

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
1 W. Wilson St.
Madison WI 53703

To: Medicaid Eligibility Handbook (MEH) Users

From: Shawn Tessmann, Bureau Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 15-02**

Release Date: 07/30/2015

Effective Date: 07/30/2015

EFFECTIVE DATE The following policy additions or changes are **effective 07/30/2015** unless otherwise noted. **Grey highlighted text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

POLICY UPDATES

5.5.1 Reconsideration/Hearing Introduction **Claims in the CARES system:** For claimants found disabled, DDB ~~will~~ **will** send all the evidence and a completed SSA-831 (Disability Determination and Transmittal form) to the CARES system. The paper file at DDB will be destroyed after it is confirmed that the information is in CARES.

Claims NOT in the CARES system (paper claims): For claimants found disabled, DDB will send the paper file with all the evidence and a completed SSA-831 to the IM Agency for storage for future use in the redetermination process. ~~The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.~~

9.2 Nursing Home and Hospital Insurance **9.2 Nursing Home, and Hospital, and Long-term Care Insurance**

9.2.1 Nursing Home and Hospital Insurance Introduction **9.2.1 Nursing Home and, Hospital, and Long-term Care Insurance Introduction**

All members must cooperate in providing Third Party Liability (-TPL) coverage ~~and access~~ information for nursing home, ~~and~~ hospital, ~~and~~ long-term care insurance policies. All members must do the following:

- ~~1. Sign over~~ Assign to the state of Wisconsin ~~all~~ their rights to payments from a nursing home ~~or~~, hospital, ~~or~~ long-term care insurance policy (See 9.2.2 Assignment). ~~Members enrolled in a Managed Long Term Care program must assign payments to the Managed Care Organization (MCO).~~
- ~~2. Turn over~~ Send any payments to the state of Wisconsin ~~(See 9.2.3 Recovery of Payments)~~ that he or she received from a nursing home, ~~or~~ hospital, ~~or~~ long-term care insurance carrier while receiving Medicaid. ~~Members enrolled in a Managed Long Term Care program must turn over payments to the Managed Care Organization (MCO). (See 9.2.3 Recovery of Payments)~~

Any nursing home, ~~or~~ hospital, ~~or~~ long-term care insurance payments that exceed the

amount that Medicaid has paid in benefits for that member will be refunded to him/her that member.

9.2.2 Assignment

To assign hospital or nursing home long-term care insurance payments, the member must complete the Long-Term Care Policy-Assignment of Benefits form (F-01567) that requests provide a statement in writing to the insurance company requesting that all current or future payments be made payable to the state of Wisconsin. Request a copy of the member's letter to the insurance company and send it to the following address:

ForwardHealth
TPL Unit
313 Blottner Blvd
Madison WI
53714-2405

The member must send the completed Long-Term Care Policy-Assignment of Benefits form to his or her long-term care carrier and mail a copy to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The long-term care carrier must mail payments to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The assignment of payments includes all ongoing payments for as long as the member receives Medicaid is received. Terminate Medicaid eligibility for the individual who refuses to sign over assign these payments.

9.2.3 Recovery of Payments

In some cases, the insurance policy will require that payments can only be made directly signed over to the patient or member. The member must cooperate in turning over forward these payments to the state of Wisconsin. Failure to forward any payment may result in the member losing or his or her eligibility will end for not cooperating with providing TPL coverage and access information. When forwarding payments, the member must write on the back of the check "Pay to the order of the State of Wisconsin" and sign the check.

Members should mail payments Collect the payments monthly from the members along with the corresponding Explanation of Benefits (-EOB-) and send them to the following address:

State of Wisconsin
Department of Health Services
IBB Department
P.O. Box 6220
Madison, Wisconsin 53784

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the member refuses to forward the third-party payments to the state turn over the payments.

17.5.2 Calculating the Penalty Period For divestments on or after January 1, 2009, the divestment penalties are calculated in days. Use the average daily nursing home private pay rate of ~~\$241.78~~ **\$252.95 per day**.

Example 1: Was updated.

17.5.3 Penalty Period Begin Date for Applicants

Examples 2-6: Were updated.

17.5.5.1 Full Refund

Example 8: Was updated.

17.5.5.3 Divestments During a Penalty Period

Example 10: Was updated.

25.1 Special Status Medicaid

When you are calculating a Medicaid deductible, a patient liability amount, ~~or a community waivers cost share or a community waivers spenddown~~ for a "503" AG, a DAC Disabled Adult Child, or a widow or widower, use the total income before any COLAs or OASDI (-DAC or widow/widower) increases ~~were~~ **are** subtracted.

25.4 Medicaid Deductible, Cost of Care

When calculating a Medicaid deductible, a patient liability amount, ~~or a community waivers cost share or a community waivers spenddown~~ for a "503" AG, a DAC, or a widow or widower, use the total income before any COLAs or OASDI (DAC or widow/widower) increases ~~were~~ **are** subtracted.

28.1 Home and Community-Based Waivers Long Term Care (HCBWLTC) Introduction

Community waivers enable elderly, blind, and disabled (EBD) persons to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for community services, which normally are not covered by Medicaid. Community waivers include the following programs:

1. Community Integration Program I (CIP 1A and CIP 1B).
2. Community Integration Program II (CIP II).
3. Community Options Program Waiver (COP-W).
4. ~~Brain Injury Waiver.~~
5. Program of All-Inclusive Care for the Elderly (PACE).
6. Wisconsin Partnership Program (WPP).
7. Children's Long Term Support waiver programs (CLTS). These programs serve children with physical disabilities, developmental disabilities and mental health needs.

