Medicaid Eligibility Handbook (MEH)
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INTRODUCTION (CH 1)

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1.1.1 Introduction

Medicaid is a state/federal program that provides health coverage for Wisconsin residents that are elderly, blind, or disabled (EBD) or receive Wisconsin Well Woman Medicaid. Medicaid is also known as Medical Assistance, MA, and Title 19.

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

- *SSI*-related Medicaid
- *MAPP*
- Institutional Long Term Care
- Home and Community Based Waivers Long Term Care
- Family Care Long Term Care
- Partnership Long Term Care
- Program of All-Inclusive Care for the *Elderly* (PACE)
- Katie Beckett
- Tuberculosis (*TB*) -related
- Medicare Premium Assistance (*MPA*): *QMB*, *SLMB*, SLMB+, *QDWI*;
- Emergency Medicaid
- SeniorCare
- Wisconsin Well Woman Medicaid (WWWMA)

A person may fit into one (or more) of the above subprograms based on non-financial factors. A person is eligible if s/he meets all Medicaid non-financial and financial requirements. Individuals who are not elderly, blind or disabled (EBD) may be eligible for BadgerCare+ (BC+). See the BC+ Handbook for more information.

1.1.3 Financial Introduction

See 39.4 for EBD asset limits. See 25.7.2 for TB-Related asset limits. See 1.1.3.3
to determine Medicaid eligibility for disabled minors that fail BadgerCare Plus financial
tests.

1.1.3.1 Assets

Use the EBD Related Determination worksheet when doing manual eligibility determinations for non institutionalized EBD Medicaid applicants and recipients. The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any *member* of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate EBD medically needy asset limit are ineligible for Medicaid.

1.1.3.2 EBD Fiscal Group

An EBD fiscal group includes the individual who is non financially eligible for Medicaid and anyone who lives with them, who is legally responsible for them. Spouses who live together are in each other's fiscal group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled *minor* living with their parents would be a one person fiscal group. Special instructions for deeming parental income and assets to the disabled minor are described in 24.1 SSI Related Medicaid Introduction.

Another exception to the fiscal group policy involves SSI recipients. If one *spouse* is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's fiscal group. For this situation you would again have a one person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual living in a medical institution for 30 or more consecutive days would be a one person fiscal group. If the institutionalized person is married, refer to 18.1 Spousal Impoverishment Introduction for special instructions regarding *spousal impoverishment* procedures.

1.1.3.3 Disabled Minors

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.

1.1.3.4 Income

See 39.4 EBD Assets and Income Tables for EBD income limits. See 39.5 FPL Table for all other MA income limits. Chapters for each type of MA explain how to determine the income that you compare to the income limits.

See 39.4.2 EBD Deductions and Allowances for TB-Related income limits.

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.)

EBD Eligibility	BC+ Eligibility	System Choice
MS/NS/MAPP w/no premium	No premium	EBD
MS/NS/MAPP w/no premium	Premium	EBD
MS/NS/MAPP w/o premium	BC+ *Deductible*	EBD
MAPP w/premium	No premium	BC+
NS Deductible	No premium	BC+
MAPP w/premium	Standard Plan with Premium	The program with the lesser premium
MAPP w/premium	Benchmark Plan with Premium	EBD
NS Deductible	Premium	Member Choice
MAPP Premium	Deductible	Member Choice
NS Deductible	Deductible	Member Choice

1.1.5 How to Apply

The following application options are available for anyone who is applying for EBD Medicaid:

1. ACCESS online application at https://access.wisconsin.gov/
2. Face-to-Face Interview at the local county/tribal office
3. Mail-In
4. Telephone Interview

Click here to view the Directory of local county/tribal agencies in Wisconsin or call *Member* Services at (800) 362-3002.

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APPS AND REVIEWS (CHS. 2-3)

2 APPLICATIONS

2.1 APPLICATIONS INTRODUCTION

2.1.1 Affirmative Action and Civil Rights

Anyone has the right to apply for Medicaid. However, individuals under 18 years of age must have a parent or a legal guardian apply for Medicaid on their behalf unless living independently.

They may be assisted by any person s/he chooses in completing an application.

Encourage anyone who expresses interest in applying to file an application as soon as possible. When an application is requested:

1. Suggest the *applicant* use the ACCESS online application at the following site http://access.wisconsin.gov ; or
2. Mail-In using the Wisconsin Medicaid for the *Elderly*, Blind,and Disabled Application Packet (HCF 10101).
3. Schedule a telephone or face-to-face interview.

Provide any information, instruction and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP 2477) and Good Cause Notice (DWSP 2018) to each applicant with children applying for Medicaid or to anyone that requests either of these.

Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to:

http://dhs.wisconsin.gov/forms/paperfpc.htm

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the 3 months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than 4 months after the date of death, s/he is not eligible.

2.1.1 Affirmative Action and Civil Rights

The Rehabilitation Act of 1973 requires a person with impaired sensory, manual, or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Notify members during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the Wisconsin Medicaid Eligibility and Benefits brochure (P-00079).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

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2.2 APPLICATION TYPES/METHODS

Medicaid applicants have the choice of one of the four following methods:

1. ACCESS https://access.wisconsin.gov/access/
2. Mail-In using the Wisconsin Medicaid for the *Elderly*, Blind,and Disabled Application Packet (F-10101).
3. Telephone Interview. When a request for assistance is made by phone, the filing date is not set until a signed application and/or registration form is received by the agency.
4. Face-to-Face Interview.

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2.3 WHERE TO APPLY

2.3.1 Where To Apply Introduction
2.3.2 Intercounty Placements
2.3.3 Applications Outside Wisconsin

2.3.1 Where To Apply Introduction

The *applicant* must apply in the county in which s/he resides. If applying online via ACCESS, the application must be processed by the county in which the applicant resides. Click here to view the Directory of local county/tribal agencies in Wisconsin or call 1 (800) 362-3002.

An individual who resides in a nursing home/ hospital for 30 days or more and will have his or her Medicaid eligibility determined as an institutionalized person is a resident of the county in which the nursing home/hospital is located.

The applicant's county of residence at the time of admission must receive and process applications for persons living in these state institutions:

1. Northern, Central, and Southern Centers.
2. Winnebago and Mendota Mental Health Institutes.
3. The University of Wisconsin Hospital.

Waupaca County receives and processes all applications and reviews for residents of the Wisconsin Veterans Home at King, regardless of the county of residence.

When an applicant contacts the wrong agency, redirect him/her to the agency responsible for processing the application immediately. Anytime an application is received in the wrong agency, it must be redirected to the agency responsible for processing that application no later than the next business day. A paper application must be date stamped before it is redirected. The filing date remains the date originally received by the wrong agency.

2.3.2 Intercounty Placements

When a county 51.42 board, 51.437 board, human services department or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the applicant's Medicaid eligibility. A congregate care facility is a:

1. Child care institution.
2. Group home.
3. Foster home.
4. Nursing home.
5. *Adult* Family Home (AFH).

6. Community Based Residential Facility (*CBRF*).
7. Any other like facility.

The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in Medicaid and reviews for Medicaid members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility. If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

1. The applicant's name, age, and SSN.
2. The date of placement.
3. The applicant's current Medicaid status.
4. The name and address of the congregate care facility in which the applicant has been placed.
5. The name of the county and agency making the placement.

When there is a dispute about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health and Family Services' Area Administration office for resolution. Pending a decision, the county where the person is physically present must process the application, any changes, and reviews.

2.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when s/he is living outside of Wisconsin. An exception is when a Wisconsin resident becomes ill or injured outside of the state or is taken out of the state for medical treatment. In this case, the application may be taken, using Wisconsin's application forms (See 2.2 Application Types/Methods), by the public assistance agency in the other state. The forms should be forwarded to the Income Maintenance agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.

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2.4 VALID APPLICATION

A valid application for Medicaid must include the applicant's:

1. Name,
2. Address, and
3. Signature in the Rights and Responsibilities section of a MA application (F-10101) on the Medicaid, BadgerCare and Family Planning Waiver Registration Application (F-10129), or the BadgerCare Plus Application Packet (F-10182).

The date the application is received by the IM agency with the applicant's name, address and a valid signature is the filing date. Applications must be processed within 30 days of the filing date. (See 2.7 Timeframes)

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2.5 VALID SIGNATURE

2.5.1 Valid Signature Introduction
2.5.2 Witnessing the Signature
2.5.3 Spousal Impoverishment MA Signatures

2.5.1 Valid Signature Introduction

The *applicant* must sign (using his/her own signature):

1. The paper application form,
2. The signature page of the Application Summary (telephone or face to face), **or**
3. The ACCESS application form with an electronic signature.

Except when:

1. A guardian signs for him/her. When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on his/her behalf. Scan the copy of the document in the Electronic Case File.

   Your agency's social services department determines the need for a guardian or conservator. Determine the guardian type specified by the court.

   Only the person designated as the guardian of the estate, guardian of the person and the estate, or guardian in general may sign the application. You may not require a conservator or guardian of the person to sign the application, **or**

2. An *authorized representative* signs for the applicant. The applicant may authorize someone to represent him/her. An authorized representative must be an individual, not an organization.

   If the applicant wishes to authorize someone to represent him/her when applying by mail, instruct him/her to complete the authorized representative section of the application form.

   If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Authorization of Representative form (F-10126).

   An authorized representative is responsible for submitting the signed application (completed insofar as able) and any required documents.

   When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required, **or**

3. The applicant's durable power of attorney (§ 243.07, Wis. Stats.) signs the application. A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the

authority will continue even if the applicant later becomes disabled or otherwise incapacitated.

When a submitted application is signed by someone claiming to be the applicant's durable power of attorney:

a. Obtain a copy of the document the applicant used to designate the signer of the application as the durable power of attorney.

b. Review the document for a reference that indicates the power of attorney authority continues notwithstanding any subsequent *disability* or incapacity of the applicant.

Do not consider the application properly signed unless both of these conditions are met. File a copy of the document in the case record. An individual's Durable Power of Attorney may appoint an authorized representative for purposes of making a Medicaid application if authorized on the power of attorney form. The Durable Power of Attorney Form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent an individual from filing his/her own application for Medicaid nor does it prevent the individual from granting authority to someone else, to apply for public assistance on his/her behalf, **or**

4. Someone acting responsibly for the individual signs the form on behalf of the individual, if the individual is incompetent or incapacitated, **or**

Example 1: Carl is in a coma in the hospital. Sherry, a nurse who works at the hospital, can apply for Medicaid on Carl's behalf.

5. A superintendent of a state mental health institute or center for the developmentally disabled signs on behalf of a patient, **or**

6. A warden signs the application for an applicant that is an inmate of a state correctional institution that is out for more than 24 hours, **or**

7. The director of a county social or human services department delegates, in writing (retain a copy of this written authorization), to the superintendent of the county psychiatric institution the authority to sign and witness an application for residents of the institution.

The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.

2.5.2 Witnessing the Signature

The signatures of two witnesses are required when the application is signed with a mark.

An agency staff person is not required to witness the signature of a mail-in, online or telephone application.

Note: This does not affect the State of Wisconsin's ability to prosecute for fraud nor does it prevent the Medicaid program from recovering benefits provided incorrectly due to an applicant or member's misstatement or omission of fact.

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.

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.

