

Instructions for Standardizing Member Income Considered Available for Room and Board

1

MEDICAL AND REMEDIAL EXPENSES



March 10, 2010
Department of Health Services
Division of Long Term Care



Overview

2

General Information

- Background
- Policy Summary
- Summary of areas addressed in instructions

Medical & Remedial Expenses

- Appendix E
- MRE FAQ
 - Definitions
 - Application
 - Calculating, Monitoring
 - Checklist and Grid
- Transitioning and Next Steps

Member Contribution Instructions

3

POLICY SUMMARY

INSTRUCTIONS FOR MEMBER INCOME AVAILABLE TO CONTRIBUTE TO ROOM AND BOARD OBLIGATION WILL BE STANDARDIZED AND APPLIED UNIFORMLY ACROSS DLTC WAIVER PROGRAMS FC, FC-P AND IRIS

Background

4



Attachments to View

5

Please see:

DLTC Numbered Memo Series 2010-05, 3/5/2010

Family Care Member Income Calculation for
Payment of Room and Board in Substitute Care

[http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DLTC/CY2010/
NMemo2010_05.htm](http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DLTC/CY2010/NMemo2010_05.htm)

Attachments

6

• **Attachment #1 A and B** Instructions on gaining access to Program Participation System (PPS) and screen shots of online automated version

• **Attachment #2** DHS Instructions for Determining a Member's Income Available to Pay for Room and Board in Substitute Care

• **Appendices to Attachment #2**

- **Appendix A** - Certification of Cost-Effectiveness of Room and Board Supplementation by MCO
- **Appendix B** - Principles in the Treatment of Expenditures Individuals May Make When Determining Income the Member Has Available to Pay Room and Board in Substitute Care
- **Appendix C** - Policy Related to Payment of Guardian Fees and Room and Board for People Who Live in Substitute Care (Reserved)
- **Appendix D** - Strategies When Members Refuse to Pay Room and Board Obligations
- **Appendix E** - Medical Remedial Expenses Frequently Asked Questions

Instructions for all the following:

7

- Earned Income
- Unearned Income
- Personal Needs Allowance
- Health Insurance Premiums
- Special Exempt Income
- Family Maintenance Allowance
- Spousal Income Allocation
- Medical and Remedial Expenses

Medical and Remedial Expenses

8

- Sources of Information and Decisions
 - Start Point
 - × Existing applicable DHS Policy
 - Reference Documents
 - × Medicaid Handbook
 - × DHS 1 Uniform Fee
 - × Waiver Wise Memos
 - × DHS Policy Meeting
 - × MCO Workgroup
 - × County Stakeholder Review and Comments

Definition Medical Expenses

9

- Medical expenses are expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source.
- The following are examples (not an all-inclusive list) of medical expenses:
 - Deductibles and co-payments for Medicaid, Medicare, and private health insurances
 - Bills for medical services which are not covered by the Wisconsin Medicaid program
 - Medical services received before the person became eligible for Medicaid

Definition Remedial Expenses

10

Costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. If an item can be covered in the Family

Care, or Partnership benefit package it is not a remedial expense.

Certain medical/remedial expenses cannot be counted.

See operations memos : *Medical/Remedial Expenses Used for LTC Medicaid Eligibility and Cost Sharing*

- IM operations Memo:
<http://dhs.wisconsin.gov/em/ops-memos/2008/pdf/08-02Corr.pdf>, and
- DLTCmemo:http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DLTC/CY2008/NMemo2008-02.pdf

Definition Specialized Medical Equipment and Supplies

11

Items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence.

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied. Items or devices provided must be of direct medical or remedial benefit to the participant.

Allowable items devices or supplies may include incontinence supplies, wound dressings, IV or life support equipment, orthotics, nutritional supplements, vitamins, over the counter medications and skin conditioning lotions/lubricants. Additionally allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a participant's health and safety outcomes.

Excludes separate additional charges for shipping, handling, mailing or delivery of items.

