

Revised July 22, 2011

Employees' Manual
Title 8
Chapter M

MEDICAID SERVICES



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Overview

This chapter contains an explanation of the services and programs available to Medicaid members (people who have been determined eligible for Medicaid benefits). Detailed information about coverage of specific services, conditions of provider participation, and billing and payment can be found in the provider manuals that are part of 8-Appendix.

Providers of Medical Services

Legal reference: 441 IAC 77, 79.6(249A), 80.1(249A), 81, 82, 85.1(249A)

Participation in the Medicaid program is open to all qualified providers of medical and remedial services in the following categories:

◆ Noninstitutional providers:

- Advanced registered nurse practitioners
- Ambulance services
- Ambulatory surgical centers
- Area education agencies
- Assertive community treatment providers
- Audiologists
- Behavioral health service providers
- Behavioral health intervention providers
- Birth centers
- Case management organizations
- Chiropractors
- Community mental health centers
- Dentists
- Family planning clinics
- Federally qualified health centers
- Hearing aid dealers
- Home health agencies
- Home- and community-based habilitation service providers
- Home- and community-based waiver service providers
- Hospices
- Independent laboratories
- Indian Health Service facilities
- Infant and toddler programs
- Lead investigation agencies
- Local education agencies
- Maternal health centers
- Medical equipment dealers
- Occupational therapists
- Opticians
- Optometrists
- Orthopedic shoe dealers
- PACE organizations
- Pharmacies
- Physical therapists
- Physicians
- Podiatrists
- Psychologists
- Rehabilitation agencies
- Rural health clinics
- Screening centers

◆ Institutional providers:

- Acute-care hospitals
- Critical-access hospitals (CAHs)
- Intermediate care facilities for persons with mental retardation (ICFs/MR), including the state resource centers
- Nursing facilities for people with mental illness aged 65 and older (NFs/MI)
- Nursing facilities, including facilities certified to provide skilled care (SNFs)
- Psychiatric medical institutions for children (PMICs)
- State mental health institutes (MHIs) licensed as hospitals

All providers that wish to participate in the Iowa Medicaid program must apply to the Iowa Medicaid Enterprise (IME) for certification as a Medicaid provider. The IME Provider Services Unit assigns a Medicaid provider number to each approved provider and issues instructions on accessing the Medicaid provider manual on the Internet and a supply of claim forms (when the claim forms are not available commercially).

Medical institutions in Iowa are licensed by the Department of Inspections and Appeals. After being licensed, the institution can ask to be certified to participate in the Medicaid program.

Nursing facilities that are certified in the Medicare program for skilled nursing care can provide and be paid either for skilled nursing care or nursing care, depending upon the needs of the member. A nursing facility that is not certified in the Medicare program may be paid only for nursing care, even if the care the member receives would be considered skilled nursing care in a Medicare-certified facility.

Direct questions about facilities participating in the Medicaid program to the IME Provider Services Unit.

Requirements for Providers

Legal reference: 441 IAC 79.2(249A), 79.3(249A), 79.5(249A), 79.6(2), 79.8(249A), 80.4(249A)

Providers cannot charge members for Medicaid services in addition to the Medicaid reimbursement the provider receives. However, they can charge members or agencies for services that are **not** covered by Medicaid.

Abortions, sterilizations, and hysterectomies have specific documentation requirements that must be included with each claim. These requirements are defined in the *Physician Provider Manual*, among others.

Certain services require prior approval from the IME to ensure that the services are necessary. Providers must submit form 470-0829, *Request for Prior Authorization*, to the IME to obtain prior approval. Providers who are unsure if an individual or service meets the Medicaid criteria for payment can also submit a prior approval request.

Medically Needy clients who are conditionally eligible must also comply with prior approval requirements to receive Medicaid payment after spenddown is met for services or items for which prior approval is required. Prior authorization is explained further in the provider manuals.

Providers must:

- ◆ Keep records for five years from the date of service documenting the services, supplies, and care furnished to Medicaid members.
- ◆ Provide records or related information when requested by the Department or by the U.S. Department of Health and Human Services.
- ◆ Comply with Title VI of Civil Rights Act of 1964, which prohibits discrimination based on race, creed, or national origin.
- ◆ Comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on handicap.

Providers may be subject to sanctions for program violation such as filing a false claim or failure to comply with provider certification on Medicaid check endorsement. Sanctions include suspension, probation from program participation, or termination from Medicaid participation.

Qualifying to Determine Presumptive Eligibility for Children

Legal reference: 441 IAC 75.1(44)

For the purposes of determining presumptive Medicaid eligibility for children, a "qualified entity" is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

Refer anyone asking about applying to be a qualified provider to the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

To begin the enrollment and certification process, the provider must submit form 470-4990, *Application for Authorization to Make Presumptive Eligibility Determinations for Children*, which is available on line at <http://www.ime.state.ia.us/Providers/Forms.html>.

After receiving form 470-4990, the Department will determine if the applicant meets the criteria to become a qualified entity. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II, Section D, Item 1](#), for copies of these forms.

Qualifying to Determine Presumptive Eligibility for Pregnant Women

Legal reference: 441 IAC 75.1(30)"a"

For the purposes of determining presumptive Medicaid eligibility for pregnant women, a "qualified provider" is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be designated, a provider must:

- ◆ Provide one or more of the following services:
 - Outpatient hospital services
 - Rural health clinic services
 - Clinic services furnished by or under the direction of a physician
- ◆ Participate or receive funds under one of the following:
 - The state perinatal program
 - The Migrant Health Centers or Community Health Centers Program
 - The Maternal and Child Health Services Program
 - The Health Services for Urban Indians Program
 - The Special Supplemental Food Program for Women, Infants, and Children
 - The Commodity Supplemental Food Program
 - The Indian Health Service or health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

In Iowa, these providers are primarily maternal and child health centers operated under the Department of Public Health. However, other providers, such as migrant health centers and rural health clinics, may also meet the criteria.

Refer anyone asking about applying to be a qualified provider to the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

To begin the enrollment and certification process, the provider must submit form 470-2579, *Application for Authorization to Make Presumptive Eligibility Determinations*, which is available on line at <http://www.ime.state.ia.us/Providers/Forms.html>.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II, Section E, Item 1](#), for copies of these forms.

Qualifying to Determine Presumptive Eligibility for BCCT

Legal reference: 441 IAC 75.1(40)"c"(1)

For the purposes of determining presumptive Medicaid eligibility for women who need treatment for breast or cervical cancer, a "qualified provider" is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be qualified to do presumptive eligibility determinations, a provider must be eligible for payment under the Medicaid program and either:

- ◆ Have been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the Department of Public Health; or
- ◆ Have a cooperative agreement with the Department of Public Health to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the "Care for Yourself" breast and cervical cancer early detection program.

Refer anyone asking about applying to be a qualified provider to the Bureau of Financial, Health and Work Supports in the Division of Adult, Children and Family Services.

To begin the enrollment process, a provider must submit form 470-3864, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*, to the Bureau of Financial, Health and Work Supports for approval.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See *Medicaid All Providers Manual*, [Chapter II, Part F, Item 1](#), for copies of these forms.

Nonemergency Medical Transportation

Legal reference: 441 IAC 78.13(249A)

The Department pays for the Medicaid member's transportation to receive medical care, including prescribed drugs, if the requirements in this section are met. Effective October 1, 2010, the Department has hired a transportation broker to manage the nonemergency medical transportation program.

TMS Management Group, Inc. (TMS) is the vendor the Department has contracted with to provide the brokerage service. TMS is responsible for arranging and reimbursing for all nonemergency medical transportation for dates of service on and after October 1, 2010. TMS also responsible for appeals associated with the nonemergency medical transportation program.

If members have questions regarding scheduling their trips or seeking travel reimbursement, direct them to call 1-866-572-7662. Members must contact TMS to make travel arrangements at least 72 hours **before** they travel to a medical provider, unless the need is urgent.

Managed Health Care

“Managed health care” (MHC) is a delivery system in which the member is linked to a primary care provider who monitors, coordinates, and provides medical care. Enrolled members must receive care from or be referred by their designated provider for most health care needs.

Coverage of specific medical services under managed care is subject to the same general conditions and restrictions that are applicable in regular Medicaid. Any Medicaid-covered services that are not covered or managed by the managed health care provider are available to enrolled members under regular Medicaid.

There may be three different managed care initiatives in Iowa: the Iowa Plan for Behavioral Health (Iowa Plan) , patient management (MediPASS), and health maintenance organizations (HMOs). A brief description of these initiatives follows.

Recovery of Medicaid capitation payments from the member is calculated differently, depending on whether the error was caused by the member or by the agency. Initiate recovery as directed in 6-G, [Medicaid and Iowa Plan Managed Care Capitation Recovery](#).

If you have questions about HMOs or MediPASS, you can call the managed health care office at 1-800-338-7909 (the IME Provider Services Unit). This number is for Department staff and providers only. Do not give this number to members.

Managed Care Hot Line

A managed health care hot line is available to managed care members Monday through Friday from 8:30 a.m. to 5:00 p.m. The hot line numbers are 1-800-338-8366 or 515-256-4604 in the Des Moines area. Staff managing the hot line can:

- ◆ Explain managed health care and answer questions about managed health care programs.
- ◆ Enroll members with managed health care providers, either MediPASS or HMO when available.
- ◆ Send county MediPASS provider lists to members.
- ◆ Work with members on concerns or issues with managed health care providers.

What the Managed Health Care Hot Line Cannot Do for Members	Where to Refer Members Instead
Distribute lists of specialists, dentists, and chiropractors who accept Medicaid	Yellow pages, recommendations of friends, local medical societies, local hospitals, etc.
Answer questions about coverage	Their medical provider or a provider of the service in question, who can call the IME if necessary.
Answer questions about claims processing or the status of claims	The provider submitting the claim, who can call the IME Provider Services Unit.
Approve or authorize medical care	The member's primary care provider.
Explain why medical bills were not paid	The IME Member Services Unit number listed on the medical card, 1-800-338-8366, or in the Des Moines area call 515-256-4606.

Health Maintenance Organizations and MediPASS

Legal reference: 42 CFR 434, Subpart C; 441 IAC Ch. 88

“Health maintenance organizations” (HMOs) employ or contract with physicians, hospitals, and other providers of medical and health services to deliver medical care to enrolled members.

The HMO provider will either provide or authorize most of the member’s medical care. An HMO-enrolled member must use the medical providers that belong to the HMO’s provider panel. The following services are required of all HMOs:

- | | | |
|-----------------------|-----------------------------------|-------------------|
| Ambulance | Inpatient and outpatient hospital | Physicians |
| Care for Kids (EPSDT) | Laboratory and X-ray | Podiatry |
| Clinics | Nurse practitioners | Screening centers |
| Family planning | Optometry | |
| Home health | Physical therapy | |

Some HMOs have also chosen to include optional medical equipment or chiropractic services in addition to the required services.

HMO participation in Medicaid is established through a contract that may be terminated by either party under certain conditions. HMOs may not be available in all counties or any counties. If an HMO option is available in the member’s county of residence, the member will be notified if enrollment is required or optional.

When the Department contracts with an HMO, a payment rate is established based on an estimate of what a given amount of health care will cost during a period, usually one month. This rate is called a "capitation rate." The capitation rate is required by federal statute to be actuarially sound.

If the total costs to the HMO for care of all enrollees are higher than the sum of all capitation payments, the HMO assumes the loss. If the costs are below the capitation payments, the HMO retains the difference, so it is to the advantage of the HMO to take all steps necessary to ensure member health and prevent disease.

The "Medicaid Patient Access to Service System" (MediPASS) is a program in which Medicaid-enrolled primary care provider agrees to serve as a managed health care provider (called a patient manager) for enrolled members.

The patient manager is responsible for authorizing payment to other providers and monitoring necessary medical care. The patient manager is not responsible for contracting with and paying the other providers. Providers who are patient managers receive a monthly "management" fee for each enrolled member and also receive their normal fee-for-service reimbursement.

