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

To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 21-01**

Release Date: 03/29/2021

Effective Date: 03/29/2021

EFFECTIVE DATE		The following policy additions or changes are **effective 03/29/2021** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.3	**Spousal Impoverishment Medicaid Signatures**	Clarified policy for spousal signature requirements and added link to Process Help
3.1.5	**Administrative Renewals**	Updated policy and moved process to Process Help
5.3.6	**Routine SSI Medicaid Extension**	Clarified policy for testing member eligibility for Medicaid Savings Program when SSI is terminated
15.4.2	**Unearned Income – Sick Benefits**	Clarified policy for sick benefits that should not be counted as unearned income
15.7.4	**Impairment-Related Work Expenses**	Updated policy to include spousal IRWE in MAPP calculations
16.6.6	**Pooled Trusts**	Deleted process-related note
16.7.11.3	**Retroactive VA Aid and Attendence**	*New Section*
16.7.36	**Retroactive Federal Pandemic Unemployment Compensation (FPUC) Payments**	Updated policy effective date
17.5.2	**Calculating the Penalty Period**	Updated daily nursing home private pay rate
17.11.5	**Remainder Beneficiary Designation**	Deleted process-related text
18.1	**Spousal Impoverishment Intorduction**	Clarified policy for considering a person institutionalized for spousal impoverishment
18.4.3	**Calculated the Community Spouse Asset Share**	Clarified policy for considering a person institutionalized for spousal impoverishment
18.4.6.1.1	**Leaves Institution or**	Updated policy for LTC member asset transfer

	Becomes Ineligible During the Asset Transfer Period	
18.10	**Dual Spousal Impoverishment Cases**	Updated link to Process Help
21.4.1	**Covered Services Introduction**	Updated Medicaid-covered services for substance abuse treatment
21.5.4	**Copay Exempt Services**	Updated list of services that do not require copayment
22.1.4.3	**Returns Home to Live**	Updated policy to release a lien against a member's home if the member no longer owns the home
22.4.2	**Undue Hardship Waiver Request Process**	Clarified policy for sending members undue hardship documents
22.4.7	**Be Hold Payments and Notifications (Divestment Only)**	Deleted process-related text and added a link to Process Help
24.1	**SSI Related Medicaid Introduction**	Updated the list of income disregards and expenses
24.7	**Meeting the Deductible**	Clarified policy for starting a new deductible period
25.0	**Special Status Medicaid Introduction**	Clarified policy for special status Medicaid considerations requirements
25.1	**"503" Eligibility**	Clarified policy for 503 eligibility consideration
25.2	**Disabled Adult Child**	Updated examples
27.1.2.1	**Eligible Age**	Updated policy for new residential substance use disorder treatment benefit
27.1.2.2	**Temporary Leave**	Updated policy for new residential substance use disorder treatment benefit
27.1.3	**Hospitals**	Updated policy for new residential substance use disorder treatment benefit
27.4.1	**Institutionalized Person**	Updated policy for new residential substance use disorder treatment benefit
32.1.5	**Part B Enrollment Via the Medicare Savings Programs Buy-In Program**	Deleted process-related text and added a link to Process Help
32.6	**Medicare Savings Programs Asset Limits**	Deleted Assets and Income Tables and added link to new location
32.8.1	**QMB Backdating**	Deleted process-related text and added a link to Process Help
32.11	**Potential Adverse Effect of Medicare Savings Program Participation**	Deleted process-related text and added a link to Process Help
34.1	**Emergency Services**	Clarified policy for incarcerated immigrants
39.4	**Elderly, Blind, or Disabled Assets and Income Table**	Updated tables
39.5	**Federal Poverty Level Table**	Updated table
39.6	**COLA**	Updated table
39.11.1	**SeniorCare Income Limits Introduction**	Updated table

Table of Contents

2.5 VALID SIGNATURE

2.5.3 Spousal Impoverishment Medicaid Signatures

All *spousal impoverishment* Medicaid applications ~~and renewals~~, renewals, or changes in marital status that cause someone to be subject to spousal impoverishment rules, require the signatures of **both** the institutionalized person and the *community spouse* or of a person authorized to sign for them as described in Section 2.5.1.1 Signatures From Representatives.

If the ~~institutionalized person's signature is missing, deny the application.~~

~~Beginning with applications and renewals dated November 11, 2013, if~~benefits are denied or terminated because the community spouse refuses to sign ~~the application or renewal~~, disclose the value of assets, or provide required information on income or resources, ~~deny~~ the ~~application~~applicant or ~~renewal unless the agency determines that denial or termination of eligibility would result in undue hardship for the person (~~member must be sent information on the Undue Hardship Waiver process. For more information on this policy, see Section 22.4 Undue Hardship~~).~~ and Process Help Section 11.7

~~If the community spouse refuses to sign the application or renewal or provide required information, enter an "N-No" in the Health Care Signature field on the General Case Information page~~.

3.1 RENEWALS

3.1.5 Administrative Renewals

~~The following process replaces the administrative renewal process that was in place for *SSI* related Medicaid, *HCBW*s, MLTC (including Family Care, Family Care Partnership, and *PACE*), and *MSP* cases prior to February 1, 2017.~~

3.1.5.1 Administrative Renewals Introduction

Based on federal requirements, health care eligibility must be redetermined once every 12 months based on information available to an agency. Agencies cannot require information from health care members during an annual renewal unless the information cannot be obtained through an electronic data exchange or the information from the electronic data exchange is not reasonably compatible with the information on file. The process of using electronic data exchanges for renewals is referred to as ~~the~~an administrative renewal ~~process.~~ .

If information from electronic data exchanges validated information about the member's income as currently recorded in *CARES*, additional information about income cannot be requested from the member at renewal. This includes earned income information that is found to be reasonably compatible with member-reported information, as well as any information about unearned income verified through *SSA* or *UIB* data exchanges. Unless reported otherwise, it is assumed during the administrative renewal process that household composition has not changed.

3.1.5.2 Administrative Renewal Selection Criteria and Exclusions

To be considered for an administrative renewal, a case must be due for renewal in the following month and have one or more qualifying BadgerCare Plus, FPOS, or *EBD* Medicaid assistance groups open, including health care assistance groups open with a suspended status.

