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: Jen Mueller, Deputy Bureau Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 16-01**

Release Date: 06/10/2016

Effective Date: 06/10/2016

EFFECTIVE DATE

The following policy additions or changes are **effective 06/10/2016** 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

Signatures from Representatives

2.5.1.1 Signatures From Representatives

- Someone acting responsibly for an incompetent or incapacitated individual ~~pending a guardianship determination~~.

Example 1 was updated.

6.9.3 Inmates of State Correctional Institutions

General Medicaid Application Process for Inmates of State Correctional Institutions

2. Process the inmate as a one-person household with a living arrangement of "01- Independent (Home/Apt/Trlr)" on the Current D~~d~~emographics page.

3. If the inmate is 65 years or older or ineligible for BadgerCare Plus due to excess income, ~~test for EBD, collect~~ing asset information from DOC and test for EBD.

a. If the inmate ineligible for BadgerCare Plus is younger than 65 years old and i~~I~~f there is no disability determination on file, instruct DOC to submit a Medicaid Disability Application (F-10112) along with the Medicaid application (F-10101 or through ACCESS) and the Authorization to Disclose Information to Disability Determination Bureau form (F-14014). Suppress the verification checklist for the MADA.

b. If the inmate is 65 years old or older, instruct DOC to submit the Medicaid application (F-10101 or through ACCESS).

4. If the individual is eligible, close the case in CARES by changing the 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~~ Process Help Section 81.5 Med Stat Code Chart for a list of medical status codes), 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 situations in which an inmate has multiple inpatient admissions, see Section 6.9.4 Medicaid Application Process for Inmates with Multiple Inpatient Admissions.

Note: It is not necessary to provide a 10-day notice of termination for Medicaid when the reason for termination is the return of the individual to prison.

5. If the individual is ineligible, confirm the denial ~~on~~ in CARES, and allow CARES-generated notices to be sent to the designated DOC staff person.

~~For a list of Med Stat Codes, see Process Help Section 81.5 Med Stat Code Chart.~~

The information in this section is effective February 15, 2016.

6.9.4 State Correctional Institutions

6.9.4 ~~State Correctional Institutions~~ Medicaid Application Process for Inmates with Multiple Inpatient Admissions

This section is new. The information in this section is effective February 15, 2016.

6.9.4 State Correctional Institutions

6.9.45 State Correctional Institutions

The information in this section is effective February 15, 2016.

15.3.28 Wisconsin Works Payments

Disregard W-2 stipends and payments ~~for~~ made directly to a member as part of his or her participation in W-2. Earnings obtained through W-2's subsidized employment programs, such as ~~Transitional~~ Trial Jobs~~,~~ or Transform Milwaukee Jobs, ~~and Community Service Jobs.~~ are countable earned income. ~~Do not disregard payments for Trial Jobs.~~

15.4.7 Land Contract

Example 2 was updated.

17.8.1 Divesting by Paying Relatives Introduction

17.8.1 ~~Divesting by Paying Relatives~~ Introduction

It is divestment when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him or her. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services which the institutionalized person made to the relative in the last ~~36~~ 60 months. The form of payment includes cash, property, or anything of value transferred to the relative. It is not divestment if all of the following conditions exist:

The information in this section is effective January 1, 2014.

17.12.2 Promissory Notes on or After January 1, 2009

The purchase of a promissory note, loan, land contract, or mortgage, on or after January 1, 2009, is a divestment unless such note, loan, land contract, or mortgage meets all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the individual's life expectancy). The standards that must be used to decide whether or not a note, loan, land contract, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the SSA. The standards are found in the Period Life Table, which is available on the SSA website:

http://www.ssa.gov/OACT/STATS/table4c6.html. Use this table to calculate the individual's life expectancy as of the date the note, loan, land contract, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that he or she would receive payment in full during his or her lifetime.

- Provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payments made.
- Does not allow cancellation of the note, loan, land contract, or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically canceled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a note, loan, land contract, or mortgage contains language to cancel the balance upon the death of the lender, the note, loan, land contract, or mortgage can be amended to remove this language and avoid a divestment penalty.

If all of the criteria above are not met, the purchase of the promissory note, loan, land contract, or mortgage is a divestment. The divested amount is the value of the outstanding balance due on the note, loan, land contract, or mortgage as of the date of application for Medicaid LTC services.

18.4.2 Asset Assessment

The IM agency must make an assessment of the total countable assets of the couple at one of the following, whichever is earlier:

- The beginning of the person's first continuous period of institutionalization of 30 days or more.
- The date of the first request for HCBWs.

