

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

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To: Medicaid Eligibility Handbook (MEH) Users

From: Shawn Smith, Bureau Director  
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 14-01**

Release Date: 05/01/2014  
Effective Date: 05/01/2014

**EFFECTIVE DATE**

The following policy additions or changes are effective 05/01/2014, unless otherwise noted. **Grey highlighted text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

**CHANGES**

**1.1.4 Health Care Choice**

~~It is possible for individuals to qualify for both BC+ and Elderly, Blind and Disabled Medicaid (EBD MA). In some circumstances, CARES will automatically enroll the individual in the program with the best benefit plan and lowest cost share. The individual has the right to request coverage under the program not chosen by CARES. See table below. The change is effective in the next possible payment following Adverse Action, unless the member requests the change be effective in the month the request to change the health plan was made.~~

~~When CARES is unable to make an automatic choice between BC+ and EBD MA, a notice requesting the individual to make a choice will be generated. Once the member has made a choice the decision remains in effect until:~~

- ~~1. The member requests a change, or~~
- ~~2. The member's benefit under the health plan of his or her choice ends.  
(This includes being placed into an unmet deductible assistance group.)~~

The table has been removed.

Once an individual has been determined eligible for Elderly, Blind or Disabled Medicaid (EBD MA), s/he must be enrolled in EBD MA, even if they are also eligible for BadgerCare Plus (BC+), unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BC+. In these instances, the pregnant woman will be enrolled in BC+.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD MA and can enroll in BC+. Pending for EBD MA includes, but is not limited to, waiting for a disability determination from DDB or not eligible for Medicare. If an individual enrolled in EBD MA becomes ineligible for EBD MA for any reason, including going over the asset limit or failure to pay a MAPP premium, s/he can enroll in BC+ if s/he is still eligible to do so.

**2.5.3 Spousal Impoverishment MA Signatures**

All spousal impoverishment MA applications and reviews require the signatures of both the institutionalized person and the community spouse, or of another authorized person a person authorized to sign for them.

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

~~If the community spouse's signature is missing, test the institutionalized person's eligibility as if s/he were unmarried.~~

Beginning with applications dated November 11, 2013, if the community spouse refuses to sign the application, refuses to disclose the value of assets or refuses to provide required information on income or resources, deny the application unless the agency determines that denial of eligibility would result in undue hardship for the person (See 17.17 Undue Hardship).

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

When policy requires a witness to the institutionalized person's signature, the community spouse's signature must also be witnessed.

For ongoing cases where eligibility was determined without using spousal impoverishment rules, apply the spousal impoverishment rules at the next renewal. This includes completing an asset assessment using the couples assets on the first day of the month of the review month and determining eligibility for the next certification period by comparing the current combined assets of the couple to the total of the Community Spouse Asset Share plus the \$2000 asset limit for the institutionalized spouse.

### 6.8.2 Reciprocal Agreement

These are the states with which we have this agreement:

- Florida

### 6.9.2 Inmates Introduction

Individuals who are inmates of a public institution are not eligible for Medicaid, with two exceptions (outlined below). An inmate is a person who is residing in a public institution on an involuntary basis.

Individuals who are inmates of a public institution are not eligible for Medicaid, with the following two exceptions:

1. **Prenatal Exception** - Pregnant women may apply for and receive BCPP while they are an inmate.
2. **Inpatient Exception** - If an inmate resides outside of a public correctional institution for more than 24 hours at any one time, s/he can qualify for Medicaid during that time period if s/he meets all other eligibility criteria. For example, if an inmate of a public institution is admitted, as an inpatient to a medical institution for 24 hours or more, and is otherwise eligible, manually certify him/her for Medicaid from the admission date through the discharge date.