~~***3.1.5.2.1 Medicaid Cases That Could Be Administratively Renewed***~~

The following ~~are~~ Medicaid ~~cases that could~~subprograms **can be** administratively renewed:

- SSI-related Medicaid~~. SSI-related Medicaid cases must meet all of the following criteria to be selected for an administrative renewal:~~
  - ~~Only have income that can be verified through a data exchange (for example, income from Social Security and/or UIB or employment income with a *SWICA* match or an Equifax match through the FDSH)~~
  - ~~Have countable assets at or below 50% of the asset limit~~
  - ~~**Not** have excess self-employment, child support/maintenance, or *IRWE* on file~~

- ~~***MAPP.*** MAPP cases must meet all of the following criteria to be selected for an administrative renewal:~~
  - ~~Only have income that can be verified through a data exchange~~
  - ~~Have gross income at or below 150% of the *FPL* and so would not have a premium~~
  - ~~Have countable assets at or below 50% of the asset limit~~
  - ~~**Not** have excess self-employment, child support/maintenance, IRWEs, special exempt income, or medical/remedial expenses on file~~
- ~~**MSP.** MSP cases must meet all of the following criteria to be selected for an administrative renewal:~~
  - ~~Only have income that can be verified through a data exchange~~
  - ~~Have countable assets at or below 50% of the asset limit~~
  - ~~**Not** have excess self-employment, child support/maintenance, or IRWEs on file~~
- MAPP without premiums (income up to and including 100 percent of the FPL)
- MSP
- Group A Community Waivers with eligibility based on SSI~~. Group A Community Waiver cases must be Group A eligible based on SSI eligibility to be selected for an administrative renewal.~~

~~*3.1.5.2.2 Medicaid Cases That Cannot Be Administratively Renewed*~~

The following ~~are~~ Medicaid ~~cases that~~subprograms **cannot be** administratively renewed:

- SSI-related Medically Needy Medicaid with met or unmet deductibles
- MAPP with premiums (income over 100 percent of the FPL)
- Institutional Medicaid
- Group B and B+ Community Waivers
- Group A Community Waivers with eligibility based on 1619(b), BadgerCare Plus, EBD Medicaid, or Adoption Assistance

~~*3.1.5.2.3 Exclusions From the Administrative Renewal Process*~~

~~Cases~~
SSI-related Medicaid, MAPP, and MSP **can be** ~~excluded from the administrative renewal process for a number of reasons.~~

~~Exclusions During the Administrative Renewal Process~~

~~Cases are excluded from being~~ administratively renewed if~~:~~
~~Any person~~ all members on the case ~~has or is any of the following~~have:

- Only income that can be verified through a data exchange (for example, income with a SWICA match or Equifax match through the FDSH), or only Social Security or Unemployment income

- Countable assets at or below 50% of the asset limit

SSI-related Medicaid, MAPP, and MSP **cannot be** administratively renewed if any members on the case have or are:

- Income or deductions that cannot be verified through a data exchange (for example, self-employment, in-kind income, child support/maintenance, or *IRWE*s)
- An unverified or missing *SSN*
- An unresolved Prisoner, UIB, or *SOLQ-I* discrepancy
    - ~~A new discrepancy found through a data exchange during the administrative renewal process~~
- An expired immigration status
- An expired disability diary date
- MAPP benefits with a work requirement waiver or Health and Employment Counseling enrollment
- A presumptive disability
- ~~Turning~~Persons turning 19 or 65 years old

~~- The case has or is any of the following:~~
    - ~~Income that cannot be verified or is not found reasonable compatible through a data exchange (such as self-employment or room and meals income)~~
    - ~~A BadgerCare Plus assistance group with tax deductions on file~~
    - ~~A BadgerCare Plus assistance group with a calendar year tax dependent(s)~~

~~A BadgerCare Plus Extension assistance group that is due for renewal (~~

- ~~**Note:** BadgerCare Plus Extension assistance groups will not be administratively renewed,~~Members who receive SSI and SSI MA but ~~other eligible health care categories on the same case may be selected for an administrative renewal as long as the extension is not due for renewal.)~~
- ~~A pending health care assistance group (i.e., health care eligibility has not been confirmed for all people in the case)~~
- ~~Related unprocessed ACCESS items, including applications, program adds, renewals, change reports, and *SMRF*s~~
- ~~Related unprocessed *PPRF* or SMRF documents~~
- ~~An unresolved *EPP*~~
- ~~A met deductible~~
- ~~A reason for exclusion from batch eligibility processes (for example, due to an eligibility override)~~
- ~~In review mode~~

~~Note:~~ ~~Cases that~~ are open ~~only~~in CARES for Group A Community Waivers and/or QMB ~~based on SSI eligibility~~ **will** ~~only be excluded from an~~**go through** administrative renewal ~~if~~unless the case is in review mode. The ~~other~~ criteria listed above do not apply to ~~Group A cases~~and will not exclude these types of cases from the Admin Renewal process.

~~**Exclusions When CARES Runs Eligibility**~~

~~Cases are excluded from being~~
Medicaid also cannot be administratively renewed if anyone on the case is receiving BadgerCare Plus or Family Planning Only Services benefits and is excluded from administrative renewal for a reason listed in BadgerCare Plus Eligibility Handbook 26.1.3.2.

Health care will not be successfully administratively renewed if any of the following occur ~~when CARES is running eligibility for~~during the administrative renewal process:

- A new Error Prone Profile (EPP) is generated ~~as a result of~~
- A new discrepancy if found through a data exchange~~.~~

~~- Health care or FPOS benefits pend.~~

- A new or increased premium is required
- Health care or FPOS benefits would ~~be terminated~~pend or terminate for any person on the case~~.~~
- Related unprocessed items are found, such as applications, change reports, renewals, or FoodShare Six Month Report forms

3.1.5.3 Administrative Renewal Process

~~- A premium is now required, or the premium amount increased.~~

~~**3.1.5.3 Administrative Renewal Process**~~

~~During the administrative renewal process, *CWW* will automatically do the following:~~

~~- Select cases subject to administrative renewal~~
~~- Verify and update information using data exchanges~~
~~- Determine the new 12-month certification period for health care~~
~~- Notify the member of the administrative renewal~~
~~- Notify the member of his or her eligibility determination~~

The administrative renewal process ~~will occur~~begins in the 11th month of a member's certification period~~, prior to a 45-day renewal letter being sent. On the first Saturday of~~

~~the 11th month, CARES will determine~~. CARES determines who qualifies for an administrative renewal, verifies and ~~initiate a batch request through the *RRV* service through the *FDSH* to request Equifax data.~~

~~On the second Saturday of the 11th month, the following will occur:~~

- ~~CARES will determine who qualifies for an administrative renewal.~~
- ~~Data exchange~~ updates ~~occur for~~ information based on data exchanges, tests employment income and SWICA~~, New Hire, and *EVHI*.~~
- ~~The existing batch process will update SSA~~ and ~~UIB data.~~
- ~~The RRV response with Equifax data will be processed.~~

~~Reasonable~~ FDSH results for reasonable compatibility ~~will be tested as applicable~~, and runs through batch eligibility. See Process Help 4.7 Administrative Renewals.

