

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 11-02**

Release Date: 07/27/11
Effective Date: 07/27/11

EFFECTIVE DATE The following policy additions or changes are effective 07/27/11, 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) > 3 Reviews > 3.1 Reviews > 3.1.5 Administrative Renewals This new section was added based on information in Ops Memo 11-21. The effective date is May 1, 2011.

3.1.5 Administrative Renewals

An administrative renewal is an extension of program eligibility for certain low-risk cases based on the information in CARES as of the month prior to the review month. Cases selected for administrative renewal are cases that are highly unlikely to lose eligibility at renewal due to increases in income or assets.

The extension of program eligibility under an administrative renewal is based on the information in CWW as of the month prior to the month a full renewal would otherwise have been due. An administrative renewal case will not receive an eligibility renewal notice and is not required to provide the IM agency with any additional information in order to have program eligibility continued.

Administrative renewal cases remain subject to change reporting requirements. The administrative renewal notice 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.

MA cases that could be selected for administrative renewal include:

- SSI-related Medicaid
- Home and Community Base Waivers (HCBW)
- Managed Long Term Care (MLTC including Family Care, Partnership, PACE)
- Medicare Savings Programs (MSP)

MA cases must also meet all the following criteria to be selected for an administrative renewal:

SSI-related Medicaid

- No MAPP eligibility
- No earned income
- No Medicaid deductible
- Countable income at or below 84% FPL
- Countable assets at or below 50% of the asset limit

HCBW, MLTC (Family Care, PACE/Partnership)

- No spouse
- Living at home (i.e., living arrangement code must be "01")
- No Group B or C eligibility
- No Group A eligibility due to BC+, MAPP, or Medicaid deductible
- No earned income
- Countable income at or below 223% FPL
- Countable assets at or below 50% of the asset limit

Medicare Savings Programs

- Countable income at or below 120% FPL
- Countable assets at or below 50% of the asset limit

Open for Multiple Programs

If the case is open for MSP and one of the MA categories listed above, the case may be selected for administrative renewal if the Medicaid renewal is due and the case meets all the selection criteria listed above. If the MSP renewal is due but not the Medicaid renewal, or the case does not meet all the selection criteria listed above, the case will not be selected for administrative renewal.

Continuous Eligibility

To be selected for an administrative renewal, the case must be open and currently eligible with continuous program eligibility for at least the twelve month period prior to the month in which the case is being considered for an administrative renewal. Additionally, the case must have had at least one full regular renewal.

Alternate Years

Cases will not be selected for administrative renewal if the last renewal requirement was met through an administrative renewal. Administrative renewals will be done every other year. The exceptions to this rule are:

- HCBW or MLTC members who are Group A due to their eligibility for SSI or 1619b
- Family Planning Only Services cases where the only eligible case member is under 18 and will not turn age 18 in the current or next month.

New Text:

When the regular disability determination is denied by DDB, a new presumptive

(EBD) > 5.9 Presumptive Disability > 5.9.1 Presumptive Disability Introduction

Nonfinancial (Chs. 4 - 14) > 5 Elderly, Blind, or Disabled (EBD) > 5.9 Presumptive Disability > 5.9.5 Eligibility

disability determination can not be made for that individual unless there has been a change in the person's condition.

New Text:

PD-MA coverage begins on the date on which the presumptive disability finding is made by DDB or the IM worker.

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

The [F-10110](#) may be returned by:

1. Mail:
 - HP Enterprise Services
 - P.O. Box 7636
 - Madison, WI 53707
2. Email:
 - VEDS3070@wisconsin.gov
3. Fax:
 - (608) 221-8815

Do not grant retroactive eligibility until DDB makes a formal disability determination, (when the case folder is returned to the IM Agency). Once DDB does the final determination, the case may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met.

When backdating eligibility after DDB has made the formal disability determination, the member could qualify for Medicaid by meeting a 3 month deductible even if s/he had excess income in the 3 month backdate period. This is an exception to the normal 6 month Medicaid deductible requirements. The deductible amount for this 3 month deductible period will be the total excess income for those same 3 months. All other deductible rules will apply and the individual can be certified for Medicaid for that period on the first day they meet the deductible during that 3 month period.

Nonfinancial (Chs. 4 - 14) > 7 U.S. Citizen or Qualifying Immigrant > 7.3 Immigrants > 7.3.4 Immigration Status Chart

Information from Ops Memo 11-03 was added.

New Text:

CARES TCTZ Code	Alien Status	Arrived Before 08/22/96	Veteran/ Amerasian Arrived before 8-22-96	Arrived on or after 8-22-96	Veteran/ Amerasian Arrived on or after 8-22-96	Children under 19 and pregnant women
01	Lawfully admitted resident	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible effective 10-01-09
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210 (A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Alien	Eligible	Eligible	Ineligible for 5 years	Ineligible for 5 years	Eligible effective 10-01-09
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-born American Indian	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing - to be used for all persons admitted under one of the Class of Admission Codes found in the table in section 7.4.4	Ineligible	Ineligible	Ineligible	Ineligible	Eligible

**Nonfinancial (Chs. 4 - 14) > 9
Third Party Liability (TPL) >
9.5 Casualty Claim Process
(Subrogation) > 9.5.2 Reporting
Accident or Injury Claims**

Old Text:

If members are in an accident or are injured and receive a cash award or settlement due to the accident or injury and Medicaid pays for part or all of the care, it must be reported.

