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:	Shawn Tessmann, Bureau Director Bureau of Enrollment Policy and Systems
Re:	**Medicaid Eligibility Handbook Release 15-03**
Release Date:	11/24/2015
Effective Date:	11/24/2015

EFFECTIVE DATE

The following policy additions or changes are **effective 11/24/2015** unless otherwise noted. **Grey highlighted text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

POLICY UPDATES

2.6.3 By ACCESS

The filing date on an ACCESS application is the date the application is electronically submitted ~~or the next business day if submitted after the agency's regularly scheduled business hours~~.

2.7.1 Time Frames Introduction

All applications received by an agency (except those submitted from the FFM) must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from ~~the filing date~~ when the agency receives the application. This includes issuing a notice of decision.

5.4.1 Disability Determination Bureau Action Introduction

To check on the status of a disability case, call (608) 266-1565 and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to ~~Cassandra Quinn at 608-266-8730~~ Betsy DeMets at 608-266-8732.

5.7.1 Redetermination Introduction

Complete and/or forward the following **paper** forms to DDB at

Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886

- Medicaid Disability Redetermination Report (F-10114).
- Signed Confidential Information Release forms.
- The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

~~Disability Determination Bureau~~
~~P.O. Box 7886~~
~~Madison, WI 53707-7886~~

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-832).

Item 9 (SSA-832) indicates the decision of (A) continuing, or (B) ceased.

Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If the member's disability is found to continue, the DDB will send the paper folder, which includes the SSA-832, to the IM agency to be kept until the next redetermination is made.

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid benefits will continue until a Hearing is held and a decision is made. DDB will retain the SSA-832 in these cases.

~~DDB will immediately send the SSA-832 to the IM agency whenever disability continues, but the form will be held by DDB in disability cessations.~~

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a paper folder with a revised SSA-832 will be sent to the IM agency at that time.

If the member appeals the proposed cessation and DDB is unable to reverse this decision, the file will be forwarded directly to the DHA for a hearing. DHA will notify the IM agency of their final decision.

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send the paper folder that contains the original SSA-832 to the IM agency following the expiration of the 45-day appeal period. DDB will add a Medicaid Disability Cessation Case note to the front of the folder to highlight these cases. See Section 5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text for an example.

7.2.1.2 Exempt Populations

The following populations are exempt from the new citizenship and identity documentation requirement:

- Anyone currently receiving SSDI or a Disabled Adult Child benefit (SSDC).

15.1.2 Special Financial Tests for Disabled Minors

This section has been rewritten.

15.3.14 Payments to Native Americans

18. Disregard Tribal Per Capita payments from gaming revenue up to the first $500 of the monthly payment per individual. If the payments are received less than monthly, prorate the gross payment amount over the months it is intended to cover and disregard $500 from the monthly amount.

    This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons **except** the following:

    - Senior Care ~~and~~
    - Long-term care programs such as the following: ~~Institutional Medicaid, Family Care, and HCBWs including Partnership and PACE.~~
        - Institutional Medicaid
        - HCBW
        - Managed Long-term Care/IRIS

For these subprograms, which are treated differently because they are covered under a different section of federal law, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.5.6 Worker's Compensation

Worker's compensation is compensation for lost wages which would have been earned, except for an injury suffered during the course of employment. Count worker's compensation as ~~earned income in Family Care Non-Medicaid. For EBD cases, it is~~ unearned income. The amount of the income is the amount that the applicant or member can access. This may be the entire lump sum if distributed at once or the monthly amount available for withdrawal if the total sum was placed in a restricted account (for example, as a result of a settlement).

15.5.10 Census 2010

15.5.10 Census ~~2010~~

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from his or her income to allow for maintaining the home, ~~or~~ apartment, or room at the assisted living facility that does not exceed the SSI payment level plus the E supplement for one person (see Section 39.4.1 EBD Assets and Income Table). The amount is in addition to the personal needs allowance (see Section 39.4.2 EBD Deductions and Allowances). It should be enough for mortgage, rent, property taxes (including special assessments), home or renters insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.

16.5.1 Burial Trusts

In non-spousal impoverishment EBD Medicaid cases, each fiscal group member may have one or more irrevocable burial trust, of which the total face value may not exceed ~~$3,000~~ $4,500. Any principal amount over ~~$3,000~~ $4,500 is a countable asset (see Section 18.4 Spousal Impoverishment Assets for information about burial assets for persons with a community spouse).

16.7.2 Loans

16.7.2 Loans, Reverse Mortgages, and Promissory Notes

The following information applies except as directed otherwise in Section 16.7.2.1 Reverse Mortgage and Section 16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes.

If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes

This section is new.

16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case

This section is new.

17.5.3 Penalty Period Begin Date for Applicants

For divestments that occurred **on or after January 1, 2009**, the penalty period for an applicant ~~for a HCBW program or Family Care~~ begins on the date all of the following have occurred:

- The person applies for Institutional LTC Medicaid, ~~a~~ HCBW, ~~program or Family Care.~~ or Managed LTC/IRIS.
- The person enters an institution or meets the appropriate LOC and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements~~,~~ (for waiver applicants this can be met regardless of whether or not the waiver funding is actually available).

