

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

FREQUENTLY ASKED QUESTIONS

A. Requirements and Exclusions

A.1. What are the requirements for an expense to be counted as a medical or remedial expense (MRE) in Family Care, including Family Care Partnership, PACE (Program of All-Inclusive Care for the Elderly), and IRIS (Include, Respect, I Self-Direct)?

The service or item must meet the definition of a medical or remedial expense:

- a. **Medical expenses** are 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.
- b. **Remedial expenses** are 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, for ameliorating its symptoms, and/or managing its functional consequences, or for improving, maintaining, or slowing 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.

The expense must be incurred by, and be the legal responsibility of, the applicant or member/participant, and that person must be paying for it out of pocket, including by following a payment plan or schedule. Since MREs are determined prospectively, there must be a firm basis for projecting expenses over the 12 month eligibility period, and it must be subsequently verified that included expenses were incurred and paid as projected. The member/participant is responsible for reporting to the managed care organization (MCO) or IRIS consultant agency (ICA) when actual paid medical and remedial expenses differ from those projected for the eligibility period, following normal change reporting requirements.

The expense cannot be paid or reimbursed for the individual by another source, including Medicaid (which includes Family Care, Partnership, PACE, and IRIS), Medicare, private health insurance, another public program, an employer, or any other third party.

A.2. What types of bills may NOT be counted as an MRE?

According to the Medicaid State Plan and [Medicaid Eligibility Handbook, Section 27.7.7.2](#), the following bills and/or payments on these types of expenses cannot be counted as MREs:

- a. Medical bills that remain unpaid but were previously used to meet a Medicaid deductible.

- b. Bills for the cost of institutional care provided during a previous Medicaid divestment penalty period.
- c. Bills that represent a patient liability amount or cost share incurred, but not paid, during a prior period of Medicaid-covered institutional care, or an unpaid Family Care, IRIS, or legacy waiver program cost share obligation.
- d. Medical bills that will be paid by a legally liable third party, such as private health insurance, Medicare, Medicaid, etc.
- e. Medical bills that were previously counted as an MRE and used to reduce a Family Care, IRIS, or a legacy waiver program's cost share or used to reduce a nursing home patient liability obligation.
- f. Expenses that are not verified.

A.3. What unpaid medical bills can be counted as MREs?

Any bills not excluded in question A.2 that meet the definition of medical expense in question A.1, but only actual payments made on those bills or anticipated payments to be made under a payment plan or schedule, with payments subsequently verified.

A.4. What if the unpaid bills that the individual is making payments on have already been used to meet a deductible? Can payments be counted as MREs for the Family Care or IRIS program, as well?

No. When there are unpaid bills that the member/participant is making payments on, the payments may not be counted as an MRE if the unpaid bills were previously used to meet a Medicaid deductible.

A.5. Are payments of deductibles, coinsurance, and copayments for services covered by Medicare, Medicaid, or any other health insurance countable as MREs?

Yes, as long as the payments were not previously used to attain Medicaid eligibility by meeting a deductible or previously used to reduce a cost share.

A.6. Can a widow/widower's payment on a deceased spouse's medical debt count as an MRE for someone who is applying for, or is enrolled in, Family Care or IRIS? This expense is countable when meeting a Medicaid deductible.

No. To count as a deduction when determining a cost share, the expense must be for items or services received by the applicant or member/participant. This is a different rule than applies when attaining Medicaid eligibility by meeting a deductible, where bills incurred by a now deceased spouse may be counted because the spouse was in the same fiscal group as the applicant.

A.7. Can an individual's premium payment for a life insurance policy be counted as a remedial expense?

No. Life insurance premium payments are not MREs because the policy benefits the heirs, with one exception. It is now possible to purchase life insurance with a long-term care rider that pays for long-term care services to the policy holder in addition to paying a death benefit to the heirs.

While it is unlikely that many applicants or members/participants would have such a policy, only the cost of the long-term care rider is an MRE. Health insurance premiums are considered a separate category of deductible expenses, so they can be deducted as health insurance premium costs but not as an MRE. The cost of the basic life insurance policy is **not** an MRE.

B. Specific Services and Expenses

B.1. Can a member/participant's out-of-pocket costs for prescription drugs be counted as MREs?

Yes. Even though Family Care members and IRIS participants normally do not have copayments for prescription drugs covered by their Medicare Part D plans, if certain prescription drugs are not covered by his or her Part D plan, Medicaid, or private insurance and the member/participant pays for the prescription drugs out of pocket, the expense can be counted as an MRE.

