

STATE OF WISCONSIN  
Department of Health Services  
Division of Long Term Care

**DLTC Numbered Memo Series 2010-05**

**Date: March 5, 2010**

**Index Title: Family Care Member Income  
Calculation for Payment of Room and Board in  
Substitute Care**

**To:** Listserv

**For:** Aging and Disability Resource Center Directors  
Area Administrators/Human Service Area Coordinators  
County Aging Units/Directors  
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County Department of Developmental Disabilities Services Directors  
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DLTC Bureau Directors  
DLTC Section Chiefs  
Family Care Managed Care Organizations  
IRIS Contract Agencies  
Long Term Support Planning Committee Chairs

**From:** Susan Crowley  
Administrator

**Subject:** Member Income Calculation for Payment of Room and Board in Substitute  
Care for Long Term Care Programs in Family Care Counties

**SUMMARY OF POLICY**

This document establishes the procedures for determining the amount of income a member has available to pay for the cost of room and board. The attached forms and instructions are applicable for all adult long term care programs in Family Care counties (i.e., Family Care, Partnership, PACE and IRIS).

## **BACKGROUND**

In the winter of 2008, the Department of Health Services Office of Family Care Expansion convened a Room and Board Workgroup charged with developing standardized policies and procedures for supplementation of room and board in substitute care facilities and homes. Substitute care facilities include community-based residential facilities (CBRF), residential care apartment complexes (RCAC), and all types and sizes of adult family homes (AFH).

The Room and Board Workgroup includes members from managed care organizations and the Department of Health Services Office of Family Care Expansion.

In determining when it was cost-effective to supplement room and board payments, the workgroup identified three procedures that needed to be addressed.

1. Standardized policies and procedures for determining the amount of income a member has available to pay for the cost of room and board.
2. Standardized methods for establishing the cost of room and board in facilities and homes.
3. Standardized procedures for documenting when it is cost-effective to supplement room and board costs for an individual member.

Based on the Workgroup's analyses, the Department has developed a standardized methodology for establishing the cost of room and board in facilities and homes based on HUD Fair Market Rents (issue #2 above). A separate memo outlining the methodology will be circulated soon with implementation expected by January 1, 2011. This topic will not be addressed in this memo.

This memo addresses the procedures for determining income available (#1 above) and documenting the cost-effectiveness of supplementing room and board (#3 above).

### **DETERMINATION OF PARTICIPANT INCOME AVAILABLE TO PAY FOR ROOM AND BOARD.**

DHS has prepared an online automated version that is available and required for MCOs to use. Attachment #1 (A and B) provides instruction on how to gain access to the Program Participation System (PPS) and screen shots of the online automated version. Attachment #2 provides detailed instructions for completing the online automated version.

There are two implementation issues in determining the income available to pay for room and board, including:

- A. Medical or remedial expenses,
- B. Discretionary income allowance.

The policies and procedures related to each topic will be discussed separately.

#### **A. Medical or remedial expenses**

An item can be counted as a medical or remedial expense for the purposes of determining Medicaid eligibility and cost share amount for individuals when:

1. The person pays for the item out-of-pocket; **and**

2. The item or support is effective in diagnosis, cure, treatment, or prevention of disease (medical expense) or in relieving, remedying, or reducing a medical or health condition (remedial expense); **and**
3. The expense of the item is the responsibility of the person and cannot be reimbursed by any other source available to the person, such as Medicaid, Family Care, IRIS, or private insurance.

The Family Care, Family Care Partnership, PACE and IRIS programs include the service category of “Specialized Medical Equipment and Supplies” as part of their benefit packages, which includes items that are commonly purchased over-the-counter. Inclusion of this category in the benefit packages enables those programs to pay for many items that have previously been considered medical or remedial expenses. Any item included in the Family Care, Family Care Partnership, PACE or IRIS benefit packages cannot be considered a medical or remedial expense.