If a member has hired an attorney or is working with an insurance agency to settle the claim, that must also be reported.

1. If a member reports a claim and is:
2.
 - a. getting Supplemental Security Income (SSI) or
 - b. lives in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, Rock, Trempealeau, Vilas, Walworth, Waushara or Winnebago County,

they must report the accident or injury case to the Casualty Recovery Unit at :

Casualty Recovery
Bureau of Program Integrity
P.O. Box 6220
Madison WI 53716-0220
-
Telephone: (608) 221-4746 ext 80062
Fax: 608-221-4567

2. ~~All other Medicaid members should report in person or phone to their local agency before the case is settled. Refer casualty claims for Non-SSI recipients and members of agencies not listed in 1b above to HP Enterprise Services at 608-221-4567 or call at 608-221-4746 EXT 80062 with MA#, date of accident and insurance/attorney to bill.~~

New Text:

If a member has hired an attorney or is working with an insurance agency to settle the claim, that must also be reported.

1. If a member reports a claim and is:
 - a. getting Supplemental Security Income (SSI) or
 - b. **on the date of the accident or injury, lived** in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, **Milwaukee**, Rock, **Sheboygan**, Trempealeau, Vilas, Walworth, Waushara, or Winnebago County,

they must report the accident or injury case to the Casualty Recovery Unit at :

WI Casualty Recovery - HMS
5615 Highpoint Dr., Suite 100
Irving, TX 75038-9984

Telephone: (877)391-7471
Fax: (469)359-4319
e-mail: wicasualty@hms.com
Website: <http://www.wicasualty.com/wi/index.htm>

If the member is enrolled in an HMO or MCO they must also report the accident or injury to that organization.

2. **All other Medicaid members should report in person or phone their local**

agency and any HMO or MCO that may have provided services, before the case is settled. Members should include the date of the accident and any insurance/attorney information.

Financial (Chs. 15 - 19) > 16 Assets > 16.6 Non-Burial Trusts > 16.6.6 Pooled Trusts

New Text:

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

Financial (Chs. 15 - 19) > 17 Divestment > 17.5 Penalty Period

Information from Operations Memo 11-29 was added. The effective date is July 1, 2011.

The average nursing home cost for a private pay patient was raised from \$6,216 to \$6,554. The math in several examples was changed because of this.

Financial (Chs. 15 - 19) > 18 Spousal Impoverishment > 18.6 Spousal Impoverishment Income Allocation > 18.6.2 Worksheet 7 Section A -- Community Spouse Income Allocation

The amounts used in the Community Spouse Income Allocation were updated. The effective date is October 1, 2010. The CARES tables were updated timely.

If <i>Community Spouse</i> pays:	Add
Heat and utilities	\$433
Utilities only	\$299
Telephone only	\$33

~~If the community spouse lives in a condominium or cooperative~~

Program Admin. (Chs. 20 - 23) > 20 Verification > 20.2 General Rules

Old Text:

1. Apply these verification instructions only to Medicaid.

New Text:

1. Apply these verification instructions only to health care programs.

Program Admin. (Chs. 20 - 23) > 22 Administration > 22.1 Estate Recovery > 22.1.2 Recoverable Services

Old Text:

5. ~~In pilot counties,~~ Family Care services received by members age 55 or older on or after February 1, 2000 and:

New Text:

5. Family Care services received by members age 55 or older on or after February 1, 2000 and:

Program Admin. (Chs. 20 - 23) > 22 Administration > 22.2 Corrective Action > 22.2.1 Overpayments > 22.2.1.1 Recoverable Overpayments

Old Text:

~~**Example 1:** Joe and his family were determined eligible for BadgerCare with a premium in July. In November, Joe's worker learned that, effect August 1st, Joe had access to health insurance for his family through his employer, with the employer paying more than 80% of the premium for this coverage. The worker entered the information in CARES and closed the case effective November 30th.~~

~~What can now be recovered?—~~

~~Because Joe did not report the insurance access to his worker, the capitation payments to the BadgerCare HMO for the months he was incorrectly certified for BC are overpayments. With AA notice, BadgerCare would have ended August 31st. The overpayment would be the amount of HMO capitation payments less any premiums paid for September, October and November.~~

~~**Example 4:** John and his family were determined eligible for BadgerCare in June. John accepted a new job in South Carolina and the family moved out of state on July 20th. Since they were no longer residents of Wisconsin, they were no longer eligible for BC. However, because the move to South Carolina was not reported, capitation payments continued to be made for John and his family until~~

the worker closed the case effective December 31st.

-
What can now be recovered?

Giving 10 days to report and following AA logic, the case would have closed August 31, 2005. Fee For Service claims and/or HMO capitation payments for September, October, November and December are recoverable.