Who Is Enrolled

Legal reference: 441 IAC 88.1(249A), 88.3(249A), 88.21(249A), 88.23(249A), 88.42(249A), and 88.45(249A)

In counties designated as mandatory managed health care counties, all Medicaid members are required to enroll in managed care **except** for the following:

- ◆ Members in SSI-related aid types
- ◆ Medically Needy members
- ◆ Refugee spenddown members
- ◆ Members who are Medicare beneficiaries
- ◆ Members in automatic redetermination aid types (eligibility reviewed)
- ◆ Members over 65 or under 21 who live in a psychiatric institution
- ◆ Children in foster care or subsidized adoption
- ◆ Women in presumptive eligibility coverage groups
- ◆ Members in the HIPPP program
- ◆ Children receiving comprehensive services through Title V
- ◆ Native American Indians
- ◆ Alaska Natives

How Members Are Enrolled

Once eligibility is established, members in managed care counties receive an informational mailing from the IME. This mailing includes:

- ◆ Comm. 106 or Comm. 106(S), *Your Choice: Managed Health Care*.
- ◆ A list of participating MediPASS providers. (Providers who are not accepting new patients or who are new to the program may not appear on the list.)
- ◆ Information about HMOs available in that county (if any).
- ◆ A letter telling members that they must enroll in one of the managed health care plans and giving a tentative provider assignment.
- ◆ An enrollment form (a postage-paid self-mailer).

The IME Member Services Unit assigns members to an HMO or MediPASS provider in their area, based on their age and sex. In counties with one or more HMO options available, tentative assignments are divided equally between the HMO options and the MediPASS providers.

Members may choose another provider by calling, mailing, or faxing their choice to the IME Member Services Unit before the date on their notice. Members have a minimum of ten days to make a choice. If the member does not make a choice, the member is assigned to the tentative provider selection or plan listed on their notice.

Enrollment can also be processed in the following ways:

- ◆ At a MediPASS provider's office. Each MediPASS provider has enrollment forms available. Members may enroll with the provider or change providers by voluntarily completing the form and mailing it to the IME.
- ◆ At an HMO provider office if an HMO is available in the county of the member's residence. The member may elect to enroll in an HMO after receiving enrollment information and a form from the HMO provider.
- ◆ At the local Department office. (Although you do not directly enroll members, give an enrollment form to members and provide assistance as requested to complete it.)
- ◆ Through the Member Services Unit's toll-free telephone number, 1-800-338-8366, or local number 515-256-4606 in the Des Moines area. Members may call this number for information about choices and provider availability. They can also enroll directly during this call.

Members can change providers by completing and mailing the form in the *Your Choice* booklet or by calling 1-800-338-8366.

Extended Participation Program

Legal reference: 441 IAC 88.3(7)"e" and 88.46(2)"f" and "g"

Members enrolled in managed care are given 90 days to choose the managed care provider they wish to be enrolled with for the six-month extended participation program. After the 90 days, members must remain enrolled with the managed care provider they last chose (or were assigned to) for the following six months, with these exceptions:

- ◆ A member makes a request for disenrollment for good cause.
- ◆ A provider makes a request for disenrollment for good cause.
- ◆ A new, previously unavailable, managed health care entity becomes available. In this instance, members will be allowed to select that entity for the remainder of the current extended participation period.
- ◆ Before the end of each extended participation period, members are notified of their ability to enroll with a different managed care option. During that time, members are allowed to change managed care options and continue to be enrolled in managed care.
- ◆ A change in enrollment or failure to change enrollment will begin a new extended participation period at the end of the current extended participation period.

Disenrollment

Legal reference: 441 IAC 88.4(249A), 88.24(249A), 88.47(249A)

Disenrollment occurs automatically through the ABC system when:

- ◆ The member becomes ineligible for Medicaid.
- ◆ The member moves outside the HMO or MediPASS service area or to a non-HMO or MediPASS county.
- ◆ The member transfers to a coverage group not eligible for managed health care enrollment.
- ◆ The member's health care coverage code indicates Medicare benefits.
- ◆ The contract between the Department and the managed health care provider is terminated.

When members move from a managed-health-care county to a non-managed health care county or move to another managed health care county with a different set of doctors or HMOs, ABC automatically disenrolls the member if the county, aid type, etc., is no longer appropriate. Disenrollment is subject to timely notice.

ABC automatically resets the managed health care status in the new managed health care county so enrollment information for the current county is sent. Encourage members to make a new enrollment selection as soon as possible.

Effective Date of Enrollment and Disenrollment

Legal reference: 441 IAC 88.4(249A), 88.3(249A), 88.46(249A), and 88.47(249A)

The effective date of enrollment, change, or disenrollment is prospective--not retroactive.

Mrs. A applies for FMAP on March 15. Eligibility under FMAP is established effective March 22. This is after the timely notice date for March. She has indicated which managed care plan she prefers.

Mrs. A is entitled to retroactive Medicaid for December, January, and February. She will receive a *Medical Assistance Eligibility Card*. Managed health care enrollment begins effective May 1.

However, newborns born to mothers enrolled in an HMO are automatically enrolled from their date of birth with the same HMO as the mother if the newborn is deemed eligible for that month.

Enrollment is subject to timely notice guidelines unless the member has already been enrolled in managed health care, is then canceled, and becomes reinstated to Medicaid. Such a member should be reinstated to the managed health care provider the member was enrolled with at the time cancellation occurred.

To do this, reinstate the member using an entry reason/status code/notice reason combination of "B – B - 207." If an entry reason of "A" or "C" is used to reopen the case, the member must again go through the process of choosing a provider.

List of Providers and Counties Served

If you are uncertain about whether or not an HMO is available for members in any specific county, you may contact Provider Services. However, MediPASS is required in most Iowa counties. Members residing in those counties will receive the enrollment packet if they are required to enroll. You should ask members to call the Member Services Call Center if they have questions.

Iowa Plan for Behavioral Health

Legal reference: 441 IAC 88.63(249A), 88.65(249A)

The Iowa Plan for Behavioral Health (Iowa Plan) is a statewide Medicaid managed care plan for mental health and substance abuse treatment services. The Iowa Plan contractor operates under a capitated, risk-based contract.

The Department makes a Medicaid capitation payment to the Iowa Plan contractor for each enrollee for each month the Medicaid member is eligible to receive Medicaid services through the Iowa Plan, regardless of whether services are used during the month. The capitation payment is like an insurance premium paid monthly for coverage.

The amount of the capitation payment per member per month is determined to be actuarially sound, based on historical Medicaid cost and utilization data. A capitation payment is considered payment for medical services and is subject to overpayment recovery.

Enrollment

Enrollment with the Iowa Plan is mandatory. The following are **excluded** from enrollment:

- ◆ Members who are medically needy with a cash spenddown.
- ◆ Members residing at Glenwood or Woodward Resource Center.
- ◆ Members whose Medicaid benefit package is limited, such as QMB, SLMB, E-SLMB, presumptive eligibles, and illegal aliens.

The Medicaid Eligibility system automatically generates enrollment when Medicaid eligibility is initially identified for each month. Once determined, enrollment may not be altered for current or past months of service and may not be updated through Quality Assurance updates. Changes or corrections entered in the ABC system affect future months of enrollment only.

Enrollment begins with the month of application. It does not cover months of retroactive Medicaid eligibility. EXCEPTIONS:

- ◆ Enrollment begins with the month of admission for Medicaid members residing in a substance-abuse-licensed PMIC or a child or adolescent treatment unit at Cherokee MHI or Independence MHI, even when that month is a month of retroactive Medicaid eligibility.
- ◆ Enrollment begins with the month the Department receives notice from the State Data Exchange for members who gained Medicaid eligibility based on a determination of SSI eligibility.
- ◆ Enrollment is not generated for any month that Medicaid eligibility is established by worker updates through the Quality Assurance System.

Iowa Plan enrollment is designated on the SSNI screen in the MHC Code column. Any **letter** in this column designates Iowa Plan enrollment. A **number** designates that the member is not enrolled with the Iowa Plan. For a detailed explanation of each code, see 14-C, [Managed Health Care Systems](#).

Services

Through the Iowa Plan, enrollees may access an expanded array of medically necessary community-based services in addition to traditional Medicaid services.

NOTE: When a Medicaid member is **not** enrolled with the Iowa Plan, the Medicaid fee-for-service program covers mental health and substance abuse treatment services, in accordance with regular Medicaid fee-for-service program policies and procedures.

Regular Medicaid does not cover the expanded array of community-based services provided by the Iowa Plan. Providers that contract with the Iowa Plan contractor may not necessarily participate in Iowa Medicaid.

Medicaid members enrolled with the Iowa Plan must access mental health and substance abuse treatment services through providers that have contracts with the Iowa Plan contractor to provide Iowa Plan Medicaid services.

To access services through the Iowa Plan, Medicaid members may:

- ◆ Call the IME Member Services Unit toll free at 1-800-338-8366 to obtain a list of participating providers.
- ◆ Ask a provider directly if the provider participates in the Iowa Plan.
- ◆ Obtain emergency services at an emergency room.

Services by a mental health PMIC are not covered by the Iowa Plan and remain available to Iowa Plan enrollees through the Medicaid fee-for-service program.

Information for Enrollees and Providers

Medicaid members who are enrolled with the Iowa Plan receive an informational packet from the Iowa Plan contractor within ten days after initial enrollment. The member is also sent a card from the Iowa Plan contractor with the contractor's telephone number on the card for the member to call when there are questions about behavioral health services.

Members seeking information about the Iowa Plan may also call the Iowa Medicaid Enterprise (IME) Member Services Unit toll free at 1-800-338-8366. This number is printed on the *Medical Assistance Eligibility Card*.

Providers seeking information regarding whether a member is enrolled with the Iowa Plan may:

- ◆ Call the Eligibility Verification System (ELVS) line at 1-800-338-7752.
- ◆ Call the Iowa Plan contractor at 515-223-0306 or 800-638-8820.
- ◆ Log onto IME web portal, www.ime.state.ia.us.
- ◆ Log onto the Magellan web site, www.magellanhealth.com.

Program for All-Inclusive Care for the Elderly (PACE)

Legal reference: 42 CFR 460; 441 IAC Ch. 88

The program for all-inclusive care for the elderly (PACE) is designed to allow enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing “managed” long-term care to Medicaid members. PACE becomes the sole source of services for Medicare and Medicaid eligible enrollees.

PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and meet nursing facility level of care in order to qualify. PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

PACE providers receive a monthly Medicaid capitation payment for each eligible PACE enrollee. PACE providers are responsible for ensuring that eligible enrollees receive any services determined necessary for their health and well-being. These services may include but are not limited to:

- ◆ Adult day services
- ◆ Dietary services
- ◆ Durable medical equipment
- ◆ Hospitalization and emergency care
- ◆ In-home support and care
- ◆ Medications
- ◆ Nursing facility care
- ◆ Physician and nursing services
- ◆ Rehabilitation and restorative therapies
- ◆ Respite care
- ◆ Social work services
- ◆ Transportation

Who Can Be Enrolled

Legal reference: 42 CFR 460.150; 441 IAC 88.84(249A)

In counties served by a PACE provider, Medicaid members or individuals who are eligible for Medicaid have the option to enroll in PACE to meet their long-term health care needs if they:

- ◆ Are 55 years of age or older.
- ◆ Reside in a county served by a PACE provider.
- ◆ Live in a community setting at the time of enrollment (are not institutionalized) and choose to receive PACE services instead of HCBS waiver services.
- ◆ Are determined eligible for SSI-related Medicaid, including the 300% group but excluding the Medically Needy coverage group.
- ◆ Are determined to need nursing facility level of care.

NOTE: PACE eligibility cannot be concurrent with any other Medicaid eligibility. Other Medicaid programs must be canceled before PACE eligibility begins.

How Medicaid Members Are Enrolled

Legal reference: 42 CFR 460.152-156; 441 IAC 88.84(249A)

The income maintenance (IM) worker, the PACE provider, and the Iowa Medicaid Enterprise (IME) Medical Services Unit share the responsibility for determining that all PACE eligibility criteria have been met.

Application Processing

Legal reference: 441 IAC 76.1(249A), 441 IAC 88.84(1)

The IM worker determines income and resource eligibility for PACE based on a Medicaid application. A prospective PACE enrollee wanting to apply for PACE services must complete an application online at <https://secureapp.dhs.state.ia.us/oasis>, or one of the following forms:

- ◆ Form 470-2927 or 470-2927(S), *Health Services Application*, for Medicaid.
- ◆ Form 470-0462 or 470-0462(S), *Health and Financial Support Application*, for Medicaid, when the family is also applying for FIP or Food Assistance.

