

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 11-01**

Release Date: 04/04/11
Effective Date: 04/04/11

EFFECTIVE DATE The following policy additions or changes are effective 04/04/11, unless otherwise noted. **Yellow text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

CHANGES

All References to EDS were changed to HP Enterprise Services throughout the handbook.

**Introduction (Ch 1) > 1.1
Introduction To Medicaid>
1.1.3 Financial Introduction>
1.1.3.3 Disabled Minors**

Old Text:

A blind or disabled minor (or dependent 18 year old) ~~would~~ have their Medicaid eligibility determined according to special procedures when the disabled minor fails BadgerCare Plus ~~financial~~ tests. See section 15.1.2 Special Financial Tests for Disabled Minors.

New Text:

A blind or disabled minor (or dependent 18 year old) **can** have their Medicaid eligibility determined according to special procedures when the disabled minor fails BadgerCare Plus eligibility test **or when the parent chooses to decline BC+ for their child and have their child receive EBD Medicaid if eligible.** See section 15.1.2 Special Financial Tests for Disabled Minors.

**Nonfinancial (Chs. 4 - 14) > 5
Elderly, Blind, or Disabled
(EBD) > 5.9 Presumptive
Disability> 5.9.2 PD
Determined By The IM
Workers**

New Text:

When a *member* has an urgent need for medical services attested to in writing by a medical professional, and is likely to be found disabled by DDB because of an apparent impairment, the member may be certified as presumptively disabled by the IM worker. **When the IM worker is making the PD decision, they should do so as quickly as possible. However, the normal 30 day application processing requirements (See 2.7.1) are still applicable even for PD determinations.**

**Financial (Chs. 15 - 19) > 17
Divestment > 17.5 Penalty
Period> 17.5.3 Penalty Period
Begin Date For Applicants>
17.5.3.2 Divestments That
Occurred On or After January
1, 2009**

New Text:

For divestments that occurred **on or after January 1, 2009**, the penalty period for an **applicant** for a HCBW program or FC begins on the date:

- The person applied for a HCBW/FC program **and**
- Meets the appropriate level of care and functional screen criteria **and**
- Meets all other Medicaid non-financial and financial eligibility requirements, regardless of whether or not the waiver funding is actually available

Note: If a person who had excess assets divests those assets during the 3 month backdated period of an application, they are ineligible for excess assets until the date that they divested those assets. The divestment penalty period as

well as the potential eligibility for card services would begin on the date of the divestment.

**Program Admin. (Chs. 20 - 23)
> 21 Benefits > 21.4 Covered
Services> 21.4.1 Covered
Services Introduction**

New Text:

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the Forward Health Provider Online handbook at:

<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>

A covered service is any medical service that Medicaid will pay for an eligible *member*, if billed. The Division of Health Care Access and Accountability(DHCAA) certifies qualified health care providers and reimburses them for providing Medicaid covered services to eligible Medicaid members. Members may receive Medicaid services only from certified 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 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 Preferred Drug Plan (PDP) card will be issued to them and it must be used for prescription drugs instead of their Forward Card.

Individuals who are enrolled in Medicare (Part A and/or B) and are Medicare Beneficiaries (See 32.1 Medicare Savings Programs - MSP), except for Qualified Disabled and Working Individuals (QDWI), are also be 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.

**Program Admin. (Chs. 20 - 23)
> 21 Benefits > 21.7 Forward
Health (Medicaid) Cards>
21.7.1 Medicaid Cards
Introduction**

New images of Forward Health and SeniorCare Cards were added to this section.

New Text:

ForwardHealth cards are issued to Medicaid members. These cards are permanent, plastic, and display the word "ForwardHealth" on them. Members use the same ForwardHealth card each month. Monthly cards are not issued.

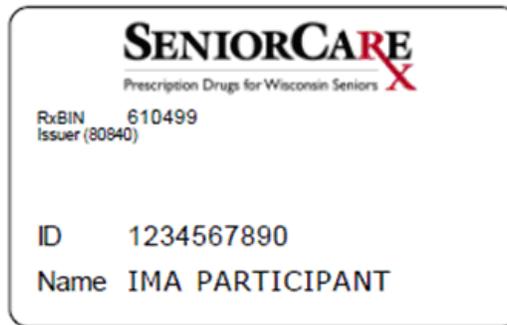
The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Cards should not be thrown away. If a member becomes eligible again, s/he will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can log into [ACCESS](#)> Change My Benefits or call Member Services at 1-800-362-3002.

BadgerCare Plus and Medicaid



SeniorCare



Subprograms (Chs. 24- 38) >
24 SSI Related Medicaid and
Deductibles > 24.9 Notice to
Fiscal Agent

This section was renamed from “Notice to EDS” to “Notice to Fiscal Agent.”

Old Text:

24.9 Notice to EDS

When the *member* receives a medical bill that is equal to or greater than the amount s/he still owes on the deductible, s/he can be certified for Medicaid.

S/he must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update ([F-10109](#)) to ~~EDS~~ indicating the amount of the bill that the member owes. ~~EDS~~ subtracts this amount from the bill and Medicaid pays the rest.

New Text:

24.9 Notice to Fiscal Agent

When the *member* receives a medical bill that is equal to or greater than the amount s/he still owes on the deductible, s/he can be certified for Medicaid.

S/he must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update ([F-10109](#)) to **the fiscal agent** indicating the amount of the bill that the member owes. **The fiscal agent** subtracts this amount from the bill and Medicaid pays the rest.

Subprograms (Chs. 24- 38) >
32 Medicare Savings
Programs (MSP) > 32.2 QMB>
32.2.3 QMB Income Limit

New Text:

Example 4: Big Al is a QMB recipient. He has income of **\$900.00**. The QMB income limit in December is **\$907.50**. In January, a COLA increase of \$11.17 increases Big Al's income to **\$911.17**. Disregard the COLA increase in any determination of Big Al's continuing QMB eligibility. On April 1st, new, higher QMB in-come limits are published. Redetermine Big Al's QMB eligibility in May. At this redetermination, do not disregard the January COLA increase.

**Subprograms (Chs. 24- 38) >
35 Long Term Care Insurance
Partnership (LTCIP) > MEH
35.1 Long Term Care
Insurance Partnership
(LTCIP)> 35.1.3 Verification>
35.1.3.2 Reciprocity Standards**

This section was renamed from “Verification of Residency” to “Reciprocity Standards.” Information from Ops Memo 10-71 was added.

Old Text:

35.1.3.2 Verification of Residency

~~The insured must have been a Wisconsin resident when the qualified LTCIP policy was issued. This must also be verified.~~

New Text:

35.1.3.2 Reciprocity Standards

Participation in Wisconsin’s LTCIP program is allowed for individuals who purchased qualified policies in any state that is subject to the LTCIP reciprocity standards as documented in that state’s Medicaid State Plan. Such states are referred to as "Participating States."

Contact the CARES Call Center if presented with a LTCIP policy issued by a state other than Wisconsin to see if the state is a Participating State.

If the policy was issued by a Participating State:

1. Apply the policies specified at 35.1.2 LTCIP Asset Disregard.
2. Apply the policies specified in this subsection, 35.1.3 Verification.

If the policy was not issued by a Participating State, the individual is not eligible to participate in Wisconsin’s LTCIP program. The LTCIP asset disregards and estate recovery offsets do not apply to such individuals.

**Appendix (Chs. 39-40) > 39
Tables > 39.5 FPL Table>**

Effective 02-01-11: The Federal Poverty Level table was updated. The changes are too numerous to list.