

MMIS WebEx Questions and Answers from August 2012

- I. Slide 7 states: All SD budget periods are prorated (shortened), when the individual: Dies, Becomes institutionalized, or Becomes eligible in another full benefit Medicaid covered group. Prospective and consecutive SD budget periods may also be prorated when the individual becomes ineligible for another reason. Retroactive budget periods are not prorated when the individual is ineligible for another reason; income for all three months is counted.

According to SD policy in M1330.100,B(6), page 1 and M1330.200,B page 3: there are only two reasons a retro SD budget period can be prorated: 1) when one/two of the retro months was included in a prior SD that was already met and 2) death.

Question: Is there another policy reference that states that the retro SD period can be prorated when the individual is institutionalized or becomes eligible in another full benefit Medicaid group?

Q&A Response:

No, there is no policy to prorate the spenddown budget period when an individual is institutionalized or becomes eligible in another categorically needy covered group. The actual (not averaged) gross income minus allowable exclusions for all three months of the retroactive period must be counted unless the individual established spenddown eligibility or died in one or more of the retroactive months. See M1330.200 C for an example of proration based on one month in a retroactive period in which spenddown eligibility was established and no proration when an individual was eligible as a Child Under Age 19 (FAMIS Plus) for one month.

- II. Slide 12 states: When an individual has established more than one SD period, first deduct expenses from the SD period in which they were incurred. If eligibility is not achieved, the bill can be evaluated for use in future budget periods.

Question: If a client recently submits an old bill for the first time, but multiple SD budget periods have been established (but not met) over the past few years, can the client opt to have the old bill applied to the current SD budget period, or does policy require that the old bill be applied to the first SD budget period that was established even if it was 2-3 years ago?

Q&A Response:

There is no option to have an old bill applied to the current spenddown when it was incurred prior to or during an earlier spenddown budget period. When an individual has established more than one spenddown period, medical expenses are first deducted for the spenddown period during which they were incurred. If not used to achieve eligibility, the bill can be evaluated for use in succeeding budget periods. See M1340.100.B. 4.

- III. Slide 32 states: Local agencies should NOT attempt to enter past SD eligibility using Retro Cancel Reinstatement as this function does not allow for the entry of an end date.

Question: While it is true that the MMIS system does not allow for entry of an end date, would it be acceptable if the worker used the following procedure:

- 1) worker used the Retro Cancel Reinstatement and enters SD begin date only
- 2) worker cancels SD coverage with 070 (entered in error/same day)

3) worker re-accesses case/update and re-enters SD coverage begin & end dates

Q&A Response:

NO! The codes noted are not for the purpose of working around a SD and are specific to the tasks they were designed to complete in the MMIS. Using these codes in this manner would be a misuse and misleading. The system of record Medicaid transactions must be as specific to the reason the action is being taken as possible.

IV. If there is a spenddown period that the applicant does not meet and then the applicant provides bills with a new application and requests a retro spenddown that falls during the initial period, should the first initial period that the applicant did not meet be reevaluated or only the retro spenddown period?

Q&A Response:

Yes, re-evaluate the initial spenddown period from the prior application first and then, if that period is not met, evaluate the retro spenddown period of the new application.

V. We were told to use cancel reason code 042 when moving a member from a LTC AC to an AG AC and vice versa, why does the presentation say to use 032 when doing a retro cancel reinstate for these members?

Q&A Response:

Cancel reason code 042 can be used for prospective closures, only cancel reason code 032 can be used for these aid categories retroactively.

VI. What changes in demographics cause a new Medicaid card to be sent to a member?

Q&A Response:

If any of the information that is printed on the physical card is changed on the member's Demographic screen and new card will be generated. For example, the member's name, date of birth, or gender.

VII. Where do the Medicaid cards come from?

Q&A Response:

An outside vendor prints and mails the cards. A report is sent to the vendor each night and cards are issued and mailed out daily.

VIII. Can changes be made to the Cancel Reason 012 report in Data Warehouse to allow users to drill down to the data by caseload? Currently it only lets you see the results by agency.

Q&A Response:

DMAS does not control Data Warehouse, VDSS does. While we cannot make the changes, we can make a recommendation that this change be made.

- IX. If a FAMIS Mom who is assigned to AC 005 comes into a local agency and reports the birth of her baby what action should be taken by the LDSS?

Q&A Response:

The LDSS should take the action to assist the member in reporting the birth to the CPU or report the birth to the CPU on behalf of the member.

- X. Explain the "Same as Case Address" field and the "Same as Case FIPS" field in the Member Demographic screen.

Q&A Response:

If a member's address is different than the case address the "Same as Case Address" field should be changed to a "N" for "No". An example of when this field is used is for members who live on the boarder of Virginia and Maryland. While their actual residence is in Virginia, their mailing address is in Maryland. These members would have the Maryland mailing address on the Demographics screen and their physical home address in Virginia on the Member Case screen.

The same applies for the "Same as Case FIPS" field. While it is rare, the case FIPS could be different than their member FIPS. For example, a child who lives away from home could have a "N" for "No" on the Member Demographic screen if they do not live in the same locality as their parent who is on the Case screen.

If ever in doubt about how to complete these screens and what addresses to use contact the Eligibility and Enrollment Unit for clarification.

- XI. Is DMAS advising agencies not to enter spenddowns in the MMIS?

