WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
Madison WI 53703

To: Medicaid Eligibility Handbook (MEH) Users

From: Rebecca McAtee, Bureau Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 17-03**

Release Date: 11/03/2017

Effective Date: 11/03/2017

EFFECTIVE DATE

The following policy additions or changes are **effective 11/03/2017** 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

2.8.2 Backdated Eligibility

Medicaid eligibility can be backdated up to three months prior to the month of application.

The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month.

A backdate request can be made at any time except when the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

If a member has incurred a bill from a Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.

2.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, ~~the applicant can provide the necessary information to reopen~~ Medicaid can be reopened without ~~filing~~ requiring a new application. The person may need to provide required verification.

If more than a calendar month has passed since a member's enrollment was terminated, the applicant must file a new application to reopen his or her Medicaid.

If EBD Medicaid, HCBW, Institutional Medicaid, MAPP, or MSP eligibility closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the person may be reopened without filing a new application if he or she provides the necessary information within three months of the renewal date (see Section 3.1.6 Late Renewals).

2.9.2 Denial

If less than 30 days has passed since the ~~client's eligibility was denied, allow the client to re-sign and date the application or page one of Form 03-07 Combined Application Form to set a new filing date.~~ applicant's eligibility was denied, allow the applicant or his or her representative to re-sign and date the original application, sign page 16 of the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet, sign the signature page of the application summary, or call the agency to submit a telephonic signature to set a new filing date.

5.9.2.3 Presumptive Disability Certification Process

Example 2

~~Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (see Section 5.3 Disability Application Process). The MADA form (F-10112, formerly DES 3071) must be completed and sent to the DDB along with the necessary copies of the Confidential Information Release Authorization form (F-14014).~~

~~Note:~~ Regardless of whether the IM worker makes the presumptive disability determination or DDB makes the presumptive disability determination, the Medicaid Disability Application (MADA) (F-10112) must be completed ~~"~~before~~"~~ the IM worker certifies a member for presumptive disability.

The following forms are required for the presumptive disability process:

- Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101)
- Medicaid Disability Application (MADA) (F-10112)
- Medicaid Presumptive Disability (F-10130)
- Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014)
- Authorized Representative form (if applicable)

Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (see Section 5.3 Disability Application Process and Process Help Chapter 12 Automated Medicaid Disability Determination). The Medicaid Disability Application (MADA) (F-10112) must be completed and sent to the DDB along with the necessary copies of the Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014).

The DDB will then process the disability application and make a final disability determination.

5.9.5 Eligibility

Because CARES usually certifies Medicaid from the beginning of the month, you must do a manual F-10110 (formerly DES 3070) to apply the correct begin date.

The form may be returned by fax to 608-221-8815 or by mail to the following address:
~~1.Mail:~~

~~HP Enterprise Services~~
ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

~~2.Fax:~~
~~(608) 221-8815~~

8.2.1 Medical Support/Child Support Agency

Unless the person is exempt, or has good cause for refusal to cooperate (see Section 8.3 Claiming Good Cause), each applicant or member that is referred, must, as a condition of eligibility, cooperate in **both** the following:

Cooperation

- Establishing the paternity of any child born out of wedlock for whom Medicaid, including Medicare Savings Programs, is requested or received
- Obtaining medical support for the applicant and for any child for whom Medicaid, including Medicare Savings Programs, is requested or received

9.5.2 Reporting Accident or Injury Claims

This section has been rewritten.

15.4.6 Gifts

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less for each AG member for each calendar quarter.

Funds received through a crowdfunding account, such as GoFundMe and Kickstarter, would be considered a gift and counted as unearned income in the month of receipt and as an available asset in subsequent months as long as the funds are still in the person's possession (i.e., the person did not spend it in the month of receipt).

Funds that are not accessible for a person to withdraw are an unavailable asset. Disbursements would be unearned income in the month withdrawn and an available asset in subsequent months if the funds are still in the person's possession.

15.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. ~~Do not count the principal as income since it is the conversion of one asset form to another.~~ If the land contract cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be considered an available asset. Count any repayments toward the principal of the loan as income. If the land contract can be sold, it is counted as an available asset, and the principal portion of the repayment remains an asset. Disregard any repayments toward the principal of the loan as income. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

(This was effective August 1, 2017.)