### **Impact on Eligibility and Cost Share**

Aging and Disability Resource Centers, Managed Care Organizations, and IRIS Consultants will begin using the criteria listed above when providing local Economic Support/Income Maintenance Units with the dollar amount of medical and remedial expenses for the purposes of determining Medicaid eligibility and cost share amounts. For current program participants, a medical/remedial expense amount using the new criteria will be communicated to Economic Support/Income Maintenance at the person’s next Medicaid eligibility review. For individuals who become eligible for Medicaid by meeting a deductible amount, local Economic Support/Income Maintenance Units will determine which medical and remedial expenses can be used to meet the deductible when processing MA eligibility.

### **Impact on Care Plan Development**

In order for a program to provide an item/service to a participant that is included in the program’s benefit package, that item must be included in the care plan developed with the program participant. Any item/service that is included in a benefit package, but is not included in an individual’s care plan, will not be provided by the program and **may not** be counted as a medical or remedial expense should the individual choose to buy the item out-of-pocket.

In managed care, the care team, which includes the member, determines supports, supplies and items, including any over the counter supplies and medications that will support the member’s desired outcomes. Supports/services that are determined to be the most effective and cost-effective way to support outcomes will be included in the care plan. Any supports or services that do not meet those standards will not be included in the plan and also cannot be counted as medical or remedial expenses. Any denial, reduction or termination of a good or service, including decisions regarding inclusion or exclusion of a good or service in a care plan, are subject to appeal and consumers will receive appropriate notice.

The care planning process will include a detailed review of all drugs and supplies the person now buys with his/her funds and a determination of whether or not these will be included in the care plan. 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.

If an item that was previously purchased by the member and counted as a medical/remedial expense is now purchased by the MCO or denied so that it may not be counted as a medical/remedial expense, the change in the member's out-of-pocket medical/remedial expenses shall be reported to Economic Support/Income Maintenance by the MCO at the member's next Medicaid eligibility recertification.

In IRIS, the participant, together with his/her consultant, develops a support and service plan to meet the participant's desired outcomes. The support and service plan will now include the cost of all over the counter medications and supplies that may have previously been counted as medical or remedial expenses. The IRIS participant continues to determine which medications and supplies will meet his/her needs, and the IRIS consultant agency will sign off on the plan to ensure health and safety requirements are met. When the individual's IRIS allocation is insufficient to pay the cost of these medications or supplies, the person can request an IRIS allocation adjustment to be able to add the cost of these goods to the plan. The request for an IRIS allocation adjustment is subject to review and approval by the Department.

If an item that was previously purchased by the participant and counted as a medical/remedial expense is now part of the IRIS support and service plan (so that it may no longer be counted as a medical/remedial expense), this change in the participant's out-of-pocket medical/remedial expenses shall be reported to Economic Support/Income Maintenance by the IRIS Consultant Agency at the participant's next Medicaid eligibility recertification.

## **B. Discretionary income allowance**

Some MCOs will use \$80/month as the minimum discretionary income allowance. MCOs that already allow \$100/month as the discretionary income allowance will continue to do so. The online automated version will use the discretionary income allowance associated with the MCO.

## **C. Access to online automated version**

The online automated version is part of the Program Participation System (PPS). To gain access to PPS, a WAMS ID and submission of a PPS Web Access Request form are required. Information at:

<http://dhs.wisconsin.gov/ltcare/Generalinfo/pps.htm>

Instructions for entering PPS (after a WAMS ID and PPS Web Access Request Form are submitted) are in Attachment 1.

## **COST-EFFECTIVENESS OF SUPPLEMENTING ROOM AND BOARD.**

Supplementation of room and board costs for a member is cost-effective for the MCO if:

- Without it the member would need nursing home care, and
- The supplementation is less than the cost of room and board in a nursing home.

## **MEMO SUMMARY AND EFFECTIVE DATES**

The online automated version will be used to determine a member's income available to pay for room and board in substitute care facilities and to document the cost-effectiveness of any supplementation of room and board.

An out-of-pocket payment can be counted as a medical or remedial expense for the purposes of determining Medicaid eligibility and cost share under limited situations when there is no other available payment source.

Use of this form to determine income available for room and board following these policies will be required as of April 1, 2010.

### **CENTRAL OFFICE CONTACT:**

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### **REGIONAL OFFICE CONTACTS:**

Area Coordinators

[Attachment 1A 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
- [Fillable Medical and Remedial expenses checklist \(F-00295\)](#)