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

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2.6 FILING DATE

2.6.1 In Person
2.6.2 By Mail or Fax
2.6.3 By Phone
2.6.4 By ACCESS
2.6.5 Low Income Subsidy Program of Medicare Savings Programs

2.6.1 In Person

The filing date is the day a signed valid application/registration form (F-10101 or F-10182) or registration (F-10129) form is delivered to the Income Maintenance agency or the next business day if it is delivered after the agency's regularly scheduled business hours.

2.6.2 By Mail or Fax

When an application is submitted by mail or fax, record the date (date stamp) that the IM agency received the valid application form.

2.6.3 By Phone

When a request for assistance is made by phone, the filing date is not set until a signed application and/or registration form is received by the agency.

2.6.4 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 4:30 PM or on a weekend or holiday.

2.6.5 Low Income Subsidy (LIS) Program of Medicare Savings Programs (MSPs)

Effective January 1, 2010, *LIS* data sent electronically to CARES from the *SSA* is considered a request for *MSP* and must be processed using the same

processing guidelines that would be followed if a request for MSP was submitted directly by the *applicant*.

Because the data sent by SSA is not sufficient to determine Medicaid or MSP eligibility, the data from the LIS application will be used to establish a Request for Assistance (RFA) in CARES. The contact date on the RFA is the date the LIS data was received by DHS from SSA. The filing date for the MSP request is the filing date for LIS application set by SSA.

A completed, timely application will have to be submitted by the applicant to the local agency in order to determine Medicaid and MSP eligibility for the person. If an application is not submitted within 30 days of the RFA contact date, the RFA will be automatically withdrawn and a notice generated.

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2.7 TIMEFRAMES

2.7.1 Timeframes Introduction
2.7.2 Changes

2.7.1 Timeframes Introduction

All applications received by an agency must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from the filing date. This includes issuing a notice of decision.

IM workers should not delay eligibility for an individual in a household when waiting for another household *member*'s citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members.

Extend the 30-day processing time up to an additional 10 days if you are waiting for the *applicant* to provide additional information. CARES will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due Page.

Deny the application for failure to provide information or verification if:

1. Requested information or verification is required by program policy to determine eligibility (See 20.1 Verification), **and**
2. The applicant had the power to produce the information or verification within the period, but failed to do so, **and**
3. The applicant had a minimum of 10 days to produce the verification.

Example 1: A signed application was received on March 15. The worker processed the application on April 7 and requested verification. Verification was due April 17, but was not received by that date. Even though the end of the 30-day application processing period was April 13, the application should not have been denied until April 18 to allow at least 10 days to provide verification.

If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, as a result of their most recent Medicaid application, redetermine eligibility using the filing date associated with that most recent application.

Example 2: A signed application was received on May 15th. The first day of the 30-day period was May 16th. The end of the 30-day period would have been June 14th. The application was approved on June 20th, and the applicant is determined eligible beginning May 1.

2.7.2 Changes

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For changes that occur after the confirmation date, follow the adequate and timely notice requirements outlined in IMM Chapter 1.2.2.

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2.8 BEGIN DATES

2.8.1 Begin Dates Introduction
2.8.2 Backdated Eligibility

2.8.1 Begin Dates Introduction

Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. Those begin dates are the date a valid application is submitted, all program requirements are met, and:

1. Deductible - The date the deductible was met.
2. Inmates –The date the *member* is no longer an inmate of a *public institution*.
3. Person Adds - The date the person moved into the household.
4. Recent Moves - The date the member moved to Wisconsin

Exception: The begin date for an *SSI* recipient who moves to Wisconsin is the 1st of the month of the move.

Example 1: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April, 2009. He becomes eligible 04-01-09 in Wisconsin.

5. Home and Community Based Waivers: The program start date provided by the care manager.
6. Family Care and Pace or Partnership-the date the individual is enrolled in the *Managed Care* Organization.
7. Institutionalized - His/her entry into the nursing home or hospital.
8. *QMB* - The first of the month following the eligibility determination
9. SeniorCare – The first of the month following the month in which all program requirements have been met

2.8.2 Backdated Eligibility

If certifying for retroactive Medicaid, do not go back further than the first of the month, three months prior to the application month. Certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month.

A backdate request can be made at any time, except in the case where the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

If a member has incurred a bill from a Medicaid certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example 2: Mary who is 66 years old, applied for Medicaid on April 6th, and was found eligible. At the time of application, Mary did not request a backdate.

In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for Medicaid for both months.

For backdating rules for Medicare Beneficiaries, see 32.8 Medicare Beneficiaries Backdating.

Assets

A person's asset eligibility in a backdate month is determined by whether or not s/he had excess assets on the last day of the month. If s/he had excess assets on the last day of the month, s/he is ineligible for the entire month. If s/he was asset eligible on the last day of the month, s/he is eligible for the whole month.

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2.9 DENIALS AND TERMINATIONS

2.9.1 Termination
2.9.2 Denial

2.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, the *applicant* can provide the necessary information to reopen Medicaid without filing a new application.

If more than a calendar month has passed since a member's enrollment was terminated, the applicant must file a new application to reopen his/her Medicaid.

2.9.2 Denial

If less than 30 days has passed since the client's eligibility was denied, allow the client to re-sign and date the application or page one of the CAF to set a new filing date.

If more than 30 days has passed since a client's eligibility was denied and the client is not open for any other program, the client must file a new application to reopen his/her MA.

If the client is open for any other program of assistance, do not require him/her to re-sign his/her application or sign a new application.

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3 REVIEWS

3.1 REVIEWS

3.1.1 Reviews Introduction
3.1.2 Choice of Review
3.1.3 Review Processing
3.1.4 Signature at Review

3.1.1 Reviews Introduction

A review is the process during which all eligibility factors subject to change are reexamined and a decision is made if eligibility should continue. The group's continued eligibility depends on its timely completion of a review. Each review results in a determination to continue or discontinue eligibility.

The first required eligibility review for a Medicaid case is 12 months from the certification month except for deductible. A review is not scheduled for a case that did not meet its deductible unless someone in the case was open for Medicaid. For cases that did meet the deductible, the review date is six months from the start of the deductible period.

Note: For manually certified Medicaid cases, send a manual review notice 45 days prior to the end of the review month.

Agency Option

The agency may review any case at any other time when the agency can justify the need. Examples include:

1. Loss of contact, **or**
2. *Member* request

Note: Shortening certification periods in an attempt to balance agency workload is not permissible.

3.1.2 Choice of Review

The *member* has the choice of the following methods for any Medicaid review:

1. Face-to-Face Interview,
2. Telephone Interview.
3. Mail in: Mail in renewals can be submitted using the paper application (F-10101) or the pre-printed renewal packet generated through CWW. Cases requesting to complete a Mail In renewal must be sent the pre-printed renewal packet if the case includes a blind or disabled child, **or**
4. ACCESS

3.1.3 Review Processing

A Medicaid eligibility review notice is generated on the first Friday of the 11th month of the certification period. The notice states that "some or all of your benefits will end" if a review is not completed by the end of the following month. Do not process a review until after *adverse action* in the month prior to the month of review.

Example 1: CARES sends out the review letter on July 7 for a review due in August, do not process the review prior to July 18.

Do not require a new *Authorized Representative* form at review if the person signing the review is the Authorized Representative on file.

If the review is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES at adverse action in the review month.

3.1.4 Signature at Review

The member must include a valid signature at the time of review. This includes signing one of the following:

1. 1. The MA application (F-10101), the Medicaid, BadgerCare and Family Planning Waiver Registration Application (F-10129), or the BadgerCare Plus Application Packet (F-10182) used for the review, **or**
2. The signature page of the CAF (telephone or face-to-face), **or**
3. The ACCESS application form with an electronic signature.

The signature requirements for reviews are the same as those for applications. See 2.5 Valid Signature.

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NONFINANCIAL (CHS. 4 - 14)

4 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?

4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?

To be eligible for Medicaid, an individual must meet the following criteria:

1. Be *elderly*, blind, or disabled (See 5.1 Elderly or 5.2 Determination of Disability)
2. Be a resident of the state of Wisconsin (See 6.1 Residency Eligibility)
3. Be a US citizen or Qualifying Immigrant (See 7.1 US Citizens and Nationals)
4. Cooperate with medical support liability (See 8.1 Medical Support)
5. Cooperate with third party liability (*TPL*) (See 9.1 Third Party Liability)
6. Provide SSN or apply (See 10.1 SSN Requirements)
7. Pay a premium if required (See 11.1 Premium or Cost Share)
8. Pay a community waiver/FamilyCare cost share if required (See 11.1 Premium or Cost Share)

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5 ELDERLY, BLIND, OR DISABLED (EBD)

5.1 ELDERLY

Elderly is defined as an individual 65 years of age or older. (See 4.1 Who is Nonfinancially Eligible for Medicaid?) An individual who is elderly is non-financially eligible.

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5.2 DETERMINATION OF DISABILITY

Definition of *Disability*
The law defines disability for Medicaid as: 'The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable

physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.' See 39.4.1 EBD Assets and Income Table for the current SGA limits. See 26.1 MAPP Introduction for the Medicaid Purchase Plan (*MAPP*) disability definition.

An individual who is blind or disabled is non-financially eligible. (See 4.1 Who is Nonfinancially Eligible for Medicaid?) Disability and blindness determinations are made by the Disability Determination Bureau (*DDB*) in the Department of Health and Family Services. The IM Agency should submit an application for a disability determination even if the *member* has already applied for *SSI* or *SSDI*. (See 5.3 Disability Application Process).

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5.3 DISABILITY APPLICATION PROCESS

5.3.1 Application Form
5.3.2 Agency Form Processing
5.3.3 Release Form
5.3.4 Medical Report
5.3.5 SSI Application Date
5.3.6 Routine SSI-MA Extension
5.3.6.1 Case Processing
5.3.7 Other SSI-MA Extensions

5.3.1 Application Form

Give a Medicaid - *Disability* Application (MADA) form (F-10112) to each person applying for Medicaid Disability. The MADA form must be completed by the Medicaid *applicant* or his/her representative.

The applicant must send the following to the local/county/tribal human or social service agency:

1. The completed MADA form (F-10112).
   Applicants must list information about all of his/her medical problems and contact information for all medical providers that have treated him/her,
2. One copy of the Authorization to Disclose Information to Disability Determination Bureau (F-14014),

and if applicable

3. The Medicaid/FoodShare Wisconsin Authorization of Representative form (F10126).

5.3.1.1 Claims filed on behalf of Deceased Applicants

Even when the applicant is deceased *DDB* needs medical and other information upon which to base the disability decision. If available, the IM worker should send copies of the following to DDB, along with all other application materials:

1. Medical reports (if available from the person filing the Medicaid disability application on the decedent's behalf.)
2. Death Certificate.
3. Medical releases (F-14014), . If the claim was initiated prior to the applicant's death and the applicant signed medical releases, those should be sent to DDB. If the applicant was able to sign the releases only with an "X" or other mark, two witness signatures are needed on the release form.
4. Documentation of guardianship or power of attorney should be included if medical releases are signed by a guardian or person with power of attorney.

The IM worker should complete the MADA form as thoroughly as possible, including:

1. Name, address, and phone number of next of kin, friend, or other person initiating the Medicaid application on the decedent's behalf (Section I).
2. The date on which the applicant became unable to work (Section I, number 2).
3. Contact information for medical sources treating the applicant prior to and at time of death (Section III).