The Partnership and PACE programs include Medicare and Medicaid prescription drug benefits in their benefit packages. In these programs, members should not have any copays for covered prescription drugs. However, if the program denies coverage of a prescribed drug that the member then pays for out of pocket, he or she may use the cost as an MRE. This is based on the answer in C.1, which specifies that out-of-pocket costs for services or items that are part of the benefit package, but denied for the individual, can be counted as MREs. In this circumstance, members can use the internal and external appeal processes to contest the denial of coverage for the prescription drug.

For Family Care members with Medicare Part D who are incurring out-of-pocket costs for a prescription drug because it is not on their plan's formulary, the care manager should use the Centers for Medicare & Medicaid Services' (CMS) plan finder to assist the member in determining whether there is a plan that covers the drug or that provides better overall coverage. If a better plan exists, the care manager should ask whether the member would like to switch plans, and if so, assist the member in doing so. Alternatively, the care manager should assist the member, working with the member's physician, to request an exception so the Part D plan will cover a medication that the member is paying for out of pocket, especially if it is prohibitively expensive for the member. If a member is paying a premium for a Part D plan because he or she is not in a low-cost plan, that premium is a countable MRE if it has not previously been deducted from income in CARES. Any Medicaid drug copayments for members are countable MREs.

B.2. Can the cost of long distance calls to providers be counted as a remedial expense?

No. Most telephone services—cellular and landline—now include local and long distance calls as part of the service. In addition, many health plans and providers have toll-free numbers.

B.3. Can the cost of landline or cellular phone service be a remedial expense for a member/participant who is utilizing a Personal Emergency Response System (PERS) or other electronic monitoring device?

Yes, if all of the following conditions are met:

- a. The member/participant does not already have the type of phone and service needed to operate the device.

- b. The member/participant resides in a private residence (i.e., not in a regulated residential setting).
- c. The phone service is in the member/participant's name and is the member/participant's financial obligation.

If the member/participant does not have a PERS or other electronic device requiring phone service to operate, the cost of phone service cannot be counted as a remedial expense.

If a member/participant already had the needed phone service before getting the PERS or other electronic monitoring device, the cost of the service cannot be counted as a remedial expense. If phone service will also be for personal use, only a reasonable share of the cost is countable.

B.4. Can the cost of food ever be considered an MRE?

Yes, the additional cost of a special diet can be counted as a remedial expense if the following all apply:

- a. The member/participant lives in a private residence (i.e., not in a regulated residential facility).
- b. The special diet is necessary because of a medical condition and has been prescribed or recommended by a physician or other licensed health care provider operating within the scope of his/her license.

When the above conditions apply, the cost of the USDA low-cost food plan for a family of one may be used as a proxy for the cost of a normal diet, www.cnpp.usda.gov/USDAFoodPlansCostofFood/reports. Calculate excess food costs as the difference between actual costs and the value of the low cost plan.

B.5. Can high energy (heating, cooling, and electricity) costs paid by the member/participant be counted as an MRE?

Yes, but in limited circumstances. **ALL** of the following must apply:

- a. The member/participant lives in a private residence that is not a regulated residential facility.
- b. The high energy costs are due to a medical condition (e.g., high heating costs related to arteriosclerosis or peripheral artery disease, high cooling costs related to heart failure or COPD, or high electrical cost due to operating medical equipment).
- c. Only actual costs that exceed "normal" energy use are countable. Actual costs are average monthly costs calculated over 12 months. For heating costs, "normal" usage is the difference between the Heating Standard Utility Allowance and the Limited Utility Allowance in the FoodShare program. Refer to: www.dhs.wisconsin.gov/library/p-00654.htm. For electricity, only actual costs that exceed the FoodShare Electric Utility Allowance are a countable MRE. (These figures are updated yearly.)
- d. The expense is countable as an MRE only to the extent the member/participant's calculated maintenance needs allowance exceeds the maximum allowable. Since high energy costs would already be at least partially accounted for in the member/participant's maintenance needs allowance reducing any cost share, to avoid double-counting, the expense only the portion not included in the maintenance needs allowance, if any, can be used as an MRE deduction.

C. Services in the Family Care or IRIS Benefit Package

C.1. Can a member/participant's out-of-pocket purchase of services that are part of the Family Care or IRIS benefit package, but which are denied for the member/participant, count as MREs?

Yes. CMS guidance states that countable MREs include member/participant purchase of services that are not part of the benefit package, as well as services that are part of the benefit package but denied by the program, as long as the services otherwise meet the Medicaid Eligibility Handbook criteria for countable MREs.

