

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
1 W. Wilson St.
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To: Medicaid Eligibility Handbook (MEH) Users

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

Re: **Medicaid Eligibility Handbook Release 10-03**

Release Date: 11/15/10
Effective Date: 11/15/10

EFFECTIVE DATE The following policy additions or changes are effective 11/15/10, unless otherwise noted. **Yellow text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

CHANGES

Apps and Reviews (Chs. 2-3) > 2 Applications > 2.7 Timeframes > 2.7.1 Timeframes Introduction

New Text:

If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, **as a result of their most recent Medicaid application**, redetermine eligibility using the filing date associated with that most recent application.

Apps and Reviews (Chs. 2-3) > 3 Reviews > 3.1 Reviews > 3.1.2 Choice of Review

New Text:

The member has the choice of the following methods for any Medicaid review:

1. Face-to-Face Interview,
2. Telephone Interview.
3. Mail in: Mail in renewals can be submitted using the paper application (**F- 10101**) or the pre-printed renewal packet generated through CWW. Cases requesting to complete a Mail In renewal must be sent the pre-printed renewal packet if the case includes a blind or disabled child, **or**
4. ACCESS

Financial (Chs. 15 - 19) > 15 Income > 15.2 Prospective Income > 15.2.2 Prorating Income

New Text:

Prorated Income is an Unavailable Asset

A source of income which is received in a particular month cannot also be counted as an asset for that same month. This policy also applies to income which has been prorated and will be budgeted over the appropriate prorated period (e.g. 12 months). The client is expected to use this prorated income for their personal needs over an extended period of time. Therefore, any unbudgeted balance is an unavailable asset during the period of time for which the prorated income is being counted. The amount of the unavailable asset will decrease with each month in which the prorated income is budgeted.

Example 3: Jay regularly receives a \$1200.00 annual payment from a wealthy relative every January. This income is prorated over 12 month so \$100 per month is counted as unearned income beginning in January. The initial \$1200 payment and any remaining unbudgeted balance is an unavailable asset during the 12 month budgeting period. In January the entire \$1200.00 is considered unavailable. In February, \$1100.00 is considered unavailable. The unavailable amount will decrease with every month that income from this source is counted.

**Financial (Chs. 15 - 19) > 15
Income > 15.3 Disregarded
Income > 15.3.7 Foster Care**

New Text:

Disregard *foster care* payments. Foster care payments are considered to be the income of the child or *adult* who is receiving foster care and these payments are exempt income for the foster care recipient. However in some situations the foster care recipient uses these payments to pay the foster parent for their room and board expenses. The room and board payments that are received by the foster parent are not disregarded and should be counted as non-exempt earned income (See [15.5.15](#)) for the foster parent's Medicaid eligibility determination.

**Financial (Chs. 15 - 19) > 15
Income > 15.4 Unearned
Income**

New Text:

Count all Alimony, Maintenance, and Other Spousal Support Payments.

**Financial (Chs. 15 - 19) > 15
Income > 15.7 Income
Deductions > 15.7.1
Maintaining Home or
Apartment**

New Text:

If an institutionalized person has a home or apartment, deduct an amount from his/her income to allow for maintaining the home or apartment that does not exceed the SSI payment level plus the E supplement for one person (See [39.4.1](#)).

**Subprograms (Chs. 24- 38) >
28 Home and Community
Based Waivers Long Term
Care (HCBWLTC) > 28.14
HCBWLTC Children's Long
Term Care > 28.14.2 CLTC
CARES Processing**

New Text:

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

If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, SSI Medicaid or Katie Beckett Medicaid (see [28.8.1](#) for waiver processing instructions for Katie Beckett MA individuals), the child will be eligible as a Group A Waiver.

**Subprograms (Chs. 24- 38) >
29 Family Care Long Term
Care (FCLTC) > 29.4 FCLTC
Functional Eligibility**

New Text:

Resource Center staff use the Long Term Care Functional Screen to assess a Family Care applicant's long term care needs and to determine level of care. The functional level of care information is provided to the IM Worker so that s/he can determine eligibility for Family Care.

Effective January 1, 2008 the levels of care are:

1. Nursing Home (formerly Comprehensive NH)
2. Non-Nursing Home (formerly Intermediate and Comprehensive non-NH)

**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**

A typo was fixed.

New 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 **three** 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.

**Subprograms (Chs. 24- 38) >
30 Partnership Long Term
Care > 30.5 Partnership
Enrollment/Disenrollment and
Intercounty Moves > 30.5.4
InterCounty Moves**

New 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 **three** 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.

**Subprograms (Chs. 24- 38) >
31 PACE (Program of All-Inclusive Care for the Elderly)
> 31.1 Program of All-Inclusive Care for the Elderly (PACE)**

New Text:

This chapter is under development. In the meantime, please see the following Operations Memos for information on this program.

- [99-98](#)
- [00-82](#)
- [01-43](#)
- [01-79](#)
- [07-63](#)
- [10-48](#)

**Subprograms (Chs. 24- 38) >
37 IRIS > 37.1 IRIS**

This new chapter was added, based on Ops Memo 08-38

New Text:

37.1.1 Introduction

The Include, Respect I Self-Direct (IRIS) program is a fee for service alternative to Family Care, PACE or Partnership for individuals requesting a long-term care support program in Family Care counties.

Under IRIS, the participant will be able to access services comparable to those provided under the Home- and Community-Based Waivers (HCBW) while managing an individual budget to meet their service needs.

37.1.2 Role of the Aging and Disability Resource Center

Since self-directed supports are also available under the Family Care program, participants must be fully aware of the available choices and understand the implications of choosing one option over the other in order to make a meaningful decision. Aging and Disability Resource Centers (ADRCs) will be responsible for informing participants of all available options through an objective enrollment counseling process.

ADRCs will inform IM agencies of persons choosing to enroll in IRIS and provide the IM worker with certain information necessary to determine IRIS eligibility, such as functional eligibility information, medical/remedial expenses, and program start date.

37.1.3 IRIS Eligibility

The IRIS option is available to people living in Family Care counties when they come to the ADRC and are found in need of publicly-funded long term care services. It is also available to Family Care members (and Partnership members, if Partnership is also operated in the county) if the member requests to change to IRIS. (Such individuals would need to be disenrolled from their managed care long-term support program in order to participate in IRIS).

Individuals who wish to participate in IRIS must meet the following criteria in order to qualify:

- Reside in a county operating Family Care,
- Have a nursing home level of care as determined by the LTC Functional Screen, and
- All Medicaid Home- and Community-Based waiver financial and non-financial eligibility criteria

37.1.4 IRIS In CARES

IRIS Waivers should be entered in CARES using the COP Waiver type. IRIS cost share information will not be available on the cost share reports produced for Family Care and Partnership members, IM workers may have to provide this information to the ADRC if the ADRC is not able to query the budget pages in

CWW.

Glossary

New Text:

IRIS - "Include, Respect, I Self-Direct" - A Medicaid waiver program.