



	Question	Answer
Teresa Judd, Richland County juddt@co.richland.wi.us	Where do you enter information about self support plans so it is not looked at? (Seen but not counted)	Unearned income and assets can be entered with “N” on the 'available' field with documentation in case comments. If it is earned income the override fields can be used. If it is a portion of unearned income that is auto-populated enter the portion that is disregarded as some other type of expense.
	Are presumptive disabilities “expedited?”	If by “expedited,” you mean that these cases should be considered a priority, then yes. Because Presumptive Disability MA coverage begins on the date on which the presumptive disability finding is made by DDB or the IM worker, it is imperative that these be treated as priority.
	Clarify: SSI recipient on waivers – if we don’t have an open waiver case county is not reimbursed for some services? Did we understand this correctly?	If the case is not in CARES, you should not need to worry about this. The care managers certify these manually using a 3070. If a care manager sent in a certification and the services are not being paid for, the correct Waiver med stat may not have been sent to EDS. The care manager may need to contact their contacts at TMG to find out what they need to do to fix the problem.
	Comment: The burial assets policy is very confusing. Please change the individual asset policy to be “reasonable” like the spousal burial assets.	We are required to follow SSI policy regarding assets, so this isn’t a policy change that DHFS can make.
	We learned this morning that Card Services begin the month following the date that we open the case and the state pays any previous months of care. Could we prevent this by doing a backdate	This question will be addressed in a separate document (see attachment below).

	after we process the case instead of at the same time that we open it?	
	What is the process for divestment backdating?	 H:\Data\Medicaid QC Presentations\divestr
	If the budget bill doesn't pass by 10/1/07 will the state be unable to implement the DRA federal policies?	No. The DRA asset transfer provisions will be implemented within three to four months after the budget bill is signed.
	What is the fax number for sending the verification form to the VA?	We cannot publish a fax number because there is not one specific place that these are sent. You will need to coordinate with the VA Regional Office (see ops member 06-52) to identify where they would like these sent.
	If we receive a completed MA presumptive application in the agency, does that decision on the MAPD need to be done on the day that this application is received within the agency? Within 3 days? Within 30 days.	<p>Although there is no policy that states when a PD application needs to be processed, PD-MA coverage begins on the date on which the presumptive disability finding is made by DDB or the IM worker. In order to get coverage on file at the earliest possible date, these applications should be processed as soon as possible.</p> <p>DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM Agency within three business days of receiving the request for presumptive disability and the HCF 10112 form (not including the day the fax was received).</p>
	Comment: Please put requirement that there needs to be a repayment agreement with the medical provider to allow for med/remedials.	We will require verification of the expense, but requiring a repayment agreement would go beyond our legal authority. The other consideration is that in many cases, a repayment plan will not be required because the expense is a one-time cost. That said, a repayment plan could

		be requested by an agency on the basis that it will help to assure that the patient liability is correctly calculated when the expense cannot be paid within one month.
cmills@milwcnty.com	Who puts in the provider number on the RE screen when the managed care is waiting to get paid?	<p>The provider number is updated manually by the EDS based on enrollment/disenrollment dates that are sent from CARES to MMIS. Enrollment information is updated manually by EDS, so it takes up to 5 business days to update in MMIS after CARES has been confirmed.</p> <p>Running eligibility with dates will not fix enrollment. It is the enrollment date (or disenrollment date that is populated by CARES for FC) on the Family Care or the waivers page that is sent to MMIS and used for enrollment and disenrollment purposes.</p>
cmills@milwcnty.com	What can we do as workers to put the provider number in sooner?	There is nothing that can be done to get the provider number on any sooner. As stated above, it can take up to 5 business days to update MMIS.
mgrell@waukeshacounty.gov	If applicant for presumptive MA/DA goes home before financial eligibility is determined is it still ES determined presumptive MA/DA?	<p>Urgent need is defined as:</p> <ol style="list-style-type: none"> 1. The applicant is a patient in a hospital or other medical institution; or 2. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment; or 3. The applicant is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect; or 4. The applicant is unable to return home