- ~~The administrative renewal process will run through a batch eligibility cycle to determine if the administrative renewal is successful or unsuccessful.~~

3.1.5.3.1 ~~Administrative Renewal Data Exchange Results~~

~~If new income information is identified from SSA or UIB during the administrative renewal process, the case will be updated with the new information. Income information obtained from SWICA or FDSH will be tested for reasonable compatibility.~~

~~For health care and/or *FPOS* only cases where a person in the household has current employment, the Begin Month on the Employment page will be updated to the current month. In addition, the wage verification code on the Employment page will be set to "Q?" if the existing verification code is not "?," "QV," "NV," "Q?," "?O," "WN," or "SP." These verification codes will allow CARES to test wages for reasonable compatibility. The income types and amounts will not be systematically updated. For cases that include programs other than health care and/or FPOS or for cases for which the administrative renewal is unsuccessful, the original wage verification code will be retained. Keeping the original verification code will ensure that other programs only have to verify wages when appropriate for their program rules.~~

~~*3.1.5.3.2*~~ *Successful Administrative Renewals*

Cases that ~~pass the~~have a successful administrative renewal ~~criteria after the~~ will have health care eligibility ~~batch run will go through the administrative renewal confirmation process. During the confirmation process, the following will occur:~~

- ~~Case level review dates~~redetermined and will be ~~set.~~
- ~~A case comment~~certified for a new 12- month certification period. The member will be ~~added by CARES that states "Administrative Renewal completed."~~
- ~~The Interview Details page will display "Admin Renewal" as the interview type for health care and/or FPOS.~~

- ~~The Generate Summary page will display "Admin Renewal" as the signature type.~~
- ~~The appropriate administrative renewal~~sent a letter~~,~~ notifying them that their eligibility has been renewed, along with ~~or without~~ a case summary~~, will be generated and mailed. The letter will be stored in the *ECF*.~~
- ~~The Enrollment and Benefits Handbook will be sent to the member.~~

~~Most categories of health care will be renewed during the administrative renewal. For example, if a case is open for both BadgerCare Plus and MAPP without a premium, and the programs have different renewal dates, both programs would be renewed and their renewal dates would be synced to the later of the two renewal dates. This does not apply to time limited health care benefits (such as pregnancy related BadgerCare Plus), because these benefits are not renewed for additional months. In addition, FPOS benefits will be renewed separately from other categories of health care, and the renewal date will not be synced, unless it is due for renewal at the same time as the other health care program(s).~~

~~If health care and/or FPOS can be successfully recertified through an administrative renewal~~ (except for cases open only for Group A Community Waivers and/or QMB based on SSI eligibility~~), the member will be sent an administrative renewal letter with an attached case summary.~~). The member must review the information on the case summary and report if any of the information is incorrect within 30 days ~~from~~of the mailing date~~ on the letter.~~. The member ~~has the option to~~can make the changes on the summary and mail or fax it to ~~his or her~~their agency, or ~~to call his or her agency to~~they can report ~~the~~their changes~~. When changes are applied to the case, a Notice of Decision will be sent and will include the message, "Your health care renewal has been completed."~~ through ACCESS or by phone. If all of the information on the case summary is correct, the member does not need to take any other action. Members who have their health care administratively renewed will be sent a Notice of Decision.

If a successfully administratively renewed case is open only for Group A Community Waivers and/or QMB based on SSI eligibility, the member will be sent a different administrative renewal letter that does not include a case summary. Because these ~~people~~members are categorically eligible based on their SSI eligibility, the letter informs them that their benefits have been renewed because they continue to receive SSI. These members will not need to review a case summary and do not need to take any other action.

~~Cases will go through a batch run on the second Saturday of the 12th month of the certification period, approximately 30 days after the administrative renewal. This batch run will generate a Notice of Decision, unless one has already been sent following the processing of a change or a renewal for another program(s).~~

3.1.5.3.~~3~~2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the case will be excluded from the administrative renewal process.

If the administrative renewal process was initiated, but not completed, any updates made to the case, with the exclusion of data exchange updates, will be undone, and the case will be returned to its original status. The member will be sent a 45-day renewal letter and a Pre-Printed Renewal Form (PPRF). The PPRFmember will include any SSA or UIB updates.

Members have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS. Failure to complete a renewal by the end of the certification period will result in the termination of benefits.

3.1.5.3.43 Change Reporting After Administrative Renewal

Cases that have a successful administrative renewal remain subject to their applicable change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the attached case summary and informs him or her of the potential consequences for not reporting those changes. If a member does not correct information that is wrong and gets benefits that he or she should not get, the member would be liable for any resulting overpayments. In addition, administrative renewal cases will receive a Notice of Decision that identifies program-specific change reporting requirements, as well as the potential consequences for not reporting changes timely. Changes reported for a case that has undergone an administrative renewal should be processed under existing policy.

Changes reported as part of a renewal for another program should also be applied to health care. The other program may require the person to verify his or her information. Once verification is received for the other program, the information should also be used for ongoing health care eligibility.

5.3 DISABILITY APPLICATION PROCESS

5.3.6 Routine SSI Medicaid Extension

An SSI Medicaid member is eligible for a redetermination of Medicaid eligibility and Medicare Savings Program (MSP) when SSI is terminated. Members that are eligible for Medicare should also be tested for the Medicare Savings Program unless the member requests not to be tested for the Medicare Savings Program. The person is allowed an extra month of SSI Medicaid eligibility and MSP to allow the IM agency to redetermine eligibility. The IM agency must fill the gap by ensuring continued Medicaid and MSP eligibility between the last date of SSI Medicaid and the date an eligibility determination for continuing Medicaid and MSP on another basis is completed (see Process Help Section 26.2~~).~~ Routine SSI Medicaid Extension). Determining Medicaid and MSP eligibility should usually occur within the month after the person loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps." The exception to this is in Section 5.3.5 SSI Application Date.

There is no fill the gap provision for those who lose their SSI eligibility because of:

- Death
- Leaving Wisconsin
- Incarceration
- Fleeing drug felon

Reminder: For all cases (CARES and non-CARES), even if the member does not meet Medicaid eligibility requirements for the months between when he or she lost SSI and when you are re-determining eligibility, he or she is still eligible. Do not require the member to come into the office. Ineligibility starts, following timely notice, when he or she:

a. Does not return the application (the fiscal agent takes care of this), or
b. Fails to respond to an information request, or
c. No longer meets eligibility requirements (as of when the review or application is done).

15.4 UNEARNED INCOME

15.4.2 Sick Benefits

Sick benefits are payments, such as income continuation, received from insurance. Do not count the following:

- Reimbursement for medical or social services
- Payments restricted to the future purchase of a medical or social service
- Any flat-rate benefits, such as per diem hospitalization or disability insurance, cancer insurance policies, or dismemberment policies

15.7 INCOME DEDUCTIONS

15.7.4 Impairment-Related Work Expenses

IRWE are expenses used to determine eligibility for Medicaid, MAPP, and premium calculations. IRWE are anticipated incurred expenses by the member (and for MAPP only, their spouse) related to the member's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as Medicaid, private insurance, or the member's employer. If an anticipated IRWE is later paid by an unanticipated source, it is still allowable for past months in which it was budgeted but not for future months.

Example 2: On March 25, Cecil was told by Harvey's Auto Repair Shop that his wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of $2,000 for the repairs. The $2,000 estimate was determined to be a standard charge for this type of repair in the community.

On March 26, Cecil applied for MAPP in Milwaukee County. At this time, the anticipated expense of the van repair was deducted from Cecil's income.

Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time, Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his *IM* worker.

Cecil's IM worker should not deduct the anticipated cost of the van repairs for any subsequent eligibility and premium determinations.

Deduct any MAPP member's expenses which:

- Do not exceed his or her gross monthly earned income (plus room and board income, if any).
- Are reasonably related to his or her earned income. Expenses which are reasonably related to earned income include those incurred in performing on the job and improving the person's ability to do the job.

Bills from months prior to the months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the member's community. If you count an expense as an IRWE, do not also use the expense as a medical/remedial expense.