Note: The date of the first request is the date a functional screen was completed and the person was determined functionally eligible.

18.6.1 Spousal Impoverishment Income Allocation Introduction

Dependent family members include:

- Dependent minor children (natural, adopted, step) of either parent who live with the community spouse.
- Children (natural, adopted, step), 18 years old or older, of either parent, who are claimed as dependents for tax purposes under the ~~Service Code Internal Revenue Code (IRSC)~~ IRC and who live with the community spouse.
- Siblings of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.
- Parents of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

18.6.2 Community Spouse Income Allocation

The table was updated.

20.10 Verification Resources

Workers can ~~access~~ verify many sources of information, such as income, Social Security, Unemployment Compensation (UC), and birth records, through data exchanges. See ~~the~~ Process Help Handbook, Chapter 44 Data Exchange for instructions.

Verification of liquid assets can also be obtained electronically at renewal via IntegriMatch, Wisconsin's Asset Verification System (AVS). For instructions on using AVS, see Process Help, Section 50.3 Asset Verification.

22.2.6 Agency Retention

The IM Agency can retain 15 percent of the payments recovered (see Income Maintenance Manual Section ~~3.3.8~~ 13.8 Local Agency Retention.

25.1.3 Calculating the Cost-of-Living Adjustment Disregard	Example 1 was updated.
26.3.8 Institutionalization	~~Clients~~ Members in an institution may qualify for MAPP if they fail institutional Medicaid. If the member's income equals or exceeds 150 percent of the FPL (39.5 FPL Table), he or she is responsible to pay a monthly premium instead of a patient liability or cost share (27.7 ILTC Cost of Care Calculation) and (27.7.4 Partial Months).
26.3.9 Community Waivers	MAPP is a full-benefit Medicaid subprogram for community waiver participation (21.2 Full Benefit Medicaid). If the member's monthly income equals or exceeds 150 percent of the FPL (39.5 FPL Table), he or she is responsible to pay a monthly premium instead of a cost share.
26.5.1 Calculation	Calculate premiums using only the member's income. Calculate a premium if the member's gross monthly amount equals or exceeds 150 percent of FPL (39.5 FPL Table) for the appropriate fiscal test group size.
26.5.1.1 Independence Account Penalty	Example 1 was updated.
26.10 MAPP/Health and Employment Counseling Program (HEC) Specialists	**26.10 ~~MAPP/~~Health and Employment Counseling Program ~~(HEC) Specialists~~ Contact Information** ~~See P-20222 for an updated list of MAPP / HEC specialists, by region.~~ For more information about the HEC Program, call 866-278-6440.
27.7.2 Hospitalized Persons	**27.7.2 Hospitalized ~~Persons~~ People** Effective December 1st, 2008, hospitalized people will be responsible for paying a patient liability. See 27.7.~~5~~4 Transfers Between Institutions for information about patient liability calculations when a person transfers between a hospital and nursing home(s).
27.7.7.1 Introduction	Effective January 4, 2008, ~~allowable payments that an institutionalized person is actually making for all medical/remedial expenses they have incurred and are legally obligated to pay,~~ medical or remedial expenses an institutionalized applicant or member has incurred, is actually paying, and is legally obligated to pay are allowable expenses and are used as a need item when determining his or her eligibility for Medicaid. These actual payments are also allowed as an income deduction to reduce the cost share or patient liability amount. This includes payments for medical or remedial expenses that the ~~person~~ institutionalized applicant or member is currently incurring as well as payments for certain previously incurred medical or remedial expenses. **Note:** This does not include any medical or remedial expenses that another person has incurred. In order to use the medical or remedial expense as a need item and as an income deduction in the cost share calculation, the expense must meet the following criteria:

1. The institutionalized individual must be legally liable for payment of the incurred medical or remedial expense. Any portion that will be paid by a legally liable third party such as private health insurance, Medicare, Medicaid, etc. cannot be allowed as a deduction; and
2. The institutionalized individual must provide verification of the allowable expense. See 27.7.~~8~~7.2 Disallowed Expenses

27.7.7.2 Disallowed Expenses

Example 6

- The expense is unverified.

33.1 Introduction

SeniorCare is a prescription drug assistance program for Wisconsin residents who are at least 65 years old and meet the program's eligibility criteria. SeniorCare began September 1, 2002.

SeniorCare is designed to help seniors with covered prescription drug costs. Eligible participants are issued SeniorCare identification cards and may receive SeniorCare benefits.