		<p>from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.</p> <p>If the applicant returns home before financial eligibility has been determined, the person has one of the listed impairments, but not an urgent need. Therefore, follow the normal disability application process as noted in MEH 3.6.8.2.</p>
	Milwaukee County workers are not getting completed VA forms without the “VA number”.	<p>There have been no other complaints about this process. Please note, that if you send in the form, it takes some time to get them completed. A few best practices to remember: 1) If you are looking for an immediate answer, use the telephone number indicated in Ops Memo 06-52. This will get you a much quicker response. 2) Always include a release if you are sending the form in.</p>
	Medical/Remedial Expense Limits policy: They requested that verification of the payment plan be a required eligibility element to allow the bill.	<p>We will require verification of the expense, but requiring a repayment agreement would go beyond our legal authority. The other consideration is that in many cases, a repayment plan will not be required because the expense is a one-time cost. That said, a repayment plan could be requested by an agency on the basis that it will help to assure that the patient liability is correctly calculated when the expense cannot be paid within one month.</p>
	Real Property: How can a worker verify that they maintained this effort? At least with the current process, the contract provides some indication of the length of time. An example provided was an individual that listed their home for sale for one	<p>When this policy is changed, there will likely be a limit on the number of months that the property can be considered exempt because it is for sale. Another point to consider is estate recovery.</p>

	week only, during the month of review.	
	Spousal Support: What if the support is voluntary? How should this be treated?	This issue will be addressed in detail in an upcoming Operations Memo. “Voluntary” means that the contribution isn’t being made at the request of the local agency. Agencies will no longer be permitted to request or require a contribution from a community spouse.
	VA Income Budgeting: In cases where both spouses are in a state veteran’s home, the veteran spouse is provided funds by the VA for support of their spouse. This leads to excess income currently cannot be disregarded in the eligibility determination. Chippewa commented that other states disregard this payment when both individuals are in a nursing home.	I’m confused by this question. Not sure what is meant by “funds” (aid and attendance, housebound or unusual medical expense allowance? Or compensation? Or pension?) or why it would result in excess income that cannot be disregarded. Is this the situation where the VA provides an “unusual medical expense” that is exempt for eligibility purposes and also cannot be allocated since the veteran does not have a “community spouse”? And if the funds aren’t spent each month the veteran would lose eligibility due to excess assets? If so, this would only happen if the veteran lived in an institution other than the state veteran’s home. If he lived in the state veteran’s home, the amount over \$90 would be applied toward the patient liability. Perhaps Chippewa’s comment was that other states count the income in the patient liability calculation instead of disregarding it?
Gail.Heaslet@goracine.org	Would like a copy of the EBD LTC Medicaid Policy Updates presentation.	 H:\Presentations\ EBD 082207.ppt
	How can I get the appropriate notices and letter to authorized representatives (and other interested parties)?	The review notice is sent off of the alternate mailing address (the old ACMA) if one is listed. If none is listed, then it goes off of the regular address on General Case Info which would have

		<p>been the old ACCH. So, even if they have ACDP coded with an auth rep and the address listed there and the switch to send the notices says "Y", you still need to do this for the review part of it to work correctly. Below is an example that was sent to LaCrosse about a similar situation. This addresses the need to have an authorized rep and in this instance a nursing home on ACDP.</p> <p>If the rep payee from the current ACDP MA Payee field is coded "Y", complete ACMA for this same person. The mailing address will then pick up correctly from ACMA.</p> <p>If the rep payee from the MA Payee field is coded "N", this means the MA card needs to be mailed to the nursing home address on ACCH. You need to complete ACDP/ACMA for a spouse or anyone that is supposed to be the authorized rep for this client. Then you need to pf16 for a fresh ACDP screen and enter the nursing home address from ACCH to ACDP again. Make sure the MA payee field is "Y" for the NH ACDP address screen.</p>
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