Denials of requests for services are subject to Notice of Action and appeal and grievance requirements. The member/participant is not required to appeal the denial before he or she can count the out-of-pocket purchase of a denied service as an MRE.

C.2. If a member/participant has a prescription for an over-the-counter (OTC) drug, can he or she purchase the drug and use the cost as an MRE?

Yes. If an OTC drug is prescribed by a physician or another authorized prescriber, but is not covered by either the Medicaid drug benefit, the MCO, or IRIS, then the member/participant's cost is a countable MRE. The MCO interdisciplinary team (IDT) or IRIS ICA should follow a two-step process. First, determine if the Medicaid state plan drug benefit covers the prescribed OTC drug. The prescription drug benefit covers a limited set of prescribed generic OTC drugs. See the list of covered OTC drugs available at:

www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/pharmacy/resources.htm.spag e#.

If it is covered, the member/participant should use his or her Medicaid (ForwardHealth) card to purchase the item and any drug copay would be a countable MRE. If, based on the list of covered OTCs, the IDT or ICA determines the Medicaid drug benefit will not cover it (the Medicaid fee-for-service program does not need to issue an actual denial in this circumstance), the IDT or ICA should determine if Family Care or IRIS will cover the drug. If that program does not cover it, a denial must be issued so the member/participant has the option to purchase it and count the expense as an MRE.

C.3. Can the cost of a brand name OTC drug purchased by the member/participant after the MCO, IRIS ICA, or Medicaid drug benefit denied coverage, though it would have covered the generic version, be counted as an MRE?

Yes, it is a countable MRE if the drug is prescribed and the prescription indicates, or the prescriber confirms, that the brand name is necessary. If only the generic version was prescribed or the prescriber does not confirm that the brand name is necessary, neither the full purchase price nor the difference in price between the brand name and generic version is a countable MRE.

C.4. The Medicaid drug benefit, the MCO, or ICA would cover a generic OTC drug, but a member/participant believes a brand name is necessary (though the prescriber has not prescribed or confirmed the need for a brand name). Can the member/participant purchase the

brand name and count the cost difference between the brand name and the generic version as an MRE?

No.

C.5. Can a member/participant pay a neighbor or family member for lawn care or snow shoveling, and count that cost as an MRE?

Yes, but only if the MCO or ICA first denies coverage of these services, the member/participant is responsible for ensuring these activities get completed, the services are not available from known community resources for free, and the member/participant demonstrates that it meets the definition for a remedial expense, see A.1 (i.e., the need for these services to support the member/participant's health, safety, and continued community living).

C.6. Can a member/participant pay a neighbor or family member for assisting with supportive home care and count that cost as an MRE?

Yes, if the MCO or ICA has denied coverage of these services, the services are not otherwise available from voluntary natural supports, and the member/participant demonstrates that it meets the definition for a remedial expense, see A.1 (i.e., the need for these services to support the member/participant's health, safety, and continued ability to function at home).

C.7. Can a member/participant supplementing the wages of his or her supportive home care worker or personal care worker (who is funded by the Family Care or IRIS benefit) count that supplementation as an MRE?

No. For services the MCO or ICA has authorized, the member/participant is not permitted to use personal resources to supplement the amount paid by the MCO or IRIS fiscal agent to the provider. Such supplementation violates the law and the DHS-MCO contract, which require the provider to accept Medicaid payment as payment in full. If the MCO or ICA becomes aware of the practice, it should use due diligence to end it. Any such supplemental payments are never countable as MREs.

C.8. Where a member/participant pays for an enhanced version of a covered service authorized by the program, is the extra cost a countable MRE? (Note: "Enhanced" means it offers a broader scope or additional features, or an additional amount or longer duration than authorized.)

Sometimes. It depends on the nature of the enhanced service. Additional member/participant-paid amounts, duration, or scope of a covered service, if denied by the MCO or ICA, are a countable MRE if they otherwise meet the definition of an MRE (see A.1). Enhancements in community residential care, if they are considered part of room and board, must meet the basic requirements for a remedial expense. For individuals subject to a cost sharing determination (Groups B and B Plus), such enhancements may already be accounted for in the personal maintenance allowance. In that case, such costs are only countable as an MRE to the extent the member/participant's calculated maintenance needs allowance exceeds the maximum allowable. Member/participant-paid enhancements in community residential care that are part of the care and service portion of the facility rate are a countable MRE if they meet the same basic requirements as nonresidential services for being countable.