Determine if the applicant resides in a county served by a PACE provider. All other application policies and general eligibility requirements, other than those described under [Who Can Be Enrolled](#), are the same for people applying for PACE services.

Follow the processing procedures described in 8-B, [APPLICATION PROCESSING](#), and the eligibility requirements found in the following:

- ◆ 8-C, [NONFINANCIAL ELIGIBILITY](#),
- ◆ 8-D, [RESOURCES](#),
- ◆ 8-E, [INCOME](#),
- ◆ 8-F, [COVERAGE GROUPS](#), and
- ◆ 8-I, [When Applying for or Receiving Waiver or PACE Services](#).

Provide the applicant a copy of Comm. 316, *Iowa Medicaid - Program for All-Inclusive Care for the Elderly*.

Level of Care

Legal reference: 441 IAC 88.84(1)

PACE enrollees must meet the nursing facility level of care. The PACE provider coordinates completion of form 470-4490, *Level of Care Certification for PACE Program*:

- ◆ By the applicant's active physician for the initial certification, and
- ◆ By the PACE physician for annual recertifications.

The completed form is faxed to the IME Medical Services Unit. The Medical Services nurse reviewer will review the form and the supporting documentation. The Medical Services Unit sends a level-of-care notification through ISIS to the IM worker and the PACE provider.

Effective Date of Enrollment

Legal reference: 441 IAC 88.84(2)

If level of care is approved:

1. Process financial and nonfinancial Medicaid eligibility. A PACE enrollee is considered as an institutionalized person. Treat the applicant as an institutionalized person for attribution of resources and deeming of income and resources.

There is no retroactive eligibility for PACE. However, examine retroactive eligibility under other coverage groups, such as Medically Needy.

2. The PACE provider will obtain applicant's signature on the PACE organization's *Enrollment Agreement* (a non-DHS form).
3. Once Medicaid eligibility has been determined and the PACE enrollment form has been signed, approve PACE eligibility on the Automated Benefit Calculation (ABC) system effective the first day of the month following the date the PACE provider receives the signed enrollment form.

NOTE: PACE enrollment cannot be concurrent with any other Medicaid eligibility. All other Medicaid programs must be canceled before PACE eligibility can begin. Timely notice is not required because the member has signed the PACE enrollment form accepting PACE services.

4. A *Facility Notice of Client Participation*, form 470-0371, will be issued to notify the PACE provider of the effective date of approval and any client participation.

Client Participation for Enrollee Living at Home

Legal reference: 42 CFR 460.152-156; 42 CFR 435.725; 441 IAC 88.84(249A)

Client participation is the amount a PACE enrollee is required to contribute to the cost of PACE services. The PACE provider arranges directly with the enrollee to collect client participation.

To calculate client participation for PACE enrollees who are receiving services in their homes:

1. Determine the total gross monthly income of the enrollee only, according to 8-I, [Income Available for Client Participation](#).
2. Subtract 300% of the SSI benefit for one person. See 8-E, [SSI-Related Income Limits](#).
3. Add in the following:
 - ◆ Veteran's aid and attendance,
 - ◆ Veteran's housebound allowance,
 - ◆ Third-party medical payments, and
 - ◆ Medical assistance trust amounts determined as directed at 8-I, [Trust Payments](#).

The result is the client participation amount.

Mr. J, age 60, lives alone and applies for PACE services on October 2. His gross monthly income includes \$843 Social Security benefit, \$250 private pension, and \$100 VA aid and attendance. The worker determines client participation as follows:

$\$843 \text{ Social Security} + 250 \text{ pension} = \$1,093 \text{ total gross monthly income}$

$\$1,093 - \$2,094 \text{ (300\% of SSI benefit)} = \0

$\$0 + \$100 \text{ VA aid and attendance} = \$100 \text{ client participation}$

See 14-B(9), [SSI-RELATED MEDICAID AND FACILITY CASE ACTIONS](#), for the necessary case actions for the ABC system. ISIS will notify the PACE provider of the amount of client participation to be paid, if any.

Case Maintenance

Legal reference: 42 CFR 460.160; 441 IAC 88.84(249A)

In general, follow the procedures in 8-G, [CASE MAINTENANCE](#).

Once a member is enrolled to PACE, the PACE provider will provide all of the member's medical needs and services. A PACE enrollee can continue to be enrolled in PACE even if the enrollee enters a medical institution.

If a PACE enrollee enters a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care. Do not make entries to the member's PACE case in the ABC system. All transfers to and from a medical institution are done in ISIS. See [PACE Enrollee Enters a Medical Institution](#).

A PACE enrollee who moves out of the PACE service area will no longer be eligible for PACE services. For involuntary disenrollment, see [Disenrollment](#).

See the following sections for detailed procedures for the following:

- ◆ [PACE enrollee enters a medical institution](#)
- ◆ [PACE enrollee leaves a medical institution](#)
- ◆ [Annual recertification](#)

PACE Enrollee Enters a Medical Institution

No changes are needed when a PACE enrollee enters a **hospital**.

When a PACE enrollee enters a **nursing facility, ICF/MR, or NF/MI** for other than respite care, make changes through ISIS as follows:

- ◆ Click on the "entering facility" button on the PACE program request.
- ◆ A pop-up box will appear for you to enter the date the PACE enrollee went into the facility. Enter the date of entry according to the *Case Activity Report* and click "move consumer."
- ◆ ISIS will create a new program request with the new begin date. The program field in ISIS will show as "PACE-NF."
- ◆ A workflow is generated to notify the PACE provider that the member has entered a facility.

Do not recalculate client participation for the month the PACE enrollee enters the facility from a private living arrangement.

- ◆ Recalculate client participation for ongoing months in the facility according to 8-I, [Client Participation](#).

The PACE provider is paid a monthly capitation fee, so changes to client participation must be made effective the first of the month after the PACE enrollee enters a medical institution.

Enter the new client participation amount on the ABC TD05 screen effective the first day of the month following the month of entry to a medical institution.

The new client participation amount will roll to ISIS. A *Facility Notice of Client Participation*, form 470-0371, will be issued to the PACE provider any time there is a change in client participation.

1. Mr. J, a PACE enrollee, enters a nursing facility from his home on May 15. His gross income is \$989 monthly and his PACE client participation while he is living at home is \$0.

The IM worker enters the transfer to the program request in ISIS to move Mr. J from PACE at home to PACE-NF effective May 15.

The IM worker recalculates Mr. J's client participation effective June 1 allowing for a \$50 personal needs allowance, making his client participation \$939. The IM worker then enters the new client participation amount on TD05.

2. Ms. J, a PACE enrollee, is admitted to the hospital on April 28. On May 8 she is transferred to a nursing facility for a long-term stay. Her gross monthly income is \$1,015 and her PACE client participation while she is living at home is \$0.

The IM worker enters the transfer to the program request in ISIS to move Ms. J from PACE at home to PACE-NF effective May 8.

The IM worker redetermines Ms. J's client participation as follows:

April: Since Ms. J was living at home in April, her client participation for April does not change.

May: The PACE provider receives the full capitation payment for May, so Ms. J's client participation continues to be \$0.

June: The \$50 personal needs allowance is subtracted from Ms. J's gross monthly income, making her client participation for June \$965. The IM worker enters the new client participation amount on the ABC TD05 screen.

PACE Enrollee Leaves a Medical Institution

When a PACE enrollee is discharged from a medical institution:

- ◆ Click on the "leaving facility" button on the PACE program request in ISIS.
- ◆ A pop-up box will appear you to enter the date the PACE enrollee was discharged from the facility. Enter the date of discharge as recorded on the *Case Activity Report* and click "move consumer."
- ◆ ISIS will create a new program request with the new begin date. The program field in ISIS will show as "PACE."
- ◆ A workflow is generated to notify the PACE provider that the consumer has left a facility.
- ◆ Recalculate client participation for the month the PACE enrollee leaves the facility and goes to a private living arrangement. See 8-I, [Deductions From Client Participation](#).
- ◆ Recalculate the client participation amount for ongoing months according to [Client Participation for Enrollee Living at Home](#).

Enter the new client participation amount on the ABC TD05 screen effective the first day of the month following the month of discharge from a medical institution.

The new client participation amount will roll to ISIS. A *Facility Notice of Client Participation*, form 470-0371, will be issued to the PACE provider any time there is a change in client participation.

Mr. S, a PACE enrollee, enters a nursing facility from his home on April 16. His gross income is \$838 monthly and his PACE client participation while living at home is \$0.

The IM worker recalculates his client participation effective May 1 as follows:

\$	838	Income
-	<u>50</u>	Personal needs allowance
\$	788	Client participation

Mr. S is discharged from the nursing facility and returns to his home on June 5. The worker recalculates his client participation for June and July as follows:

<u>June</u>		<u>July</u>	
\$	838	Income	\$ 838
-	698	HMA month of discharge	- <u>2,094</u>
-	<u>50</u>	Personal needs allowance	\$ 0
\$	90	Client participation to NF	Client participation

Annual Recertification

Legal Reference: 42 CFR 435.916; 441 IAC 76.7(249A); 441 IAC 88.84(4)

The PACE provider completes a level of care determination at least annually for all PACE enrollees. The IME Medical Services Unit will determine whether nursing facility level of care continues to be met.

Review financial eligibility according to the requirements for the enrollee's particular coverage group.

Document a change in eligibility in the case record. Respond to ISIS milestones to record cancellation of PACE services or a change in level of care or client participation. Send the appropriate notice of decision to the enrollee.

Disenrollment

Legal reference: 441 IAC 88.84(249A)

The effective date of PACE Medicaid cancellation shall be the Medicaid timely notice date. See 8-A, [Notification](#). Complete an automatic redetermination to see if the member is eligible for Medicaid under another coverage group. See 8-G, [AUTOMATIC REDETERMINATION](#).

Circumstance	Policy
Enrollee death	The effective date of PACE Medicaid cancellation shall be the date of death.
Enrollee voluntary disenrollment	PACE enrollees may voluntarily disenroll at any time.
Enrollee involuntary disenrollment	<p>A PACE enrollee may be involuntarily disenrolled for the following reasons:</p> <ul style="list-style-type: none">◆ Failure to pay client participation, if applicable.◆ Disruptive or threatening behavior.◆ Behavior that jeopardizes the enrollee's health or safety or the safety of others.◆ Consistent refusal by the enrollee to comply with the individual plan of care or the terms of the <i>PACE Enrollment Agreement</i> (when the enrollee has decision-making capacity).◆ The enrollee moves out of the PACE service delivery area.◆ The enrollee no longer meets the nursing facility level of care requirement and is not eligible for deemed continued eligibility.◆ The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.
Provider disenrollment	A PACE provider cannot disenroll a member without prior approval from the Department.

A Facility Notice of Client Participation, form 470-0371, will be issued to notify the PACE provider of the date PACE eligibility ends.

List of Providers and Counties Served

The following PACE organizations have contracts with Iowa Medicaid and are located in the following counties:

Siouxland PACE	313 Cook Street
Counties served:	Sioux City, IA 51103
Cherokee	(712) 224-7223
Ida	1-888-722-3713 (24 hours)
Monona	www.siouxlandpace.org
Plymouth	
Sioux	
Woodbury	

Immanuel Pathways PACE	219 S. Main Street
Counties served:	Council Bluffs, IA 51503
Harrison	(712) 256-7284
Mills	www.immanuelpathways.org
Pottawattamie	

Medicare, VA, and Private-Pay PACE Enrollees

The Department is federally required to do level-of-care assessments for all PACE enrollees whether they apply for Medicaid or not. The following steps are taken for the enrollees who do not apply for Medicaid.