If Medicaid coverage is needed for less than three full months prior to application the IM worker should include a statement regarding the necessary coverage dates in Part VI of the MADA. For example, when the applicant died shortly after an accident or start of illness and coverage is needed only for brief medical care and/or burial expenses.

5.3.2 Agency Form Processing

See Process Help 12 Automated Medicaid Disability Determination.
When completed MADA forms are received by the local agency, the IM worker must:

Determine if the applicant meets all other Medicaid eligibility requirements, with the exception of the disability determination and income. Do not send the MADA to DDB if the applicant does not meet all other Medicaid eligibility requirements aside from disability and income, with one exception:

If a non-qualifying immigrant would qualify for Emergency Services Medicaid only if s/he was disabled, send the MADA to DDB.

5.3.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization – Release to Disability Determination Bureau form (F-14014), . This is the only form DDB can accept. See Process Help 12 Automated Medicaid Disability Determination.

Leave the box blank that asks for the "Name and Address – Agency/Organization Authorized to Release Information." DDB has scanners that will automatically fill in the blank. Filling it in creates problems for them.

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative's signature on the release is not acceptable unless s/he has a court order.

5.3.4 Medical Report

If the applicant has copies of any medical records, school records, etc., include them with the application.

A medical report of disability does not need to be submitted with the application. DDB will obtain all of the medical reports necessary for the disability determination. However, if the applicant or the representative has already provided medical records/reports to the IM agency, this evidence must either scanned into the electronic case file (ECF) along with the completed Medicaid disability application (MADA) form .

DDB will contact the IM agency for applications that are not fully completed with names and addresses and work information. See Process Help 12.5 How to Resend an Application to DDB.

5.3.5 SSI Application Date

Occasionally a person applies for *SSI* and is determined ineligible for SSI payments. In these cases, determine Medicaid eligibility from the SSI application date, if it is earlier than the Medicaid application date.

An application for SSI is also an application for Medicaid.

S/he must still meet all Medicaid eligibility requirements. You must request the SSI application date by using the state on line query (SOLQ).

Use the SSI application date as the filing date if the *member* contacts the IM agency within the calendar month following the month of the SSI denial. If the

contact to the IM agency is later than the above, the filing date is the regular date s/he applied at the IM agency .

5.3.6 Routine SSI-MA Extension

The IM agency fills the gap in eligibility between the loss of SSI-MA and an eligibility determination by the IM Agency. Certify the member for the period between the loss of SSI-MA eligibility that appears on MMIS and when you will be able to determine their Medicaid eligibility. Determining Medicaid eligibility should usually occur within the month after s/he loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps." The exception to this is in 5.3.5 SSI Application Date.

The IM agency will fill the gap in eligibility when an ongoing SSI case is terminated. The person is eligible for a re-determination of Medicaid eligibility by the IM agency . S/he should apply within the calendar month of notification of termination. An extra month of SSI-MA eligibility is posted on MMIS to allow the member time to have eligibility determined by the IM agency .

There is no fill the gap provision for those who lose their SSI eligibility because of:

1. Death
2. Leaving Wisconsin
3. Incarceration
4. Fleeing drug felon

5.3.6.1 Case Processing

The processes differ based on if the member is already open for another program in CARES or if they aren't open in CARES. The starting point for both CARES and non-CARES cases is an MMIS and SOLQ query.

Active CARES cases- An active case in CARES is one in which the person is part of a case where at least one person is currently open, or closed less than 30 days for at least one program of assistance. If the member has an active case in CARES, EDS sends a list to the agency's CARES coordinator of those losing SSI and sends those members a letter saying the IM worker will contact them if there isn't enough information to determine eligibility.

As soon as the IM worker receives the list of those in active CARES cases, s/he:

1. Opens the member for Medicaid in CARES. This may seem unusual since s/he will show eligibility on MMIS for a grace month. The reason you open all of them in CARES is to provide a tracking mechanism to show you "filled the gap" and that the member receives the correct notice, if s/he fails eligibility later. CARES instructions are:

a. Case Information> ***Request Medicaid*** page- Request Medicaid
b. Benefits and School> ***Benefits Received*** page- Change the Y in the SSI field to N or on the ***Benefits Received*** page– change the Y in the 1619(b) field to N.
c. Don't change any financial information (unless you need to in order to make the person eligible). Complete any other required demographic information.
d. Verifications aren't required at this point.
e. Run eligibility and confirm.

2. The day after you open the case, request verification of any items you need to determine continued Medicaid eligibility. At this point, treat the case as a regular case, and all verification rules, etc. apply. The member has 10 days to provide verifications.

Non CARES- If the member doesn't have an active case on CARES, EDS sends a letter along with an application telling him/her that s/he must apply. The member sends the application to EDS and EDS forwards it to the CARES coordinator, who assigns it to a worker. The worker enters the case and determines eligibility. MMIS will close those cases that do not send an application within 30 days of their request.

3. **Reminder**: For all cases, (CARES and Non-CARES) even if the member doesn't meet Medicaid eligibility requirements for the months between when s/he lost SSI and when you are re-determining eligibility, s/he is still eligible. Don't require the member to come into the office. Ineligibility starts, following timely notice, when s/he:

   a. Does not return the application (EDS takes care of this, or
   b. Fails to respond to an information request, or
   c. No longer meets eligibility requirements (only forward from when the review or application is done).

5.3.7 Other SSI-MA Extensions

Fill the gap between the loss of SSI-MA and an eligibility determination by the IM agency when:

1. Retroactive SSI approval and termination occurs. A person applies for SSI and is approved. The approval is retroactive and the SSI also is terminated retroactively.
2. Eligibility for Medicaid is not determined timely by the IM agency through no fault of the member.

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5.4 DDB ACTION

5.4.1 DDB Action Introduction
5.4.2 Diary Date
5.4.3 Allowances
5.4.4 Denials

5.4.1 DDB Action Introduction

DDB will attempt to process the *disability* determination within 60 days of the date it receives the signed application. If a delay in processing the application occurs because the extent of an impairment will not be known until several months after its onset, DDB will notify the *applicant* in writing that additional evaluation time is necessary. DDB will give the reason for the delay and will inform the person of the right to appeal the delay. The IM agency will receive a copy of the letter.

A DDB disability decision on a *SSDI* or *SSI* case generally has binding authority. A Medicare or SSDI disability certification notice is acceptable verification of disability.

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 Carol Rounds at (608) 267-7362.

5.4.2 Diary Date

Item 17 on the *SSA*-831 form indicates whether or not medical re-examination is required for recipients not on SSI or SSDI. An exam is required when improvement is expected to occur in a person's condition. A date on the box to the right of item 17, "Diary Type", tells you when DDB wants to review the case again. When the Diary Date is earlier than the current date refer to the instructions that follow under 5.7 Redetermination.

5.4.3 Allowances

Files on persons found disabled will be returned to the IM agency with a completed SSA-831 Determination of *Disability*.

5.4.4 Denials

Persons found not disabled will be sent a notice by DDB (a copy will be sent to the IM agency) along with forms to apply for a Reconsideration/Hearing. Files on denied cases will be kept at DDB for 60 days. If the IM agency needs a file after 60 days, call Robin Kast at (608) 266-3300 and the files will be returned to the IM agency.

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5.5 RECONSIDERATION / HEARING

5.5.1 Reconsideration/ Hearing Introduction
5.5.2 Reversed Disability Denial Decision
5.5.3 CARES Processing

5.5.1 Reconsideration/ Hearing Introduction

Send Reconsideration/Hearing requests to:

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

Requests for Reconsideration/Hearing must be received by *DDB* within 45 days of the date of the Denial Notice. Late requests cannot be honored. DDB will notify the *member* that his/her request for a reconsideration/hearing has been denied if the member's request was not received by DDB within the 45 day deadline.

DDB will conduct a reconsideration of the denial. If DDB reverses the decision to an allowance, the determination and folder will be sent to the IM Agency.

If DDB affirms the denial, a Reconsideration Denial notice will be sent to the *applicant* (a copy will be sent to the IM Agency) and the file will be sent directly to the Division of Hearings and Appeals, which will then schedule a hearing.

If, in a fair hearing, a person is found to be disabled, and the hearing officer does not specify a date for review, contact DDB and request a date to review the disability.

When a DDB disability denial decision is overturned by the Division of Hearings and Appeals (DHA), the disability determination is valid as of the disability approval and disability onset dates established by DHA.

5.5.2 Reversed Disability Denial Decision

When DDB notifies the IM agency that a disability denial decision has been reversed (approved) as a result of a Reconsideration/Hearing request, the IM agency must redetermine the individual's Medicaid eligibility.

1. Use the original Medicaid application filing date that was associated with the MADA decision that has now been reversed (approved).
2. Re-evaluate the member's Medicaid eligibility for all months between the Medicaid application filing date (and 3 month backdate period if appropriate) and the date of the DDB approval. For this retroactive period, certify the member only for those months for which they met all Medicaid eligibility requirements.
3. Send the member a positive notice, advising them of the months of retroactive eligibility, and current ongoing eligibility if appropriate. If the member was ineligible for Medicaid for some of the prior months, send the member a negative notice, advising them of his/her retroactive ineligibility for those specific months.

For these types of cases, the IM worker is simply doing what ordinarily would have been done if the original DDB decision had been approved, rather than denied.

5.5.3 CARES Processing

Based upon the assumption that the Medicaid CARES case has been closed for more than 30 days since the original denial decision date, you will now have to enter a new application in CARES using the application function. Do not require the member to file a new application. Use the recent DDB disability approval date as your Medicaid application filing date. You should now be able to use CARES to determine and certify the current month's Medicaid eligibility and up to 3 backdate months. If you need to go back any further than this, do the eligibility determination and certification manually.

When the disability denial decision is overturned by DHA, enter the disability approval and disability onset date established by DHA, in CARES on the Disability page in CWW , as if it was approved by DDB. Document in case comments that this disability approval decision was actually made by DHA and not DDB, and record the fair hearing case number. Run eligibility to determine Medicaid eligibility for current and future months and also for any past months in which the person was determined disabled.

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5.6 MEDICAL EXAM COST

If the person's Medicaid application is approved, Medicaid will pay the cost of any medical examination necessary for the completion of a current medical report. If it is denied, you may claim the cost of the examination as an administrative expense. Reimbursement is from the Medicaid administrative account.

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5.7 REDETERMINATION

5.7.1 Redetermination Introduction
5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text
5.7.2 Recipients Exceeding the Substantial Gainful Activity Level

5.7.1 Redetermination Introduction

Review a *disability* determination when:

1. The *Disability* Determination and Transmittal (*SSA*-831) indicates medical re-examination in item 17 of that form, **or**

2. The person is younger than 65 years of age and no longer receives *OASDI* (Social Security) disability benefits,

   Note: Disability determinations should not be done for recipients over age 65, except in some circumstances for *MAPP* (See 26.1 MAPP Introduction), **or**

3. The medical circumstances have significantly improved (see 5.7.2 Recipients Exceeding the Substantial Gainful Activity Level), **or**

4. The person has returned to work.

Complete and/or forward the following to *DDB*:

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

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 DDB determines that the recipient is no longer disabled, DDB will first send written notice to the recipient explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and recipients are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Recipients 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 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 recipient appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a revised SSA-832 will be sent to the IM agency at that time.

If the recipient appeals the proposed cessation and DDB is unable to reverse this decision, the file will be forwarded directly to the Division of Hearings and Appeals (DHA) for a Hearing. DHA will notify the IM agency of their final decision.

