denial or approval in the ABC system and responds to any final ISIS workflow.</li> <li>5. Requests for payment of additional reserve bed days must be approved in writing by the service area manager or designee.</li> </ol>

Duties of Service Staff	Duties of IM and Others
	6. Upon discharge from the PMIC, the IM worker determines if a child is continuously eligible or completes an automatic redetermination of Medicaid eligibility. See 8-F, <a href="#">Continuous Eligibility for Children</a> , or 8-G, <a href="#">AUTOMATIC REDETERMINATION</a> .

### **Children in Foster Care or Subsidized Adoption in PMICs**

When a foster child enters a PMIC, both the service worker and income maintenance (IM) worker must be involved. The following chart summarizes the responsibility for processing the cases of children for whom the PMIC placement is the first foster care placement and for foster children who are already Medicaid members when they enter the PMIC. IM worker responsibilities are explained in more detail throughout the chapter.

When children in subsidized adoptions go into PMICs, it may not involve a service worker. However, some children who are in subsidized adoption can become foster children when placed in a PMIC.

Summary of Responsibility for Processing PMIC Cases When Service Worker Is Involved	
Duties of Service Staff	Duties of IM Staff
1. Contact the facility to request IME Medical Services Unit or Iowa Plan approval before placement.  2. Request an application within five working days from placement, if the child is not a Medicaid member. (When a child is assigned to a juvenile court officer instead of a service worker, the juvenile court office is responsible for the application.)	1. Send <i>Case Activity Report</i> to service worker with level of care decision.  2. Pend case in ABC and respond to ISIS milestones.

Duties of Service Staff	Duties of IM Staff
3. Complete the application if necessary and forward it to IM within two working days of receipt, with form 470-2479, <i>Case Activity Report</i> . Attach a copy of the court order or voluntary placement agreement, and <i>IV-E Initial Placement Information</i> , form 470-3839.	3. Determine financial eligibility under IV-E, if first placement.
4. Refer to SSI if needed.	4. Determine Medicaid eligibility.
5. Initiate payee change for unearned income, if needed.	5. Open a Medicaid case and make referrals to the IV-D agency using the REFER system.
6. Use FACS to communicate placement information to FCRU per instructions in 18-G.	6. Inform the member and the service worker of the decision and client participation by sending form 470-2479, <i>PMIC Exchange of Information</i> .
7. Assist IM with verification needed to establish eligibility.	7. Inform service worker of visit and hospital days.
8. Report changes in income, resources, placement, or pregnancy to IM staff.	8. Review case and report changes in eligibility to service staff.
9. Review visit plans.	9. Inform the service worker of the discharge and last month's client participation.
10. Assist IM with reviews.	10. Determine if a child is continuously eligible or complete an automatic redetermination of Medicaid eligibility. See 8-F, <a href="#">Continuous Eligibility for Children</a> or 8-G, <a href="#">AUTOMATIC REDETERMINATION</a> .

Some policies only apply to a foster child entering a PMIC. These policies are outlined in the following sections:

- ◆ [IV-E eligibility](#)
- ◆ [State-only funding](#)

### **IV-E Eligibility**

**Legal reference:** P.L. 96-272, 45 CFR 1355 and 1356

If a child in subsidized adoption is currently eligible under the IV-E coverage group, IV-E eligibility continues while the child is in a PMIC, as long as the child retains the specified status. Eligibility for IV-E-related Medicaid in subsidized adoption does not depend on living in a IV-E placement. See 8-H, [Title IV-E](#), for a full description of IV-E eligibility.

If a foster child is already IV-E Medicaid-eligible when entering a PMIC, IV-E-related Medicaid eligibility is suspended after the month of entry, since no foster care maintenance payment is made. This eligibility must be determined under a coverage group other than IV-E. See [Coverage Groups](#) earlier in this chapter.

If a IV-E-eligible foster child from out of state is placed in a PMIC, the child loses IV-E Medicaid eligibility. Since the child has no Iowa residency, payment for the child's care is a responsibility of the placing state.

When a child's first foster care placement is in a PMIC, IV-E is not the correct coverage group for Medicaid eligibility, since PMICs are not IV-E-eligible placements.

Even though a foster child cannot be eligible for Medicaid under the IV-E coverage group while in a PMIC, determine if the child meets the income and resource requirements for IV-E eligibility at the time of application. It is much easier to establish the child's initial financial circumstances at the time than to attempt to make this determination later when the child enters a IV-E-eligible placement.

See 8-H, [Title IV-E](#), for additional information about IV-E-related Medicaid eligibility criteria.

### **State-Only Funding**

**Legal reference:** 441 IAC 75.1(10)

If a foster child meets the PMIC level of care but is not eligible for Medicaid under a FMAP- or SSI-related group, the child is eligible for Medicaid under state-only payment.

The child under state-only funding is treated as a Medicaid-eligible child for payment, client participation, IME Medical Services Unit or Iowa Plan determination, and reserve bed days. Code the child with the state-only fund code of "4."