C.9. For Family Care, if a member pays out of pocket for a service that was denied by the MCO because the member chose to use a non-network provider, despite being offered a choice of network providers, can the member's cost be counted as an MRE?

Yes. Use of a non-network provider is part of the scope of the service, so the service the member purchases will differ in scope from what the MCO authorized. Since the MCO authorized the service except for the provider, the service meets the basic requirements for an MRE. The member must get a denial from the MCO for the expense to count. For waiver services, the chosen provider must meet the applicable provider standards in the waiver except for payment rate and having a contract with the MCO; for state plan services, the provider should meet Medicaid certification standards even if not Medicaid certified. The payment rate can differ from what the MCO would pay and the provider need not have a contract with the MCO. For both types of services, the entire amount the member pays is countable, not just the amount that the MCO would have paid to a network provider.

C.10. If a member/participant pays out of pocket for transportation to receive medical services, regardless of the mode of transportation, can this be counted as an MRE?

Yes, but only if the MCO or ICA first denied coverage of the medical transportation service.

C.11. If a member/participant pays out of pocket for nonmedical transportation, regardless of the mode of transportation, can this be counted as an MRE?

The expense would be a countable MRE if the MCO or ICA denied coverage of the trip and if the trip meets the basic criteria for a remedial expense (see A.1). That is, if the person can demonstrate that the remedial benefit of the trip is connected to a medical condition or disability. Not all trips the member/participant takes would normally meet this requirement. Trips for purely recreational or diversional purposes are not remedial expenses.

D. Other Services

D.1. A member/participant purchases various herbs, minerals, and other alternative remedies based on the belief that they alleviate the effects of an illness or disability. As of 2015, these supplements (with the exception of a prescribed multivitamin, calcium supplement, and vitamin D) are no longer covered under the Family Care or IRIS benefit package. Can out-of-pocket expenses for supplements be counted as an MRE?

Yes, but only if the supplements are prescribed by a physician or other prescriber authorized under state law per the Family Care program's 1915(c) waiver and IRIS policies. If the supplements are purchased without a prescription, then they are not a countable MRE.

D.2. For members/participants, are payments for services not in the Family Care/IRIS benefit package—and not covered by the Family Care program as an alternative service or by IRIS as a customized good or service—countable as an MRE?

Yes, provided the service purchased meets the definition of MREs, there is a reasonable basis for the remedial effect (see A.1), and the costs are not specifically excluded by the Medicaid Eligibility Handbook (see A.2).

D.3. Can a care manager/IRIS consultant or the member/participant assign a monetary value for the assistance that a spouse or other natural support provides to the member/participant and count that amount as a remedial expense?

No. By definition natural supports are voluntary and unpaid. For something to be a remedial expense there must be an actual expense incurred and payment by the member/participant.

D.4. Can member/participant-provided room and board be counted as remedial expenses when a member/participant has a live-in attendant?

The board cost paid by the member/participant for a live-in attendant is a countable remedial expense. Generally, the attendant's proportionate share of household food costs (half in the case of a two-person household) would be counted. While the cost of housing the attendant (a proportionate share of rent, or mortgage and property taxes, heat and utilities) meets the definition of a remedial expense, these housing costs are usually not countable MREs. This is because housing-related costs are already accounted for in the maintenance needs allowance that is part of the cost-sharing determination. To avoid double counting, such costs are a countable remedial expense only to the extent the member/participant's calculated maintenance needs allowance exceeds the maximum allowable.

E. Calculating Medical and Remedial Expenses

E.1. Can a projection of anticipated, but undetermined, medical bills for services that have not been received or scheduled be counted as an MRE?

No. MREs can only include payments for services or items received, or payments the member/participant will make pursuant to a payment plan or schedule. Since the Medicaid Eligibility Handbook definition of medical expenses includes the phrase "anticipated, incurred expenses," payments not yet made, but anticipated to be made under a payment plan, for services received or scheduled to be received are countable as long as there is verification that scheduled payments are made. However, the language does not extend to permitting MRE deductions for services that have neither been received nor scheduled and that are without a specific known cost and agreed payment schedule.

E.2. If the applicant or member/participant paid for medical or remedial items or services with a credit card or loan and is making payments to the credit card company or bank, can these payments be counted as MREs?

If the debt meets the definition of a medical or remedial expense in A.1 and does not fall under one of the types of bills not counted in A.2, then the payments are countable MREs, up to the cost of the item or service. The person must provide documentation to verify that the item or service was received, when it was received, and its cost.