There is neither an asset test nor estate recovery for SeniorCare. Participation levels are determined by comparing the anticipated annual income of the FTG to a percentage of the FPL corresponding to the FTG size.

SeniorCare is administered by the DHS, through EM CAPO. County and tribal agencies are not responsible for determining eligibility, but may need to coordinate with workers in the EM CAPO for mixed cases. Mixed cases include those persons eligible for SeniorCare and:

33.3.2.3 Opt-In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the EM CAPO if he or she chooses to "opt in" to the program. He or she would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

33.3.3 Age Limitation

A single applicant should apply for SeniorCare no sooner than the calendar month ~~before~~ of his or her 65th birthday.

36.2.1 EM CAPO Administrating Enrollment for Wisconsin Well Woman Medicaid

Any applications received in local IM~~, ESC,~~ or tribal agencies should be faxed to the EM CAPO at (608) 267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the applicant.

36.2.2 Enrollment Through the Wisconsin Well Woman Program

WWWP Local Coordinating Agencies (LCA) enroll women in WWWP and perform some of the basic non-financial and all financial data gathering, and verification for ~~Well Woman Medicaid~~ WWWMA. They also coordinate the WWWP ~~client's~~ member's referral to a health care provider for breast and cervical cancer screening.

1. The WWWP LCA will complete the F-44818 (formerly DPH-4818) with the assistance of the applicant prior to the applicant's health care screening. The F-44818 enrolls the woman in WWWP. Her WWWP eligibility will be recorded in interChange as "Med Stat CS."
2. The WWWP ~~client~~ member will receive a breast and cervical cancer screening from a WWWP provider. If the WWWP ~~client~~ member is diagnosed with breast or cervical cancer, her provider will complete the F-10075 recording the diagnosis and indicating that treatment is required. The provider will sign and date the F-10075. The WWWP ~~client~~ member will also sign and date the F-10075. The signature dates do not have to be the same date.
3. The provider will fill in the beginning and end dates of the temporary enrollment/presumptive eligibility for WWWMA on the F-10075

4. The provider will forward a copy of the F-10075 to the WWWP LCA.
5. The WWWP LCA will provide the ~~client~~ member with a copy of the signed F-10075 and F-44818 forms.
6. The WWWP LCA will check to be sure correct temporary eligibility dates (if appropriate) are entered on the F-10075 and explain that the ~~client's~~ member's temporary enrollment for WWWMA will end on the last day of the following calendar month.

36.2.2.1 Temporary Enrollment/Presumptive Eligibility (TE) Available Only To Women Enrolling Through WWWP

The WWWP LCA should then fax a copy of the completed F-10075 to the fiscal agent at (608) 221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of CB) and send the ~~client~~ member a ForwardHealth card with the temporary enrollment dates activated on the card. (If the ~~client~~ member had a previous ForwardHealth card, it will be reactivated.)

Until the ForwardHealth card arrives or is reactivated, the new WWWMA member may receive services by presenting both of the following completed forms to any Medicaid provider:

- WWWP Enrollment Form (F-44818)
- WWWMA Determination Form (F-10075)

To continue receiving WWWMA, the member or the WWWP LCA must submit an F-10075 to the EM CAPO. If the member does not apply, her WWWMA benefits will terminate at the end of the month following the month of diagnosis.

The TE period extends from the date of diagnosis on the F-10075 through the following month. A new TE period would only occur if a new cancer diagnosis was established for the same member.

Note: If the member applies during her TE certification period and the EM CAPO is not able to process her application, within the 30-day processing time frame, the EM CAPO will extend the members' eligibility for an additional 30 days from the last day of her Wisconsin Well Woman Medicaid TE with a medical status of "CB". Submit an F-10110 (formerly DES 3070) to extend the Well Woman Medicaid TE for an additional calendar month.

36.2.3 WWWP Clients Enrolling For Continuous WWWMA

36.2.3 WWWP ~~Clients~~ Members Enrolling For Continuous WWWMA

36.2.3.1 Applications For WWWMA Through Well Woman Program (WWWP)

To apply for WWWMA through the WWWP, the applicant or the WWWP Local Coordinating agency must send or fax the completed F-44818 and F-10075 forms to the EM CAPO. The applicant may apply for WWWMA at any time after the WWWP screening and diagnosis. Eligibility may only be backdated to the first of the month up to three months prior to the application date or from the date of diagnosis, whichever is most recent. (For requests to back date farther than three months, refer to the BEPS policy analyst.)