15.4.8 Loans/ Promissory Notes

15.4.8 Loans, ~~/~~Promissory Notes, and Mortgages

If an AG member makes a loan, ~~or~~ promissory note, or mortgage (~~except~~ including a land contract), treat the repayments as follows:
1. Count the interest as unearned income in the month received.
2. Count any repayments toward the principal of the **loan**, regardless of whether it is a full payment, a partial payment, or an installment payment, as an asset but only if the **promissory note** itself is an available counted asset.
3. When the **promissory note** cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be considered an available asset. Count any repayments toward the principal of the loan as income.
4. If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

(This was effective August 1, 2017.)

15.5.1 Income In-Kind

The examples are new.

15.6.5.1 IRS Tax Forms

~~Do not fill out~~ IM workers should not complete any IRS tax ~~forms (or the Self-Employment Income Report Form [F-00107]) yourself~~ on an applicant's or member's

behalf. ~~This~~ It is the responsibility of the applicant or member to complete IRS tax forms.

Workers should consult IRS tax forms only if **all** of the following conditions are met:

- The business was in operation at least one full month during the previous tax year~~, and~~.
- The business has been in operation six or more months at the time of the application~~, and~~.
- The person has not claimed a significant change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see Section 15.6.5.3 Anticipated Earnings).

15.6.5.3 Anticipated Earnings

This section has been rewritten.

15.6.5.3.1 Reporting Anticipated Earnings

This section is new.

15.6.6 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see Section 20.3.8 Income).

Completed and signed IRS tax forms (see Section 15.6.2.2 By IRS Tax Forms) are sufficient verification of farm and self-employment income. A completed and signed SEIRF (or SEIRFs) is also sufficient verification.

Note: It is not necessary to collect copies of supportive ~~items~~ verification, such as receipts from sales and purchases. However, ~~you can require~~ verification can be requested when the information given is in question (see Section 20.4.1 Questionable Items Introduction). If requesting verification, workers must document the reason for the request in case comments.

16.2.1 Assets Availability Introduction

Example 1

Note: An unavailable asset may still be considered when determining whether an institutionalized person has divested (see Section 17.2.10 Unavailability).

16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes

~~Beginning with promissory notes created on or after July 14, 2015, all promissory notes that are not considered divestments (see Section 17.12.2.1 Promissory Notes on or After July 15, 2015) are negotiable liquid assets. Count the value of this asset as available.~~

The current market value of a promissory note or loan made by an AG member will be assumed to be equal to the outstanding balance, and the promissory ~~notes~~ note or loan will be a countable asset~~s~~ in a Medicaid eligibility determination unless it cannot be sold.

An applicant who disputes the value used by the IM worker must provide credible evidence from a knowledgeable source that the note is non-negotiable or has a different current market value.

Promissory notes or loans that cannot be sold because they are not negotiable, assignable, enforceable, or otherwise marketable are considered unavailable assets (see Section 17.12.2.1 Promissory Notes regarding divestment policy).

16.7.11 Lump Sums

Lump sum payments (rather than recurring payments) from such sources as

Payments

insurance policies, veterans benefits, sale of property, Railroad Retirement, unemployment compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

16.7.31 Crowdfunding Accounts

This section is new.

16.9 Non-Home Property Exclusions

Example 3

If the excluded portion produces less than a six percent return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a six percent return, continue to consider the first $6,000 in equity as excluded.

Note: Rental property cannot be exempt as a business property unless the property owner is in the business of renting and managing properties. If a person simply owns a piece of property and is renting it, he or she is not considered to be the owner of a trade or business (see 2. above for more information).

17.2.1 Divestment

2. It is also divestment if a person takes an action to avoid receiving income or assets he or she is entitled to. Actions which would cause income or assets not to be received include:
   a. Irrevocably waiving pension income.
   b. Disclaiming an inheritance.
   c. Not accepting or accessing injury settlements.
   d. Diverting tort settlements into a trust or similar device.
   e. Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.
   f. Refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate. ~~Count the action as a divestment only if:~~
      - ~~The value of the abandoned portion is clearly identified, and~~
      - ~~There is certainty that a legal claim action will be successful. The agency Corporation Counsel makes this determination.~~

This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of his or her spouse's estate. If the institutionalized person does not contest his or her spouse's will in this instance, the inaction may be divestment.