Frequently Asked Questions

12

- Co pays
- Not Allowable
 - DLTC Memo Series 2008-2 Date: January 23, 2008
Index Title: Medical/Remedial Expenses used for Long-Term Care Medicaid Eligibility and Cost-Sharing Memo 2008-2
- Additional Q&A on Medical bills
 - Other unpaid medical bills
 - Medical bills used to meet deductible
 - Widow's payment on spouses medical bills
 - Life insurance

FAQ Continued : Phone and Food

13

- Phone and Food typically considered housing cost and not MRE
- Basic phone and long distance
- Phone related to PERS
- Cell phone in place of PERS
- Exceptional Food Cost

Services that are part of the Program Benefit

14

- Any service in the program benefit package (FC/ FC P) is either authorized via the RAD by the IDT or denied via the RAD by the IDT.
- Services denied in the RAD cannot be then counted as medical or remedial expenses.
- If an IDT denies authorization of an item that is in the benefit package that a member is currently paying for as a medical/remedial expense, the IDT should provide the member with a notice of action in accordance with contract requirements in relation to service authorization decisions that deny or limit a requested service. Denials of requests for services are subject to Notice of Action and Appeals and Grievances.

Services that are part of the Program Benefit

15

A Quick Decision Took for IDTs

		In the benefit package	
		Yes	No
Appropriate to support outcomes	Yes	A MRE – No Provide – Yes	B MRE – Yes Provide – No
	No	C MRE – No Provide – No	D MRE – No Provide – No

Authorization Services that were MRE

16

- If the exact service in the exact amount that was MRE is now authorized via the IDT RAD the IDT will:
 - Update the member care plan
 - Update the member contribution worksheet and/ or cost share
 - Authorize the service with contracted vendor
 - Close the care coordination loop by assuring the authorized services are provided in the appropriate amount, duration and frequency
 - Use caution to assure timing of change from MRE to authorized service is conducive to usage. I.e. if member has already purchased MRE in the month the change will take effect the change should be made effective for the next month.

Denial of Services that were MRE

17

- If less than exact service and/ or less than exact amount that was MRE will be authorized by the IDT via the RAD, the IDT will:
 - Discuss with member using the RAD process
 - Issue a notice of action for the denial of service
 - Follow contract requirements related to continuation of services if requested by member pending resolution of A&G
 - If resolution of A&G results in concurring with reduction IDT to implement change as noted with steps in previous slide: care plan update, etc.
 - Service requested and denied via the RAD cannot be MRE

FAQ -Services that are part of Program Benefit

18

Specialized Medical Equipment & Supplies

- Over the counter medications
- Brand name vs Generic
- Paying the Difference

Transportation

- Common Carrier 2010
- Common Carrier 2011
- Neighbors, family, member transportation costs

Other Examples Services in the Benefit Package

19

- Value Assigned to Care Provided By a Spouse
- Live In Attendant
 - Group B
 - Group C
- Group C Caution. If changes to Group C MRE that will not be in the care plan /cost share results in member's loss of eligibility report to internal representatives for verification of accuracy and share with OFCE prior to processing changes that result in loss of financial eligibility.

MRE Specifics

20

Calculating

- Projected Expenses
- Bills paid with credit cards
- Lump sum payments
- MRE for Group C

Verifying, Documenting and Monitoring

- Comply with FAQ instructions
- Be document
- Illustrate monitoring of compliance with FAQ

Attachments

21

MRE Expenses Checklist

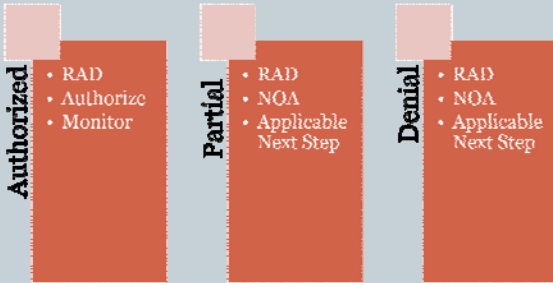
- Attached
- Lists MRE categories and space for indicating

Grid / At a Glance

- Costs that are never MRE
- Cost that are not MRE because in program benefit package

Summary MRE to Authorize or Denial

22



Notifying Economic Support

23

- Notify ES of changes that require ES action AT NEXT ANNUAL REVIEW!
- The clarification in MRE in this memo and FAQ should not result in additional ES workloads.
- If changes do not include necessary ES reporting updates can be made earlier.

Next Steps

24

- Start using instructions, including FAQ
- Report Questions to MCO representative
- DHS to establish forum for monthly conference with stakeholders on issues
- Submit Questions to : DHSOFCE@wisconsin.gov.