Some examples of IRWE are modified audio/visual equipment, typing aides, specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the member's disability.

Exceptions: Always count the expenses of getting to and from work and the child care expenses as an IRWE for blind individuals.

16.6 NON-BURIAL TRUSTS

16.6.6 Pooled Trusts

Disregard pooled trusts for disabled persons managed by:

1. WISH Pooled Trust
2. WisPACT Trust I
3. ARC of Greater Milwaukee, Inc. Community Trust II

~~**Note:** Contact the CARES CALL Center for instructions on treating any other pooled trusts.~~

The WISH Pooled Trust and the WisPACT Trust I must meet the following conditions:

1. Are established and managed by a non-profit association. The pooled trust can contain funds that hold accounts funded by third parties for the benefit of the disabled person's own assets or income.
2. Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a *disability*.
3. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court. If the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member.
4. For WISH Trusts, if the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member. This requirement does not apply to WisPACT trusts.
5. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.

    - This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.
    - This requirement can also be satisfied when the pooled trust account includes *real property*, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid member who is disabled (as established under SSI rules) or *elderly* (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid member.

Note: The assets that have been placed in a potential pooled trust pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by *DDB*, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.

16.7 LIQUID ASSETS

16.7.11.3 Reimbursement of Cost Share or Patient Liability Payments

To prevent the loss of eligibility due to counting a lump sum reimbursement of cost share or patient liability as an asset, the payment must be excluded as an asset in the month of its receipt, and for the next nine months. At the end of this period, any remaining available portion will be counted as an asset for purposes of determining eligibility. This time period gives members time to use these assets while also maintaining their Medicaid eligibility. This policy aligns with the treatment of lump sum payments received by members for retroactive Social Security payments (see Section 16.7.11.1, Retroactive SS Payments).

Example 5: Michelle is a former SSI recipient and now receives Social Security Disability Income and a surviving child benefit. She is considered a Disabled Adult Child (DAC) by the Social Security Administration. She applies for Medicaid but does not know when she stopped receiving SSI. Instead of being determined eligible for Medicaid as a DAC with no premium or cost share, she is determined eligible for Waiver Medicaid as a Group B with a cost share, which she pays each month. When her previous receipt of SSI is discovered, Michelle is owed the money that she paid towards her cost share and must be reimbursed that amount. Michelle has nine months after the month of receipt in which the reimbursed amount will not be considered an asset. If she receives the reimbursement in January, any remaining amount from the reimbursement will be counted as an asset in November.

16.7.11.4 Retroactive VA Aid and Attendance

Retroactive Aid and Attendance payments from the VA are an exempt asset through the month after the month of receipt.

Example 6: Gloria receives $5000 in retroactive VA aid and attendance as a lump sum payment in May. The amount of that payment is disregarded through June 30. Any remaining funds as of July 1 are a countable asset.

16.7.36 Retroactive Federal Pandemic Unemployment Compensation (FPUC) Payments

Retroactive Federal Pandemic Unemployment Compensation (FPUC) payments are counted as an asset the month they are received. This policy is effective November 23, 2020.

17.5 PENALTY PERIOD

17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated by days using the average daily nursing home private pay rate. The rate effective ~~July~~January 1, ~~2019~~2021 is $~~287.29~~303.38. This rate may be updated annually (see Section 39.4.3 Institutional Cost of Care Values).

CWW will calculate the penalty period once a worker enters the appropriate information into the Transfer/Divestment of Assets page, runs eligibility, and confirms.

Example 1: Jeff applied for Family Care. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. Since $18,500 divided by $~~287.29~~303.38 equals ~~64.39~~60.97 days, CWW will calculate a divestment penalty period of ~~64~~60 days for Jeff.

17.11 ANNUITIES

17.11.5 Remainder Beneficiary Designation

The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, F-10190) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.

When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days of the date the Notice of Obligation form was sent, the *IM* agency must contact the issuer by phone and request that the issuer respond within 10 days. ~~If the issuer does not respond 40 days after the Notice of Obligation form was sent, contact the CARES Call Center for further guidance.~~

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. ~~If the issuer has not responded 10 days after the request was made, contact the CARES Call Center for further guidance.~~

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation (F-10190).
Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until one of the following occur:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,
- Verification has been received that the beneficiary designation change is in process,

- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, **or**
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular Medicaid financial limits. Spousal impoverishment policy applies to institutionalized persons. For purposes of spousal impoverishment, an institutionalized person means someone who:

1. Participates in Group B or B Plus Home and Community-Based Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution, or
4. Is residing in an *IMD*. There is no 30 day requirement for this population.

Note: An individual is not considered "institutionalized" for purposes of spousal impoverishment if he or she has resided in a medical institution for 30 or more consecutive days, is likely to reside in a medical institution for 30 or more consecutive days, or is residing in an IMD, and the sole purpose for residing in the medical institution or IMD is to receive residential substance use disorder treatment.

The policy's purpose is to prevent impoverishment of the *community spouse*. A community spouse is:

1. Married to an institutionalized person and
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community spouse is not an institutionalized person residing in an institution, his or her living arrangement can have no effect on his or her asset share (see Section 18.~~2.2~~4.3 Calculate the Community Spouse Asset Share) or income allocation (see Section 18.6.2 Community Spouse Income Allocation~~Spousal Impoverishment Income Allocation~~).

> **Example 1:** Joe is an institutionalized person living in a nursing home. His wife, Carla, is receiving HCBW services in a *CBRF*. Because Carla is not residing in a medical institution, Joe's eligibility is determined using Spousal Impoverishment rules.

Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, he or she is allowed to retain additional assets and income without liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See Section 2.5.3 Spousal Impoverishment Medicaid Signatures for application and review signature requirements.

18.4 SPOUSAL IMPOVERISHMENT ASSETS

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	**Then the community spouse asset share is:**
$~~257,280~~260,760 or more	$~~128,640~~130,380
Less than $~~257,280~~260,760 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

18.4.6.1.1 Leaves Institution or Becomes Ineligible During the 12-Month Transfer Period

If the institutionalized spouse **during** the 12-month transfer period:

1. Leaves the institution for 30 days or more **and** becomes institutionalized again, **or**
2. Becomes ineligible for Medicaid **and** then becomes eligible for Medicaid once again~~.~~, **or**
3. Changes from Group B/B+ waivers to Group A waivers then becomes eligible once again for Group B/B+ waivers all within the 12-month transfer period.

The time allowed to transfer assets does not start over again.

If the individual left the institution or became ineligible during the 12-month transfer period, without regaining eligibility during the 12-month transfer period, and reapplies for long-term care **after** the 12- month transfer period has ended, he/she is eligible for a new transfer period.

Example 3: Daniel is in a nursing home, while Susan, his wife is in the community. Daniel is found eligible for Medicaid beginning March 28, 2020 (the date of institutionalization), starting the 12-month asset transfer period. In May 2020, Daniel is discharged from the nursing home and his Medicaid eligibility ends. In July 2020, Daniel returns to the nursing home. Because Daniel became institutionalized again within the 12-month transfer period, the transfer period does not start over.

