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To: Aging and Disability Resource Centers
IRIS Consultant Agencies
Managed Care Organizations

From: Curtis Cunningham, Assistant Administrator
Long Term Care Benefits and Programs

Medical and Remedial Expenses in the Family Care, Family Care Partnership, PACE, and IRIS Programs

This memo revises policy for countable medical and remedial expenses for the Family Care, Family Care Partnership, PACE (Program of All-Inclusive Care for the Elderly), and IRIS (Include, Respect, I Self-Direct) programs. It repeals the policy in memo 2010-05 that prohibited an individual's out-of-pocket purchase of a service or item from counting as a medical or remedial expense when it was coverable by the program's benefit package, but was denied for that individual.

Policy is changing to align with guidance from the Centers for Medicare & Medicaid Services' (CMS) [Home and Community-Based Services \(HCBS\) Waiver Instructions, Technical Guide and Review Criteria](#) regarding allowable medical and remedial expenses.

Background

Medical and remedial expenses are used in HCBS waiver programs as a deduction in determining any cost-sharing obligation for applicants, members, and participants in eligibility Groups B and B Plus. Aging and disability resource centers (ADRCs) collect this information from applicants; managed care organizations (MCOs) and IRIS consultant agencies (ICAs) collect the information for current members and participants. The information is sent to the income maintenance agency and then income maintenance uses it to determine any cost-sharing obligation.¹

Policy for Medical and Remedial Expenses and Its Implementation

Effective January 1, 2018:

1. Out-of-pocket purchases of services or items in the benefit package that are denied by the program are a countable medical or remedial expense in determining cost-sharing liability. These expenses must still meet all requirements for allowable medical or remedial expenses in the [Medicaid Eligibility Handbook](#).
2. For applicants:
 - a. The policy applies on and after the effective date.

¹ In addition, individuals may use medical and remedial expenses to attain Medicaid financial eligibility through the Medicaid deductible option by using incurred, though not necessarily paid, medical and remedial expenses to lower excess income to the medically needy limit. That process is handled entirely by income maintenance. This is rare in HCBS waiver programs since individuals almost always have more stable Medicaid eligibility at lower cost to them as Group B members.

- b. ADRC staff will follow this policy when determining the medical and remedial expenses to be sent to income maintenance for use in determining eligibility and cost-sharing.
3. For current members and participants:
 - a. The policy applies on the date of the person's first Medicaid eligibility review or care plan review, whichever comes first.
 - b. Those who might benefit from this change will receive a notice from DHS prior to the policy's effective date. The notice will advise them that they may contact their care manager or IRIS consultant before their next care plan or Medicaid eligibility review to request an earlier recalculation of their medical and remedial expenses.
 - c. For an out-of-pocket purchase of a service or item in the benefit package to count as a medical or remedial expense, the program must deny coverage and issue a Notice of Action (NOA). Since the individual may not be fully aware of what the program covers, the care manager or IRIS consultant must ensure that the individual (or representative, if any) understands the services and items included in the benefit package. The care manager or IRIS consultant needs to assist the member or participant in identifying needs and in framing those needs as requests for coverage. Then, should the program deny the request, or authorize it in a lesser amount, duration, or scope than requested, and the individual purchases it on his or her own and has a cost-share obligation, the individual may benefit from the medical and remedial deduction. Members and participants should also be reminded of the availability of appeal and grievance processes for contesting coverage denials.
 - d. As part of scheduled reviews, or upon the member or participant's request, care managers and IRIS consultants must:
 - i. Inform members and participants of this policy change.
 - ii. Work with current members and participants to determine if expenditures for previously denied services in the benefit package are now allowed as medical or remedial expenses. If a denial by the program is required for the expenditure to be a countable medical or remedial expense, assist the member or participant to make the service request to the program.
 - iii. Convey the updated medical and remedial expenses to the income maintenance agency for revised determination of any cost-sharing obligation.