If the recipient chooses not to appeal or fails to file the appeal on a timely basis, DDB will send 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 5.7.1.1 for an example.

Once the IM agency receives final notice of a cessation, then they must follow existing procedures to notify the recipient of the termination of Medicaid benefits (unless the recipient qualifies for Medicaid on some other basis). The recipient will be given another 45 days to appeal that decision.

Note: The process described above provides the Medicaid recipient with two opportunities to file an appeal regarding whether or not they continue to be disabled. This is the result of federal laws which require the Disability Determination Bureau (DDB) to notify a disabled recipient of Medicaid or Social Security benefits that they no longer meet the disability criteria necessary to continue receiving those benefits. These notice requirements for DDB also include an opportunity for the recipient to appeal the DDB decision within 45 days. Medicaid benefits must be continued during this potential 45 day appeal period, whether or not the client actually files an appeal. DDB cannot notify the Income Maintenance (IM) agency that the client is no longer disabled until this 45 day appeal period has expired, and the client did not file an appeal within that timeframe. Once this initial 45 day appeal period expires, with no appeal request from the client, DDB will then notify the IM agency that the Medicaid recipient is no longer disabled.

Upon receipt of the notification (Medicaid Disability Cessation) from DDB, the IM agency must then re-determine whether or not the recipient qualifies for some category of Medicaid other than that related to disability. If the recipient is not eligible for any other Medicaid category, the IM agency would then take the necessary action to discontinue the recipient's Medicaid eligibility in the normal manner, issuing all required notices. The recipient would then have another opportunity to appeal the termination of their Medicaid eligibility. The fact that this second potential fair hearing essentially involves the same issue (disability) that was the subject of the first appeal is irrelevant. As stated earlier, this process is required by federal law.

5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text

To: _____
Medicaid Disability Cessation Case

The Disability Determination Bureau has determined that _____ SSN:_____ is no longer disabled. (See the SSA-832 decision in file.)

The recipient has not appealed this decision within the 45-day appeal period that expired on _____.

Unless this individual qualifies for Medicaid on some basis other than disability, please initiate action to terminate MA coverage. See MA Eligibility Determination Handbook instructions in section 5.7.1.

5.7.2 Recipients Exceeding the Substantial Gainful Activity Level

A Medicaid recipient who loses *SSDI* because s/he exceeds the Substantial Gainful Activity level does not lose Medicaid coverage if:

1. S/he is a recipient with a disability, who was receiving non-MAPP full benefit Medicaid, and is currently working, **or**

2. S/he is a current MAPP recipient.

In these cases, a MAPP disability determination must be done and MAPP continued until the determination is made.

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5.8 CONFLICTING CLAIMS

Disability determinations for Social Security, *SSI* and Medicaid are completed under the same regulations. DDB's decisions will be consistent if the person files for any of these programs. If a decision on one program is later changed by appeal or because of new evidence, etc., *DDB* will notify the other program's to change their determinations to match.

DDB may request return of Medicaid disability files when reviews of conflicting or updated decisions are needed.

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5.9 PRESUMPTIVE DISABILITY (PD)

5.9.1 Presumptive Disability Introduction
5.9.2 PD Determined by the IM Worker
- 5.9.2.1 Definition of Urgent Need
- 5.9.2.2 Impairments
- 5.9.2.3 PD Certification Process

5.9.3 PD Determined by DDB
5.9.4 Deceased Applicants
5.9.5 Eligibility
5.9.6 Disability Application Denials
- 5.9.6 1 DDB returns a negative Presumptive Disability decision
- 5.9.6.2 Recipient ineligible for non-medical reasons
- 5.9.6.3 DDB Reverses PD Decision Made by DDB or by the IM Worker

5.9.1 Presumptive Disability Introduction

Federal *SSI* law and regulations state that the SSI program can find an individual to be presumptively disabled and will be treated as a person with a *disability* until a final disability determination can be completed. To be treated as presumptively disabled by SSI means that the applicant's benefits can begin before *SSA*, or its contracted agency, has formally determined the individual to be disabled.

Wisconsin's Medicaid program also allows a determination of presumptive disability.

Presumptive *Disability* (PD) is a method for temporarily determining a disability for an individual while a formal disability determination is being done by *DDB*. Presumptive disability is determined either by the DDB, or in some circumstances, by the IM worker. The regular disability application process (5.3 Disability Application Process) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until the DDB makes its final disability determination.

5.9.2 PD Determined By The IM Workers

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.

In determining that the *applicant* is presumptively disabled, the IM worker will need a "medical professional" to attest in writing that:

1. The individual's circumstances constitutes an urgent need (See 5.9.2.1 Definition of Urgent Need) for medical services, **and**
2. The individual has one of a certain set of impairments (See 5.9.2.2 Impairments).

A "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an 'urgent need' and the presence of one of the impairments. (A medical professional is a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

5.9.2.1 Definition of Urgent Need

A person must be in one of the following situations to be considered to have an urgent need:

1. The applicant is a patient in a hospital or other medical institution; **or**
2. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment; **or**
3. The applicant is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect; **or**
4. The applicant is unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.

Note: In addition to health conditions of a physical nature, the above criteria may also apply to an urgent need resulting from an individual's serious and persistent mental illness.

Example 1: An individual with schizophrenia who will need to be hospitalized if he or she does not take prescribed medication has an 'urgent need' if such medication is not available without Medicaid coverage.

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM worker can certify the member as presumptively disabled if the member has one of the

following readily apparent impairments, as attested to in writing by a medical professional:

1. Amputation of a leg at the hip.
2. Allegation of total deafness.
3. Allegation of total blindness.
4. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that's expected to last 12 months or longer.
5. Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.
6. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
7. Allegation of Down's syndrome.
8. Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. Note: 'Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.
9. A physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker or medical records custodian) confirms an individual is receiving hospice services because of a terminal condition, including but not limited to terminal cancer.
10. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
11. End stage renal dialysis confirmed by a medical professional.
12. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.
13. The member has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.

5.9.2.3 PD Certification Process

A medical professional must complete and sign the Medicaid Presumptive Disability form (HCF 10130) attesting to both the urgent need and the impairment, before an IM worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the

medical professional beyond the Medicaid Presumptive Disability form. Once completed, place a copy of this form in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, certify Medicaid eligibility (see 5.9.5 Eligibility).

Changes in Urgent Need Prior to PD Medicaid Certification
Sometimes, an individual's medical condition improves between the date of the PD Medicaid application and the date of the PD Medicaid certification. This improvement results in the individual no longer meeting the urgent need criteria at the time of the PD Medicaid eligibility determination.. The most common example of this situation is that of a person who is hospitalized on the date of the PD Medicaid application, but released from the hospital prior to being certified by the IM worker for PD Medicaid eligibility. Under these circumstances, if the PD applicant no longer has an urgent need as of the date that you are making the PD Medicaid eligibility determination/certification, the PD request must be denied. Follow the procedures described in section 5.9.6.1 when notifying the applicant that their request for a PD eligibility determination has been denied.

Example 2: Bob is 55 years old and has been hospitalized since February 01, 2008 after suffering his second stroke in the last 4 months. Bob applies for Medicaid on February 07, 2008. His physician attests in writing that Bob has an urgent need (he is hospitalized), and that he has one of the impairments listed on the Medicaid Presumptive Disability form (F-10130). The IM worker has requested verification of Bob's non exempt assets and completion of the MADA (F-10112). On February 14, 2008 Bob returns the completed MADA and asset verification information to his IM worker. He also indicates that he was released from the hospital on February 11, 2008 and is recuperating at home. On February 14, 2008, the IM worker has all the necessary information to make a PD Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for PD Medicaid must be denied.

Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (See 5.3 Disability Application Process). The Medicaid Disability Application form (F-10112, formerly DES 3071) must be completed and sent to the DDB along with the necessary copies of the Confidential Information Release Authorization form (F-14014).

Note: Whether the IM worker makes the PD determination or DDB makes the PD determination, the Medicaid Disability Application F-10112 must be completed "before" the IM worker certifies the member for PD.

The DDB will then process the disability application and make a final disability determination.

5.9.3 PD Determined By DDB

If the applicant has an urgent need, but does not have one of the listed impairments, the IM worker must request DDB to make a presumptive disability determination. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form (F-10130), that there is an urgent need for medical services.

Note: If someone has an impairment, but not an urgent need, follow the normal disability application process (See 5.3 Disability Application Process).

1. Document the urgent need by placing the Medicaid Presumptive Disability form (F-10130) in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:
   a. The Medicaid Disability Application form F-10112, formerly DES 3071).
   b. Release to Disability Determination Bureau form (F-14014).
3. See Process Help 12.0 for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM Agency within three business days of receiving the request for presumptive disability and the F-10112 form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

5.9.4 Deceased Applicants

While a deceased person can be eligible for Medicaid in the months prior to his/her death, presumptive disability determinations are not allowed for individuals that are deceased. Process such requests for a final disability determination through the disability process through DDB.

5.9.5 Eligibility

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:
   EDS
   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.

5.9.6 Disability Application Denials

5.9.6.1 DDB Returns a Negative Presumptive Disability Decision

If the DDB returns a negative Presumptive Disability decision, the IM worker must send a manual notice of decision to the applicant. The notice must state:

"Your request for Medicaid is based upon your statement that you are disabled. The final decision on your disability has not yet been made, however we have determined that you cannot be considered presumptively disabled. This means that you cannot be certified as eligible for Medicaid as a person with a disability until a final disability decision has been made. You will be informed when the Disability Determination Bureau makes the final disability decision. (Wis. Stats. ss. 49.46 and 49.47)"

5.9.6.2 Recipient Ineligible for Non-Medical Reasons

If a recipient is determined ineligible for non-medical reasons, you may terminate PD with timely notice without waiting for DDB's final disability decision. In such a case, notify DDB immediately at, (608) 266-1565, that a medical determination is no longer needed.

5.9.6.3 DDB Reverses PD Decision Made by DDB or by the IM Worker

If the DDB denies a disability application their decision reverses a PD decision made by the IM worker or by DDB. Terminate Medicaid eligibility following timely notice requirements. Medicaid eligibility based on a PD decision does not

continue during the period a person is appealing DDB's decision that they are not disabled.

Benefits received while the disability decision was pending are not subject to recovery, unless the individual made misstatements or omissions of fact at the time of the presumptive disability determination.

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5.10 MAPP (MEDICAID PURCHASE PLAN) DISABILITY

5.10.1 MAPP Introduction
5.10.2 MAPP recipients over age 65

5.10.1 MAPP Introduction

When a *disability* determination for the *MAPP* is required, complete the application process in 5.3 Disability Application Process.

Sections 12 and 13 of the Application for Medicaid *Disability* form (F-10112) must be completed in full detail in all MAPP disability determination requests. The Disability Page in Cares Worker Web should be coded to indicate whether the request is for a MAPP disability determination, or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an *applicant* may move from regular Medicaid disability to MAPP disability.

A determination of disability for MAPP excludes consideration of Substantial Gainful Activity (SGA), while a regular Medicaid disability determination does not.

5.10.2 MAPP recipients over age 65

A MAPP recipient who loses *SSDI* benefits solely because s/he turns 65 does not need a disability re-determination until the next scheduled diary date. If there is no scheduled diary date a MAPP disability determination must be done, and MAPP eligibility continued until the MAPP disability determination is made by the Disability Determination Bureau (*DDB*).