1. The PACE provider contacts the IME Medical Services Unit to do a level-of-care assessment.
2. The Medical Services Unit sends a message to either the ISIS-Facilities inbox or the PACE policy specialist and requests to have the PACE enrollee manually entered into ISIS.
3. A PACE program request is created with a unique case number and the enrollee information is logged on a spreadsheet. The case number represents the type of funding and the sequence number on the log.
 - ◆ For a veteran enrollee, the case number is coded as PACEVA1, PACEVA2, etc.
 - ◆ For a private-pay enrollee the case number is coded as PRIPAY1, PRIPAY2, etc.
4. The PACE workflow is started and the level of care information is recorded in ISIS.
5. Once the person is enrolled in PACE, the workflow is completed and a begin date is added to the PACE program request. The program request remains open so that ISIS can generate the annual LOC Review workflow.

NOTE: There will not be an active ABC case for these PACE enrollees and the PACE provider will not receive the monthly Medicaid capitation payment.

Care for Kids (EPSDT)

Legal reference: 42 CFR 441, Subpart B; 441 IAC 84

Federal law requires states to provide early and periodic screening, diagnosis, and treatment (EPSDT) to Medicaid members who are under age 21. In Iowa this program of preventive health screening and follow-up treatment is called "Care for Kids."

Care for Kids provides children with regular health check-ups, continual health maintenance, and a means of early detection and treatment of disease. The program includes outreach, follow-up, and supportive services to encourage participation. All Medicaid members who are under 21 years of age are eligible for Care for Kids.

Screening Services

Legal reference: 441 IAC 84.3(249A); Section 1905(a)(4)(b) of Social Security Act

Periodic screenings or examinations allow a child's overall health to be continually monitored. Screening services include:

- ◆ A comprehensive health and developmental history.
- ◆ Assessment of both physical and mental health development.
- ◆ An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination with physical inspection of:
 - Eyes, ears, nose, and throat.
 - Mouth and teeth.
 - All organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Immunizations appropriate for the child's age and health history.
- ◆ Health education, including anticipatory guidance.
- ◆ Vision and hearing screening.
- ◆ Direct dental referral for children over age 12 months.
- ◆ Appropriate laboratory tests, including:
 - Hematocrit or hemoglobin.
 - Rapid urine screening.
 - Blood lead testing for all children aged 12 months to 72 months.
 - Hemoglobinopathy screening.
 - Serology.
 - Tuberculin test.

Recommended Ages for Screenings

Legal reference: 441 IAC 78.18(3), 84.4(1) and 84.4(2)

Iowa recommends that children receive health, vision, and hearing screenings at the following ages:

- ◆ Two or three days if released from the hospital 24 hours or less after delivery
- ◆ 1 month, 2 months, 4 months, and 6 months
- ◆ 9 months, 12 months, 15 months, 18 months, and 24 months
- ◆ 3 years, 4 years, 5 years, and 6 years
- ◆ 8 years, 10 years, 12 years, 14 years, 16 years, 18 years, and 20 years

Dental screenings are recommended at ages one year, two years, and every six months thereafter. These schedules are the minimum requirements for screenings and are called "periodicity schedules."

Children may need more frequent examinations. Examinations performed more frequently are "interperiodic" screenings. Interperiodic screening, diagnosis, and treatment strengthen the preventive nature of the program. Interperiodic screenings are usually requested by the parent or guardian and may be required by foster care or for educational purposes. The screenings may also be necessary for camp or sport activities.

Screening Providers

Members may choose their screening provider. Encourage families to choose a permanent provider. Members enrolled in the MediPASS program are encouraged to obtain the services from their MediPASS provider.

Each county has a designated child health center under contract to the Department of Public Health to provide well-child services. These centers are listed below in alphabetical order by the city of the center's address. The counties each center serves are listed in alphabetical order.

Counties	Child Health Center	Counties	Child Health Center
Fremont Montgomery Page Taylor	Taylor County Public Health 405 Jefferson St Bedford IA 50833 712-523-3405 800-425-0051	Clinton Jackson Jasper Mahaska Polk Poweshiek	Visiting Nurse Services of Iowa 1111 9th St Ste 320 Des Moines IA 50314 515-558-9955
Audubon Carroll Dallas Guthrie Sac	New Opportunities 23751 Highway 30 PO Box 427 Carroll IA 51401 712-792-9266 ext. 217 800-642-6330	Allamakee Chickasaw Clayton Dubuque Fayette Howard Winneshiek	Visiting Nurse Association of Dubuque 1454 Iowa St PO Box 359 Dubuque IA 52004 563-556-6200 800-862-6133
Mills Pottawattamie	Family, Inc. 3501 Harry Langdon Blvd Suite 150 Council Bluffs IA 51503 712-309-0041	Calhoun Emmet Greene Hamilton Humboldt Palo Alto Pocahontas Webster Wright	Webster County Health Department 330 1st Ave N Ste L-2 Fort Dodge IA 50501 515-573-4107 888-289-3318
Adair Adams Buena Vista Clay Decatur Dickinson O'Brien Osceola Ringgold Union	MATURA Action Corporation 203 W Adams St Creston IA 50801 641-782-8431	Davis Des Moines Jefferson Lee Van Buren	Lee County Health Department 2218 Avenue H Fort Madison IA 52627 319-372-5225 800-458-6672
Scott	Scott County Health Department 600 W 4 th St Davenport IA 52801 563-326-8618 ext. 8857	Benton Jones Linn	Hawkeye Area Community Action Program 1515 Hawkeye Dr Hiawatha IA 52233 319-393-7811 ext. 1031 800-332-5289
Cass Crawford Harrison Monona Shelby	Crawford County Home Health, Hospice, & Public Health 105 N Main St Denison IA 51442 712-263-3303		

Counties	Child Health Center	Counties	Child Health Center
Clarke Madison Warren	Warren County Health Services 301 N Buxton Ste 203 Indianola IA 50125 515-961-1074	Cedar Louisa Muscatine	Trinity Muscatine Public Health 1609 Cedar St Muscatine IA 52761 563-263-0122
Iowa Johnson	Johnson County Public Health 855 S Dubuque St Ste 217 Iowa City IA 52240 319-356-6040 ext. 5891	Keokuk Wapello	American Home Finding Association 123 E 3rd St Ottumwa IA 52501 641-682-8784 800-452-1098
Appanoose Lucas Marion Monroe Wayne	Community Health Services of Marion County 104 S Sixth St PO Box 152 Knoxville IA 50138 641-828-2238	Woodbury	Siouxland Community Health Center 1021 Nebraska St Sioux City IA 51102 712-202-1033 888-371-1965
Boone Hardin Marshall Story Tama	Mid-Iowa Community Action 1001 S 18 th Ave Marshalltown IA 50158 641-752-7162 ext. 163	Henry Washington	Washington County Public Health & Home Care 110 N Iowa Ave Suite 300 Washington IA 52353 319-653-7758 800-655-7758
Butler Cerro Gordo Floyd Franklin Hancock Kossuth Mitchell Winnebago Worth	North Iowa Community Action Organization 100 1st St NW Ste 200 Mason City IA 50401 641-423-5044 ext. 17 800-657-5856	Black Hawk Bremer Buchanan Delaware Grundy	Black Hawk County Health Department 1407 Independence Ave 5th Fl Waterloo IA 50703 319-291-2413

Other providers who can do screenings include:

- ◆ Physicians
- ◆ Child health centers
- ◆ Advanced registered nurse practitioners
- ◆ Rural health centers
- ◆ Federally qualified health centers
- ◆ Clinics
- ◆ Dentists

If a member wants to choose a private provider, remind the member to find out if the provider participates in Medicaid screenings and to tell the provider at the time of the appointment that the visit is for an EPSDT "Care for Kids" screening examination.

Treatment Services

Legal reference: Section 1905(a)(4)(b) of the Social Security Act

Medicaid covers services necessary to diagnose or to treat a condition identified during a health, visual, hearing, or dental screening examination when all of the following conditions exist:

- ◆ The service is required to treat the condition.
- ◆ The provider of services is a Medicaid provider.
- ◆ The service is consistent with federal and state laws that govern health care.
- ◆ The service is medically necessary, safe, and effective, and is not considered experimental.

Services not ordinarily covered under the Medicaid program can be covered under Care for Kids (EPSDT) when they meet these conditions.

If a child needs services not covered under Medicaid or beyond Medicaid limits, first make referrals to similar child health programs, such as:

- ◆ Head Start
- ◆ Special Supplemental Food Program for Women, Infants and Children (WIC)

If no other source of payment is available, request authorization for Medicaid payment from the Division of Medical Services under an exception to policy. Send the following information in with the exception to policy:

- ◆ Physician's name and address.
- ◆ Physician's statement of the need for service.
- ◆ Member care plan.
- ◆ Estimated cost.
- ◆ Expected outcome.

(See procedures in 1-B, [EXCEPTIONS TO POLICY](#).)

Procedures for Notification and Tracking

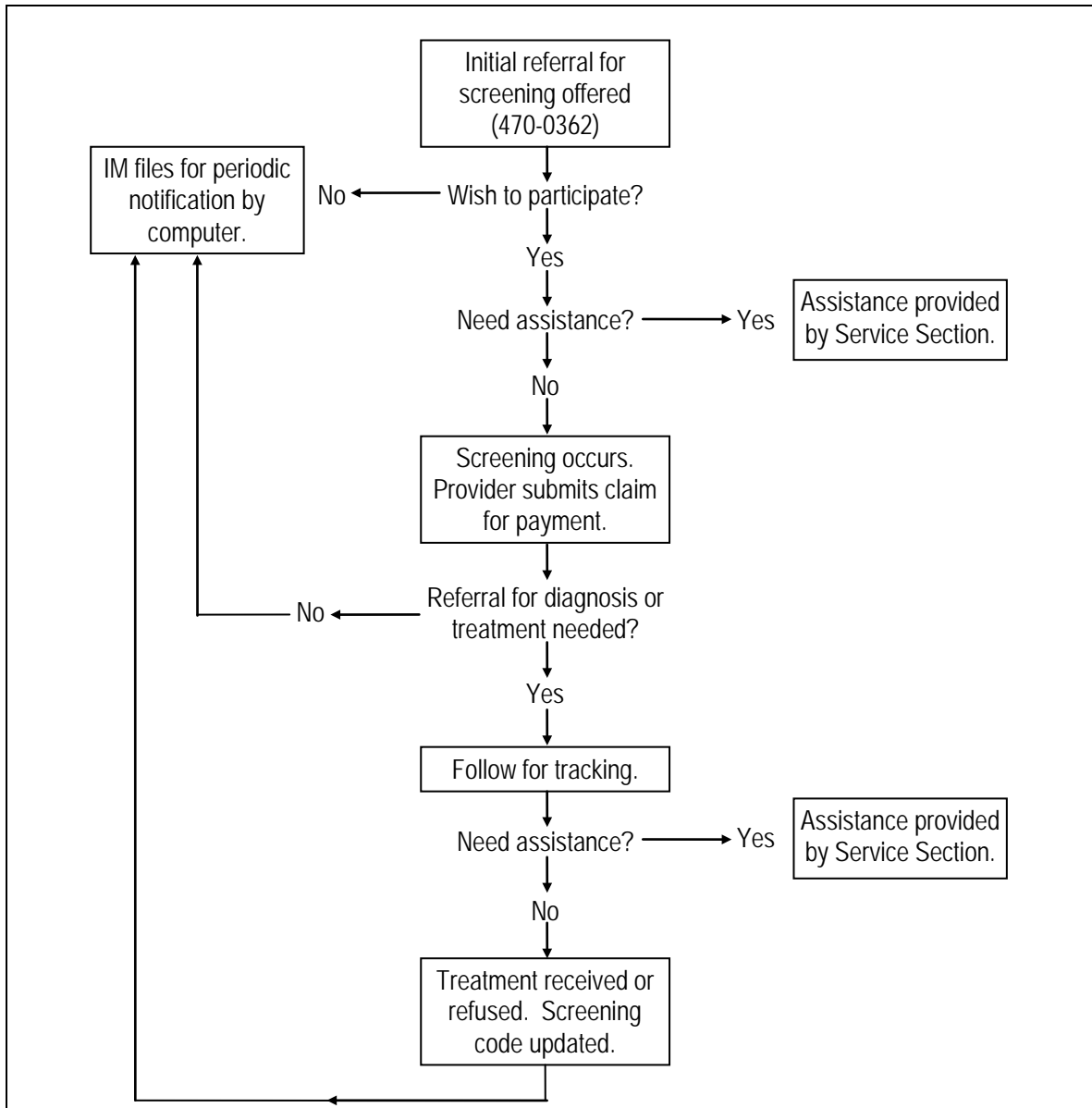
This section explains IM procedures for the initial offer of screening, tracking after screening is accepted or rejected, and ongoing notification.