### 6.9.3 Inmates of State Correctional Institutions

1. Department of Corrections ( DOC ) staff submits an ~~paper application (F-10182 or F-10104)~~ ACCESS application, which will be systematically routed to EM CAPO. ~~The mailing address for the inmate will be the DOC central office.~~ Superintendents of state correctional facilities (Wardens) or their designee may sign the application for the inmate. Refer to 6.9.4 State Correctional Institutions for the list of state correctional facilities at which the Warden may sign the application.
2. Process the inmate as a one-person household and code ANLA with a living arrangement of "01- Independent (Home/Apt/Trlr)" on the demographics page.
3. If the inmate is between the ages of 19 and 64, and is not a pregnant

woman 65 years or older or ineligible for BC+ due to excess income, test for EBD, collecting asset information from DOC. If there is no disability determination on file, instruct DOC ~~will to~~ submit a Medicaid Disability Application (F-10112) along with the Medicaid application ( F-10101). Suppress the verification checklist for the MADA. Forward the disability application to the Disability Determination Bureau (DDB), even if there is no Confidential Information Release Authorization – Release to Disability Determination Bureau form (F-14014) signed by the inmate, and pend the Medicaid application in CARES until a disability determination has been made. If the disability determination is not made within the 30-day processing period, send a manual notice to the designated DOC staff person that the Medicaid eligibility determination has been delayed because additional information is needed.

**Note:** In many cases a Confidential Information Release Authorization – Release to Disability Determination Bureau form (F-14014) will not be necessary for DDB to obtain medical information from DOC. If a release is necessary, DDB will obtain it from DOC.

4. If the individual is eligible, close the case in CARES by changing the request on ACPA for Medicaid Health Care Request page to "N". Suppress CARES generated notices for Medicaid and any program the Individual has not requested. Manually certify the Individual with the appropriate medical status code (see below), from the hospital admission date through the date of discharge. If the individual has not yet been discharged, certify the individual from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility.

For a list of Med Stat Codes, see [Process Help 81.5](#).

[The table of Med Stat codes in the section has been removed.]

#### 6.9.4 State Correctional Institutions

The list of State Correctional Institutions has been updated.

#### 9.3 Health Insurance Risk Sharing Plan (HIRSP)

Coverage under the Health Insurance Risk Sharing Plan (HIRSP) ended as of April 1, 2014.

For information about coverage prior to April 1, 2014, please call HIRSP Customer Service at 1.800.828.4777 or go to <http://www.hirsp.org/>.

~~The Health Insurance Risk Sharing Plan ( HIRSP ) is available for purchase by Wisconsin residents under age 65 who are not able to find adequate health insurance coverage in the private sector.~~

~~Advise Medicaid members who are covered by HIRSP that they must let the HIRSP Authority know immediately when they begin Medicaid eligibility. To do this, contact:~~

~~HIRSP Authority  
Customer Service  
1751 W. Broadway  
P.O. Box 8961  
Madison, WI 53708-8961~~

~~Telephone: 1-800-828-4777 or (608) 221-4551~~

## 16.7.5 Life Insurance

Workers should enter the total of the face value plus any riders or other attachments as the "Face Value" on the Life Insurance Assets Page.

Face value is the basic death benefit of the policy ~~exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions~~ including the value of riders and other attachments.

Cash value means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it.

Count the cash value of all life insurance policies. For persons age 65 or over, blind or disabled, count it only when the total face value of all policies, including riders and attachments, owned by each person exceeds \$1,500. Do this calculation for each EBD person. In determining the face value, do not include any life insurance which has no cash value.

## 17.3 Look Back Period

This section was formerly listed as **17.3.1 Look Back Period Introduction**.

Effective January 1, 2014, the look back period is 60 months for all divestments

### 17.3.2 Divestments Prior To January 1, 2009

This section has been removed with this release.

### 17.3.3 Divestments On or After January 1, 2009

This section has been removed with this release.

## 17.4 Exceptions

2. The community spouse divested assets that were part of the community spouse asset share AND this transfer occurred more than five years after the institutionalized spouse was determined eligible:
  - a. Five years after the institutionalized person is determined eligible, the community spouse can divest assets that are part of the community spouse asset share (See 18.4.3 Calculate the CSA ). S/he can give them to anyone without affecting the eligibility of the institutionalized spouse.
  - b. Homestead property is an exception. After the institutionalized person has become eligible, s/he can transfer the homestead to the community spouse, and the community spouse can transfer it to anyone once five years have passed since the eligibility of the institutionalized spouse. The community spouse's divestment of homestead property five years after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.
  - c. ~~If the community spouse has assets that were not part of the community spouse asset share and that the eligible institutionalized spouse did not give to her, she can give them to anyone. Her divestment will not affect the institutionalized spouse's eligibility.~~

**Note:** While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination don't affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if s/he later enters an institution and applies for Medicaid.