For more information on MAPP, see Ch. 26.1 MAPP Introduction.

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6 RESIDENCY

6.1 RESIDENCY ELIGIBILITY

6.1.1 Residency Eligibility Introduction
6.1.2 Migrant Farm Worker

6.1.1 Residency Eligibility Introduction

A person must be a Wisconsin resident to be eligible for Medicaid. S/he must:

1. Be physically present in Wisconsin. There is no required length of time the person has to have been physically present, **and**
2. Express intent to reside here (See 6.2 Intent to Reside).

Example 1: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For Medicaid purposes, George is a Wisconsin resident.

6.1.2 Migrant Farm Worker

A migrant who meets the following conditions is a Wisconsin resident:

1. His/her primary employment in Wisconsin is in the agricultural field or cannery work, **and**
2. S/he is authorized to work in the US, **and**
3. S/he is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crewleader"), **and**
4. S/he routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

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6.2 INTENT TO RESIDE

Intent applies to any *adult* age 18 or older who is capable of indicating intent. An adult is incapable of indicating intent when:

1. His/her I.Q. is 49 or less or s/he has a mental age of 7 or less, based on tests acceptable to Wisconsin's Department of Health and Family Services (DHFS); **or**
2. S/he is judged legally incompetent by a court of record; **or**
3. Medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental *disability* supports a finding that s/he is incapable of indicating intent.

If the *applicant*/*member* is incapable of indicating intent, the guardian or person acting on behalf of the applicant/member can indicate the applicant's/member's intent to reside.

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6.3 DETERMINING RESIDENCE

6.3.1 Under Age 21
6.3.1.1 In an institution
6.3.1.2 Not in institution
6.3.2 Age 21 and Over
6.3.2.1 In an institution

6.3.1 Under Age 21

6.3.1.1 In an institution

The residence of an institutionalized person under age 21 when his/her parents or legal guardian lives outside of Wisconsin is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.

If the parents have abandoned him/her and no legal guardian has been appointed, his/her residence is the state in which the institution is, if the person making the Medicaid application lives in that same state.

If s/he is married, his/her residence is the institution's state.

6.3.1.2 Not in institution

A person under age 21 and not residing in an institution is a Wisconsin resident if s/he is:

1. Living here more than temporarily.
2. Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family *member* who is a migrant farm worker.
3. Living in another state when Wisconsin or one of its county agencies has legal custody of him/her.
4. Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or *disability*.)

6.3.2 Age 21 and Over

6.3.2.1 In an institution

The residence of an institutionalized person aged 21 or over is the state in which s/he is residing with the intent to remain.

If s/he is incapable of indicating intent, his/her residence is determined in the same way as the residence of an institutionalized person under age 21.

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6.4 SPECIAL SITUATIONS

6.4.1 State Supplementary Payment (SSP)
6.4.2 Homeless Persons

6.4.1 SSP Payment

The State Supplementary Payment (SSP) is the portion of an *SSI* payment paid by a state, not by the federal government. An SSP recipient's residence is the state making the SSP payment.

6.4.2 Homeless Persons

A homeless person living in Wisconsin meets the requirement of being physically present in Wisconsin. The agency must, by using its own address or some other fixed address, make Medicaid cards available to eligible applicants who have no fixed dwelling place or mailing address.

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6.5 ABSENCE

6.5.1 Absence Introduction
6.5.2 Temporary Absence

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until abandoned. Being out-of-state, in and of itself, is not abandoning residence. Residence is not abandoned when an Medicaid group or group *member* is temporarily out-of-state.

6.5.2 Temporary Absence

Temporary absence ends when another state determines the person is a resident there for Medicaid purposes.

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6.6 EFFECTIVE DATE OF MEDICAID FOR SSI RECIPIENTS

SSI recipients who move to Wisconsin become eligible for Medicaid in Wisconsin on the 1st of the month in which the move occurred.

Example 1: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April, 2009. He becomes eligible 04-01-09 in Wisconsin.

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6.7 WISCONSIN VETERANS HOME

Waupaca County receives and processes all Medicaid applications and reviews for residents of the Wisconsin Veterans Home at King, regardless of the county of residence.

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6.8 INTERSTATE PLACEMENTS

6.8.1 Interstate Placements Introduction
6.8.2 Reciprocal Agreement

6.8.3 Disputes

6.8.1 Interstate Placements Introduction

An interstate placement occurs when a state or state contracted agency arranges for an individual to be admitted to an institution in another state.

"Arranges for" means any action by a state or state-contracted agency beyond providing information to the person or the person's family (or both). Do not consider the following to indicate interstate placement:

1. Giving information to individuals about another state's Medicaid program.
2. Giving information to persons about the availability of health care services and facilities in another state.
3. Helping a person locate an institution in another state when that person is capable of indicating intent and independently decides to move.

When a state or state-contracted agency makes the placement, the state making the placement is the person's Medicaid residence. The person's intent makes no difference. If Wisconsin places a person into an institution in Tennessee, Wisconsin remains the state of residence for Medicaid even if the person expresses an intent to reside in Tennessee.

If Tennessee places a person in Wisconsin, Tennessee is the Medicaid residence despite an indicated intent by the person to make his/her home in Wisconsin.

Follow this rule even when placement is made by a state because that state lacks a sufficient number of appropriate facilities to provide services to its residents.

Use the general rule of residency when a competent person leaves an institution in which s/he was placed by another state. If the person is not able to indicate intent, Medicaid residence continues to be that of the state that made the placement.

6.8.2 Reciprocal Agreement

Wisconsin has a reciprocal agreement with some other states (see the list below) in which persons that are placed in out-of-state institutions (not placed there as a result of an interstate placement) are the residents of the state where the institution is. For example, a person institutionalized in Wisconsin who would otherwise be considered a resident of Minnesota is a Wisconsin resident for Medicaid purposes.

These are the states with which we have this agreement:

- Alabama

- Arkansas
- California
- Florida
- Georgia
- Idaho
- Kansas
- Kentucky
- Maryland
- Minnesota
- Mississippi
- New Mexico
- N. Dakota
- Ohio
- Pennsylvania
- S. Carolina
- S. Dakota
- Texas
- Virginia
- W. Virginia

6.8.3 Disputes

The state in which the person is physically present is the Medicaid residence when two or more states disagree about the person's residence.

If you determine that a state other than Wisconsin is the person's legal residence, contact the other state about providing Medicaid coverage.

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6.9 INMATES

6.9.1 Definitions
6.9.2 Inmates Introduction
6.9.3 Inmates of State Correctional Institutions
6.9.4 State Correctional Institutions

6.9.1 Definitions

An inmate is a person residing in a *public institution* on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate.

"Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include a medical institution (See 27.1 Institutions), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which foster care maintenance payments are made under title IV-E.

Note: The following are not publicly operated community residences, even though they may accommodate 16 or fewer residents:

1. Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex, **or**
2. Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

6.9.2 Inmates Introduction

Individuals who are inmates of a public institution are not eligible for Medicaid, with two exceptions. An inmate who is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate.

Inmates are ineligible for Medicaid services on any day in which they are residing in a public institution. Providers are prohibited from receiving payment for any services rendered to an inmate even if the inmate is still certified as eligible for Medicaid and has not received any negative notice. Inmates may never be considered temporarily absent from a household and receive Medicaid benefits. Temporary absence policies do not apply in the case of inmates.

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

1. Pregnant women may apply for and receive BCPP while they are an inmate.
2. 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.

Procedures for processing inmates of state facilities are covered in 6.9.3 Inmates of State Correctional Institutions below.

6.9.3 Inmates of State Correctional Institutions

Use the following process for inmates of state correctional institutions:

1. Department of Corrections (DOC) staff submits a paper application (F-10182 or F-10101). The mailing address for the inmate will be the DOC central office. Superintendents of state correctional facilities (Wardens)

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)"
3. If the inmate is between the ages of 19 and 64, and is not a pregnant woman, DOC will submit a Medicaid *Disability* Application (F-10112) along with the Medicaid application (HCF 10100 or HCF 10101). 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 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.

Note: It is not necessary to provide a ten-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 CARES, and allow CARES generated notices to be sent to the designated DOC staff person.

Category	**Medical Status Codes**
Minors Under 18	
Income Below AFDC-Related Categorically Needy Limit	38
Income Below AFDC-Related Medically Needy Limit	39
18-year-olds	

Income Below AFDC-Related Categorically Needy Limit	38
Pregnant Women	
Income Below AFDC-Medicaid Limit	31
Income Below AFDC-Related Categorically Needy Limit	38
Income Below AFDC-Related Medically Needy Limit	39
Income Below Healthy Start Categorically Needy Limit	PW
60-day Extension Period E3	E3
Income Below Healthy Start Medically Needy Limit	P1
60-day Extension Period	E4
Elderly	
Income and Assets Below *SSI*-Related Categorically Needy Limit	4
SSI-Related Medically Needy	5
Blind	
Income and Assets Below SSI-Related Categorically Needy Limit	14
SSI-Related Medically Needy	15
Disabled	
Income and Assets Below SSI-Related Categorically Needy Limit	22
SSI-Related Medically Needy	23
Undocumented Aliens	AE

6.9.4 State Correctional Institutions

Brown
Institutions Green Bay Correctional Institution
Sanger Powers Correctional Institution

Chippewa
Highview Correctional Institution
Stanley Correctional Institution

Columbia
Columbia Correctional Institution

Crawford
Prairie du Chien Correctional Facility (Division of Juvenile Corrections)

Dane
Oakhill Correctional Institution
Oregon Correctional Institution
Thompson Correctional Institution

Dodge
John Burke Correctional Center
Dodge Correctional Institution
Fox Lake Correctional Institution
Waupun Correctional Institution

Douglas
Gordon Correctional Center

Fond du Lac
McNaughton Correctional Center
Taycheedah Correctional Institution

Grant
Supermax Correctional Institution

Jackson
Black River Correctional Institution
Jackson Correctional Institution

Kenosha
Kenosha Correctional Center

Lincoln
Lincoln Hills School (Division of Juvenile Corrections)

Milwaukee
Marshall Sherrer Correctional Center
Milwaukee Secure Detention Facility
Milwaukee Women's Correctional Facility
Felmers O'Chaney Correctional Center

Racine
Robert Ellsworth Correctional Center
Racine Correctional Institution
Racine Youthful Offender Correctional Facility
Southern Oaks Girls School

St. Croix
St. Croix Correctional Center

Sauk
New Lisbon Correctional Center

Sawyer
Flambeau Correctional Center

Sheboygan
Kettle Moraine Correctional Institution

Waukesha
Ethan Allen School (Division of Juvenile Corrections)

Waushara
Redgranite Correctional Institution

Winnebago
Drug Abuse Correctional Center
Oshkosh Correctional Institution
Winnebago Correctional Center
Wisconsin Resource Center (Department of Health and Family Services)

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7 U.S. CITIZEN OR QUALIFYING IMMIGRANT

7.1 US CITIZENS AND NATIONALS

7.1.1 US Citizens and Nationals Introduction
7.1.2 Child Citizenship Act of 2000
7.1.3 Compact of Free Association States

7.1.1 US Citizens and Nationals Introduction

All U.S. citizens and U.S. nationals are entitled to apply for and receive Medicaid if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

A U.S. citizen is anyone who:

1. Was born in the United States, the Commonwealth of Northern Mariana Islands, Puerto Rico, Guam or the U.S. Virgin Islands.
2. Was born to a U.S. citizen who was living abroad.
3. Is a naturalized U.S. citizen.