Count the action as a divestment only if **both** of the following are true:

- The value of the abandoned portion is clearly identified.
- There is certainty that a legal claim action will be successful. The IM worker must ask the agency's Corporation Counsel to make this determination.

17.2.2.1 Date of Transfer

If the Medicaid member has transferred real property, such as a homestead, the official date of transfer is the date the Quit Claim Deed was signed and notarized. It is not the date the transfer was recorded with the county Register of Deeds.

17.2.9 Value Received

2. Other assets ~~such as accounts receivable and promissory notes (both of which must be valid and collectible to be of value), stocks, bonds, and both land contracts and life estates which are evaluated over an extended time period.~~ as listed in Chapter 16 Assets.

17.4 Exceptions

2. ~~a.~~ If it is more than f~~F~~ive years after the institutionalized person is determined eligible, the community spouse can divest assets ~~that are part of the community spouse asset share (see Section 18.4.3 Calculate the Community Spouse Asset Share). He or she can give them to anyone without affecting the eligibility of the~~

~~institutionalized spouse~~.

Example 1 has been updated.

~~b. If the community spouse receives assets from the eligible institutionalized spouse that were not part of the community spouse asset share, he or she cannot give them to anyone except persons listed in Section 17.4 Exceptions, #8. Giving them to someone other than these persons could cause the institutionalized person to become ineligible.~~

Example 2 has been updated.

Homestead property is an exception. After the institutionalized person has become eligible, he or she can transfer the homestead to the community spouse, and the community spouse can transfer it to anyone once five years have passed since the eligibility of the institutionalized spouse. The community spouse's divestment of homestead property more than five years after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.

Example 3 has been updated.

17.5.1 Penalty Period Introduction

If there was a divestment during the look-back period or any time after and if none of the ~~above~~ exceptions in Section 17.4 Exceptions apply, the institutionalized person must be determined ineligible for long-term care services for a period of time.

During this penalty period, Medicaid will not pay the institutionalized person's daily care rate in the nursing home. He or she may, however, still be eligible for Medicaid card services (see Section 17.15 Medicaid Card Services).

A person applying for HCBWs would be ineligible for HCBW services for a period of time. A person ineligible for HCBWs due to a divestment may still be eligible for other non-LTC Medicaid, such as SSI-related Medicaid or MAPP, if they meet the eligibility requirements of the non-LTC Medicaid program.

17.5.2 Calculating the Penalty Period

This section has been rewritten.

17.5.3 Penalty Period Begin Date for Applicants

Examples 2, 3, 4, and 6 have been updated.

17.5.4 Penalty Period Begin Date for Members

This section has been rewritten.

17.5.5.1 Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified or cured. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if he or she met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 8 has been updated.

17.5.5.3 Divestments During a Penalty Period

If another divestment occurs when a penalty period is in effect, another penalty period must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The new penalty period will not begin until the existing period has expired. The penalty periods cannot run

concurrently.

~~Send the member a notice advising him or her that the consequence of the new divestment is an increased penalty period and specify the new penalty dates.~~

Example 10 has been updated.

~~The divestment report does not register divestment penalty changes. If it is necessary to remove a divestment penalty or change an existing penalty period in interChange, update the Transfer/Divestment of Assets page, run eligibility, and confirm. Then contact the fiscal agent at 608-421-6340. Provide the fiscal agent with the date that the divestment penalty was removed or the new end date. The LOC will then be revised. Also contact the appropriate individual at the member's nursing home to submit bills for the period that is now covered by institutional Medicaid.~~

~~Reminder: The divestment notices are inaccurate. Send a manual notice explaining eligibility for card services, the reason for service reduction, and the number of months in the penalty period when a case receives a divestment penalty. Include the legal citation Wis. Stat. § 49.453.~~

17.5.5.4 Changing Divestment Penalty Periods

This section is new.

17.6 Multiple Divestments

This section has been rewritten.

17.12.2 Promissory Notes on or After January 1, 2009

If all of the criteria above are not met, the purchase of the promissory note, land contract, loan, or mortgage is a divestment. The divested amount is the value of the outstanding balance due on the promissory note, loan, land contract, or mortgage as of the date of application for Medicaid LTC services.

If all of the criteria above are met, the purchase of the promissory note, land contract, loan, or mortgage is not a divestment. This applies even if the promissory note, land contract, loan, or mortgage cannot be sold because it is not negotiable, assignable, enforceable, or otherwise marketable.