Example 4: Betsy was admitted to the nursing home on April 14, 2018 and applied for Medicaid on June 6, requesting a two-month backdate. Nicholas, her husband, remains in the community. Betsy was discharged from the nursing home on May 7, 2019, the 12th month of her asset transfer period. Betsy returns to the nursing home on March 6, 2020 and reapplies for Medicaid on March 13. Because Betsy returned to the nursing home after her 12-month transfer period, she is allowed a new asset transfer period.

View History

18.10 DUAL SPOUSAL IMPOVERISHMENT CASES

When both *spouses* are applying for community waivers, Family Care, or *PACE*/Partnership, and neither spouse resides in a medical institution, both eligibility determinations are done using spousal impoverishment policies.

The eligibility determination for both spouses is done on one case if the couple resides together.

Since income allocated to a *community spouse* is counted as income for that spouse, the couple should decide which spouse should allocate to the other spouse and how much to allocate.

One spouse may have more income or less expenses, so he or she could allocate to the other spouse with less income or more expenses. Each case will have to be assessed individually and the income allocation adjusted to meet the needs of the couple.

For instructions on entering income allocated paid out and allocated income received, see Process Help Section 11.5.3.1~~.2~~ Income Allocation in Dual Spouse Cases.

Asset Eligibility for Dual Spousal Cases

When both spouses are applying for Waivers and neither spouse resides in a medical institution, an asset assessment should be done for both spouses using the couple's combined assets. Both are tested using the Community Spouse Asset Share calculated with the asset assessment plus $2,000.

Asset Transfer Period

Both spouses have 12 months from the time of application to decrease their countable assets to less than $2,000. The assets can be transferred from one spouse to the other and used to purchase other exempt assets such as burial assets. The assets can also be used on other necessary living expenses for either spouse. Both spouses must have their countable assets below $2,000 at the next regularly scheduled renewal to remain eligible.

21.4 COVERED SERVICES

21.4.1 Covered Services Introduction

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook.

A covered service is any medical service that Medicaid will pay for an eligible *member*, if billed. *DMS* enrolls qualified health care providers and reimburses them for providing Medicaid-covered services to eligible Medicaid members. Members may receive Medicaid services only from enrolled providers, except in medical emergencies. Medicaid reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-certified provider.

Medicaid providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain Medicaid services.

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid), including *SSI* recipients, are referred to as dual eligible individuals. Effective January 1, 2006, Medicaid no longer provides prescription drug coverage for these individuals. These dual eligible individuals do not have to file an application for "Extra Help" and are deemed eligible for "Extra Help" from *CMS* to pay their Medicare Part D costs.

A Medicare Part D Prescription Drug Plan (PDP) card will be issued to them, and it must be used for prescription drugs instead of their ForwardHealth card.

Individuals who are enrolled in Medicare (Part A and/or B) and are Medicare Beneficiaries (see Section 32.1 Medicare Savings Programs), except for *QDWI*, are also considered to be dual eligibles. These dual eligibles are also be deemed eligible for "Extra Help" from CMS to pay their Medicare Part D costs.

Examples of Medicaid covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. *FQHC* services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment & ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.
8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.

11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    a. under 21 years of age.
    b. under 22 years of age and received services immediately before reaching age 21.
    c. 65 years of age or older.
12. Intermediate care facility services, other than services at an institution for mental disease.
13. Laboratory and X-ray services.
14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services~~)~~.), including residential substance use disorder treatment.
32. TB services.
33. Transportation to obtain medical care.

If you or the member have additional questions, contact Member Services at 1-800-362-3002.

21.5 COPAYMENT

21.5.4 Copay Exempt Services

The following services do **not** require copayment:

- Case management services.
- Crisis intervention services.
- Community support program services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck.
- HealthCheck "Other Services."
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- Private Duty Nursing (PDN) and PDN services for ventilator-dependent members.
- Pregnancy related services.
- Preventive services with an A or B rating from the U.S. Preventive Services Task Force.
- Residential substance use disorder treatment services.
- School-based services.
- Substance abuse day treatment services.
- Surgical assistance.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

22.1 ESTATE RECOVERY

22.1.4.3 Returns Home to Live or No Longer Owns the Home

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live or if the member no longer owns the home, the lien must be released. Notify the ERP. ERP staff will release the lien.

View History

22.4 UNDUE HARDSHIP

22.4.2 Undue Hardship Waiver Request Process

If an applicant or member is denied long-term care services as a result of any of the situations listed in Section 22.4.1 Application of Policy, ~~except a divestment penalty period, *IM* workers are required to manually send~~ the applicant or member must be sent the following:

- Undue hardship letter (F-10187).
- Undue Hardship Waiver Request form (F-10193).

~~These~~See Process Help Section 11.7 for information on how these forms are sent. If the situation requires an IM worker to manually send these forms, the forms must be mailed the same day ~~that~~or, at the latest, within 24 hours after CWW or the IM worker mails the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) informing the applicant or member that long-term care services will be terminated or denied.

~~**Note:** Because the forms listed above are completed and mailed manually for all situations, except a divestment penalty period, workers should document in case comments that undue hardship forms were sent and scan a copy of the forms into the *ECF*.~~

22.4.7 Bed Hold Payments and Notifications (Divestment Only)

When an undue hardship waiver request is received by an IM agency from an institutionalized individual, the ~~agency will send the institution the Undue Hardship Bed Hold Notice (F-10189) to~~IM agency must inform the institution that the request was received~~. The notice will inform the institution~~ and that a bed hold payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 calendar days.

~~Use the Undue Hardship Waiver Decision (F-10188) to~~The IM agency must notify the institution of the agency's decision about the undue hardship waiver~~ and the availability of the bed hold payment (when applicable).~~.

If the request for an undue hardship waiver is approved, the divestment penalty period will be waived and the need for a bed hold payment is therefore unnecessary.

If the undue hardship waiver request is denied, the IM agency must indicate ~~on the Undue Hardship Waiver Decision (F-10188)~~ the dates for which the state will make the

bed hold payments. ~~Attach a copy of the Undue Hardship Waiver Decision (F-10188) to the manual Notice of Denial of Benefits/Negative Change in Benefits (F-16001) that you send the applicant or member.~~

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e., nursing homes, etc.) who are requesting an undue hardship waiver. Bed hold payments will not be made for individuals not residing in a medical institution.

See Process Help Section 11.7.2.1 for more information for a bed hold due to undue hardship.

24.1 SSI RELATED MEDICAID INTRODUCTION

SSI-related Medicaid is the original, basic Medicaid program for individuals who are *elderly*, blind, or disabled. SSI related individuals must meet all appropriate Medicaid nonfinancial eligibility requirements. SSI related Medicaid has the lowest income and asset limits of all EBD Medicaid programs/categories. It has two income limits which are referred to as the categorically needy limit and the medically needy limit.

Allow the following income disregards and expenses to the fiscal group's income in the order below to determine the countable net income.

- Excess Self Employment Expenses
- The 65 & ½ earned income *disregard*
- ~~Special exempt income (15.7.2 Special Exempt~~ Child support and maintenance ~~Income)~~

- $20.00 SSI general income disregard~~.~~
- Impairment related work expenses (IRWE)

A fiscal group with countable net income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test.