Most Medicaid members are informed about the Care for Kids program by child health centers designated by the Department of Public Health. In these cases, the IM worker is responsible only for notifying members that they will be contacted by the designated agency.

The SCR field on the ABC system's TD03 screen is the input field for EPSDT information. All Medicaid members under the age of 21 must have a code entered in this field. (See [14-B-Appendix](#) for more information.) On cases with informing and care coordination services provided by designated child health centers, enter code K in the SCR field.

IM workers do have specific procedural responsibilities for Medically Needy applicants with a spenddown and children in foster care. The report *Medicaid EPSDT Enrollees* listing these members is generated monthly for each local office.

IM responsibilities for these involve making system entries, tracking, and making referrals as appropriate. The following chart shows the sequence of activities for EPSDT services.



Offer of Screening

Legal reference: 441 IAC 78.18(3), 84.4(1) and (3), 84.4(2), 84.5(249A)

All families receive a computer-generated reminder, form 470-0365, *Care for Kids Notice*, which makes them aware that, as a new eligible, screening is due immediately.

Discuss the availability of the Care for Kids (EPSDT) program with Medically Needy applicants with spenddown who have children under age 21 and with the payee for members in foster care. Give them Comm. 4, "Care for Kids." If the child has not received a screening during the preceding 12 months, discuss the benefits of screening.

If the member agrees to a referral, complete form 470-0362, *Referral for Early and Periodic Screening, Diagnosis and Treatment*. Record any special informing procedures in the remarks section of the form. Record any services requested or any actions taken by the local office elsewhere in the EPSDT section of the case.

When mailing the information, ask the member to complete the form and return it to the local office. Record the date and type of information sent. A member may return the form or call with the response.

Record in the case file whether the member accepted or refused EPSDT screening. Also enter code "C" in the SCR field on TD03 if the family accepts screening or code "G" if the family refuses.

If the member does not reply within 60 days, assume the member is refusing to participate and enter code "G" into the SCR field. Document the following on form 470-0362:

- ◆ Material sent
- ◆ Date material was sent
- ◆ Current date
- ◆ Client has not responded

A sample narrative is as follows:

3-10-10	Comm. 4 and 470-0362 sent to family on January 5, 2010. As of today, no response has been received. Assume family refused EPSDT services.
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Follow-Up When the Member Accepts Screening

Legal reference: 441 IAC 84.5(249A)

The completion of screening **and** the beginning of treatment should take place within at least 180 days of the date of approval or screening due date.

When a child receives a screening examination, the provider submits a claim for payment to the IME. The information on this claim is supplied to the local office in the quarter after the bill is paid on the report *Screening-Related Services Rendered to EPSDT Enrollees*. This report also reflects any other claims that indicate treatment provided as a result of screening.

For children who are screened and need no further treatment, no further worker action is needed.

After 180 days, if there is no indication from the reports or from the family that the child has been screened, assume that the family is now refusing EPSDT services. Document that the family has not responded, and enter code "G" on the TD03 SCR field. If possible, make a further attempt to follow-up with the family before entering the coding for failure to respond.

For children who are screened and need further diagnoses or treatment, the computer generates MA-2126, *Follow-Up Notice*, which offers assistance to the member.

If the follow-up has been recommended, review the *Screening-Related Service Rendered to Medicaid EPSDT Enrollees* to determine if further treatment was received and where. If a referral was made for further treatment but the treatment has not been received within 60 days of the screening examination, provide follow-up services.

No further follow-up is needed for a condition if:

- ◆ The report indicates that treatment has been started.
- ◆ The screener is also the provider for follow-up treatment and the screener has seen the child after the screening date.
- ◆ A claim is shown from a provider who can treat the condition.

The worker receives the following report, *Screening-Related Services Rendered to EPSDT Enrollees*, on child C:

Name	Treatment Data		Screening Data	
	Specialty	Date	Last	Next
Smith, J	Dental	9/13/05	10/1/05	10/1/07
Jones, J	Medical	10/1/05		
Doe, J	Medical	11/1/05		

Based on this information, the worker knows that:

- ◆ The dentist can be expected to follow up on a dental problem.
- ◆ The medical provider can reasonably be expected to follow up on most children's problems.
- ◆ The second visit indicates that follow-up has occurred.

Always document any request for service and the actions taken to meet this request.

When follow-up efforts are completed, enter code "C" or "G" on the SCR field, according to the family's response.

Use code "G" when the family specifically refuses all treatment or follow-up. (For example, dental may be the only referral condition and the family refuses to take the child because of the child's age.) Review the refusals carefully and refer the family to the service unit if you suspect a serious condition that represents a threat to the child's health.

Use code "G" when no follow-up treatment is received and the family does not respond to any follow-up attempts. Again, refer any appropriate cases to services.

Ongoing Notification

Legal reference: 441 IAC 78.18(3), 84.4(1) and (2)

For Medically Needy cases with a spenddown and foster care cases, periodically discuss the availability of the Care for Kids (EPSDT) program with the payee for a Medicaid member under 21.

The system sends form 470-0365, *Care for Kids Notice*, to offer health, vision, and hearing screening to each eligible child. Even though this is a computerized process, you may inform families again of the program at any time it is convenient. Make the appropriate entries in the file and on the ABC system.

When the family has accepted screening, the *Care for Kids Notice* is issued according to the following schedule:

- ◆ Six times in the first year of life
- ◆ Four between the ages of 1 and 2
- ◆ Once a year at ages 3, 4, 5, and 6
- ◆ Every other year between ages 8 and 21

Because the Department encourages screening immediately after obtaining eligibility, a child may be screened and then shortly receive a notice that another screening is due because of the recommended schedule.

If the family asks, tell them that it is not necessary to receive another screening but they may. If you enter a refusal code, the next notice will be postponed for ten months. This is not recommended for children under 24 months old, since their screening is more frequent than once a year.

When the family has rejected screening, the *Care for Kids Notice* is sent annually to offer screening. Document the reply to the annual offer and reenter the SCR code on TD03 field, using the same entries as for new eligibles (code "C" for acceptance; code "G" for refusal).

If the child is screened, no further action is necessary, unless there are conditions that need follow-up. If after 180 days the family does not respond to the *Care for Kids Notice*, make a follow-up contact to the family. However, if that is not possible, enter the refusal code "G."

Responsibilities of the Service Unit

If the family indicates on the *Referral for Early and Periodic Screening, Diagnosis and Treatment*, form 470-0362, that the family needs assistance to obtain screening, refer the family to the Service Unit.

When the referral is received, the service worker has the following responsibilities:

- ◆ For foster care, inform the foster care provider of the screening program. Many foster children experience changes in foster care parents or social workers. It is to the child's benefit that the informing is done initially not only with the provider, but also with parties who have legal authority over or custody of the child.
- ◆ Enter information on the child onto the system if the family requests a service, e.g., transportation to have a screening or follow-up treatment. Once a request for services has been made, assume it applies to both the examination and follow-up diagnosis and treatment.
- ◆ Document "good faith" efforts to locate providers who furnish services not covered under the Medicaid program (for example, car seats, cosmetic care). The service worker attempts to locate providers who charge nothing or little expense to the family.
- ◆ Report to the income maintenance (IM) worker when any action is taken.
- ◆ Refer to the local Vocational Rehabilitation office any member 16 years or older who is out of school and has a disability that is a handicap to employment. Examples of such conditions are:
 - Orthopedic disorders
 - Neurological disorders
 - Hearing impairments
 - Epilepsy
 - Diabetes
 - Cardiac disease
 - Renal disease
 - Asthma

The rehabilitation counselor makes the decision regarding eligibility.

Billing and Payment

Legal reference: 441 IAC 80.2(249A), 80.3(249A)

Providers participating in the Medicaid program submit claims to the Iowa Medicaid Enterprise (IME) for services rendered that are not paid on a capitation basis. (See the provider manuals in 8-Appendix for billing instructions for providers.)

To establish the amount of payment to be made, the IME deducts from the established cost for the service the amount of any payment made directly to the provider of care by the member, relatives, or any other source. (See 8-A, [When Members Are Responsible for Payment of Medical Bills](#), for a list of member copayment requirements for various services.)

The following sections give more information on:

- ◆ [Submitting claims for payment](#)
- ◆ ["Pay and chase" provisions](#)
- ◆ [Review of trauma claims](#)
- ◆ [Medical Assistance liens](#)
- ◆ [Billing counties for a share of service costs](#)

Submitting Claims

Legal reference: 441 IAC 80.4(249A); 42 CFR 447.45(d)(4)

Providers may submit claims any time during the month for most services. Exceptions: Nursing facilities and home health agencies may not submit bills before the end of a calendar month. Most hospitals cannot bill until a member is discharged.

The IME will not pay claims received more than 365 days after the date of service unless the initial submission was delayed due to:

- ◆ Delays in receiving third-party payments, or
- ◆ Retroactive certification of eligibility on newly established cases.

To be payable, these claims must be submitted less than 24 months from the date of service, and the reason the claim is not timely submitted must be stated on the claim form.

Providers have 12 months from the time that the local office is notified of retroactive SSI eligibility to submit claims. Example: SSI notifies the worker by SDX on August 2, 2004, that the person is eligible for SSI back to June 1, 2002. Providers have until August 2, 2005, to submit the claim.

The IME processes claims older than 12 months when:

- ◆ Eligibility is established retroactively.
- ◆ There is a third-party liability problem.
- ◆ There is a DHS appeal decision or court decision. This may include claims for people who were originally denied for SSI eligibility but appealed and were then approved.

If you receive claims that need to be processed by the IME, return the claims to the provider with instructions to follow directions for the submission of such claims. The provider may contact the IME Provider Services Unit for assistance.

Pay and Chase

Legal reference: 441 IAC 75.25(249A)

Under the normal “cost-avoidance” method of paying claims, the service provider must bill the other medical resource before submitting a claim to Medicaid. The IME approves payment only for those services or that part of the cost of a given service for which no medical resources exist, unless pay and chase provisions apply.

“Pay and chase” means that the IME pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. Pay and chase applies only to claims for:

- ◆ Prenatal care for pregnant women.
- ◆ Preventative pediatric services.
- ◆ Services provided to a person for whom there is court-ordered medical support.

If providers call for more information about the program, refer them to their provider manual or the IME Provider Services Unit. Providers should call the ELVS number (515) 323-9639 or (800) 338-7742 to obtain member insurance information.

System codes that indicate pay and chase for coverage by absent parents are located on the SSNI or MMIS screen.

The absent parent indicator is located in the second position of the medical resource code on the SSNI screen. The codes are H, K, and 8. Field 10 on the MMIS screen has an indicator of absent parent insurance for the insurance coverage that is described on the page open for viewing. Each page has information on a different health insurance policy.

Review of Trauma Claims

Legal reference: 441 IAC 75.2(1)

The IME Revenue Collection Unit screens Medicaid claims indicating an accidental injury or "trauma" in order to pursue potential third-party liability for the costs of treatment. The Unit reviews all Medicaid claims over \$250 submitted with an ICD9 diagnosis code in the range of 800 through 999.9 (indicating an accident or injury), with the exception of diagnosis code 994.6.

When additional information is needed regarding the injury or illness, the Revenue Collection Unit worker sends computer-generated form 470-0398, *Priority Leads Letter* (also called the "trauma leads letter"), to the injured person. The form asks the person to supply details of the injury or illness.

Upon receipt of the completed letter, the Revenue Collection Unit worker:

- ◆ Reviews the member's response to determine if a third party is available to pay for part or all of the medical expenses.
- ◆ Follows up with the third-party resources identified to substitute the Department's claim for that of the injured person. (This process is called "subrogation.")