Example 1

(This was effective August 1, 2017.)

17.12.2.1 Promissory Notes on or After July 14, 2015

This section has been deleted and Example 3 moved to Section 17.12.2.

17.14 Both Spouses Institutionalized

If the community spouse made a divestment that resulted in a penalty period for the institutionalized spouse (see Section 17.4 Exceptions 2. b.), ~~apportion~~ split the remaining penalty period between the spouses at the time the community spouse enters an institution, ~~and~~ applies for Medicaid, and is found otherwise eligible.

Example 1 has been updated.

~~Apportion t~~The penalty period must be apportioned as follows:

1. Find the divested amount that was used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
   a. Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days of the penalty period

already served.
b. Subtracting the result from the original divested amount.

3. Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
4. Divide the new penalty period equally between the two spouses.

CARES will calculate the new penalty period and amount left to be served for workers to apportion to the spouse's case.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

20.3.1 Mandatory Verification Items Introduction

5. Divestment, for EBD long-term care (see Section 17.1 Divestment Introduction).

21.2 Full-Benefit Medicaid

5.~~EBD~~ SSI-related Medicaid (categorically or medically needy)

10.WWWMA (see ~~the BadgerCare Plus Handbook~~ Chapter 36 Wisconsin Well Woman Medicaid)

21.6.5 HP Enterprise Services Ombuds

21.6.5 ~~HP Enterprise Services~~ ForwardHealth HMO Ombudsmen

21.10.4 Process

The fiscal agent initiates the good faith claim process by sending you a Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) that they have partially completed and one or two letters, depending on what documentation of eligibility the provider included with the claim. Complete F-10111 for new members (cert. 1) or F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

~~HP Enterprise Services~~ ForwardHealth
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed F-10110 forms by fax to 608-221-8815 or by mail to:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

26.3.3 Work Requirement

To meet the work requirement, a member must engage in a work activity at least once per month or be enrolled in an HEC program (see Section 26.3.4 Work Requirement Exemption). Consider a member to be working whenever he or she receives something of value as compensation for his or her work activity. This includes wages or in-kind payments (see Section 15.5.1 Income In-Kind). The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

26.5.2 Initial Premium

Send MAPP premium payments separate from BadgerCare premium payments and other agency funds. Send premium payments to the following address:

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738

The check or money order should be made payable to the Medicaid Purchase Plan.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, anytime prior to the beginning of the next benefit month, close the case in CARES for the next possible month. If the case cannot be closed in CARES at the end of the current benefit month, do not impose an RRP. Close the case in CARES. Submit a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) by fax to 608-221-8815 or by mail to:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

27.7.3 Partial Months

If a member is residing in an institution (see Section 27.1 Institutions) and not Medicaid-eligible as of the first of the month, there is no patient liability for that month.

If a member was not institutionalized as of the first of the month or was discharged to the community prior to and including the last day of the month, there is no patient liability. However, if the member is opening for home and community-based services, he or she may owe a cost share to the MCO.

Exceptions:

- There is a patient liability if the reason the person did not reside in the institution for the entire month was due to death or being on therapeutic leave.
- There is a patient liability if the reason the person was not eligible for long-term care services for the entire month is because a divestment penalty period ended in that month. Members who are institutionalized for the entire month in which their divestment penalty period ends must pay the full patient liability for that month.

27.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month, send a completed Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) by fax to 608-221-8815 or by mail to:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

28.1 Home and Community-Based Waivers Long-Term Care Introduction

Community waivers enable elderly, blind, or disabled people to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for ~~community~~ services and supports permitting a person to remain in a community setting that normally are not covered by Medicaid.

Community waivers include the following programs:

- CIP I (CIP 1A and CIP 1B).
- CIP II.
- CLTS Waiver Program~~s~~. ~~These programs~~ This program serves children with physical disabilities, developmental disabilities, and severe emotional disturbance or mental health needs.
- COP-W.
- Family Care.
- Family Care Partnership.
- IRIS.
- PACE.
- ~~WPP~~.

28.2 Home and Community-Based Waivers Long-Term Care Application

All waiver applicants must complete a Medicaid application unless they are already receiving full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid). Adult waiver applicants receive level of care assessment and case planning services from the ADRC. The ADRC will submit the waiver program start date to the IM agency along with the waiver functional eligibility determination.