If a fiscal group's countable net income exceeds the categorically needy income limit, their income is then compared to a medically needy limit of 100% FPL, which is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. If the fiscal group's countable net income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

If a fiscal group fails the medically needy income test because their countable net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 24.2 Medicaid Deductible Introduction for more information about Medicaid Deductibles and to chapter 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid Deductible.

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for more information.

24.7 MEETING THE DEDUCTIBLE

The fiscal test group meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group has not yet met the deductible within the deductible period, it may choose to start a new deductible period that begins with a later month in the current deductible period ~~without~~with a new application (see Section 24.3 Deductible Period).

> **Example 1:** Stanley's deductible period is from January through June. In April Stanley incurs a large medical expense that would meet his deductible. Stanley requests to start his deductible April 1st. His new deductible period is April through September. Stanley ~~would not~~will have to submit a new application.

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in Section 24.7.1 Countable Costs below.

View History

25.0 SPECIAL STATUS MEDICAID INTRODUCTION

Federal provisions require *DHS* to continue to consider specified groups of former *SSI* beneficiaries as SSI beneficiaries for Medicaid purposes, as long as they would otherwise be eligible for SSI payments "but for" the income disregards required to be given in each special status group.

These "special status" Medicaid groups include the following:

- 503 cases (see Section 25.1 "503" Eligibility)
- *DAC* (see Section 25.2 Disabled Adult Child)
- Widows and widowers (see Section 25.3 Widows and Widowers)
- 1619 cases (see Section 25.5 1619 Cases)

When determining the eligibility for Special Status Medicaid applicants and members, the appropriate *COLA* and *OASDI* income disregards, as described in the policy for each group, must be given.

Each Special Status Medicaid group has a specific set of requirements that must be met before the member can be considered a Special Status MA member (see sections listed above). Simply losing SSI or receiving a DAC or Widow/Widower payment does not automatically qualify a member for a Special Status disregard. To receive the Special Status Medicaid considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not always.

Note: "Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which SSA recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI.

"Concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits.

25.1 "503" ELIGIBILITY

25.1.1 "503" Introduction

Federal law requires that the *IM* agency provide Medicaid eligibility to any person for whom the following conditions exist:

- He or she is receiving OASDI benefits.
- He or she was receiving *SSI* concurrently with OASDI but became ineligible for SSI **for any reason**.
- Total countable income, excluding the "503" disregarded income, is less than or equal to the categorical income limits for SSI-related Medicaid.
- Total countable assets must be below the categorical asset limits for SSI-related Medicaid.

Note: "Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which *SSA* recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits. To receive the 503 eligibility considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive the OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not always.

An assistance group with these two characteristics is often referred to as a "503" assistance group. The name comes from Section 503 of the law that implemented this policy (Public Law 94-566).

Example 1: Kathy received SSI and SSSS (Social Security Surviving Spouse) payments for five years. She lost her SSI payment due to an increase in unearned income when she began receiving a pension payment in January of this year. While an increase in the COLA was not the reason for her loss of the SSI payment, she is still entitled to receive a COLA disregard on any OASDI payments she receives because she received OASDI concurrently with SSI and lost SSI.

Kathy will receive COLA disregards on her SSSS payment in order to determine her eligibility for special status Medicaid.

25.2 DISABLED ADULT CHILD (DAC)

25.2.1 Disabled Adult Child Introduction

A *DAC* is a person who meets the following criteria:

- At least 18 years old at the time *SSI* was lost.
- Classified by *SSA* as disabled before age 22.
- Receives an *OASDI* (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.

Note: Receipt of Railroad Retirement is not considered OASDI for this policy.

- Was receiving SSI but lost SSI eligibility because the OASDI (DAC) payment or an increase in the OASDI (DAC) payment exceeded the SSI income limits.

Federal law requires that the *IM* agency provide Medicaid eligibility to any DAC for whom the following condition exists:

- Total countable income, excluding the "DAC" disregarded income, is less than or equal to the SSI-related categorical income limits.
- Total countable assets are less than or equal to the categorical asset limit for SSI-related Medicaid.

25.2.2 Disabled Adult Child Payment Disregard

When a Disabled Adult Child applies for Medicaid, *disregard* all OASDI (DAC) payments which caused him or her to lose SSI eligibility.

Example 1: Disregard the **entire** OASDI (DAC) payment when the initial OASDI (DAC) payment caused the member to be ineligible for SSI:

Harvey is an SSI recipient. While his father worked, Harvey received a monthly SSI payment of $686.78. When his father retired, Harvey began receiving an OASDI (DAC) payment of $900. ~~He received an SSI payment and an OASDI (DAC) payment concurrently for one month. The next month, the $900 OASDI (DAC) payment made Harvey ineligible for SSI~~The OASDI payment exceeded the SSI income limits, causing his SSI to end. It is not necessary for the payments to be received concurrently (in fact, often they will not be) but the SSI payment must have ended because of the OASDI increase.

When Harvey applies for *EBD* Medicaid, the **entire** initial OASDI (DAC) payment of $900 (and any subsequent COLA disregards) will be disregarded when his EBD Medicaid eligibility is determined.

Example 2: George is an SSI recipient. While his father worked, George received a monthly SSI payment of $686.78.– When his father retired and began receiving social security retirement, George began receiving an OASDI (DAC) payment of $500 a month. While George's SSI payment decreased, the initial OASDI (DAC) payment did not cause him to lose SSI eligibility.

When his father died, ~~George began receiving an~~George's OASDI (DAC) payment ~~of~~increased to $750 a month. The increased amount put him over the SSI income limit, and he lost SSI.

George applies for EBD Medicaid. The IM worker must disregard the ~~total~~OASDI (DAC) payment increase of $250 ($750 - $500 = $250) because it was the **increase** that caused George to lose SSI eligibility.

Example 3: Jane is an SSI recipient. While her father worked, Jane received a monthly SSI payment of $686.78. When her father retired and began receiving social security retirement, Jane began receiving an OASDI (DAC) payment of $1372 a month. The OASDI payment exceeded the SSI income limits, causing her SSI to end.

When Jane applies for EBD Medicaid, the **entire** initial OASDI (DAC) payment of $1372 (and any subsequent COLAs) will be disregarded when her EBD Medicaid eligibility is determined.

Two years later, Jane's DAC payment increased to $2539 because her brother graduated from high school. Because this increase did not cause Jane to lose her SSI, only the initial DAC payment ($1372 plus any subsequent COLAs) is disregarded.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.

27.1 INSTITUTIONS

27.1.2.1 Eligible Age

IMD residents under age 21 and over age 64 may be Medicaid eligible. ~~-~~Persons aged 21 through 64 are not eligible unless ~~they~~:

1. They are receiving residential substance use disorder treatment in the IMD; or
~~1.~~2. They were IMD residents immediately prior to turning age 21.~~-~~ If they were, they are eligible until discharge (a 21 year old can be transferred from one IMD into another and remain eligible for Medicaid) or until turning age 22, whichever comes first.