Medical Assistance Lien

Legal reference: Iowa Code Section 249A.6, 441 IAC 75.4(249A)

The Department has the legal right to file a lien to recover Medicaid payments made on behalf of any member if another (third) party is determined to have liability. "Third parties" include:

- ◆ Private health insurance
- ◆ Auto insurance
- ◆ Casualty insurance
- ◆ Worker's compensation insurance
- ◆ Tort liability cases

Tort liability exists when a member sues a third party and it is determined that injuries sustained were caused by the negligence of a third party.

When the Department makes Medicaid payment on behalf of a member, the IME Revenue Collection Unit files a lien for all monetary claims that the member may have against third parties, to the extent of Medicaid payments. For a lien to be effective, the Revenue Collection Unit must file a notice:

- ◆ With the clerk of the district court in the county where the member resides and
- ◆ With the member's attorney when the member's eligibility is established.

These notices serve as formal notice to the third party of the Department's interest and right to be reimbursed for the member's medical expenses. Possible liable third parties should be informed of the Department's interest at the earliest possible date, no later than 45 days from the time that the Revenue Collection Unit becomes aware of the involvement of the third party.

Billing Counties for Services

Legal reference: Iowa Code Section 249A.26

Counties must reimburse the Department for the nonfederal share of the cost of care for members ages 18 or older who:

- ◆ Live in an ICF/MR or
- ◆ Qualify for the ICF/MR level of care but receive HCBS services under the intellectual disabilities, brain injury, or personal disability waiver.

Counties also pay 50% of the nonfederal share of the cost of:

- ◆ Case management.
- ◆ Partial hospitalization and day treatment when these services are not covered under the Iowa Plan.

The member's county of legal settlement must be established in order for the Department to bill the county. The Department pays for the service, then bills the county monthly (or quarterly for ICF/MR members living in a state resource center).

Legal Settlement

Legal reference: Iowa Code Section 249A.12, 441 IAC 82.14(2)

The primary responsibility for determination of legal settlement rests with the county, but the IM worker does a preliminary determination. If there is a service worker, you may consult with the service worker to get information to help make the decision about county of legal settlement. This decision is tentative and not binding on the county initially identified.

See 8-Appendix, [MR/CMI/DD Case Management Provider Manual](#), for guidelines to help determine the county of legal settlement. Complete form 470-0375, *ICF/MR Placement Statement*, per instructions in 6-Appendix, and send a copy to the county identified as the county of legal settlement.

Whenever there are questions regarding county of legal settlement, refer the case to your service area manager. Each county has procedures in place for resolving issues regarding legal settlement.

If the Board of Supervisors contests the legal settlement opinion on the *ICF/MR Placement Statement*, form 470-0375, send a memo to the Iowa Medicaid Enterprise. Include:

- ◆ Name of the member
- ◆ Case number
- ◆ ID number
- ◆ Worker's name
- ◆ Worker's county
- ◆ Any correspondence from the board

If staff at a state resource center or in the Bureau of Purchasing, Payments, Receipts and Payroll, determine that the resident has no county of legal settlement, the state pays the nonfederal share.

For these cases, indicate "state case" in the county box of form 470-0375. Send all copies of the form to the Iowa Medicaid Enterprise for signing. Division staff will retain a copy and send the others back to the local office.

Billing for Case Management

Providers of case management services must request prior authorization. Prior authorization for Medicaid payment for targeted case management (TCM) services for Medicaid members not covered under the Iowa Plan is completed through the Individualized Services Information System (ISIS).

For a member on the home- and community-based service (HCBS) brain injury (BI), children's mental health (CMH), or intellectual disabilities (ID) waiver, TCM prior authorization requests are approved or denied through the TCM enhanced services workflow process in ISIS.

For all other TCM prior authorization requests, the approval or denial will be determined by the Iowa Medicaid Enterprise Medical Services Unit:

- ◆ The targeted case manager starts the TCM prior authorization process and submits the supporting documentation regarding diagnosis and need for services to IME Medical Services Unit.
- ◆ The IME Medical Services Unit has 15 calendar days to approve or deny the request.

Medicare

Legal reference: 441 IAC 75.2(249A)

This section describes general policies for Medicare (Title XVIII of the Social Security Act) including eligibility groups, available services, and the buy-in process.

Medicare coverage is shown as a third-party resource on the ABC system to ensure that there is Medicare involvement in payment of any covered service. The health coverage code does not have a direct bearing on the buy-in process, but the health insurance resource should reflect Medicare coverage as soon as a member becomes eligible for Medicare, even if the buy-in has not been completed.

Medicare pays on claims for services covered by both programs before Medicaid pays. Medicaid is responsible for paying the deductible and coinsurance required by Medicare. Exceptions:

- ◆ For members eligible for the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only the Medicare premiums, deductibles, and coinsurance. See 8-F, [Qualified Medicare Beneficiaries](#).
- ◆ For members eligible for the specified low-income Medicare beneficiary (SLMB) coverage group or the expanded specified low-income Medicare beneficiary (E-SLMB) coverage group, Medicaid pays only the Medicare Part B premiums. See 8-F, [Specified Low-Income Medicare Beneficiaries](#) and [Expanded Specified Low-Income Medicare Beneficiaries](#).

Remember that some people are not entitled to social security benefits but are entitled to Medicare. Most people are entitled to both Part A and B. However, some people are not eligible for free Part A. These people have an "M" suffix on their claim number (e.g., 123-45-6789M). In most cases, the state will pay the Part A premium for these people.

The beneficiary's *Health Insurance Card* indicates if the person is entitled to both parts. If a person was eligible for Part B but did not choose to enroll in Part B, the health insurance resource code reflects both part A and B, because the state will automatically buy-in to Part B coverage.

Refer clients who ask for more information on Medicare to the local Social Security office.

Medicare Part A

Legal reference: 42 CFR 406.10, 406.11, 406.12, 406.13, 406.20, and 409.5;
OBRA 1989

Medicare Part A helps pay for the following services:

- ◆ Hospital
- ◆ Skilled nursing care
- ◆ Home health services
- ◆ Hospice programs

Part A may require a deductible or coinsurance and may limit the number of days covered during a spell of illness (benefit period).

To be eligible for Medicare Part A, an applicant must be in one of four categories:

- ◆ **Age 65 or older** and one of the following conditions is met:
 - Is entitled to social security retirement or survivor benefits.
 - Is entitled to railroad retirement benefits.
 - Would qualify for social security benefits if federal employment was treated the same for social security purposes.
- ◆ Is not a social security retirement or railroad retirement beneficiary, but had at least a minimum number of quarters of coverage under social security or railroad retirement. This was a special transition provision that expired in 1974.
- ◆ Does not have a work history that qualifies for social security or railroad retirement benefits but voluntarily enrolls in Medicare and pays a premium.

- ◆ **Under age 65** and one of the following conditions is met:
 - Has been entitled to disability benefits from Social Security or the Railroad Board for 24 consecutive months. This does not include a person receiving SSI.
 - Is insured under Social Security or Railroad Board and receives renal dialysis or has had a kidney transplant or is a spouse or dependent child of an insured or entitled person. There may be a three-month waiting period.

Persons who receive Medicare because of a permanent kidney failure are eligible for Medicare benefits for 12 months after the month in which maintenance dialysis treatment stops, or 36 months after the month in which the person receives the kidney transplant.
- ◆ Is a **widow** age 50 or over who has been severely disabled for at least 24 consecutive months but who has not filed a claim on disability because the widow receives social security checks as a mother caring for a young or disabled child.
- ◆ Has received social security disability for more than 24 months, and whose social security was terminated when the person went to work but who continues to have a disability. Medicare continues up to 36 months after the disability benefit ends.

A disabled person may be able to purchase Medicare Part A benefits if the person has exhausted the 36 months of extended Medicare benefits provided after a social security disability benefit stops. This person must meet the following conditions:

- ◆ Be under age 65.
- ◆ Be blind or continue to have the disabling physical or mental condition that was the basis of the person's social security disability insurance or to be a disabled qualified railroad retirement beneficiary.
- ◆ Have earnings that exceed the substantial gainful activity limits, resulting in termination of entitlement for social security disability insurance.
- ◆ Have worked continuously for 48 months while receiving the extended social security disability cash benefits for the first 12 months and then 36 months of extended Medicare benefits after termination of the cash benefits.
- ◆ Be entitled to Medicare benefits for disabled persons after the 36 months of extended Medicare has ended.
- ◆ Not be entitled to any other benefits under Medicare (Title XVIII).

Part A Premiums

Legal reference: 42 CFR 406.22(c) and 406.21, 441 IAC 75.1(29)

In most cases, social security or railroad retirement beneficiaries do not have to pay a premium for Medicare Part A coverage. For persons not entitled to these benefits, premiums can be paid by the federal government (in the case of transitional entitlement) or the state (for qualified Medicare beneficiaries or for qualified disabled and working persons).

Part A beneficiaries who do not have a work history or who are disabled and working persons may pay their own premium for Part A because they are not automatically eligible to receive the benefit at no cost. If these persons are eligible as a qualified Medicare beneficiary or as a qualified disabled and working person, Medicaid pays the Part A premium.

The Social Security Administration assesses a penalty to a person who must pay a premium for Medicare Part A if the person enrolls 12 full months after the initial enrollment period or re-enrolls 12 full months after the last period of Medicare eligibility. The penalty is 10% of the monthly premium and is twice the number of months that the person delayed enrolling in Part A.

If the state pays the premium for QMB-eligible persons through the buy-in process, the state is not assessed a penalty. Medicaid pays the Part A premium, including penalty, if a person is eligible for the qualified disabled and working persons coverage group.

1. Mr. K, age 66, an SSI recipient, does not have a work history and is ineligible to receive social security benefits. He receives Medicare Part B. His initial enrollment period for Medicare Part A ended in January 1994. He was eligible to enroll for Part A Medicare at that time, but had to pay a premium.

Since Mr. K is eligible for QMB and currently receives Medicare Part B, the state processes the Part A enrollment and pays the Part A premium. The state is not assessed a penalty for Mr. K's late enrollment.

2. The social security disability benefits for Mrs. O (age 50) were terminated January 1996, because her income exceeded the substantial gainful activity limit. She received 12 months of extended social security disability benefits and then received 36 months of extended Medicare benefits because she was continuously employed for 48 months but still had the disabling condition.

The Social Security Administration gave her the opportunity to purchase Medicare Part A from March 2000 to August 2000. Mrs. O chose not to purchase Medicare Part A during her initial enrollment period. She waited until March 2001 (during the open enrollment period) to enroll for Medicare Part A. This is a delay of eight months. Mrs. O is assessed a 10% penalty for 16 months on the Part A premium.

Mrs. O applies for Medicaid to pay for the Part A premium and meets eligibility requirements for QDWP. Since she is considered eligible for Medicaid under the QDWP coverage group, Medicaid pays the Part A premium and 10% penalty.

Part A Enrollment Period

Legal reference: 42 CFR 406.32, P.L. 100-239

People who receive social security or railroad retirement benefits because of a qualified work history may enroll in Medicare Part A at any time.

- ◆ People who are not entitled to social security or railroad retirement benefits due to insufficient work history and disabled people who have exhausted their Medicare benefits may enroll for Part A either:
- ◆ During the initial enrollment period, which is the three months before and the three months after the person becomes eligible for Medicare.
- ◆ During the open enrollment period from January 1 through March 31 of each year. If enrolled during the open enrollment period, Part A coverage is effective the following July 1.

Exception: People who are QMB-eligible and who are already entitled to Medicare Part B are not required to wait for the open enrollment period to enroll for Medicare Part A. The state buy-in process automatically establishes Medicare Part A entitlement for people already receiving Part B.

Medicare Part B

Legal reference: 42 CFR 407.2, 407.10

Medicare Supplemental Medical Insurance, referred to as Part B, helps pay for the following types of care:

- ◆ Physician, surgeon
- ◆ Outpatient physical therapy and speech pathology
- ◆ Outpatient hospital
- ◆ Prosthetic devices, durable medical equipment, medical supplies
- ◆ X-rays, laboratories
- ◆ Ambulance
- ◆ Home health care
- ◆ Rural health clinic

Part B may require a deductible or coinsurance. Medicaid pays deductibles and coinsurance for Medicaid members.

To be eligible for Part B, the person must either:

- ◆ Have Medicare Part A, or
- ◆ Be age 65 or older and either a U.S. citizen or an alien lawfully admitted for permanent residence who has lived in the United States for five years before the month of application for Medicare Part B.