A U.S. national is anyone who was born in American Samoa (including Swain's Island). The Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, therefore individuals from this country are not U.S. nationals.

7.1.2 Child Citizenship Act of 2000

The Child Citizenship Act (CCA) of 2000 amended the Immigration and Naturalization Act (INA) to provide derivative citizenship to certain foreign-born children of U.S. citizens. This applies to individuals who were under 18 years old on February 27, 2001 and anyone born since that date. The children included in the act are:

- Adopted children meeting the two year custody requirement ,
- Orphans with a full and final adoption abroad or adoption finalized in the U.S,
- Biological or legitimated children, **or**
- Certain children born out of wedlock to a mother who naturalizes

The CCA provides that foreign-born children who meet the conditions below automatically acquire U.S. citizenship on the date the conditions are met. They are not required to apply for a certificate of naturalization or citizenship to prove U.S. citizenship. These conditions are that the child:

- Has at least 1 parent who is a U.S. citizen (whether by birth or naturalization),
- Is under 18 years of age,
- Has entered the U.S. as a legal immigrant,
- If adopted, has completed a full and final adoption; **and**,
- Lives in the legal and physical custody of the US citizen parent in the U.S.

Adopted children automatically become U.S. citizens if they meet all the above conditions and were:

1. **Adopted under the age of 16**, and has been in the legal custody of and has resided with the adopting parent or parents for at least two years,
2. **Adopted while under the age of 18**, and has been in the legal custody of and has resided with the adopting parent or parents for at least two years and is a sibling of another adopted child who is under 16,
3. **Orphans adopted while under the age of 16**, who have had their adoption and immigration status approved by the *USCIS* (Form I-171, “Notice of Approval of Relative Immigrant Visa Petition”). These children need not have lived with the adoptive parents for two years, **or**
4. **Orphans adopted under the age of 18**, who have had their adoption and immigration status approved by the USCIS, and are siblings of another adopted child who is under the age of 16. These children need not have lived with the adoptive parents for two years.

7.1.3 Compact of Free Association States

Persons from the Compact of Free Association States (*CFAS*) are not considered U.S. citizens or nationals. The Compact of Free Association States include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the Compact of Free Association States have a special status with the US that allows them to enter the country, work here and acquire an SSN without obtaining an immigration status. They are not eligible for Medicaid, unless they have obtained a qualifying immigration status. Those CFAS citizens who do not have one of the immigration statuses listed in 7.3.4 Immigration Status Chart may qualify for Medicaid Emergency Services only.

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7.2 DOCUMENTING CITIZENSHIP AND IDENTITY

7.2.1 Documenting Citizenship and Identity Introduction
- 7.2.1.1 Covered Programs
- 7.2.1.2 Exempt Populations

7.2.2 Reasonable Opportunity Period
- 7.2.2.1 Applicants
- 7.2.2.2 Members

7.2.3 Good Faith Effort
- 7.2.3.1 For New Medicaid Applicants
- 7.2.3.2 For Ongoing Medicaid Members

7.2.4 Hierarchy of Documentation
- 7.2.4.1 Levels of Documentation
- 7.2.4.2 Naturalized Citizens
- 7.2.4.3 Agencies Paying For Documentation
- 7.2.4.4 Tribes With An International Border

7.2.5 Policy for Special Populations

7.2.6 Situations Which Require Special Documentation Processing
- 7.2.6.1 Person Add
- 7.2.6.2 Individuals Without Verification and Affect on Household Eligibility

7.2.6.3 Individuals Gaining Citizenship Through The Child Citizenship Act of 2000
7.2.6.4 Non-citizens
7.2.6.5 Individuals in Institutional Care Facilities

7.2.1 Documenting Citizenship and Identity Introduction

The Federal Deficit Reduction Act of 2005 requires persons applying for or receiving Medicaid (MA), BadgerCare Plus (BC+), or Family Planning Waiver (FPW) benefits, who have declared that they are a U.S. citizen, to provide documentation of their U.S. citizenship and identity.

Agencies must comply with the new Medicaid requirement to document citizenship and identity in order for the State to obtain Federal matching funds. As part of on-going DHS quality assurance initiatives, periodic quality control reviews will be done on randomly selected cases throughout the state to monitor agency compliance. Cases will be examined to determine if proper documentation was used to verify citizenship/identity and if the proper verification code was used. The Department will work with non-compliant agencies to achieve compliance.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S., or that the person is otherwise a U.S. citizen. In addition, any document used to establish identity must show identifying information that relates to the person named on the document. For a list of all the allowable documentation, see the Process Help 68.3 Acceptable Citizenship and Identity Documentation.

If an individual has provided proof of citizenship in a state other than Wisconsin, the IM worker can either request that the individual resubmit the documentation or request and obtain a copy or electronic copy of the original documentation reviewed by the other state to keep on file in Wisconsin.

Agencies may accept citizenship and identity documents from a woman whose last name has changed due to marriage or divorce if the documentation matches in every way with the exception of the last name. If there is any doubt, the agency may request that the individual provide an official document verifying the change such as a marriage license or divorce decree. If an individual has changed his/her first and last name, s/he must produce documentation from a court or governing agency documenting the change.

A document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood) is now considered a “Level 1” form of documentation of citizenship and identity.

Applicants who are otherwise eligible and are only pending for verification of citizenship and identity must be certified for health care benefits, within the normal application processing timeframe (30 days from the filing date), as long as the *applicant* has notified the worker that s/he is taking steps to obtain the necessary documentation or has asked for the worker's assistance to obtain it.

The applicant will have 90 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 90 days, the eligibility will be terminated with *Adverse Action* notice. This 90 day period applies to applications, reviews and person adds.

Once the citizenship and identity requirement is met, it need not be applied again, even if the person loses Medicaid at some point and later re-applies. A person should ordinarily be required to submit evidence of citizenship and identification only once, unless other information is received causing the evidence to be questionable.

NOTE: Do not re-verify identity for a person who has had his/her identity verified through the signing of a Statement of Identity for Children Under 18 Years of Age, HCF10154 (English) (Spanish).

Documentation submitted by the applicant or *member* to satisfy the new requirement must be maintained in the case record.

See Process Help Chapter 68.1 for tools that IM wokers can use to assist clients and applicants in meeting this requirement.

7.2.1.1 Covered Programs

The citizenship and identity documentation requirement covers all non-exempt applicants and members of:

- BadgerCare Plus
- Medicaid
- Katie Becket
  Note: Eligibility for Katie Becket is determined by Division of Long Term Care staff, therefore they will be ensuring citizenship and identity verification.
- Tuberculosis-related Medicaid (*TB* MA) **and**
- Wisconsin Well Woman Medicaid

  Note: TB and *WWW* MA eligibility is not determined in CWW, therefore it is important to ensure that citizenship and identity verification is done only once.

7.2.1.2 Exempt Populations

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

- Anyone currently receiving Social Security *Disability* Insurance (*SSDI*).
- Anyone who is currently receiving Supplemental Security Income (*SSI*) benefits.
- Anyone currently receiving Medicare.
- Anyone currently receiving *Foster Care* (Title IV-E and Non IV-E)
- Anyone currently receiving Adoption Assistance
- Inmates applying for or receiving BadgerCare Prenatal Program benefits.
- All persons who have ever been eligible for Wisconsin Medicaid or BadgerCare Plus as a CEN, are now exempt from ever having to provide documentation of citizenship.

Former SSI and Medicare Recipients
States cannot consider individuals who received Medicare or SSI in the past to be exempt. An individual is not required to be a citizen to receive these benefits. Since *SSA* does not share information regarding the reason benefits were lost, it is not possible to determine if the termination was due to citizenship status or not.

Note: Confirm the receipt of SSI, SSDI, and Medicare through the following data exchanges:

- For SSI: use DXSX
- For SSDI: use DXSA
- For Medicare: use DXSA

7.2.2 Reasonable Opportunity Period

All applicants and members must be given a reasonable period of time to present documents establishing that they are a U.S. citizen or national, and their identity. This newly designated time frame for purposes of citizenship and identity documentation is called the “reasonable opportunity period.”

7.2.2.1 Applicants

An individual applying for Medicaid currently receives the 30 day application processing period as the reasonable opportunity period in which to provide valid citizenship and/or identification verification. However, the reasonable opportunity period can be extended if s/he is trying to provide the necessary documentation, or has requested assistance from the IM worker. His/her application filing date will be honored if the necessary documentation is ultimately obtained. Unlike the policy for members, eligibility for Medicaid is not granted to applicants until the requirement is met.

7.2.2.2 Members

The "reasonable opportunity period" for members begins when they are notified of the new requirement. At or about the same time that they are notified of their upcoming review, they will receive the Citizenship Documentation Requirement letter (Draft). This reasonable opportunity period starts with the receipt of the letter and ends at the end of the review month. As such, the reasonable opportunity period for members will be about forty-five days. Recipients making a good faith effort to secure the necessary documentation, but who are unable to do so during the reasonable opportunity period, may have their Medicaid eligibility extended, even though the documentation requirement has not been satisfied.

If the member requests it, the IM worker must provide assistance to secure the necessary documentation. Medicaid eligibility may continue for as long as the member is deemed by the IM worker to be making a good faith effort to comply.

7.2.3 Good Faith Effort

The "good faith effort" policy for the citizenship and identity documentation requirements provides more time during which the member can provide the necessary verification to meet this new requirement. This policy allows for the extension of the reasonable opportunity period without jeopardizing the original filing date or review date.

By "good faith effort" we mean the individual is taking steps to obtain the necessary documentation and has notified his/her worker of such efforts or has requested assistance from the worker to obtain the necessary documentation.

Utilizing the "good faith" policies for applicants and members does not impact an agency's timeliness performance that is reported to BEM. Any cases that have a verification extension are not considered untimely until the extension date is past due with no final action taken by the worker. It is possible to provide several back to back extensions without a timeliness penalty as long as the worker takes action at the end of each extension period.

7.2.3.1 For New Medicaid Applicants

The application processing period can be extended to allow an applicant who is making a good faith effort to supply the required documentation. The IM worker must provide assistance to secure the necessary documentation if the applicant requests it. When the applicant provides the documentation, the IM worker must run eligibility from the original application filing date.

Example 1: Mary applies for Medicaid for herself on August 15, 2008. She does not have a copy of her Florida birth certificate. Mary's worker enters the appropriate codes to pend Medicaid eligibility for Mary. On September 5th, Mary informs her worker that she has contacted Florida and will receive a copy

of her birth certificate in 3 to 4 weeks. Mary's worker extends the verification due date another 4 weeks to allow Mary to comply with the new requirement. Mary presents her worker with her birth certificate on September 29th. The worker enters <BC> in the Medicaid Citizenship verification field, runs eligibility and confirms Mary's Medicaid back to the original application date of August 15th.

Once an applicant supplies the documentation, certify his/her eligibility from the original filing date on the application. Under no circumstances, however, should applicants be certified as eligible for program benefits before the citizenship and identity documentation requirement is satisfied.

7.2.3.2 For Ongoing Medicaid Members

Recipients making a good faith effort to secure the necessary documentation, but who are unable to do so during the reasonable opportunity period, may have their Medicaid eligibility extended, even though the documentation requirement has not been satisfied. If the member requests it, the IM worker must provide assistance to secure the necessary documentation. Medicaid eligibility may continue for as long as the member is deemed by the IM worker to be making a good faith effort to comply.

