

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

To: Medicaid Eligibility Handbook (MEH) Users

From: Rich Albertoni, Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 10-02**

Release Date: 06/22/10
Effective Date: 06/22/10

EFFECTIVE DATE The following policy additions or changes are effective 06/22/10, unless otherwise noted. **Bold text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

CHANGES

**Nonfinancial (Chs. 4 - 14) > 5
Elderly, Blind, or Disabled
(EBD) > 5.10 MAPP Disability >
5.10.1 MAPP Introduction**

Old Text:
Sections 12 and 13 of the Application for Medicaid *Disability* form (F-10112) must be completed in full detail in all MAPP disability determination requests. ~~Requests for a MAPP disability determination should be accompanied by a letter specifying whether the request is for a MAPP disability determination, or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an *applicant* may move from regular Medicaid disability to MAPP disability.~~

New Text:
Sections 12 and 13 of the Application for Medicaid *Disability* form (F-10112) must be completed in full detail in all MAPP disability determination requests. **The Disability Page in Cares Worker Web should be coded to indicate whether the request is for a MAPP disability determination, or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an applicant may move from regular Medicaid disability to MAPP disability.**

**Financial (Chs. 15 - 19) > 15
Income > 15.3 Disregarded
Income > 15.3.14 Payments to
Native Americans**

Old Text:
~~#16 Disregard the first \$500 of the monthly income from Tribal Per Capita payments from gaming revenue.~~

New Text:
16 Disregard Tribal Per Capita payments from gaming revenue up to the first \$500 of the monthly payment per individual.

**Financial (Chs. 15 - 19) > 16
Assets > 16.1 Assets
Introduction**

New Text:
Effective 10/01/2009, children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including MAPP, Community Waivers, FamilyCare, etc.

**Financial (Chs. 15 - 19) > 16
Assets > 16.6 Non-Burial
Trusts > 16.6.7 Ho-Chunk
Tribal Trusts**

This new subsection was added.

New Text:
16.6.7 Ho-Chunk Tribal Trusts

The Ho-Chunk Tribe, under its tribal ordinances and in conjunction with the Indian Gaming Regulatory Act establishes irrevocable trusts for tribal members who are minors or determined to be legally incompetent. These irrevocable trusts are funded primarily with per capita distribution payments derived from gaming revenue. The Department of Health Services has determined that funds placed in these trusts, for the benefit of minors and individuals who are legally incompetent are considered to be owned by the Ho-Chunk Tribe and not the trust beneficiary. Therefore, the irrevocable Ho-Chunk Tribal Trusts established for minors or legally incompetent tribal members are considered to be unavailable assets for the tribal member's Medicaid eligibility determination.

Financial (Chs. 15 - 19) > 16
Assets > 16.7 Liquid Assets >
16.7.6 Treatment of Continuing
Care Retirement Community
(CCRC) Entrance Fees

Old Text:

This section was entirely rewritten.

New Text:

A Continuing Care Retirement Community (CCRC) or Life Care Community (LCC) typically provides a variety of living arrangements, from independent living through skilled nursing care. Potential residents frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Effective January 1, 2009, entrance fees paid by an individual to a CCRC or LCC are counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when all of the following conditions apply:

1. The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care. It is not necessary for the CCRC or LCC to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met,
2. The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community. It is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies, and
3. The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community. An ownership interest generally means the right to possess and convey property, but recognize that it might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not they have an ownership interest in the CCRC or LCC by presenting documentation from the facility to that effect. If the CCRC or LCC confirms that the entrance fee does not confer an ownership interest to the resident, then this third condition is met.

Entrance fees which meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the elderly, blind, and disabled, regardless of whether or not the individual is requesting long term care services. An entrance fee which does not meet all three conditions described above is an unavailable asset.

For Medicaid eligibility determinations, all normal spousal impoverishment rules regarding income and asset allocations for a community spouse are

applicable to married couples who reside in a CCRC or LCC, when one spouse resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in a more independent living setting. CCRC and LCC contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse, before determining the amount of resources that a resident must spend on his or her own care.

This provision must be applied to all Medicaid applications and eligibility reviews that occur on or after January 1, 2009, regardless of when the entrance fee was actually paid.

Financial (Chs. 15 - 19) > 16
Assets > 16.8 Real Property>
16.8.1 Home/Homestead
Property> 16.8.1.4 Home
Equity over \$750,000.00

This new subsection was added. Subsequent subsections were renumbered.

New Text:

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e. Institutional, Community Waivers, Family Care, Partnership or PACE) are not eligible for LTC services if the equity interest in their home is greater than \$750,000. S/he is still eligible for card services if all other eligibility requirements are met.