Part B Premiums

Legal reference: 42 CFR 408.6, 408.82

People enrolled in Part B pay a premium. The state pays the part B premium for Medicaid members. See [Medicare Buy-In](#).

A penalty is assessed for a person who does not enroll in Part B as soon as the person becomes eligible. Medicaid pays the increased monthly premium when the person is eligible for the qualified Medicare beneficiary coverage group.

Part B Enrollment Period

Legal reference: 42 CFR 407.12, 407.14, 407.17

A person may enroll in Medicare Part B either at the same time social security benefits are approved or during the open enrollment period, which is January 1 through March 31 of each year.

Medicaid members do not have to wait until Medicare's next open enrollment to be eligible for buy-in of Part B. If there is a Medicare eligibility record, Medicaid automatically buys in for those members who are eligible for Part B.

Services Not Covered by Medicare

Legal reference: 42 CFR 410.10 through 410.6, 409.5

Neither Medicare Part A nor Part B pays for:

- ◆ Routine checkups.
- ◆ Glasses or examinations for glasses.
- ◆ Hearing aids or examination for hearing aids.
- ◆ Routine foot care (treatment of warts is covered).
- ◆ Orthopedic shoes.
- ◆ Cosmetic surgery.
- ◆ Most dental work.
- ◆ Most immunizations (flu, pneumococcal, and hepatitis B vaccinations are covered).
- ◆ Private duty nurse.
- ◆ Drugs given in an inpatient hospital stay that the government determines to be "less than effective."
- ◆ Items and services determined not to be medically necessary.
- ◆ Custodial care unless part of hospice.
- ◆ Personal comfort items for a patient's hospital room, such as telephone, radio, television.
- ◆ The first three pints of blood or packed red blood cells (applied separately under both Part A and Part B).

- ◆ Charges by immediate relatives or household members.
- ◆ Homemaker services except when part of hospice care.
- ◆ Meals delivered to the home.
- ◆ Surgical services for which a second opinion is required but not obtained.
- ◆ Items or services for which Medicare is the secondary payer. This includes situations where the beneficiary has worker's compensation or an employer group health plan, or is entitled to compensation from an automobile or liability insurance plan.

Medicare Buy-In

Legal reference: 42 CFR 431.625, 441 IAC 75.1(29)

The Department pays the Medicare Part B premium for Medicaid members. This "buy-in" transfers some medical costs from the Medicaid program, which is partially state-funded, to the Medicare program, which is funded by the federal government and premiums.

To be eligible for the buy-in, a person must be a full Medicaid member and be eligible to enroll in Medicare. People in the following "limited benefit" aid types are **not** eligible for buy-in:

Eligibility	Aid Type
Chronic care group	77-7 (rare)
Concurrent eligibility under two or more limited benefit aid types (blended aid types shown on SSNI)	86E, 86H, 87B, 87H, 87P, 88E, 88F, 88H, 88P, 88T, 89E, 89F, 89H, 89P, 89T, 8BE, 8BH, 8PE, 8PP
Family planning	90-6
IowaCare	60-E, 60-H, 60-P, 60-T
Medically Needy with spenddown	37-E with fund code "9," "S," or "P"
Presumptive eligibility for breast and cervical cancer treatment (BCCT)	88-9
Presumptive eligibility for children	88-7
Presumptive eligibility for pregnant women	88-8
Qualified working disabled person	90-0 or 90-2 with "W" in the SSNI SP (special claims processing) field

If requested, you can help the person apply for Medicare by calling the local Social Security office and asking that a sign-up card be sent to the person. If the person refuses to sign up for Medicare, see 8-C, [Benefits From Other Sources](#).

Iowa has an agreement with the Social Security Administration to initiate buy-in for all recipients of SSI or federally administered State Supplementary Assistance who are eligible to enroll in Medicare.

People who are already enrolled in Medicare or who discontinue their Part B coverage do not have to take any action on their own to complete the buy-in process. If a person is eligible for Medicare coverage but is not participating, tell the person to contact the local Social Security office and sign up for Medicare so the buy-in process can occur.

The Buy-In Process

Legal reference: 42 CFR 407.40

To add Medicaid members to the buy-in, the Department sends the person's claim number to the Centers for Medicare and Medicaid Services (CMS) in Baltimore. Two types of claim numbers are used for Medicare:

- ◆ A railroad claim number, which has six to nine digits with an alphabetical prefix. You can get the railroad claim number from a health insurance card, award letter, premium notice, or from the Railroad Retirement Board. Bendex reports are not issued for persons whose claim number is a railroad number.
- ◆ The social security number of the person on whose earnings social security benefits are being paid with a suffix known as the beneficiary identification code (BIC).

The BIC is a one- or two-character code that identifies the type of social security benefits the person receives, such as wage earner's benefits, spouse's benefits, or child's benefits. The BIC has a letter in the first position and may have either a number or a letter in the second position.

You can get the social security claim number from the beneficiary's health insurance card, award letter, or premium notice, or from the Social Security office. When the Social Security Administration changes a claim number because the benefit type changed or an incorrect number is sent, the number is automatically changed on the ABC system.

The Department's buy-in file is sent to CMS once a month at the system month-end cutoff, which is usually around the 21st to 23rd of the month but may be earlier or later depending on holidays and the length of the month.

CMS processes the file by comparing the claim numbers to the CMS master file. If there is a match, the buy-in is completed. If there is no match, the name is rejected. DHS is notified in either case when CMS returns the file at the beginning of the next month.

Bendex is not immediately updated when the state buy-in is completed. But buy-in information is updated on the SSBI screen. For a buy-in history, use the PF8 key. The buy-in information is updated later on the Bendex screen.

Buy-In Effective Date

Legal reference: 441 IAC 80.5(2)

The buy-in is effective the first month the person is eligible for Medicaid, unless the person:

- ◆ Is not eligible for Medicare in that month (for example, is not 65); or
- ◆ Is already on buy-in through another state that hasn't completed buy-out.

When the buy-in is complete, the Medicare premium is no longer deducted from the social security or railroad retirement check. If the person was being billed, the billing ends after buy-in is complete.

If the health coverage code on the ABC system is not consistent with the buy-in records, the code is automatically updated on ABC to show Medicare Part B coverage only. Verify whether this is correct and update the code to indicate both Part A and B coverage, if applicable.

Premium Refund Checks

Members who paid the Medicare premium or had it deducted from their monthly social security or railroad retirement payment will receive refunds for the months covered by the buy-in. Refunds of premiums are sent to the member in the same month that the buy-in is completed.

The buy-in file is sent to CMS at March month-end. CMS returns the file at the beginning of April. By the end of April, the Social Security Administration issues refunds to members whose buy-in was completed.

A member living in a nursing facility may owe the refund check to the facility.

A waiver member who has a Miller Trust may owe the refund check to a waiver provider.

Members living in a residential care facility are entitled to keep the retroactive refund check. No deduction is allowed for Medicare Part B premium when computing client participation before the buy-in is complete.

Tell members at the time of approval whether they should turn over the refund check to facility when they receive it. Recalculate the client participation in the month the refund is received.

Adjust ongoing client participation to reflect the fact that buy-in is complete. The Medicare Part B premium is no longer allowed as a deduction.

Buy-Out

Legal reference: 42 CFR 407.48

The buy-in continues until Medicaid is canceled. Entering a negative action for Medicaid on the ABC system automatically triggers the cancellation from buy-in. Buy-out is effective the month Medicaid eligibility ends.

NOTE: If CMS accepts a buy-in for a person with more than one claim number, duplicate billing has occurred. There is no retroactive time limit when adjusting duplicate billing.

When the buy-out occurs, a member can choose to withdraw from Part B coverage. The date a person notifies the Social Security Administration of the choice to withdraw from Part B determines when Part B coverage ends.

- ◆ If the member requests a withdrawal from Part B more than six months after buy-out occurred, Part B coverage ends at the end of the calendar quarter after the quarter Social Security is notified.
- ◆ If the member requests a withdrawal from Part B during the last month of the buy-in coverage or during the six succeeding months, Part B ends in the month the notice was filed.
- ◆ If the member is not receiving social security or railroad benefits and is not paying the Part B premium, coverage ends at the end of the third month.

Health Insurance Premium Payment Program (HIPP)

The Health Insurance Premium Payment (HIPP) Program allows Medicaid funds to be used to pay for health insurance coverage through an employer-related plan or an individual plan. Medicaid then becomes the secondary payer of claims.

The HIPP Unit, at the Iowa Medicaid Enterprise (IME), determines if it is cost-effective to pay for a member to get and keep group or individual health insurance coverage or for Medicaid to pay for the services. If the insurance is determined cost-effective, the HIPP program pays the premium directly to the employee, the employer, or the health insurance company on behalf of the member.

IM duties concerning HIPP include:

- ◆ Distributing the combined English and Spanish pamphlet Comm. 255 and 255(S), "Important Information About the HIPP Program," to all Medicaid applicants and to any person who reports new or beginning employment.
- ◆ Distributing Comm. 91, "The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients" upon request. This brochure contains form 470-2875, *Health Insurance Premium Payment Program Application*.
- ◆ Making referrals to the HIPP Unit when insurance is available to:
 - Applicants or members at application or when new employment is reported.
 - Parents in Medicaid households with children who are Medicaid-eligible.

To make a referral to the HIPP Unit:

- ◆ From the TD03 screen on the ABC system use the PF6 key, labeled "REF MENU" (see 14-C, [Adding a HIPP Referral](#)); or
- ◆ Fax or mail form 470-2844, *Employer's Statement of Earnings*, to the HIPP Unit.

Inform the HIPP Unit of changes in the household that may affect HIPP or the health insurance coverage. Contact the HIPP Unit as follows:

Phone: toll-free 1-888-346-9562; local (515) 974-3282

Fax: (515) 725-0725

Interoffice mail: IME/HIPP

E-mail: HIPP@dhs.state.ia.us

U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Examples of changes that need to be reported include, but are not limited to:

Event	Why the HIPP Unit Needs to Know
Birth of a baby	Generally, a baby must be added to the health insurance within 30 days after the date of birth. Otherwise, the baby's hospital bills from birth will not be covered by the insurance plan.
The policyholder leaves the household	If the policyholder is not in the Medicaid household, the HIPP Unit will need to reevaluate whether reimbursement can continue.
Loss of employment	Usually when the employment ends the insurance ends. The HIPP Unit will need to determine if there is COBRA coverage available or if there is a new employer with health insurance available.

For more information on IM procedures and member cooperation requirements, see 8-C, [Cooperation With the Health Insurance Premium Payment \(HIPP\) Unit](#).

Who Is Eligible for HIPP

Legal reference: 441 IAC 75.21(1), (2) and (4) and (249A)

Three groups of people may be eligible for HIPP:

- ◆ **Mandatory participants** are Medicaid members who receive or are eligible to receive group health insurance through an employer. Mandatory participants are automatically evaluated for HIPP.

If the HIPP Unit determines that the employer group health insurance is cost-effective, a mandatory participant must receive or enroll in this health insurance as a condition of Medicaid eligibility, unless insurance is being maintained on the Medicaid member through another source (e.g., an absent parent is maintaining insurance on the member's children).

- ◆ **Voluntary participants** are Medicaid members who receive health insurance from a source other than an employer, such as a credit union, church affiliation, private organization, or individual policy. They can be eligible for HIPP if they apply and it is determined that the health insurance is cost-effective. They are not required to receive or enroll in the health insurance as a condition of Medicaid eligibility.

- ◆ **Non-Medicaid-eligible participants** are family members who are not eligible for Medicaid but who must be enrolled in the health insurance plan in order to obtain coverage for the Medicaid-eligible family members. Only the needs of the Medicaid-eligible members are considered in determining the cost-effectiveness of the plan.

1. Mr. and Mrs. M have three children who are all eligible for Medicaid under MAC. Mr. and Mrs. M are eligible only for Medically Needy with a spenddown. Mr. M's employer offers group health insurance to his employees. Mr. M states he cannot afford to pay the employee's share of the premium.

Two of the children have serious medical conditions that require frequent treatment and hospitalization. These services would be covered by the group insurance available through Mr. M's employer.