Example 4 has been removed.

**17.5.2 Calculating the Penalty Period**

This section was formerly listed as **17.5.2.2 Penalty Period for Divestments on or after January 1, 2009.**

**17.5.2.1 Penalty Period for Divestments prior to January 1, 2009**

This section was removed with this release.

**17.5.3 Penalty Period Begin Date For Applicants**

This section was formerly listed **17.5.3.2 Divestments That Occurred On or After January 1, 2009.**

**17.5.3.1 Divestments That Occurred Prior to January 1, 2009**

This section was removed with this release.

**17.5.4 Penalty Period Begin Date For Recipients**

Example 9 was updated with this release.

Beginning with penalty periods with a start date of November 11, 2013 or later, a recipient's penalty period begins on the first of month after timely notice is given.

~~The penalty period begin date for a divestment that occurs after the member has been determined eligible is the first day of the month in which the divestment occurred.~~

~~Before the actual penalty can be imposed the IM agency must provide timely and adequate notice to the recipient, advising him/her of the negative action.~~

~~Whether benefits are recoverable during the time between the penalty period start date and the date the LTC benefits were terminated depends on whether the divestment was reported timely (within 10 days).~~

When a recipient divests, the IM worker must enter the date the divestment was reported as the transfer date on the Transfer/Divestment of Assets page. CARES will close the person using Adverse Action logic. The actual penalty period should be calculated based on the first day of the month of closure. Those dates should be entered in case comments to be adjusted with the monthly Divestment Report completed by the CARES Call Center.

Manual notices must be sent with the correct divestment dates.

**17.5.5.2 No Reduction for Partial Refund**

As of November 11, 2013, individuals who are currently serving a divestment penalty may receive no longer reduce this penalty period by receiving a partial refund of a previously transferred resource.

**Cash payment**

~~When part of a resource or its equivalent value is returned through a cash payment, the divested amount and the penalty period is recalculated only if the returned resource is used to pay for medical and remedial expenses incurred during the divestment penalty period or for the cost of care previously provided to the individual during the divestment penalty period.~~

~~The costs must be for care that was provided to an individual by a nursing home or other medical institution, a community based residential facility ( CBRF ), or other assisted living facility. The individual must verify that s/he used the refund to pay for previously provided care s/he was obligated to pay or other medical and remedial expenses.~~

~~Payments for care or remedial expenses provided by family members, (i.e. supportive home care), are not allowed under this partial refund policy unless~~

there was a written and notarized contract in existence at the time the service was provided, which specified the services that were being provided and the cost of those services. The cost for services cannot exceed reasonable compensation for the services provided. "Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

In situations where the partial refund is made with a non-cash item such as land, stocks, bonds, etc, the refund will result in a reduced penalty period even though no payment is made for previously incurred medical, remedial, or care expenses.

To shorten a divestment penalty period when some of the originally divested amount is returned, subtract the divestment amount returned from the original divestment amount. Then divide the divestment remainder by the original average nursing home pay rate that was used to calculate the original divestment penalty period. Use the begin date of the original divestment penalty period as the begin date of the new shortened penalty period.

Send the member a notice advising him/her that the consequence of the partial divestment payoff is a reduced penalty period and specify the new penalty dates.

### 18.4.3 Calculate the CSAS

Effective January 1, 2014

IF the total countable assets of the couple are:	Then the CSAS is:
\$231,840 \$234,480 or more	\$115,920 \$117,240
Less than \$231,840 \$234,400 but greater than \$100,000	½ of the total countable assets of the couple
\$100,000 or less	\$50,000

### 21.4.2 Transportation

This subsection has been rewritten with this release.