28.2.2 Tentative Approval

Persons who apply for waivers may receive tentative waiver approval while their Medicaid eligibility is being determined.

The tentative approval process begins when the care manager refers the waiver applicant to the IM Agency with accompanying information about the type of waiver, waiver begin date, ~~and~~ medical/remedial expenses, ~~and Medicaid card coverable expenses.~~

28.5.2 Spenddown

Effective July 1, 2015 Group C was replaced with Group B Plus, ending the group of members with a spenddown. See Section 28.8.3 Group B and B Plus for eligibility and cost share information.

~~The spenddown obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or Medicaid card services to lower countable income to the Medically Needy Income limit (See 39.4 EBD Assets and Income Tables). The care manager monitors and documents that this occurs monthly.~~

~~A single Group C waivers participant must:~~

1. ~~Incur, and~~
2. ~~Be held financially responsible for the spenddown amount on a monthly basis.~~

~~A married Group C waivers participant must:~~

1. Incur the spenddown amount, and
2. Pay the cost share monthly, if applicable.

28.7 Home and Community-Based Waivers Long Term Care (HCBWLTC) Effective Date

The begin date of waiver eligibility is the program start date submitted to the IM agency by the care manager or the ADRC.

~~For persons in Groups B and C B Plus, will receive tentative approval of eligibility for waiver services when the case manager submits a waiver service plan packet to DDES and receives a tentative approval in return.~~

~~The start date stated in this tentative approval becomes the date of waiver eligibility if the person is determined eligible for Medicaid as of that date. This start date is considered tentative while the IM agency determines their Medicaid eligibility (see Section 28.2.2 Tentative Approval). If the Medicaid eligibility date is determined to be later than the tentative program start date, the effective date will become the Medicaid eligibility date.~~

28.8.1 HCBWLTC Instructions Introduction

Eligibility for Group A, B, and C B Plus community waivers cases are determined in CARES. ~~Group A~~

~~Katie Beckett cases are Group A, and because of the small number of these cases, the certification process will not be automated in CARES. Certification are will be processed manually outside CARES by care managers and Katie Beckett staff, are processed manually outside of CARES.~~

Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett Program.

~~Katie Beckett waiver cases will now be considered "Group A". The Katie Beckett medical status code will be retained. Because of the small number of these cases, the certification process will not be automated in CARES. Certification will be processed manually by care managers and Katie Beckett staff.~~

28.8.2 Group A

Clients who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share, ~~or Group C with a potential spenddown/cost share.~~

28.8.3 Group B

28.8.3 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit. (See 39.4 EBD Assets and Income Tables)

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (See 39.4 EBD Assets and Income Tables).

For Group B and B Plus, calculate a cost share based on the member's income and allowable deductions. Count only the income of each individual when you calculate that individual's cost share.

28.8.3.1 Personal Maintenance Allowance

The Personal Maintenance Allowance is an income deduction used primarily when calculating a cost share for a Group B or B Plus waiver member. However, it is also used in the cost share calculation of a Group C waiver member when completing Section C of the Spousal Impoverishment Income Allocation Worksheet (18.6.4).

28.8.4 Group C

Effective July 1, 2015, Group C has been replaced with Group B Plus.

~~Persons in Group C meet the medically needy income test for waiver members.~~

~~Most Group C members have a monthly spenddown. They must meet the spenddown each month to remain eligible. The care manager monitors the monthly spenddown.~~

28.14 Home and Community-Based Waivers Long Term Care (HCBWLTC) Children's Long Term Care (CLTC)

28.14 HOME AND COMMUNITY-BASED WAIVERS LONG TERM CARE (HCBWLTC) CHILDREN'S LONG TERM CARE SUPPORT (CLTCCLTS)

28.14.1 CLTC Introduction

28.14.1 CLTC CLTS Introduction

28.14.2 CLTC CARES Processing

28.14.2 CLTC CLTS CARES Processing

The child should first be tested with his or her family to see if there is eligibility for BadgerCare Plus Standard plan and the Group A Waiver eligibility.

If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, SSI Medicaid or Katie Beckett Medicaid, the child will be eligible as a Group A Waiver (see 28.8-4 for waiver processing instructions for Katie Beckett MA individuals), the child will be eligible as a Group A Waiver.

If the child is not eligible for other categories of Medicaid or BadgerCare Plus Standard Plan, CARES will test the child for a Group B or B Plus Group C Waiver, based on the child's income.

~~If the child is placed in a county funded slot and has not been determined disabled, the question "Has the individual been established disabled by the DDB?" on the Disability Page in CWW must be answered 'Yes' with a verification code 'OW'. Document in Case Comments that there is no DDB determination.~~

Since a disability determination is not always required for these members, it is the responsibility of the CLTS Support and Service Coordinator to identify to the IM workers which cases do not require a disability determination. Income Maintenance workers should update the Community Waivers page based on the information received from the CLTS case manager.

39.4.2 Elderly, Blind, and Disabled Deductions and Allowances

	Description	Amount
7	Community Spouse Lower Income Allocation Limit	\$2,621.67 \$2,655.00
8	Community Spouse Excess Shelter Cost Limit	\$786.50 \$796.50
9	Family Member Income Allowance	\$655.42 \$663.75