The Department determines that it would cost less to pay Mr. M's share of the premium than to pay for these services only with Medicaid. By purchasing a family plan to cover the children, Mr. and Mrs. M will also have insurance coverage, even though they are not eligible for Medicaid.

2. Mr. and Mrs. K have two children who are eligible for Medicaid under MAC. Mr. and Mrs. K are eligible only for Medically Needy with a spenddown. Mr. K's employer offers the following options under the group health insurance plan:

Employee	\$10 per pay period
Employee + spouse	\$60 per pay period
Employee + children	\$40 per pay period
Family	\$100 per pay period

Since Mrs. K is not a Medicaid member, and the employer offers an option to cover only the employee and the children, this option is examined for cost-effectiveness. Payment is not made for the family coverage, since it is not necessary to purchase the family option to provide coverage to the Medicaid-eligible children.

When some household members are eligible for full Medicaid benefits and some only for the Medically Needy program, the premium is paid if determined cost-effective based only on the people receiving full Medicaid benefits. If HIPP pays the premium, the people in the Medically Needy program cannot use the premium as a deduction.

1. Household composition:

Ms. M, age 36, potentially eligible for Medically Needy
Billy, age 4, receiving Medicaid under the MAC program
Julie, age 2, receiving Medicaid under the MAC program

Ms. M's employer group health insurance is determined cost-effective when comparing its cost to the average Medicaid expenditures for the children only. Therefore, Ms. M is required to enroll in the policy as a condition of her Medicaid eligibility.

The premium is not used as a deduction when determining the remaining amount of Mrs. M's spenddown.

2. Same as Example 1, except that Ms. M is already enrolled in the health plan and the premium is being used as a deduction to spenddown when determining the remaining amount of Ms. M's spenddown for an May-June certification period.

On June 10, the HIPP worker determines the policy is cost-effective. Eligibility for the HIPP program is approved as of July 1. The premium is not used as a deduction to Ms. M's income for her July-August certification period.

3. Ms. J and her two children are eligible for Medicaid under the Transitional Medicaid coverage group. Mrs. J's employer provides insurance free to her. The cost for insuring the children is \$50 per month.

The Department determines it would be cost-effective to pay the \$50 monthly premium to insure the children and requests that Ms. K apply for coverage. Ms. K responds that her ex-husband has insurance coverage on the children and provides verification. Ms. K is not required to add the children to her health insurance plan.

Situations Not Covered by HIPP

Legal reference: 441 IAC 75.21(5) and 75.21(9)

If one of the following circumstances applies, premiums will not be paid by the HIPP program:

- ◆ On the date HIPP eligibility is determined, no one covered by the insurance is a Medicaid member.
- ◆ On the date HIPP eligibility is determined, the coverage is no longer cost-effective.
- ◆ The only Medicaid-eligible member is a recipient of:
 - Medicare
 - IowaCare
 - Family Planning Waiver
 - Medicaid for Kids with Special Needs (MKSN)
- ◆ Insurance is provided by the Health Insurance Plan Iowa (HIPIOWA).
- ◆ Another entity is maintaining health insurance on the Medicaid member (e.g., an absent parent is maintaining insurance on the Medicaid member children, or when the policyholder is not in the Medicaid household).
- ◆ The insurance plan is designed to provide coverage for a temporary period.
- ◆ The insurance plan is an indemnity policy that supplements the policyholder's income or pays a predetermined amount for medical services, e.g., \$50 per day for hospital services instead of 80% of the charge.
- ◆ The insurance plan is offered on the basis of attendance or enrollment at a school.
- ◆ The policyholder is an absent parent. CSRU is responsible for obtaining cash and medical support for children in households where a parent is absent.
- ◆ The health insurance premium is used as a deduction in computing the client participation.
- ◆ Household members who are only eligible through the Medically Needy program with a spenddown, or when the health insurance premium is used to meet spenddown.
- ◆ The policyholder or potential policyholder is an undocumented alien.

HIPP eligibility ends when:

- ◆ The policyholder leaves the household and becomes an absent parent.
- ◆ The policyholder fails to provide requested information.
- ◆ All members covered by the policy lose Iowa Medicaid eligibility.
- ◆ The insurance is no longer cost-effective.
- ◆ The insurance coverage is no longer available.

For more information on the Health Insurance Premium Payment Program, see [5-B](#).

AIDS/HIV Health Insurance Premium Payment Program

Legal reference: 441 IAC 75.22(249A)

The AIDS/HIV Health Insurance Premium Payment (HIPP) Program pays for continuing health insurance coverage for people living with AIDS or HIV-related illnesses who can no longer pay the insurance premiums. This program is funded by 100% state funds with an annual appropriation of \$60,000.

The HIPP Unit in the Iowa Medicaid Enterprise administers the program. The HIPP Unit is responsible for:

- ◆ Maintaining the application log.
- ◆ Tracking expenditures and reserving funds for future premium payments.
- ◆ Determining initial and ongoing eligibility.
- ◆ Tracking the remaining unobligated funds.
- ◆ Maintaining the waiting list.

Local office responsibility is to receive applications. Give people who ask about the program Comm. 99, "The Iowa AIDS/HIV Health Insurance Premium Payment Program," which includes the application and a business reply envelope to send the application directly to the HIPP Unit.

The Department must protect the confidentiality of people applying for or participating in the program. When contacts are made, acknowledge only that information is needed to determine eligibility for public assistance. Never acknowledge that the person is living with AIDS or an HIV-related illness without the person's express written consent.

Application Processing

Legal reference: 441 IAC 75.22(2)"a" and "b"

People applying for the program must complete form 470-2953, *AIDS/HIV Health Insurance Premium Payment Application*, included in Comm. 99. The application must contain the applicant's name, address, and signature.

Applicants who do not use the business reply envelope in Comm. 99 may file the application at the local office. If the local office receives an application:

- ◆ Date-stamp the application.
- ◆ Take all precautions to ensure its confidentiality.
- ◆ Send the application to the IME/HIPP Unit addressed to the HIPP supervisor by:

Fax: (515) 725-0725

Interoffice mail: IME/HIPP

U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

For more information on the Iowa AIDS/HIV Health Insurance Premium Payment Program, see [5-C](#).

Money Follows the Person (MFP) Grant Services

Legal reference: P.L. 109-171, Deficit Reduction Act (DRA), Section 6071; Affordable Care Act, ACA, Section 2403

Money Follows the Person (MFP) grant services provide an opportunity for members to move out of intermediate care facilities for persons with mental retardation (ICF/MR) and into their own homes in the community of their choice.

Grant funds provide funding for the transition services and enhanced supports needed for the first year after they transition into the community. MFP assistance is available to members who:

- ◆ Have a diagnosis of mental retardation or brain injury,
- ◆ Have lived in an ICF/MR for at least six months,
- ◆ Have expressed an interest moving from the ICF/MR into the community, and
- ◆ Need home- and community-based services (HCBS) in order to reside successfully in a community-based setting.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support participants in community living. Participants may be covered by the MFP program for 365 days, after which time an HBCS waiver will provide ongoing services.

The MFP program helps participants locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. The assistance of a transition specialist in coordinating transition planning, implementation, and follow-up in securing essential services are included.

The following sections give further instructions on:

- ◆ [Referrals to MFP services](#)
- ◆ [Approval of MFP services and transitioning from ICF/MR to MFP](#)
- ◆ [Discharge for the ICF/MR](#)
- ◆ [Transfer to waiver at day 365 of MFP](#)
- ◆ [Case maintenance](#)

Referral to MFP Services

The ICF/MR will make a referral to a transition specialist when a resident requests MFP grant services. (The ICF/MR should not contact the IM worker to make a referral for targeted case management. If you are contacted by the ICF/MR provider, refer the provider to the transition specialist to make the MFP referral.)

The transition specialist will create an MFP program request in ISIS and start a workflow. You will receive an informational milestone in ISIS notifying you:

- ◆ When a member has applied for MFP, and
- ◆ When a member has been approved for MFP.

Members referred for MFP grant services continue to be active on an ICF/MR facility case.

Mr. J has been in an ICF/MR for two years and is a Medicaid member. He requests MFP services. The ICF/MR makes a referral to the transition specialist.

The transition specialist creates an MFP program request in ISIS and starts a workflow. The IM worker receives a milestone in ISIS that MFP services have been requested. The IM worker responds to the milestone. No further action is required until Mr. J is discharged from the ICF/MR.

Approval of MFP Services and Transition Period

MFP services begin before a member is discharged from the ICF/MR. MFP funds can be used to transition the member into a community-based setting. The member continues to be active on an ICF/MR case.

You will receive an informational milestone in ISIS when a member has been approved for MFP. Do not make ABC system entries to pend or approve a waiver case until the member is discharged from the ICF/MR.

When the member is close to being discharged from the ICF/MR, the transition specialist will provide a signed statement from the member or the member's representative requesting waiver services (in lieu of an application). The transition specialist will send the statement to the IM worker by FAX or email.

Discharge From ICF/MR

The transition specialist will email you with the member's date of discharge from the ICF/MR. Once you have received the *Case Activity Report* from the facility indicating a discharge from the ICF/MR, you can approve the member for MFP.

Set up the MFP case as a waiver case in the ABC system. Use the member's ICF/MR case to approve MFP by either:

- ◆ Closing the ICF/MR case first and reopening the case as a waiver. NOTE: When making these entries, the end date of the ICF/MR case and the positive date of the waiver case **must** be the same date. Or,
- ◆ Making transfer entries to move the member from ICF/MR to a waiver. See 14-B-(9), [Facility Case Actions Move, Same Day](#).

Use the aid type and waiver code applicable for the person's age and the type of disability. Most MFP cases are set up as intellectual disabilities (ID) waiver cases. However, a member may also qualify for another home- and community-based services waiver. Contact the transition specialist to determine what waiver type would be most appropriate, if questionable.

Code the INFO field on the ABC TD01 screen to indicate that the member is active for MFP.

Once the ABC entries pass to ISIS, ISIS will:

1. Add the end date on the ICF/MR program request.
2. Add a future end date on the MFP program request 365 days from the ICF/MR end date.
3. Create a new waiver program request with a future beginning date 366 days from ICF/MR end date.

The member may remain on MFP for 365 days after discharging from the ICF/MR.

Transfer to Waiver at Day 365 of MFP

Once the member has used 365 days of MFP, the member will be transitioned to an HCBS waiver.

A full waiver workflow will be started in ISIS 60 days before the end date of MFP. You may need to request case manager information from the member to assign the CM/SW role in ISIS, if unknown.

You will receive the milestone. *"The consumer has been given a choice between HCBS waiver services and institutional services. Do you want to continue with waiver eligibility?"* Respond, *"Continue, consumer has chosen HCBS."* The signed statement choosing HCBS waiver should have already been received the previous year when the member applied for MFP.

You may also receive a milestone, *"Make county of Legal Settlement in IABC agree with the County of Legal Settlement in ISIS."* Make any necessary changes and respond *"OK"*. NOTE: Failure to respond to this milestone will hold up the rest of the workflow.

Once the full waiver workflow is completed, the program request will be authorized for payment. The waiver case manager will issue a *Notice of Decision* to the member and the providers regarding the authorized services under the waiver program.

You will **not** need to make entries in the ABC system, since the member is already active on a waiver case. Since there is no change in Medicaid benefits, there is no need to issue a new *Notice of Decision* when the member switches from MFP to the waiver.

Case Maintenance

In general, follow the procedures in 8-G, [CASE MAINTENANCE](#). If a member goes into a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care.

Occasionally, a member may need to return to the ICF/MR. If you receive a *Case Activity Report* from a facility indicating that a member has been admitted back to the ICF/MR, either:

- ◆ Close the waiver case and re-open it as an ICF/MR case, or
- ◆ Make transfer entries to move the member from waiver back to the ICF/MR. See 14-B-(9), [Facility Case Actions Move, Same Day](#).

Follow the steps under [Discharge From ICF/MR](#) when the member is discharged from the ICF/MR and moves back to MFP.

The MFP program manager and transition specialist will determine the number of days the member was on MFP and will manually adjust the dates in ISIS. NOTE: The MFP days do not start over at 365 days.