MEDES QUESTIONS AND ANSWERS

Administration and Use of System

Question 1: Some DMH employees (Reimbursement Officers and such) currently have limited access to the FAMIS system to verify benefits of our consumers. We currently have no access to the new MEDES screens. What needs to be done for these few DMH employees to also get the same type of limited access to the MEDES screens? No information has been sent out by DMH yet regarding this upgrade.

Answer: DSS and DMH are reviewing when and how to allow DMH staff access to MEDES screens.

Question 2: Will on-site caseworkers be trained in MEDES?

Answer: Yes

Question 3: Does DSS have encryption software available for providers?

Answer: There are directions on the DSS web site about how to send us an encrypted email. The link is http://dss.mo.gov/encrypt.htm. You will need to follow the third set of instructions on the page.

Question 4: Do documents submitted to FSD need to be encrypted?

Answer: It is necessary to encrypt applications and documents that contain any two personal identifiers submitted via email. If you don't have encryption abilities, you can fax documents. DSS does provide encryption capabilities on its web site.

Question 5: Since Missouri has awarded a contract for a new contact center/enrollment broker operation will 800 numbers be changing?

Answer: We do not anticipate any changes in the telephone number for the Contact Center.

Question 6: Is it ok to fax supporting documentation to FSD.MEDES@dss.mo.gov?

Answer: Yes. FAX Number: (573) 751-0282

Question 7: We have old pending cases in FAMIS. Can you help us get these cases resolved before FAMIS is closed out?

Answer: Please submit related information to COLE.MHNPolicy@dss.mo.gov.

Question 8: No question. Just want to thank you for past support through FSD.MEDES@dss.mo.gov

Answer: Thanks.

Authorized Representative

Question 9: Is it possible to build into the system a feature that would allow Authorized Representatives to log into a password protected page where they could view all of their cases on one screen and then click on them individually to view their cases versus having to go into each individual case?

Answer: We are researching various options to address this need. We may decide to establish a provider portal that will provide the level of support suggested by this question.

Question 10: When will we get "Authorized Representative" designation fixed in the Worker Portal?

Answer: This fix is in development. We will notify everyone when this functionality is available.

Question 11: Can you add an authorized representative after the application has been submitted?

Answer: Currently the caseworker portal is not configured to allow authorized representatives to be added to an application. We are taking steps to correct that problem.

Question 12: Can you help someone without checking the authorized representative box?

Answer: It would be up to the applicant to determine if they need assistance. If a provider is not an authorized representative they would not have access to case specific information, except information available through eMOMED.

Question 13: What should you do to receive copies of communications sent to the applicant?

Answer: A second box must be checked by the authorized representative indicating that they desire to receive copies of all communications. Currently, only the electronic application is configured to allow you to check a box to receive such communications. The caseworker portal needs to be configured to allow authorized representative not only to be added to the application but to also allow such representatives to receive copies of communications.

Question 14: What document needs to be submitted to document the designation of an authorized representative?

Answer: An IM-6AR is required to be filed with the application to document the designation of an authorized representative. The IM-6AR may be downloaded from the FSD Forms file.

Dates of Coverage

Question 15: How does Medicaid treat medical bills between the submission of the application and approval of the application?

Answer: Applicants will be eligible for coverage from the first day of the month of application unless they are required to pay a premium or meet spend down. Prior quarter coverage of medical bills is

available if the applicant meets Medicaid eligibility requirements for any of the three months preceding the submission of the application.

Question 16: How do you determine dates of service for children of non-citizens?

Answer: Ineligible non-citizen pregnant women can apply for Emergency Medical Care for Ineligible Aliens to cover the cost of the birth. There must be an application for MO HealthNet for the children to have coverage. Coverage dates for eligible children will be based on the date of application.

Newborns

Question 17: When will the functionality be available to back date dates of coverage for newborns?

Answer: We can assist with such requests now. You need to submit an email to FSD.MEDES@dss.mo.gov requesting backdated coverage for newborns.

Question 18: Health plans have told us that we have not reported newborns to FSD. We believe that we have. What should we do?

Answer: Send a list of newborns that you think have been properly reported to FSD to FSD.MEDES@dss.mo.gov. Ask for verification that the newborns on the list have been added to Medicaid coverage.

Pregnant Women

Question 19: If self attestation is all that is required for determination of pregnancy, is there a particular format for providers who are willing to confirm the pregnancy and provide the estimated due date?

Answer: A note on a notepad with clinic letterhead that includes identifying information of the patient (name and DCN and/or SSN) and due date will suffice.

Question 20: Is coverage during pregnancy under Medicaid considered minimum essential coverage.

Answer: No. Pregnant women can have coverage through a health plan purchased on the FFM and also be approved for MO HealthNet for Pregnant Women. Medicaid would be the payer of last resort.

Question 21: How are women with incomes in excess of 100% FPL but not more than 196% FPL who have coverage through a Qualified Health Plan (QHP) offered through the marketplace impacted by Medicaid coverage for pregnant women in the event they become pregnant.

Answer: Since Medicaid coverage for pregnant woman is not considered minimum essential coverage (MEC), pregnant women will be able to retain their coverage through the marketplace. Such women may apply for Medicaid. If they do, they actually will be dually eligible for Medicaid and QHP coverage in which case Medicaid will be the payer of last resort to the marketplace plan.

Presumptive Eligibility

Question 22: Are hospitals authorized to file Presumptive Eligibility applications in other states?

Answer: Applications need to be filed with the state of residence for the patient.