E.3. If a monthly installment payment was used when paying off a medical bill before the member or participant makes a lump sum payment to pay the entire remaining balance, does the monthly MRE need to be recalculated?

Yes. If the member/participant paid off a medical bill that would have otherwise been paid in monthly installments, the expense cannot continue to be counted at the installment amount

throughout the remainder of the year. The lump sum payment can only be counted as an MRE in the month it was paid. The care manager/IRIS consultant is required to inform the income maintenance (IM) worker that MREs have changed and the IM worker will make the change in the CARES system.

E.4. If a lump sum payment was made before a person became eligible for Family Care or IRIS, can this be used to reduce a cost share?

No. MREs represent a firm estimate of future expenses that the member/participant will pay over the next 12 months. If an applicant paid off a \$6,000 medical bill one month before starting on the Family Care or IRIS program, the amount of the payment cannot be applied toward the cost share deduction because the debt was eliminated before the cost share obligation was established. However, this MRE might be used by the IM worker to establish Medicaid eligibility under the Medicaid deductible program, which would eliminate any cost-sharing liability for the deductible period.

F. Verification, Documentation, and Monitoring

F.1. How far should the care manager/IRIS consultant go to verify payment of MREs?

The system or level of verification used should be tailored to the member/participant. Some people are very aware of the cost of items they routinely use and they know where every dollar of their budget goes. Other people are less aware of their routine expenses and do not keep receipts.

One option a care manager/IRIS consultant might use is to ask the member/participant to save his or her receipts and review them regularly with the care manager or IRIS consultant. Other options could include reviewing the member/participant's checkbook ledger, canceled checks, money order receipts, bank statements, and other receipts or billing statements that list past payments made on the account. It is good practice to check the original medical and remedial estimates for accuracy at regular intervals with the member/participant.

If the member/participant has difficulty keeping accurate records, the care manager/IRIS consultant might:

- Ask the member/participant to keep his or her receipts for MREs in a designated place like an envelope, shoebox, or drawer.
- Ask the member/participant's support staff to shop with the member/participant and collect the receipts for medical and remedial items purchases.

If receipts are not available, the care manager/IRIS consultant could:

- Ask the member/participant what medical and remedial expenses he or she regularly incurs and pays for, then verify the costs.
- Ask the member/participant's in-home caregivers what OTC medications and supplies the individual uses, and how frequently.
- Ask someone who shops for, or with, the member/participant what OTC medications and supplies the individual purchases, and how often he or she does so.

- After obtaining a release from the member/participant, request a printout of the pharmacy's customer profile listing prescribed medications, what Medicare, Medicaid, and any private insurance pay, what they don't pay, and the customer's out-of-pocket payments. The member/participant may also request this from his or her pharmacist and provide a copy to the case manager or IRIS consultant.
- Ask the pharmacist or pharmacy technician to keep a list of prescription drugs, OTC drugs, supplements, and supplies neither Medicare nor Medicaid pays for, and review the list.

F.2. How should payments for outstanding medical bills be monitored?

For all countable bills, care managers or IRIS consultants should monitor payments to ensure that they are actually occurring. It is not acceptable to use one-twelfth of the outstanding bill as the monthly deduction, unless that is the payment plan. It is easiest if the care manager or IRIS consultant and member/participant agree upon a set dollar amount to be paid each month. A review of canceled checks, money order receipts, printed receipts for online payments, or monthly statements from medical providers are most often used to verify the dollar amounts paid on an outstanding bill. MCOs and ICAs may choose to develop standardized documentation tools for use by care managers/consultants and members/participants.

F.3. What kind of documentation is required for MREs?

The care manager or IRIS consultant must have a list of all medical and remedial expenses in the member/participant's file. The MRE amount is determined using [F-00295 Medical and Remedial Expense Checklist](#), which is sent to the IM worker to enter in CARES. The information entered in CARES should be the same dollar amount listed for MREs in the individual's file. The record should provide sufficient documentation to indicate the nature and amount of each expense and how it was verified.

F.4. If a care manager or IRIS consultant has questions about whether a particular expense is a countable MRE, where should he or she look for answers?

Consult this Frequently Asked Questions document and the associated [Medical and Remedial Expense Checklist](#), the applicable sections of the Medicaid Eligibility Handbook, or contact the IM worker, or for Family Care, the appropriate MCO staff member. If still in doubt, MCOs should send Family Care questions to the contract coordinator in the Bureau of Adult Long Term Care Services. In IRIS, the ICA should contact state IRIS staff.