Explanation

The CMS [HCBS Instructions, Technical Guide and Review Criteria](#) provides guidance that state Medicaid agencies must follow in operating their 1915(c) waiver programs. Specifically, the CMS guidance requires that allowable medical and remedial expenses include services not covered under the state's Medicaid plan, which includes services not paid for by Medicaid for that particular individual. In other words, it includes services that are not covered for any Medicaid-eligible person (because they are not a covered service), yet meet the Medicaid Eligibility Handbook definition of a medical or remedial expense, and services that are coverable by Medicaid, but are not covered for a particular individual (because the MCO or ICA has denied coverage for that individual). In both instances, the item or service may be used by the individual as a medical or remedial expense.

DHS expects the impact of the policy change to be smaller in the IRIS program since an IRIS participant manages his or her goods and services within an individual budget, while in Family Care, Partnership, and PACE, most services require MCO authorization.

Requirements for Medical and Remedial Expenses in Cost-Sharing Determinations

This section summarizes Medicaid requirements regarding countable medical and remedial expenses as a deduction in cost-sharing determinations. In the event of any inconsistencies between these requirements and the [Medicaid Eligibility Handbook](#), the Medicaid Eligibility Handbook should be followed. This section does

not apply to the use of medical or remedial expenses to attain Medicaid eligibility by meeting a deductible. For information on the use of medical and remedial expenses to meet a deductible see [Medicaid Eligibility Handbook, Section 24.7](#).

1. Criteria for countable medical and remedial expenses:
 - a. The service or item must meet the definition of a medical or remedial expense stated below.
 - i. **Medical expenses** are for items or services that have been prescribed or provided by a professional medical practitioner licensed in Wisconsin or another state. The expense is for the diagnosis, cure, treatment, or prevention of disease or injury, or for treatment affecting any part of the body.
 - ii. **Remedial expenses** are for items or services provided to relieve, remedy, or reduce a medical or health condition. This includes items or services intended to reverse or slow the progression of a condition, ameliorate its symptoms, or manage its functional consequences; or to improve, maintain, or slow the rate of decline in a health condition or its impact on functional ability. There should be some evidence or reasonable basis for concluding such effects will occur. Expenditures for items or services that merely promote general health or well-being, or would have been incurred for non-remedial or non-medical reasons, are not countable. Remedial expenses do not include housing or room and board.
 - b. The expense must be incurred by and be the legal responsibility of the applicant, member, or participant, and that individual must, over the course of the eligibility period, be paying for it out-of-pocket, including following a payment plan or schedule, with actual payments verified.
 - c. The expense cannot be paid or reimbursed by another source, including Medicaid (which includes Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, an employer, or any other third party.²
2. Criteria for excluding medical or remedial expenses (the [Medicaid Eligibility Handbook, Section 27.7.7.2](#) specifies that the following costs may not be counted as medical or remedial expenses):
 - a. Unpaid bills previously used to meet a deductible for attaining Medicaid eligibility.
 - b. Bills for the cost of institutional care received during a Medicaid divestment penalty period.
 - c. Bills that represent a patient liability amount or a cost-share incurred, but not paid, for a prior period of Medicaid-covered institutional care or enrollment in Family Care, IRIS, or a legacy waiver program.
 - d. Medical bills that will be paid by a legally liable third party, such as Medicare, Medicaid, or private insurance.
 - e. Bills that were previously allowed as a medical or remedial expense and used to reduce a Family Care, IRIS, or legacy waiver cost share or nursing home patient liability amount.
 - f. Expenses that are not verified.

If you have questions about this information, please email dhsbmc@dhs.wisconsin.gov.

Related Material

- [Medical and Remedial Expense Checklist, F-00295](#)
- [Frequently Asked Questions, P-02006](#)
- [Member and Participant Notice](#)

² Premiums paid for by any public or private health insurance meet these criteria and the Medicaid Eligibility Handbook includes health insurance premiums as countable medical expenses. While they are countable medical expenses for purposes of determining cost share, they are deducted separately and therefore considered apart from countable medical expenses for this purpose. They are deducted—just separately.