17.5.5.3 Divestments During a Penalty Period

The divestment report does not register divestment penalty changes. If it is necessary to remove a divestment penalty or change an existing penalty period in interChange, update the Transfer/Divestment of Assets page, run eligibility, and confirm. Then contact the fiscal agent at ~~(608) 224-6521~~ 608-421-6340. Provide the fiscal agent with the date that the divestment penalty was removed or the new end date. The LOC will then be revised. Also contact the appropriate individual at the member's nursing home to submit bills for the period that is now covered by institutional Medicaid.

17.10.1 Life Estates Introduction

Examples 1, 2, and 3 were updated.

17.10.2 Joint Owners

Example 4 was updated.

17.10.3 Purchase of a Life Estate in the Home of Another Person

Examples 5, 6, 7, and 8 were updated.

17.12.2.1 Promissory Notes on or After July 15, 2015

This section is new.

18.6.2 Community Spouse Income Allocation

1. The community spouse maximum income allocation is:

   a. ~~$2,621.67~~ $2,655.00 plus excess shelter allowance (see Section 39.4.2 EBD Deductions and Allowances) up to a maximum of ~~$2,931.00~~ $2,980.50, or

   b. A larger amount ordered by a fair hearing court.

   "Excess shelter allowance" means shelter expenses above ~~$786.50~~ $796.50. Subtract ~~$786.50~~ $796.50 from the community spouse's shelter costs. If there is a remainder, add the remainder to ~~$2,621.67~~ $2,655.00 (see Section 39.4.2 EBD Deductions and Allowances).

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to ~~$646.25~~ $663.75 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between ~~$646.25~~ $663.75 and the actual monthly income of the dependent family member.

25.7.2 Financial Tests

Assets—The asset limit for one person is $2,000. Count assets the same as for other EBD AGs.

Income—The income limit for one person is ~~$1,505~~ $1,551. This is gross income. There is no net income test.

28.1 Home and Community-Based Waivers Long-Term Care Introduction

To be eligible for these waivers, a person must meet all of the following:

- Meet Medicaid LOC requirements for admission to nursing homes.
- Meet nonfinancial requirements for Medicaid.
- Meet financial requirements for Medicaid.
- Reside in a setting allowed by community waivers policies.
- Have a need for LTC services.
- Have a disability determination if he or she is younger than 65 years old. (Disability is a nonfinancial eligibility requirement for community waiver programs for anyone younger than 65 years old.) A finding of disability made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirement until either an adult disability determination can be done, or the child's disability determination is no longer in effect, whichever occurs first).

32.6 Medicare Savings Programs Asset Limits

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

Asset Limits for QMB, SLMB, and SLMB+	
Group Size	**Asset Limit**
1	~~$7,160~~ $7,280
2	~~$10,750~~ $10,930

33.6.1 Assets

There is no asset test for SC. In general, cash that is received as a result of converting an asset from one form to another is not income. This includes withdrawals from savings and/or checking accounts, certificates of deposit, or money market accounts. However, special provisions apply to retirement benefits (See 33.6.7.1 Retirement Benefits) and Cobell buy-out payments (see Section 16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case). Income generated from any assets that the SC participant may have is considered budgetable income and must be reported on the application or renewal application.

36.1 Wisconsin Well Woman Medicaid Introduction

Wisconsin Well Woman Medicaid Eligibility

WWWMA enrollment is limited to the following groups. A woman must be enrolled in one of the following ForwardHealth programs before she can initially enroll in WWWMA:

- WWWP
- ~~Family Planning Waiver (FPW)~~ FPOS
- BadgerCare Plus ~~Benchmark Plan~~
- ~~CORE Plan~~

38.1 Introduction

Disability

To be eligible for EBD or LTC Medicaid the individual must be elderly, blind or disabled. A member eligible for the BadgerCare Plus Standard Plan, WWWMA, Foster Care or AA is not required to be determined disabled to enroll in Family Care as long as the member meets the functional level of care. If the member later loses eligibility for that program and must be tested for EBD or LTC Medicaid, he or she must then be elderly, blind or disabled to remain enrolled in Family Care.

A finding of disability made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirements for MLTC or IRIS applicants and members ~~disability requirements~~ until the first of the following:

1. An adult disability determination can be done, or
2. The child disability determination is no longer in effect ~~(whichever occurs first).~~

~~Family Care~~ MLTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

39.4.1 Elderly, Blind, and Disabled Assets and Income Table

SSI Payment Level				
Federal SSI Payment Level	Income	~~$710.00~~ $733.00	Income	~~$1066.00~~ $1,100.00
State Supplementary Payment (SSP)	Income	$83.78	Income	$132.05
Total	Income	~~$793.78~~ $816.78	Income	~~$1,198.05~~ $1,232.05
SSI Payment Level + E Supplement	Income	~~$900.77~~ $912.77		
SSI E Supplement	Income	$95.99		
Community Waivers Special Income Limit	Income	~~$2,163.00~~ $2,199.00		

39.4.3 Institutional Cost of Care Values

This section is new.