Example 2: Ben completes his Medicaid review on September 5th. The only item he was not able to verify was his citizenship. He was born in Washington but does not have a copy of his birth certificate. Ben calls his worker Tom on Sept 15th and tells him that his father who still lives in Washington, will mail him his birth certificate. Because Ben has been communicating with Tom, Tom enters <GF> in the Medicaid Citizenship verification field with <GF> for Good Faith effort, runs eligibility and confirms the case. Tom then goes back and pends the Medicaid eligibility by entering a <?> in the Medicaid Citizenship verification field to allow Ben additional time to provide the necessary documentation. Ben presents the birth certificate to Tom on October 15th. Tom changes the <?> code to <BC>, runs eligibility and confirms Ben's Medicaid eligibility.

7.2.4 Hierarchy of Documentation

The list of valid documents used to verify citizenship and identity is divided into five levels in accordance with federal regulations. Level 1 consists of documents of the highest reliability and can prove both citizenship and identity. Levels 2 through 4 consists of documents that can prove citizenship only with Level 2 being the most reliable and Level 4 the least reliable. Level 5 consists of documents that can prove identity only. Applicants and members must provide documentation from the highest level available that can be obtained during the reasonable opportunity period.

If an individual needs to verify citizenship and/or identity at the point of application or renewal s/he should try to fulfill the requirement with proof s/he already has available. If an applicant/member contacts the agency, work with him/her to check Documentation Levels 1 through 5 to determine if anything on the list is readily available to the applicant/ member. If an applicant/member was born in Wisconsin, use the online Birth Query to verify citizenship.

In certain circumstances the agency can authorize payment of documentation for an applicant/member. See 7.2.4.2 Agencies Paying for Documentation.

7.2.4.1 Levels of Documentation

See the Process Help 68.3 Acceptable Citizenship and Identity Documentation.

Level 1 – Evidence of Citizenship and Identity

Primary evidence documents both citizenship and identity. Primary evidence of citizenship and identity is the most reliable way to establish that the person is a U.S. citizen. If an individual presents documents from level 1, no other information is required; however, relatively few Medicaid applicants and members may be able to provide documents from this group.

Level 2 – Evidence of Citizenship

Secondary evidence of citizenship is the next most reliable way to establish someone is a US citizen. Many Medicaid applicants and members will be able to present documents from level 2 during the reasonable opportunity period and should be encouraged to do so. Note, however, that a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Note: Completing an on-line birth query (level 2 documentation) can be done for all persons born in Wisconsin. Enter TRAN code MNOS on CARES mainframe screen, hit enter, then F2. There is no cost to the agency to use this method of verification.

Level 3 – Evidence of Citizenship

Third level evidence of U.S. citizenship is acceptable and may be presented by applicants and members who are unable to obtain level 1 or level 2 evidence during the reasonable opportunity period. As with level 2 evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 4 – Evidence of Citizenship

Fourth level evidence of U.S. citizenship is acceptable evidence of the lowest reliability. While most Medicaid applicants and members will be able to present documents at this level, they should do so only if unable to obtain evidence of citizenship from the other levels during the reasonable opportunity period. As with second and third level evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 5 – Evidence of Identity

Level 5 documentation can only be used to verify identity. Documentation of citizenship from levels two through four must be accompanied by evidence of the applicant's or member's identity.

The applicant may provide three or more corroborating documents, such as a marriage license, divorce decree, high school or college diploma, property *deed*/title, death certificate, or employer ID card, to prove identity. This option can only be used if the applicant submitted level 2 or 3, not level 4, citizenship documentation. The applicant may not use a document that was also used for citizenship verification.

7.2.4.2 Naturalized Citizens

Naturalized citizens must provide level 1 or 2 citizenship documentation. The Citizenship Affidavit is also available for this population if no document from level 1 or 2 is available. This group cannot use level 3 or 4 documentation.

7.2.4.3 Agencies Paying For Documentation

The worker can authorize payment for a birth certificate from the state where the applicant was born and/or a WI State ID if an applicant/member:

- Has no documentation from Levels 1-5.
- Needs either an out of state birth certificate and/or has no identity documentation, **and**
- Requests financial assistance.

Note: If a member has obtained and already paid for his/her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement. If an individual has requested and paid for documentation before applying but does not yet have the documentation, do not confirm program eligibility for this individual. Eligibility can only be granted once the individual receives documentation and provides it to the agency.

If an individual was born in Wisconsin and not found in the Wisconsin online birth query, agencies may authorize payment for a WI birth certificate to verify citizenship.

IM agencies should pay for a birth certificate or state ID card before using the "Special Populations" option (See 7.2.5 Policy for Special Populations). If there is an opportunity to obtain a document that meets federal guidelines then that should be pursued.

However, when an applicant/member lacks any identity documentation needed to apply for a birth certificate or lacks any citizenship documentation to be able to apply for an ID card, it is appropriate to consider using the Written Affidavit for citizenship and/or "Special Populations Policy.

In order to obtain birth certificates or state ID cards for applicants/members, agencies need to follow the process outlined in Chapter 68.2.5 Citizenship and ID>Documentation and Verification Codes of the Process Help.

7.2.4.4 Tribes With An International Border

For Tribes having an international border, and whose membership includes non-U.S. citizens, Tribal enrollment/membership documents may be used for purposes of proving both citizenship and identity.

7.2.5 Policy for Special Populations

It is expected that all non-exempt individuals requesting or receiving Medicaid provide acceptable documentation to verify citizenship and identity from the federally approved Levels 1 through 5 at application or review. However, certain special populations may be particularly disadvantaged with regard to providing the required documentation. For some persons within a special population, it will be allowable to accept other documents besides those listed in Levels 1-5, once it is determined that the person is unable to produce any Level 1-5 documentation.

This policy only applies when it is determined that an individual within a special population is in a situation where s/he does not have the ability to obtain citizenship or identity documentation from Level 1-5 This policy should be used with discretion and only when an individual has no other means of meeting the requirement.

Examples of individuals in special populations include, but are not limited to, persons who:

- Are physically or mentally incapacitated and whose condition renders them unable to provide necessary documentation.
- Are chronically homeless and whose living arrangement makes it extremely difficult to provide the necessary documentation.
- Are minors.

- Have religious beliefs that prevent them from securing the documentation.

There are two ways for individuals in special populations to meet the citizenship and identity documentation requirement:

1. Present other documents besides those listed in Levels 1-5 to meet the requirement as long as the document meets the general documentation requirement stated here:

   "Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen. Any document used to establish identity must show identifying information that relates to the person named on the document."

   Some examples of documents that could be used to establish citizenship for special populations as long the document shows a birthplace in the U.S. or that the person is otherwise a U.S. citizen are:

   - Hospital "souvenir" birth certificate
   - Baptismal certificate
   - Native American documentation

   Below are examples of documents that could be used to establish identity for special populations as long the document shows some identifying information (e.g., name, address, telephone number, etc.) that relates to the individual:

   - Social Security Card
   - Driver education course completion certificate
   - School record or transcript
   - Credit card with signature
   - Voter registration materials
   - Permanent Resident card

Example 3: Due to their religious practices, an Amish family is not able to present a birth certificate for their child because the child was not born in a traditional hospital setting and no record of the child's birth exists within the state system. In addition, the child is home schooled so there is no school identification card to present for identification verification. However, the family is able to produce a signed letter from their church leader that states the child's birth place and birth date. This document can be used to satisfy the citizenship and identification requirement under the temporary policy for Special Populations.

2. The newly developed Statement of Citizenship and/or Identity for Special Populations form (F-10161) can be used to meet the new requirement

only when no other documentation is available from Levels 1-5 or item #1 above.

This form can be completed by a related or unrelated individual who knows the applicant/member, an *authorized representative*, an IM Agency worker, a worker for a housing agency who is aware of the individual's living situation, a Medicaid provider for a *minor*, etc. Additional requirements concerning the F-10161 are as follows:

- The person completing the form attesting to another person's citizenship must be a US citizen.
  - IM agencies are not required to verify the citizenship of the person signing the form.
  - Do not accept a form attesting to the citizenship of another individual when you know the person completing the form is not a US citizen.

Note: An F-10161 can be signed by the authorized representative of an individual who is not able to procure any other documents on his/her own.

While an IM worker is obligated to assist an applicant or member who asks for help in meeting the citizenship and identity requirement, this does not necessarily mean the IM worker must sign the F-10161 . The signatory to the F-10161 must know and be able to truthfully attest to the applicant/member's citizenship or identity. If an IM worker can do this for an applicant/member, then s/he may sign the form.

Maintain copies of any documents secured under this temporary policy in the case record. Enter Case Comments to document why this policy was used and note whether the F-10161 or another document was used to verify citizenship and identity.

Note: An individual who met the citizenship requirement by using documents obtained under the Special Populations policy or by using the F-10161 has complied with the federal requirement and is not required to provide other documentation at his/ her next review.

If you are aware of an individual who meets the special population category outlined above and whose Medicaid application has been denied or eligibility has ended because of his/her inability to provide acceptable documentation, contact the individual to see if the Special Populations policy may be applied. See Documentation Level 7 of the Acceptable Citizenship and Identity Documentation .

7.2.6 Situations Which Require Special Documentation Processing

7.2.6.1 Person Add

A person being added to a case is subject to the new verification requirement at the time of his/her application. Inform the applicant of the documentation requirement and give him/her the "reasonable opportunity period" to comply. Do not grant eligibility for the individual until he/she has submitted valid documentation. If documentation is not received timely, deny Medicaid for that individual only. Do not require other non-exempt household members to submit citizenship or identification documentation until their next review.

7.2.6.2 Individuals Without Verification and Affect on Household Eligibility

IM workers should not delay an individual household member's eligibility when awaiting another household members' citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members. See Process Help Chapter 68.2 for processing instructions.

7.2.6.3 Individuals Gaining Citizenship Through The Child Citizenship Act of 2000

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA). Within the context of the Medicaid citizenship verification requirement, this means that for any applicant or recipient claiming citizenship through the CCA, IM workers should not request documentation for that person. In these cases, IM workers need to acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

For persons who meet the citizenship verification requirement through the means allowed in the CCA, this is considered level 2 evidence. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity. The code <CA> should be used in the Medicaid Citizenship Verification field.

See 7.1.2 Child Citizenship Act of 2000

7.2.6.4 Non-citizens

As a reminder, do not request or require citizenship and identity documentation from individuals who have not declared that they are citizens. Non-citizens who apply for IM programs are not subject to this policy. Legal non-citizens are subject to the verification process through SAVE and undocumented non-citizens do not have any status that can be verified. Undocumented non-citizens can apply for Emergency Medicaid or BadgerCare Plus (BC+) Prenatal Program and should not be subject to the citizenship verification policy.

When an individual who had legal non-citizen status subsequently gains US Citizenship, this is recorded in SAVE. Therefore SAVE can be used to verify these individuals' citizenship. The verification result from SAVE will be used to

verify these individuals' citizenship. The verification result from SAVE will be "individual is a US Citizen". Please consult Operations Memo 04-10 for instructions on using SAVE. Use the <SV> code in the Medicaid Citizenship verification field when using SAVE for this population. These individuals do still need proof of identity since the SAVE verification is considered to be Level 2 citizenship documentation.