Question 23: When will the new Presumptive Eligibility system go live?

Answer: It is estimated that it will be available October 2014.

Question 24: What is the new email address for submitting presumptive eligibility applications?

Answer: Presumptive eligibility applications should be submitted to the local FSD offices. PE application processing has not changed.

Question 25: Has DSS introduced a new presumptive eligibility application?

Answer: No. The State Plan Amendment has been submitted to CMS to gain approval of its plan to implement the presumptive eligibility requirements of the Affordable Care Act. Rules and regulations are being drafted.

Question 26: Will FSD provide training for the implementation of the new presumptive eligibility requirement?

Answer: Yes.

Proof of Identify, Citizenship, etc

Question 27: If I am applying for an applicant who has or has had a service through DSS in the past, i.e., food stamps, TANF, SNAP, and we are making a new application, will I still need to provide documents proving citizenship and identification? If the patient received benefits in the past, the proof of identity and citizenship should be on file.

Answer: We do not require that applicants re-verify citizenship or identity if they have already been provided to the state. However, authorized representatives may not be able to confirm that such information is known to FSD.

Question 28: Do hospitals need to provide proof of identity for applicants who are known to FAMIS?

Answer: Hospitals are not required to provide proof of identity. If they have access to hard copy documentation of identify, they may provide it with an application for benefits. Submitting such proof of identity helps protect the integrity of the state's programs.

Question 29: Will account transfers from the FFM need ID Proofing a second time?

Answer: ID proofing conducted by the FFM will meet Medicaid requirements.

Speeding Up the Process and Other Such Questions

Question 30: How can one check on the status of an application?

Answer: The specifications included in the MEDES contract require an interface with the IVR system. This functionality will be completed in late 2014. General inquiries should go to the FSD Information Center 855-373-4636.

Question 31: What can assisters do to help with the backlog?

Answer: Use the electronic application.

Question 32: How can we speed up "pending" status?

Answer: Signing up as authorized representatives for applicants and submitting supporting documentation on behalf of the applicant. An icon on the left side of the "MyAccount" page allows authorized representatives to click on that icon and view communications sent to the applicant. If additional documentation has been requested, you may want to encourage the applicant to submit the requested documentation.

Question 33: What income is included and excluded from MAGI income?

Answer: See attachment 1.

Question 34: If Medicaid rejects an application, does it open an opportunity to enroll in the FFM?

Answer: If the applicant applied for Medicaid coverage during the FFM open enrollment period and is subsequently rejected for Medicaid coverage, then the applicant may be eligible for determination for coverage through the federal marketplace. Otherwise, the only avenue for consideration for coverage through the marketplace is to qualify for a special enrollment period. If the application is rejected for failure to cooperate there is no referral to the FFM.

Question 35: How can we find out what happened to an application filed in December, January, February and March.

Answer: Check eMOMED for possible coverage.

Question 36: Is it possible to have a confirmation number issued after signing and submitting an electronic application?

Answer: The electronic application provides a closing screen shot informing you that you have successfully completed the application process. You may print that screen shot and save it as a confirmation of the filing of the application.

Attachment 1.

UC BERKELEY LABOR CENTER

Modified Adjusted Gross Income under the Affordable Care Act

November 2013

Under the Affordable Care Act, eligibility for income-based Medicaid[1] and subsidized health insurance through the Exchanges will be calculated using a household's Modified Adjusted Gross Income (MAGI). The Affordable Care Act definition of MAGI under the Internal Revenue Code[2] and federal Medicaid regulations[3] is shown below. For most individuals who will apply for health coverage under the Affordable Care Act, MAGI will be equal to Adjusted Gross Income. This document summarizes relevant federal regulations; it is not personalized tax or legal advice. Consult the Health Insurance Marketplace for your state, your local Medicaid agency, or a legal or tax advisor for assistance in determining your MAGI.

Modified Adjusted Gross Income (MAGI) =

Adjusted Gross Income (AGI)

Line 4 on a Form 1040EZ

Line 21 on a Form 1040A

Line 37 on a Form 1040

Include:

- Wages, salaries, tips, etc.
- Taxable interest
- Taxable amount of pension, annuity or IRA distributions and Social Security benefits[4]
- Business income, farm income, capital gain, other gains (or loss)
- Unemployment compensation
- Ordinary dividends
- Alimony received
- Rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Taxable refunds, credits, or offsets of state and local income taxes
- Other income

Deduct:

- Certain self-employed expenses[5]
- Student loan interest deduction
- Educator expenses
- IRA deduction
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-basis government officials

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veterans' disability payments, workers' compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

+ Add back certain income

- Non-taxable Social Security benefits[4] (Line 20a minus 20b on a Form 1040)
- Tax-exempt interest (Line on 8b on a Form 1040)
- Foreign earned income & housing expenses for Americans living abroad (calculated on a Form 2555)

− Exclude from income

For Medicaid eligibility

- Scholarships, awards, or fellowship grants used for education purposes and not for living expenses
- Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance
- An amount received as a lump sum is counted as income only in the month received

[1] Medicaid eligibility is generally based on MAGI for parents and childless adults under age 65, children and pregnant women, but not for individuals eligible on the basis of being aged, blind, or disabled.
[2] Internal Revenue Code Section 36B(d)(2)(B)
[3] Public Health and Welfare Code Section 435.603(e)
[4] "Social Security benefits" includes disability payments (SSDI), but does not include Supplemental Security Income (SSI), which should be excluded.
[5] Deductible part of self-employment tax; SEP, SIMPLE, and qualified plans; health insurance deduction