28.8.2 Group A

Group A members are waiver functionally eligible and Medicaid eligible via SSI (including SSI-E Supplement and 1619A and B) or a full-benefit Medicaid subprogram (see Section 21.2 Full-Benefit Medicaid) other than a HCBW LTC program or Family Care (i.e., not Group B or B Plus). This does not include someone solely eligible for any of the limited benefit Medicaid subprograms (see Section 21.3 Limited Benefit Medicaid).

Members 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.

Group A members are financially eligible with no cost share.

Note: Group A members do not have an asset limit if they are Group A eligible via BadgerCare Plus, Adoption Assistance Medicaid, Foster Care Medicaid, Katie Beckett Medicaid, or Wisconsin Well Woman Medicaid since ~~BadgerCare Plus does~~ these programs do not have an asset test. All Group A members, including those who are eligible for Group A through BadgerCare Plus eligibility, are subject to the divestment policy described in Chapter 17 Divestment.

28.14.1 Children's Long-Term Support Introduction

28.14.1 Children's Long-Term Support Waiver Program Introduction

This section has been rewritten.

(This was effective July 1, 2017.)

28.14.2 Children's Long-Term Support CARES Processing

28.14.2 Children's Long-Term Support Waiver Program CARES Processing

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

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 Section 28.8 Home and Community-Based Waivers Long Term Care Instructions for waiver processing instructions).

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

~~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~~. Since a disability determination is not required for these members, IM workers should update the "Is Disability Determination Required?" question on the Community Waivers page to **No**.

(This was effective July 1, 2017.)

28.14.2.1 Processing a Children's Long-term Support Application When No Funding Is Available

This section has been deleted.

30.6 Processing

1. Determine Medicaid eligibility for all other subprograms in CARES. Do not confirm unless there is eligibility for a category of Medicaid that is not QMB, SLMB, or QDWI. If there is only QMB, SLMB, or QDWI eligibility, test the person against the TB-related financial tests. Complete the Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 (formerly DES 3070) and fax it to 608-221-8815 or mail it to the following address:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

32.1.1 Medicare Savings Programs Introduction

This section has been rewritten.

(This was effective August 5, 2017.)

32.1.2 Medicare Savings Programs Fiscal Test Group

This section has been rewritten.

(This was effective August 5, 2017.)

32.1.5 Part B Enrollment Via the Medicare Savings Programs Buy-In Program

Members receiving Medicare Part A coverage who chose not to enroll in Part B may be eligible ~~for the State~~ to enroll ~~them~~ int~~o~~ Part B ~~with no increase in the premium~~, via the MSP process with the state. The MSP eligibility should be determined in CWW. If the member is eligible for MSP, the worker must contact the ForwardHealth Medicare buy-in analyst by phone at 608-224-6126, ~~by email,~~ or by filling out a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) stating when the member will begin their Medicare buy-in eligibility. The Medicare buy-in analyst will create a manual transaction to send to CMS with the appropriate MSP information. Once CMS processes the record, the member should be enrolled into Part B with coverage beginning the first month of MSP eligibility.

Example 1 has been updated.

(This was effective August 5, 2017.)

32.2.1 Introduction

The following ~~are~~ Medicaid members ~~who~~ are ~~automatically~~ categorically eligible for QMB benefits:

32.2.2 Entitled to Medicare

1. He or she does not have to pay a premium for Medicare Part A and is ~~receiving~~ enrolled in Medicare Part A ~~services~~ as of the QMB determination.

2. b. He or she is a Medicaid member or QMB or SLMB or QDWI applicant and has never been enrolled in Medicare Part A ~~the federal Medicare system~~. In this case he or she must apply at the local SSA office for Part A Medicare eligibility. He or she will receive a receipt which entitles him or her to enrollment in Part A on the condition that he or she is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB OR SLMB or QDWI eligibility cannot begin prior to the Part A begin date.

32.2.3 Income Limit

Example 5 has been updated.

32.4.1 Introduction

3.~~Have been determined ineligible for MA (including Community Waivers, BadgerCare Plus, QMB , SLMB, and QDWI).~~ Not be enrolled in full-benefit Medicaid (such as SSI Medicaid, Community Waivers, and BadgerCare Plus), Family Planning Only Services, or Tuberculosis Only Related Services. A person with an unmet deductible should be considered ineligible for Medicaid until he or she meets the deductible.