This restriction does not apply if a spouse, minor or disabled child resides in the home.

The \$750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an “undue hardship” for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines outlined in 17.17 Undue Hardship.

The equity value of a home is the current fair market value (FMV) minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

Note: Property tax assessments can be used to determine a property’s FMV if both the local agency and applicant/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 1: Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of \$760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob’s health deteriorates and he applies for a Community Waiver program. That application is denied because Bob’s equity interest in his home exceeds the LTC eligibility limit by \$10,000.

On December 15, 2009 Bob reapplies for a Community Waiver program and reports that on December 1, 2009, he took out a \$12,000 home equity loan and used the entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob’s December 15, 2009 application for Community Waivers is approved because Bob’s equity interest in his home is now \$748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 2: Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of \$1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the \$750,000 LTC eligibility limit, his wife resides in the home, which negates the \$750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e. nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals who are current recipients of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC recipient who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the \$750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

**Financial (Chs. 15 - 19) > 17
Divestment (All)**

This entire chapter was rewritten. The changes are too numerous to list. The information on divestment in this handbook release includes information from [Operations Memo 09-01](#), which is made obsolete by this handbook release. This policy is effective 01/01/09.

**Subprograms (Chs. 24- 38) >
24 SSI Related Medicaid and
Deductibles > 24.6 Changes
During the Deductible Period>
24.6.2 Group Size Changes**

Example 4 was rewritten.

New Text:

Example 4: John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group. On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be recalculated using the smaller group size (one person fiscal test group) as of March 1.

**Subprograms (Chs. 24- 38) >
27 Institutional Long Term
Care (ILTC) > 27.1
Institutions> 27.1.2
Institutions for Mental
Disease> 27.1.2.2 Temporary
Leave**

New Text:

A person aged 21 through 64 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 s/he 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 s/he is unconditionally released from the IMD, or turns 22, whichever comes first.**

**Subprograms (Chs. 24- 38) >
27 Institutional Long Term
Care (ILTC) > 27.11
Institutions for Mental Disease
(IMDs)**

New Text:

Brown

Bellin Psychiatric Center, **Green Bay**

Brown County Mental Health Center, Green Bay

Libertas Center, Green Bay (aka St. Joseph's)

Dane

Mendota Mental Health Institute, **Madison**

Fond du Lac

Fond du Lac County Health Care Center

Milwaukee

Aurora Psychiatric Hospital, **Milwaukee**

Rogers Memorial Hospital, **Milwaukee**

**Milwaukee County Behavioral Health, 144 bed psychiatric hospital –
license #229, Milwaukee**

Trempealeau

Trempealeau County **Health Care Center IMD, Whitehall - license # 2961**

Trempealeau County IMD, Whitehall - license # 5001

Waukesha

Rogers Memorial Hospital, **Oconomowoc**

Waukesha County Mental Health Center, **Waukesha**

Winnebago

Winnebago Mental Health Institute, **Winnebago**

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid applicant/recipient resides.

**Subprograms (Chs. 24- 38) >
28 Home and Community
Based Waivers Long Term
Care (HCBWLTC) > 28.2
HCBWLTC Application> 28.2.3
Minors**

Old Text:

Minors are not eligible for waiver services unless they have been determined disabled (5.2 Determination of Disability). Consider only the disabled child's ~~assets and~~ income unless the parents make an actual cash contribution to the child. If they do, include that amount as part of the child's unearned income (28.6 HCBWLTC Uniform Fee System).

**Subprograms (Chs. 24- 38) >
28 Home and Community
Based Waivers Long Term
Care (HCBWLTC) > 28.14
HCBWLTC Children's Long
Term Care**

This new section was added in this release. The changes are too numerous to list.

**Subprograms (Chs. 24- 38) >
29 Family Care Long Term
Care (FCLTC) > 29.5 FCLTC
Enrollment/ Disenrollment and
Intercounty Moves> 29.5.4
Inter-county Moves**

Old Text:

When a FC enrollee moves permanently to a non-MCO county, s/he can remain enrolled in the MCO only if the Resource Center worker informs IM that the following four conditions are met:

1. S/he is eligible for COP or waiver services.
2. After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, CBRF, or AFH).
3. The enrollee's placement in the long-term care facility is done under and

pursuant to a plan of care approved by the MCO.

4. ~~The enrollee resided in the MCO county for at least six months prior to the date on which s/he moved to the non-MCO county.~~

**Subprograms (Chs. 24- 38) >
36 Well Woman Medicaid
(WWMA) (all subsections)**

This entire section was rewritten based on the changes in [Ops Memo 09-54](#), which is made obsolete with this handbook release. The changes are too numerous to list.