Use the F-44818 and F-10075 in place of the standard application forms. This program requires manual determination. Do not enter the woman's information into CARES as an application.

The date of receipt of the F-10075 is the filing date. Use the verification policy listed in Chapter 20 for any items requiring verification.

Complete the following steps to certify the member for WWWMA:

1. Review the F-44818. There should be a "No" answer to the following questions:

a. Does the applicant have any health insurance? (Item #32 on F-4818)
b. If the applicant answers "Yes", determine if the insurance is one of those listed in 36.3.3 that covers treatment for her breast or cervical cancer. If she has coverage for the treatment, she is ineligible for WWWMA.
c. Does the applicant have Medicare Part B? (Item #33 on F-44818)
d. Does the applicant have Medicare Part A.

If the applicant answered "Yes" to any of these questions in a-c, the applicant is ineligible for WWWMA. The EM CAPO will refer her back to the WWWP and send a manual negative notice.

2. Review the F-44818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, and 27-45.

If the form is incomplete, the EM CAPO will request that the applicant provide any missing information. If the applicant does not provide all necessary information, there may be a delay in eligibility determination and benefits.

3. Review F-10075 for an SSN. If the SSN is missing from the F-10075 and is not present on the F-44818 (# 6a); the EM CAPO will ask the applicant to provide her SSN. Providing an SSN for the WWWP is voluntary, but providing an SSN, or applying for one, is required for WWWMA.

If the applicant fails to provide an SSN, or fails to apply for an SSN within the 30-day application processing time or within ten days (whichever is later), the CAPO will send a manual negative notice to the applicant indicating that ~~the~~ she is not eligible for WWWMA because she did not provide an SSN.

4. Ask the applicant if she is a citizen.

If the applicant is not a citizen, ask her what her immigration status is and to provide her immigrant registration card. Verify that the applicant is in a qualified immigration status using the SAVE system.

Note: Some applicants with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a non-qualifying immigrant has been screened by WWWP, determine her eligibility for emergency services using the criteria in 7.1 US Citizens and Nationals.

5. If there are any questionable items, contact the WWWP Local Coordinating Agency.

6. The EM CAPO will update interChange (iC) with the WWWMA eligibility information using a medical status code of "CB" to certify any member who has met the criteria listed above. Submit the completed F-10110 to the fiscal agent through one of the following methods:
   a. Mail:
      HP Enterprise Services
      Attn: Eligibility Lead Worker WWWMA
      313 Blettner Blvd
      Madison WI
      53714-2405
   b. FAX: (608) 221-8815
   c. interChange

7. Certify the member for 12 months from the filing date and backdate to whichever is more recent:
   a. Up to three months prior to the filing date, or
   b. To the date of the diagnosis (F-10075),

Never certify a woman for WWWMA prior to her date of diagnosis.

Example 1 was updated.

For initial WWWMA certifications, if the applicant applies during her WWWMA TE certification period and EM CAPO is not able to process her application within the 30 day processing time frame, EM CAPO will extend the applicant's eligibility for an additional 30 days from the last day of her WWWMA TE in iC with a medical status of "CB." Note this extension in the CARES Comments section if appropriate.

To contact the WWWP Local Coordinating Agencies refer to #27 of F-44818.

36.2.4 Enrollment for Family Planning Only Services and BadgerCare Plus Members

36.2.4 Enrollment for Family Planning Only Services ~~and BadgerCare Plus~~ Members

Women enrolled in FPOS ~~or BadgerCare Plus~~ who meet **one** of the following criteria (regardless of age), will be eligible for WWWMA~~. These are women who~~:

- Are screened for, and diagnosed with, cervical cancer or a precancerous condition of the cervix~~, or~~
- Receive a clinical breast exam through a FPOS provider and through follow up medical testing (independent of the FPOS)~~, or are screened for and are diagnosed with breast cancer while enrolled in the BadgerCare Plus CORE or Benchmark plans,~~ and

36.2.4.1 Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services or BadgerCare Plus

36.2.4.1 Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services ~~or BadgerCare Plus~~

A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a FPOS member or her representative is a request to enroll in WWWMA and disenroll from FPOS. Women 15 through 44 years of age, enrolled in FPOS in CARES who meet the criteria 36.2.4 Enrollment for Family Planning Only Services ~~and BadgerCare Plus~~ Members above, will be eligible for WWWMA.