(This was effective August 5, 2017.)

32.4.2 Income Limit

~~Since enrollment for the SLMB+ program is not automated in CARES, it must be determined and managed manually by local agencies. See Process Help 61.6 SLMB+ Processing~~.

(This was effective August 5, 2017.)

32.7.1.1 QMB Applications

For initial applications, QMB benefits begin on the first of the month after the month in which the person is determined to be eligible,~~/~~ and the case is confirmed in CARES.

Example 1 has been updated.

(This was effective August 5, 2017.)

32.7.1.2 QMB Renewals

Example 2 has been updated.

32.7.2 SLMB, SLMB+, QDWI Begin Dates

This section has been rewritten.

(This was effective August 5, 2017.)

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for QMB ~~did~~ do not correctly begin on the first of the following month ~~as they were supposed to~~. This can occur if:

- The eligibility process was not completed within 30 days.
- Certification of eligibility was not completed.
- A fair hearing decision has ordered backdated QMB benefits.

~~To backdate QMB benefit~~ If eligibility for QMB should start prior to the month after the confirmation month, complete a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) (formerly DES 3070) and fax it to 608-221-8815 or mail it to:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

(This was effective August 5, 2017.)

32.8.2 SLMB, SLMB+, QDWI Backdating

This section has been rewritten.

(This was effective August 5, 2017.)

32.9 Medicare Savings Programs No Deductible

There is no deductible in MSP (see Section 24.2 Medicaid Deductible Introduction). If a person's income is above the appropriate income limit, he or she cannot qualify for an MSP ~~by meeting a deductible~~.

(This was effective August 5, 2017.)

32.10 Medicare Savings Programs Renewals

This section has been rewritten.

(This was effective August 5, 2017.)

32.11 Potential Adverse Effect of Medicare Savings Program Participation

When a member is found eligible for one of the MSP programs and the state pays the person's Part B premium, his or her Social Security ~~check~~ payment will increase by the same amount as the Medicare Part B premium. This increase in the Social Security ~~check~~ payment may result in the person either losing Medicaid eligibility, or being reduced from categorically needy to medically needy.

When a person would be adversely affected in this way, he or she is allowed to choose between either losing his or her Medicaid current benefits and keeping free Medicare enrollment, or giving up the free Medicare enrollment and keeping his or her Medicaid benefits. All but 503, DAC's and widow/widowers can opt out of the QMB buy-in through CARES.

When a 503, DAC, or widow/widower requests to not have the state pay the Part B premium, contact the buy-in analyst at ~~221-4746, extension 3107~~ 608-224-6126. The buy-in analyst will update MMIS with the appropriate information to prevent the automatic buy-in.

(This was effective August 5, 2017.)

34.1.3 Certification of Emergency Services Eligibility

The Medicaid/BadgerCare Plus Eligibility Certification form may be submitted to the fiscal agent by fax to 608-221-8815 or by mail to:

~~HP Enterprise Services~~ ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

36.2.3.1 Applications for Wisconsin Well Woman Medicaid Through the Wisconsin Well Woman Program

6. EM CAPO will update interChange with the WWWMA eligibility information using a medical status code of "CB" to certify any member who has met the criteria listed above. Submit the completed Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) to the fiscal agent by fax to 608-221-8815, through interChange, or by mail to:

~~HP Enterprise Services~~ ForwardHealth
Attn: Eligibility Lead Worker WWWMA
313 Blettner Blvd
Madison WI
53714-2405

38.1 Introduction

Medicaid-eligible ~~individuals~~ adults who meet the LOC requirements can receive their LTC services through enrollment in an MCO or through the fee-for-service program IRIS.

Managed LTC programs include:

- Family Care
- Family Care Partnership
- PACE

Disability

To be eligible for EBD or LTC Medicaid, the individual must be elderly, blind, or disabled. A member eligible for BadgerCare Plus, WWWMA, Foster Care, or Adoption Assistance is not required to be determined disabled to enroll in Family Care, Family Care Partnership, or PACE as long as the member meets the functional LOC. If the member later loses eligibility for that program and must be tested for EBD or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care.

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The spousal impoverishment values in the following table were effective July 1, ~~2016~~2017.

The values in the table were updated.

39.4.3 Institutional Cost of Care Values

The values in the following table were effective July 1, ~~2016~~2017.

The values in the table were updated.