27.1.2.2 Temporary Leave

A person aged 21 through 64 who is not eligible for Medicaid can go on conditional release from an IMD or convalescent leave and become eligible for Medicaid while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.

    a. The trial period must last no less than four days. It must be no longer than 30 days.
    b. The trial period begins after the initial three days of community residence following discharge.
    c. A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

    For purposes of Medicaid, conditional release is permitted only once every calendar year.

2. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD. A person under age 22 who leaves the IMD on Convalescent Leave remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

27.1.3 Hospitals

Hospitals are medical institutions that:

1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,

3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (27.4.1 Institutionalized Person) if he or she:

1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered "institutionalized" if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

27.4 DEFINITIONS

27.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Participates in Community Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until he or she is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered "institutionalized" if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

32.1 MEDICARE SAVINGS PROGRAMS

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

Members who are receiving Medicare Part A coverage, but who previously chose not to enroll in Part B, may be eligible to enroll in Part B outside of their usual enrollment periods via the MSP process with the state. See Process Help ~~61.4 Manual Updates to MSP On Forward Health iChange~~Section 62.1.2.3.

32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS

~~Asset Limits for *QDWI*~~	
~~Group Size~~	~~Asset Limit~~
~~1~~	~~$4,000~~
~~2~~	~~$6,000~~

~~*QMB, SLMB,*~~See 39.4 EBD Assets and ~~*SLMB+ have the same*~~Income Tables for MSP asset ~~limit~~limits.

~~Asset Limits for QMB, SLMB, and SLMB+~~	
~~Group Size~~	~~Asset Limit~~
~~1~~	~~$7,860~~
~~2~~	~~$11,800~~

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility. Estate Recovery does not recover MSP benefits.

32.8 MEDICARE SAVINGS PROGRAMS BACKDATING

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for *QMB* do not correctly begin on the first of the following month. 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.

~~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:~~

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

See Process Help Section 61.2.2 for instructions for QMB backdating.

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 a person's Part B premium, his or her Social Security payment will increase by the same amount as the Medicare Part B premium. This increase in the Social Security payment may result in the person either losing Medicaid eligibility, or experiencing a reduction in benefits.

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 ~~MSP~~giving up the free Medicare enrollment~~. Refer to~~ and keeping his or her Medicaid benefits. All but 503, DACs, and widow/widowers can opt out of the *QMB* buy-in through CARES. See Process Help Section 61.~~2.3 Reason~~4 for ~~Not Requesting~~processing instructions when a 503, DAC, or widower requests to opt out of MSP.

34.1 EMERGENCY SERVICES

34.1.1 Emergency Services Eligibility Introduction

Documented and undocumented non-citizens ineligible under regular Medicaid due to alien status can be eligible for Emergency Services, if he or she meets all other eligibility requirements except having or applying for an *SSN*. Non-citizens may have an SSN and may still qualify for Emergency Services. If a non-citizen would otherwise be eligible for any type of EBD Medicaid, he or she would qualify for Emergency Services.

An inmate who is a non-qualifying immigrant may be eligible for Emergency Services for the dates they are hospitalized as an inpatient for emergency treatment as long as they meet the rest of the eligibility criteria for Emergency Services.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate Medicaid could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying aliens.

The *IM* agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to the fiscal agent. It determines if a condition is an emergency medical condition covered by Emergency Services.

A citizen is not eligible for Medicaid Emergency Services even when he or she cannot produce citizenship and/or identity verification.

Example 1: Jill applies for Medicaid, declares U.S. citizenship, and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services Medicaid does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However the IM worker cannot process Emergency Services Medicaid eligibility for persons

declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

The values in the following table were effective January 1, ~~2020~~2021.

Group Size				
Category		**1**		**2**
SSI-Related Categorically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$~~866~~877.78 ~~(effective 8/1/2020)~~	Income	$1,~~307~~323.05 ~~(effective 8/1/2020)~~
SSI-Related Medically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$~~1063~~1,073.33 (effective 2/1/~~2020~~2021)	Income	$1,~~436~~451.67 (effective 2/1/~~2020~~2021)
***SSI* Payment Level**				
Federal SSI Payment Level	Income	$~~783~~794.00	Income	$1,~~175~~191.00
SSP	Income	$83.78	Income	$132.05
Total	Income	$~~866~~877.78	Income	$1,~~307~~323.05
SSI Payment Level + E Supplement	Income	$~~962~~973.77 (Home Maintenance Maximum Allowance)		$1,~~652~~668.41
SSI E Supplement	Income	$95.99		$345.36
Community Waivers	Income	$2,~~349~~382.00		

Special Income Limit				
Institutions Categorically Needy Income Limit	Income	$2,~~349~~382.00		
Substantial Gainful Activity Limit (non-blind individuals)	Income	$1,~~260~~310.00		
Substantial Gainful Activity Limit (blind individuals)	Income	$2,~~110~~190.00		
Medicaid Savings Programs				
QMB	Income	At or below 100% FPL	-	-
SLMB	Income	At least 100% FPL but less than 120% FPL	-	-
SLMB+	Income	At least 120% FPL but less than 135% FPL	-	-
QMB, SLMB, SLMB+	Assets	$7,970	-	$11,960
QDWI	Income	At or below 200%	-	-
	Assets	$4,000	-	$6,000

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, ~~2019~~2021.

Description		Amount
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,~~349~~382.00
EBD Deeming Amount to an Ineligible Minor		$~~392~~397.00
Community Waivers Basic Needs Allowance		$~~963~~974.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$~~783~~794.00 $1,~~175~~191.00
~~*MAPP* Standard Living Allowance~~ ~~Standard Living Allowance = SSI + State Supplement + $20~~ ~~**Note:** This amount is only used in MAPP premium calculations made prior to August 1, 2020.~~		~~$886.00~~ -

The spousal impoverishment values in the following table were effective July 1, 2020.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,873.34
Community Spouse Excess Shelter Cost Limit	$862.00
Community Spouse Maximum Income Allocation (monthly)	The lesser of $3,259.50 (as of 1/2021) or

	the Lower Income Allocation Limit plus excess shelter expenses
Family Member Income Allowance	$718.34
Community Spouse asset share (CSAS) maximum	$130,380.00 as of 1/2021

39.4.3 Institutional Cost of Care Values

The values in the following table were effective ~~July~~January 1, ~~2019~~2021.

Description	Amount
Daily Average Private Pay Nursing Home Rate	$~~287.29~~303.38
Monthly Average Private Pay Nursing Home Rate	$~~8,738.40~~9,227.81
Monthly Rate for State Centers for Persons with Developmental Disabilities	$~~27,930.10~~25,709.69

39.4.4 Maximum Cost Share Amount for Family Care, Family Care Partnership, or PACE

The values in the following table were effective ~~January~~February 1, ~~2020~~2021.