Example 5: Susan was determined eligible for Healthy Start in January; she was pregnant with a due date of August 15th. On February 3rd, she miscarried but did not report this change to her worker. Her HS eligibility continued until the worker closed the case effective October 31st. Once she was no longer pregnant, she would have been eligible for the two month extension only. Susan was not eligible for the months May through October.

What can now be recovered?

The change should have been reported in February. Allowing for the 2 month extension, Healthy Start should have closed April 30. Since the change to the law was not effective until July 27, 2005, claims with dates of service on or after July 27th are recoverable.

New Text:

Example 1: Ed applied for EBD Medicaid and was found eligible effective November 1, 2010. Ed originally reported \$1800 of non-exempt assets (checking and savings accounts) which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several non-exempt vehicles with an equity value of \$1000. The agency discovers Ed's ownership of these vehicles on February 10, 2011. On February 20, 2011, the agency receives verification that the equity value of Ed's non-exempt vehicles and other non-exempt assets has continuously exceeded the \$2000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Adverse Action on February 22, 2011, advising him that his eligibility is being discontinued effective March 31, 2011. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Ed from November 1, 2010 through March 31, 2011.

Example 4: Joe has been a Medicaid recipient since January 1, 2009. During a December 2010 eligibility review, the agency discovers that Joe won a \$10,000 lottery that was paid to him on June 12, 2010. Joe never reported the receipt of these lottery winnings and still has about \$8000 from the lottery proceeds. The agency verifies that Joe's non-exempt assets have been in excess of the \$2000 Medicaid asset limit since June 12, 2010 and sent him a Notice of Adverse Action, advising him that his Medicaid eligibility is ending effective January 31, 2011. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 2010 through January 31, 2011. June 2010 and July 2010 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe would have reported this change timely (no later than June 22, 2010), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 2010.

Program Admin. (Chs. 20 - 23)
> 22 Administration > 22.2
Corrective Action > 22.2.1
Overpayments > 22.2.1.2 Non-
Recoverable Overpayments

Old Text:

Example 6: Mom and child are on AFDC Medicaid. They concealed income which would have made the mom ineligible. The child would still have been eligible under Healthy Start. Only recover the incorrect payments made for the mom.

New Text:

Example 5: A Medicaid EBD recipient reports on March 25, 2011 that they have received a \$50,000 inheritance on March 23, 2011. The agency sends the member the required Notice of Adverse Action discontinuing their eligibility

effective April 30, 2011. Even though the member had excess assets during March and April 2011, there is no Medicaid overpayment for those months because the change was reported timely, and the agency was required to provide the appropriate and timely Notice of Adverse Action before discontinuing the member's eligibility. Benefits issued only because of our timely notice requirements are not overpayments and are not subject to recovery.

Subprograms (Chs. 24- 38) > 24 SSI Related Medicaid and Deductibles > 24.3 Deductible Period

New Text:

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. It begins in the month which the *applicant* chooses, and it ends six months later. See 5.9.5 Eligibility for an exception to the 6 month deductible period for backdate periods after a formal disability determination has been made for a member certified under a PD.

Subprograms (Chs. 24- 38) > 32 Medicare Savings Programs (MSP) > 32.1 Medicare Savings Programs (MSP)> 32.1.5 Part B Enrollment Via The MPAP Buy-In Program

This new subsection was added.

New Text:

Members receiving Medicare Part A coverage, who chose not to enroll in Part B, may be eligible for the State to enroll them into Part B with no increase in the premium, via the MPAP Process. The MPAP eligibility should be determined in CWW. If the member is eligible for MPAP, the worker must contract the ForwardHealth Medicare Buyin Analyst by phone, email, or by filling out a F-10110 stating when the member will begin their Buyin eligibility. The Buyin analyst will create a manual transaction to send to CMS with the appropriate MPAP information. Once CMS processes the record, the member should be enrolled into Part B with coverage beginning the first month of MPAP eligibility.

Example 1: In January 2011, the member applies for QMB benefits and is only receiving Part A Coverage. The case worker determines the member qualifies for QMB starting 02/2011. After the confirmation is done in CARES, the worker contacts the ForwardHealth Buyin Analyst to report the enrollment. The Buyin Analyst creates a transaction with the QMB information. This transaction is sent to CMS in February.

Once CMS processes the record and bills the State, the member will show Part B coverage starting 02/2011.

Appendix (Chs. 39-40) > 39 Tables > 39.4 EBD Assets and Income Tables> 39.4.2 EBD Deductions and Allowances

Information from Ops Memo 11-22 was added. The effective date was July 1, 2011.

	Description	Amount
1	Personal Needs Allowance (effective 7/1/01)	\$45.00
7	Community Spouse Lower Income Allocation Limit	\$2,451.67
8	Community <i>Spouse</i> Excess Shelter Cost Limit	\$735.50
9	Family <i>Member</i> Income Allowance	\$612.92

Appendix (Chs. 39-40) > 39 Tables > 39.11 SeniorCare Income Limits and Participation Levels> 39.11.5 Level 3: Spenddown

The income in the examples were updated.