Q&A Response:

No, the Eligibility and Enrollment Unit is advising LDSS agencies that all retro spenddowns where there is limited coverage in place must be entered into the MMIS by staff at DMAS. If there is not limited coverage in place, then the worker can enter the closed spenddown period themselves.

- XII. What would the carry over amount of a bill be if the member met the spenddown in the retro period on the day the bill was incurred? Wouldn't Medicaid pay the bill and therefore there would not be anything to carry over?

Q&A Response:

Correct, if the bill is incurred the same day the spenddown is met, Medicaid will likely be paying for the bill. This is why it is important for workers to verify the actual amount of any bill that is the member's responsibility.

- XIII. Is the Enrollment Inbox (enrollment@dmass.virginia.gov) only for spenddown issues or is it for all enrollment issues?

Q&A Response:

The Enrollment Inbox is for all enrollment issues except patient pay issues. Patient pay issues are submitted to the Patient Pay in box (patientpay@dmass.virginia.gov)

- XIV. How are old bills applied to spenddown periods? Are they only used for one spenddown or can they become carry-over bills?

Q&A Response:

As long as there is not a gap in dates between the next application and the spenddown periods the bill can be a carry-over bill. If a gap occurs between the spenddown and the next application, then only current payments on those bills can be applied towards the spenddown.

- XV. When an application is received with a physical address and a P.O. Box what screens are the addresses entered on?

Q&A Response:

If a member's address is different than the case address the "Same as Case Address" field should be changed to a "N" for "No". An example of when this field is used is for members who live on the border of Virginia and Maryland. While their actual residence is in Virginia, their mailing address is in Maryland. These members would have the Maryland mailing address on the Demographics screen and their physical home address in Virginia on the Member Case screen. The address on the demographics screen will be where the mails are sent. This is the address that the MCO's use to send their enrollment packets, ID cards, etc.

The same applies for the "Same as Case FIPS" field. While it is rare, the case FIPS could be different than their member FIPS. For example, a child who lives away from home could have a "N" for "No" on the Member Demographic screen if they do not live in the same locality as their parent who is on the Case screen. The FIPS on the Member Demographic screen needs to be the FIPS where the recipient actually lives as this is the code used to assign a person to an MCO available in that FIPS code.

If a P.O. Box is used on the Member Demographic screen (e.g. this is where the mail is sent) the LDSS worker should try to ensure that the current and correct telephone number for the recipient is listed on the Member Demographic screen so that the MCO may contact the recipient if needed.

If ever in doubt about how to complete these screens and what addresses to use contact the Eligibility and Enrollment Unit for clarification.

- XVI. If a member is found disabled by DDS and then a decision is received from SSA stating the member is not disabled how is the application processed?

Q&A Response:

The SSA decision will always take precedence over the DDS decision. If SSA has an unfavorable disability decision then the member does not meet the disabled Medicaid category.

- XVII. Can you assist with issues that occur between MedPend and ADAPT?

Q&A Response:

No, you should contact Pattie Bailey at VDSS for assistance with DSS systems such as MedPend and ADAPT.

- XVIII. Which address is the member's Medicaid card mailed to, the case address or the address on the member's demographic screen?

Q&A Response:

If the case and demographics screen addresses are the same then the system will send mail, with some exception for DMAS mailings to the case address. If the mailing address is placed on the demographics screen in keeping with MMIS procedure then the card will be mailed to that address when the same as case address data field has a "Y."

- XIX. Is anyone else having issues with running the 012 Cancellation Report and the Death Report?

Q&A Response:

Contact Pattie Bailey at VDSS for assistance with Data Warehouse reports as this is a VDSS system.

- XX. Is recovery necessary for a member who was found disabled by DDS and then found not disabled by SSA?

Q&A Response:

No, the member met a category of disabled until SSA found them no to be disabled.

- XXI. For the ABD covered group, QMB, SLMB, and Qi-1; is contiguous property exempt regardless of the value?

Q&A Response:

Yes – S11 Appendix 2, page 3

- XXII. When DDS makes a favorable disability decision does the member have to apply for Title II benefits? How long does the member have before they must apply for Title II benefits? Is the member also required to apply for Title XVI benefits?

Q&A Response:

The non-financial requirements must be met by the 45th day, not by the time the application is approved. The individual must apply for Title II benefits by the 45th day. The individual is not required to apply for Title XVI (SSI) benefits.

If the individual is claiming to be disabled and had a work history, can draw on the account of a disabled or deceased individual I who was eligible for Title II (spouse of someone who is disabled or deceased, disabled child of a deceased or disabled individual) then there may be an entitlement to Title II. There may be other reasons for having a connection to Title II.

- XXIII. **Reminder from MCO Unit: In addition to keeping the member's address up to date and ensuring accuracy in these fields, it is also very important that the most current and up to date telephone number is listed for the member.**

- XXIV. **Spenddown Reminders from the EEU:**

- a. **Spenddowns should not be left open regardless of how large the member's medical bills may be. Medically Needy spenddowns should never be for more than a six month period. The ONLY exception to this rule is if a member is widowed or single and residing in a**

PACE or nursing facility and has income that is below the Medicaid amount. Members who meet this criteria can remain in AC 058 for 12 months.

- b. Medically Needy ONLY members require a new application and evaluation every six months.
- c. Remember to verify that the member's bills are still the responsibility of the member and that they have not been written off by the provider.