Description	Amount
Maximum Cost Share Amount for an individual in Group B+ for	$2,~~837.25~~903.45

Family Care, Family Care Partnership, or PACE	

39.5 FEDERAL POVERTY LEVEL TABLE

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL
1	$12,760880	$1,063073.33	$1,276288.00	$1,414.23427.53	$1,435.50449.00	$1,595610.
2	$17,240420	$1,436451.67	$1,724742.00	$1,910.77930.72	$1,939.50959.75	$2,155.0111
3	$21,720960	$1,810830.00	$2,172196.00	$2,407.30433.90	$2,443470.50	$2,715745.
4	$26,200500	$2,183208.33	$2,620650.00	$2,903.83937.08	$2,947.50981.25	$3,275.0030
5	$30,68031,040	$2,556586.67	$3,068104.00	$3,400.37440.27	$3,451.50492.00	$3,835880.
6	$35,160580	$2,930965.00	$3,516558.00	$3,896.90943.45	$3,955.504,002.75	$4,395.004 0
7	$39,64040,120	$3,303343.33	$3,9644,012.00	$4,393.43446.63	$4,459513.50	$4,9555,01
8	$44,120660	$3,676721.67	$4,412466.00	$4,889.97949.82	$4,963.505,024.25	$5,515.0151
9	$48,60049,200	$4,050100.00	$4,860920.00	$5,386.50453.00	$5,467.50535.00	$6,075150.
10	$53,080740	$4,423478.33	$5,308374.00	$5,883.03956.18	$5,971.506,045.75	$6,635.0070
11	$57,56058,280	$4,796856.67	$5,756828.00	$6,379.57459.37	$6,475556.50	$7,195285.

12	$62,040820	$5,170235.00	$6,204282.00	$6,876.10962.55	$6,979.507,067.25	$7,755.008 0
13	$66,52067,360	$5,543613.33	$6,652736.00	$7,372.63465.73	$7,483.50578.00	$8,315420.
14	$71,000900	$5,916991.67	$7,100190.00	$7,869.17968.92	$7,987.508,088.75	$8,875.019 1
15	$75,48076,440	$6,290370.00	$7,548644.00	$8,365.70472.10	$8,491599.50	$9,435555.
16	$79,96080,980	$6,663748.33	$7,9968,098.00	$8,862.23975.28	$8,995.509,110.25	$9,995.001 2.50
17	$84,44085,520	$7,036126.67	$8,444552.00	$9,358.77478.47	$9,499.50621.00	$10,555690
18	$88,92090,060	$7,140505.00	$8,8929,006.00	$9,855.30981.65	$10,003.50131.75	$11,115.00 50
19	$93,40094,600	$7,783883.33	$9,340460.00	$10,351484.83	$10,507642.50	$11,675825
20	$97,88099,140	$8,156261.67	$9,788914.00	$10,848.37988.02	$11,011.50153.25	$12,235.01 51
21	$102,360103,680	$8,530640.00	$10,236368.00	$11,344.90491.20	$11,515.50664.00	$12,795960
22	$106,840108,220	$8,9039,018.33	$10,684822.00	$11,841.43994.38	$12,019.50174.75	$13,355.00 50
23	$111,320112,760	$9,276396.67	$11,132276.00	$12,337.97497.57	$12,523685.50	$13,91514, 01
24	$115,800117,300	$9,650775.00	$11,580730.00	$12,834.5013,000.75	$13,207.50196.25	$14,475.00 50

each additional person	$4,~~480~~540	$~~373~~378.33	$~~448~~454.00	$~~496.53~~503.18	$~~504.00~~510.75	$~~560.00~~567
		QMB BC+ Extensions trigger limit BC+ Adults limit MAPP premium limit	SLMB	BC+ adult premium limit	QI-1 (~~slmb~~SLMB+)	~~MAPP prem limit~~

		Annual figures for SeniorCare	

39.6 COST-OF-LIVING ADJUSTMENT

To calculate the *COLA disregard* amount, do the following:

1. Find the *AG*'s current gross *OASDI* Benefits income. The gross OASDI income is the sum of the following:

    - OASDI check.
    - Any amount that has been withheld for a Medicare premium.
    - Any amount withheld to repay an earlier overpayment.

    Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.

2. On the COLA Disregard Amount Table below, find the last month in which the person was eligible for and received a check for both OASDI and *SSI*.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount	
January to December 2020	0.012833
January to December 2019	0.~~015748~~028379
January to December 2018	0.~~042556~~054843
January to December 2017	0.~~061330~~073376
January to December 2016	0.~~064137~~076148
January to December 2015	0.~~064137~~076148
January to December 2014	0.~~079781~~091590
January to December 2013	0.~~093380~~ 105015
January to December 2012	0.~~108535~~119976
January to December 2011	0.~~139513~~150556

January to December 2010	0.~~139513~~ 150556
January to December 2009	0.~~139513~~ 150556
January to December 2008	0.~~186685~~197123
January to December 2007	0.~~204971~~215174
January to December 2006	0.~~230369~~ 240245
January to December 2005	0.~~260681~~270169
January to December 2004	0.~~280118~~289356
January to December 2003	0.~~294924~~303973
January to December 2002	0.~~304659~~313582
January to December 2001	0.~~322280~~330977
January to December 2000	0.~~345198~~ 353601
January to December 1999	0.~~360545~~368751
January to December 1998	0.~~368751~~376852
January to December 1997	0.~~381734~~389669
January to December 1996	0.~~399159~~ 406870
January to December 1995	0.~~414385~~421900
January to December 1994	0.~~430335~~437646
January to December 1993	0.~~444771~~451897
January to December 1992	0.~~460493~~467861
January to December 1991	0.~~480177~~486848
January to December 1990	0.~~506809~~513138
January to December 1989	0.~~528948~~ 534993

January to December 1988	0.~~547066~~552878
January to December 1987	0.~~565322~~570900
January to December 1986	0.~~570900~~ 576407
January to December 1985	0.~~583803~~ 589144
January to December 1984	0.~~597877~~603037
July 1983 to December 1983	0.~~611475~~616461
July 1982 to June 1983	0.~~638245~~642888
July 1981 to June 1982	0.~~674681~~678856
July 1980 to June 1981	0.~~715381~~719034
July 1979 to June 1980	0.~~741020~~744344
July 1978 to June 1979	0.~~756827~~759947
July 1977 to June 1978	0.~~770375~~773321
July 1976 to June 1977	0.~~784187~~786956
July 1975 to June 1976	0.~~800173~~802737

39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs, depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his or her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1:** Co-Payment (Annual income is at or below 160% of the *FPL*.)
- **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b**: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL may be adjusted annually. See 39.5 Federal Poverty Level Table for current FPLs. If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $20,~~416~~608 per individual or $27,~~584~~872 per couple annually.*	▪ No deductible or spenddown. ▪ $5 co-pay for each covered generic prescription drug. ▪ $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL**	▪ $500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the $500 deductible is met. ▪ After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

$20,~~417~~609 to $25,~~520~~760 per individual and $27,~~585~~873 to $34,~~480~~840 per couple annually.*	
Level 2b **Income above 200% and at or below 240% of FPL** $25,~~521~~761 to $30,~~624~~912 per individual and $34,~~481~~841 to $41,~~376~~808 per couple annually.	▪ $850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $30,~~625~~913 or higher per individual and $41,~~377~~809 or higher per couple annually.*	▪ Pay retail price for drugs equal to the difference between the member's and $30,~~625~~913 per individual or $41,~~377~~809 per couple. This is called "spenddown." ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an $850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the ~~2020~~2021 federal poverty guidelines, which typically increase by a small amount each year.