A Wisconsin Well Woman Medicaid Determination Form (F-10075) submitted by a FPOS ~~or BadgerCare Plus~~ member or her representative is a request to enroll in WWWMA and disenroll from FPOS ~~or BadgerCare Plus~~. Women who are enrolled in FPOS ~~or BadgerCare Plus~~ in CARES and meet the criteria in the 36.2.4 above~~, the BadgerCare Plus Handbook 43.4 Application for BadgerCare Plus CORE Plan, or BadgerCare Plus Handbook 1.1.1 BadgerCare Plus Health Plans -Benchmark~~ may be eligible for WWWMA.

The information in this section is effective April 1, 2014.

36.3.1 Introduction

The following are WWWMA specific non-financial requirements:

- Live in Wisconsin,
- Meet general EBD citizenship and ID requirements.
- Be under age 65.
- Have been screened for breast or cervical cancer by the WWWP, or enrolled in

~~the~~ Family Planning Only Services ~~Waiver, CORE or Benchmark programs~~.

- Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the clinical screener.
- Require treatment for the breast or cervical cancer, or pre-cancerous conditions of the cervix, as identified by the clinical screener.
- Not be eligible for BadgerCare Plus ~~without a premium~~ or EBD MA.
- Meet the insurance coverage requirements listed below in 36.3.2 Disqualifying Insurance Coverage

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits do not disqualify an applicant or member from WWWMA:

5. Creditable coverage plans that do not cover treatment for the breast or cervical cancer due to a waiting period, exclusion or carve out restrictions.

Note: Current coverage under Medicare Parts A or B will disqualify an applicant or member from WWWMA eligibility.

The information in this section is effective April 1, 2014.

36.5.1 Member Loses Eligibility

5. ~~Obtaining~~ Gaining coverage under Medicare Part A, Part B, or both.

If a case closes, the EM CAPO will send a manual negative notice to the member if one of these changes is reported, indicating that she is no longer eligible for WWWMA. In situations 1, 3, 4, and 5 above, offer her a BadgerCare Plus / Medicaid Application, F-10182, to test eligibility for other programs.

36.5.2 WWWMA Interagency Case Transfers

All WWWMA cases are ~~now~~ processed through the EM CAPO. There should be no interagency transfers.

36.6 Wisconsin Well Woman Medicaid Reviews/ Recertifications

Reviews/recertifications are required every 12 months after the initial eligibility determination at the member's WWWMA enrollment date. A review for WWWMA only consists of receiving an updated F-10075 WWWMA Determination form. There is no financial test.

Notices identifying the WWWMA members needing recertification are sent to the EM CAPO monthly. The EM CAPO notifies the ~~client~~ member 45 days before a review is due, and indicates what materials or information the member needs to return. The EM CAPO includes a blank F-10075 with the notice. In most cases the member will only need to supply the EM CAPO with an updated F-10075.

Note: In order to eliminate unnecessary reviews, a best practice is to check interChange to be sure that the member has not become certified for BadgerCare Plus or another type of full benefit MA (for example SSI MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare Part(s) A, B or both, prior to notifying the member that a review is due.

The member or her representative must send or fax the F-10075. to the EM CAPO via:

- Email: DHSEMCAPO@dhs.wisconsin.gov,
- Fax: (608) 267-3381, or
- Mail:

  WI DHS - EM CAPO
  1 West Wilson St. ~~Room 358~~
  P.O. Box 309
  Madison, WI 53701- 0309

	At review, the member must provide a newly completed WWWMA Determination form F-10075 indicating she is still in need of treatment for breast or cervical cancer, as certified by a physician or nurse practitioner. Members formerly enrolled in WWWP do not need to provide a new DPH 4818 at recertification. The EM CAPO sends a manual positive notice if all requirements are met. The EM CAPO will send a manual negative notice at least ten days prior to the case closing if the member does not provide an updated F-10075 or if the member reports one of the changes listed in 36.5 WWWMA Changes.
39.5 Federal Poverty Level Table	The table was updated. The information in this section is effective February 1, 2016.
39.6 Cost-of-Living Adjustment	The table was updated. The information in this section is effective January 1, 2015.
39.10 Medicaid Purchase Plan Premiums	The following are MAPP premiums for members whose gross monthly ~~–~~income equals or exceeds 150 percent of the FPL for the appropriate fiscal test group size.
39.11.1 SeniorCare Income Limits Introduction	The table was updated. The information in this section is effective February 1, 2016.
39.11.5.1 Level 3: Fiscal Test Group of One	Examples 1, 2, and 3 were updated. The information in this section is effective February 1, 2016.