#### 22.1.2.1 QMB

As of January 1, 2010, payments for premiums, copays and deductibles for Medicare Part B for a the Qualified Medicare Beneficiary (QMB) Medicare Part B premiums are not recoverable through ERP.

QMB co-payments and deductibles paid by Medicaid are recoverable through ERP. They are only recoverable if the co-payment or deductible was used to pay for a Medicaid service that is recoverable.

### 32.6 Medicare Savings Programs Asset Limits

Effective January 1, 2014

QMB, SLMB, and SLMB+ have the same asset limit.

Group Size	Asset Limit
1	\$7,080 \$7,160
2	\$10,620 \$10,750

39.4.1 EBD Assets and Income Effective January 1, 2014  
Table

Group Size				
Category		1		2
EBD Categorically Needy Limits	Assets	\$2,000	Assets	\$3,000
	Income	\$564.45 (+ actual shelter up to \$240.33)	Income	\$853.38 (+ actual shelter up to \$360.67)
EBD Medically Needy Limits	Assets	\$2,000	Assets	\$3,000
	Income	\$591.67	Income	\$591.67
<b>SSI Payment Level</b>				
Federal SSI Payment Level	Income	\$710.00	Income	\$1,066.00
State Supplementary Payment ( SSP )	Income	\$ 83.78	Income	\$132.05
<b>Total</b>	<b>Income</b>	<b>\$793.78</b>	<b>Income</b>	<b>\$1,198.05</b>
SSI Payment Level + E Supplement	Income	\$900.77		
SSI E Supplement	Income	\$95.99		
Community Waivers Special Income Limit	Income	\$2,163		
Institutions Categorically Needy Income Limit	Income	\$2,163		
Substantial Gainful Activity limit (non-blind individuals)	Income	\$1,040		
Substantial Gainful Activity limit (blind individuals)	Income	\$1740		

**39.4.2 EBD Deductions and Allowances**

	Description	Amount
1	Personal Needs Allowance (effective 7/1/01)	\$45.00
2	EBD Maximum Personal Maintenance Allowance	\$2,163.00
3	EBD Deeming Amount to an Ineligible <i>Minor</i>	\$361.00
4	Community Waivers Basic Needs Allowance	\$901
5	Parental Living Allowance for Disabled Minors	<b>1 Parent</b> \$721.00 <b>2 Parent</b> \$1,082.00
6	<i>MAPP</i> Standard Living Allowance ( SLA ) SLA = SSI + State Supplement + \$20	\$824.00
7	<i>Community Spouse</i> Lower Income Allocation Limit	\$2,585.00
8	Community <i>Spouse</i> Excess Shelter Cost Limit	\$775.50
9	Family <i>Member</i> Income Allowance	\$646.42

**39.5 Federal Poverty Level (FPL) Table**

The Federal Poverty Level (FPL) table has been updated.

**39.6 Cost of Living Adjustment (COLA)**

The COLA Disregard Amount Table had been updated.

**39.11.1 SC Income Limits Introduction**

Effective February 1, 2014

Income Limits*	
<b>Level 1</b>	
<b>Income at or below 160% of FPL</b>	
At or below <del>\$18,834</del> \$18,672 per individual or <del>\$24,816</del> \$25,168 per couple annually.*	
<b>Level 2a</b>	
<b>Income above 160% and at or below 200% FPL</b>	
\$18,385 to <del>\$22,980</del> \$18,673 to \$23,340 per individual and <del>\$24,817 to \$31,020</del> \$25,169 to \$31,460 per couple annually.*	
<b>Level 2b</b>	
<b>Income above 200% - and at or below 240% of FPL</b>	
<del>\$22,981 to \$27,576</del> \$23,341 to \$28,008 per individual and <del>\$31,021 to \$37,224</del> \$31,461 to 37,752 per couple annually.	
<b>Level 3</b>	
<b>Annual income is above 240% of the FPL</b>	
<del>\$27,577</del> \$28,009 or higher per individual and <del>\$37,225</del> \$37,753 or higher per couple annually.*	