7.2.6.5 Individuals in Institutional Care Facilities

Disabled individuals in institutional care facilities may have their identity attested to by the facility director or administrator when nothing else is available. Use the F-10175 State of Identity for Persons In Institutional Care Facilities for this purpose. A medical institution can be, but is not limited to, skilled nursing facilities (*SNF*), intermediate care facilities (*ICF* Intermediate Care Facility), institutions for mental disease (IMD Institute for Mental Disease), and hospitals.

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7.3 IMMIGRANTS

7.3.1 Immigrants Introduction
7.3.1.1 Special Provisions for Immigrants in items 7-12
7.3.2 Public Charge
7.3.3 INS Reporting
7.3.4 Immigration Status Chart
7.3.5 Iraqis & Afghans With Special Immigrant Status
7.3.5.1 End of Temporary Benefit Period
7.3.5.2 Counting Refugee Related Income
7.3.5.3 Refugee Medical Assistance

7.3.1 Immigrants Introduction

Immigrants are persons who reside in the U.S., but are not U.S. citizens or nationals. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits.

1. A refugee admitted under Immigration & Nationality Act (INA) Section 207.

   A refugee is a person who flees his/her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

   An immigrant admitted under this refugee status may be eligible for Medicaid even if his/her immigration status later changes.

2. An asylee admitted under INA Section 208.

   Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when s/he requests permission to stay.

   An immigrant admitted under this asylee status may be eligible for Medicaid even if his/her immigration status later changes.

3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.

   An immigrant admitted under this status may be eligible for Medicaid even if his/her immigration status later changes.

4. A Cuban/Haitian entrant.

   An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if his/her immigration status later changes.

5. An American Indian born in Canada who is at least 50% American Indian by blood, or an American Indian born outside the U.S. who is a *member* of a Federally recognized Indian tribe.

6. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).

7. Lawfully admitted for permanent residence under the INA.

8. Paroled into the U.S. under INA Section 212(d)(5).

9. Granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)]

10. An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

11. An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

12. An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

7.3.1.1 Special Provisions for Immigrants in items 7-12

**If these immigrants (from items 7-12) lawfully entered the U.S. on or after August 22, 1996, they must also be *one* of the following:

a. Lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces, **or**
b. Lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces, **or**
c. Lawfully residing in Wisconsin and the *spouse*, unmarried dependent child, or surviving spouse of a person described in "a" or "b" **or**
d. An Amerasian, **or**
e. Resided in the U.S. for at least five years since his/her date of entry.

Beginning, October 1, 2009, children under the age of 19 and pregnant women who are either:

1. Lawfully Admitted for Permanent Residence (CARES TCTZ Code #1 in the Immigration Status Chart below),
2. Lawfully present under Section 203(a)(7) (Code #3 in the Immigration Status Chart below),

3. Lawfully present under Section 212(d)(5) (Code #6 in the Immigration Status Chart below), **or**
4. Who suffer from domestic abuse and are considered to be a battered immigrant (Code #16 in the Immigration Status Chart below),

no longer have to wait 5 years to be eligible for full benefit Medicaid and BadgerCare Plus. This policy applies to both persons in existing open cases and new applicants. Women have the 5-year ban lifted when their pregnancy is verified and continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

Immigrants, who do not appear in the lists above, who apply for Medicaid and meet all eligibility requirements except for citizenship are entitled to receive Medicaid Emergency Services only (See the BC+ Handbook).

Pregnant immigrants who do not appear in the list above, who apply for the BadgerCare Plus Prenatal Program (BC+PP) (See the BC+ Handbook) and who meet the eligibility requirements except for citizenship are entitled to receive those benefits.

Immigration status is an individual eligibility requirement. It does not affect the eligibility of the Medicaid Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

Verify immigration status using the procedures in the SAVE Manual.

7.3.2 Public Charge

The receipt of Medicaid by an undocumented, non-qualifying, or qualifying immigrant or by the children or spouse for whom the individual is legally responsible does not establish the person as a public charge.

Undocumented, non-qualifying, or qualifying immigrants are considered to be a public charge if while receiving Medicaid, s/he is in a medical institution for more than the length of a rehabilitative stay.

Undocumented, non-qualifying, or qualifying immigrants concerned about being considered a ‘public charge’, should be directed to contact the INS field office to seek clarification of the difference between rehabilitative and other types of institutional stays.

7.3.3 INS Reporting

Do not refer an immigrant to Immigration and Naturalization Service (INS) unless information for administering the Medicaid program is needed. For example, if

Medicaid needs to determine an individual's location for repayment or fraud prosecution, or to determine his/her immigration status.

7.3.4 Immigration Status Chart

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 for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible effective 10-01-09
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible effective 10-01-09
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Ineligible for 5 years	Eligible effective 10-01-09
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Alien	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Alien	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Permanent Resident	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
13	Special	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible

	agricultural worker under Section 210(A)					
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
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

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.

7.3.5 Iraqis & Afghans With Special Immigrant Status

Some Afghan and Iraqi aliens have been granted special immigrant status. Individuals and family members granted this special status are eligible for resettlement assistance, entitlement programs and other benefits the same as refugees admitted under section 207 of the INA. These groups have been admitted to the U.S. in Lawful Permanent Resident status; however for a limited time upon arrival they are treated as if they are in Refugee status for public benefits purposes.

Though treated like refugees, the individuals in this special immigrant status category are only able to access benefits for a limited time:

- Afghan special immigrants are eligible for Medicaid benefits for up to six months from the date they enter the country.
- Iraqi special immigrants are eligible for Medicaid benefits for up to eight months from the date they enter the country.

At the end of the six or eight month period, the immigration status for these populations becomes Lawful Permanent Resident (LPR). According to federal

law, LPRs are subject to the five year bar on receiving public benefits. See 7.3.4 Immigration Status Chart.

Spouses and unmarried children under age 21, who accompany or follow-to-join the principal special immigrant *applicant* are eligible for the same benefits as the principal applicant.

Any Iraqi or Afghan immigrant granted the special status, who applied after 12/26/2007 and was denied Medicaid benefits due to citizenship or immigration status, may request Medicaid benefits back to the original application filing date.

7.3.5.1 End of Temporary Benefit Period

Medicaid eligibility for special immigrants and family members must end within six or eight months after their US entry as special immigrants or conversion to special immigrant status, regardless of rules that are otherwise applied for their eligibility group (e.g. coverage of pregnant women until the end of their postpartum period).

These individuals would not be able to receive benefits until they have been here for five years from the date of entry. The five year clock begins from the individual's original date of entry and it does not start over once the limited special status benefits expire.

Iraqi and Afghan special immigrants and their families may qualify for Medicaid coverage of emergency services, until they meet the 5-year bar for qualified immigrants.

Note: An infant born in the U.S to a woman who was Medicaid eligible as an Iraqi or Afghan special immigrant on the baby's date of birth, is a U.S. citizen and deemed Medicaid eligible as a newborn until turning age one.

7.3.5.2 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

Refugee "Reception and Placement" (R&P) payments are not counted as income for Medicaid. R & P payments are made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/ family or to a vendor.

7.3.5.3 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, s/he may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. RMA is considered a separate benefit from Medicaid but provides the same level of benefits as these programs. RMA is available only in the first eight months after a special immigrant's date of entry. If it is not applied for in that eight-month period, it cannot be applied for later. Iraqi immigrants may be eligible for RMA for eight months and Afghan immigrants may be eligible for RMA for six months.

While W-2 agencies have contractual responsibility for providing RMA, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in the W-2 Manual Chapter 20

Note: The Federal Medicaid eligibility for all other refugees admitted under Alien Status Code 04 remains the same.

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7.4 NON-IMMIGRANT, NON-CITIZENS

(This entire section is new with this release)

7.4.1 Introduction
7.4.2 New Age Group
7.4.3 VIS SAVE Verification Responses
7.4.4 Class Of Admission (COA) Codes

7.4.1 Introduction

Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), offers States the option to cover children and pregnant women under the federal Medicaid and State Children's Health Insurance Programs who are not 'Qualified Aliens'.

The law also affects children and pregnant women in a number of non-immigration statuses/classes (see table below) who are lawfully residing in the country for an indefinite period. This policy clarification allows children and pregnant women admitted to the United States in these statuses/classes to qualify for Medicaid and BadgerCare Plus, if they are otherwise eligible, starting October 1, 2009.

7.4.2 New Age Group

CMS (Centers for Medicare and Medicaid Services) requires that the new policies that apply to children also be applied to persons under age 21 who are institutionalized, including residents of Institutions for Mental Disease (IMDs). These changes are effective October 1, 2009.

7.4.3 VIS SAVE Verification Responses

All non-immigrants admitted legally to the United States for any reason will have some type of United States Citizen and Immigration Services (*USCIS*) document, for example, a Non-immigrant Visa, Employment Authorization card, Passport, etc. The USCIS document proof provided by the non-immigrant individual will usually include a two to three digit code called the "Class of Admission Code" (COA) or the Section of Federal Law citation. The COA code is also found in the SAVE response when doing a SAVE query.

A table of the COA codes or the Section of Law citation for this new non-immigrant population is included below. The non-immigrant children and pregnant women with the admission code or Federal law citation found in this table who are otherwise eligible are now able to receive full benefit Medicaid or BadgerCare Plus.

7.4.4 Class Of Admission (COA) Codes

USCIS Class of Admission Code or Section of the Federal Law Citation Authorizing Class	
Description	**Class of Admission Code (COA)/Section of Law Citation**
Aliens currently in temporary resident status pursuant to section 210 or 245A of the Act.	S16, S26, W16, W25, W26, W36 or 8 CFR 103.12(a)(4)(i)
Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the Act. Child accompanying or following to join a K-3 alien.	8 CFR 103.12(a)(4)(ii)
Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649. (These are the spouses and unmarried children of individuals granted temporary or permanent residence under Section 210 or 245A above.)	8 CFR 103.12(a)(4)(iv)
Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the	8 CFR 103.12(a)(4)(v)

President.	
Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22).	8 CFR 103.12(a)(4)(vi)
Aliens who are the *spouse* or child of a United States citizen whose visa petition has been approved and who have a pending application for adjustment of status	8 CFR 103.12(a)(4)(vii)
Legal non-immigrants from the Compact of Free Association states (Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) who are considered permanent non-immigrants.	NA
An alien who is the fiancée or fiancé of a U.S. citizen entering solely to conclude a valid marriage contract.	K-1
Child of K-1	K-2
Spouse of a U.S. citizen who is a beneficiary of a petition for status as the immediate relatives of a U.S. citizen (I-130).	K-3
Child accompanying or following to join a K-3 alien.	K-4
Parent of an alien classified SK3 or SN3	N-8
Child of N-8 or of an alien classified SK1, SK2, SK4, SN1, SN2, SN4.	N-9
Temporary worker to perform work in religious occupations.	R1
Spouse and children of R1	R2
An alien who is in possession of critical reliable information concerning a criminal organization or enterprise, is willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal	8 U.S.C. 1101(a)(15)(S)(i)

organization or enterprise	
An alien who the Secretary of State and the Attorney General jointly determine is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation; is willing to supply or has supplied such information to Federal law enforcement authorities or a Federal court; will be or has been placed in danger as a result of providing such information; and is eligible to receive a reward from the State Department.	8 U.S.C. 1101(a)(15)(S)(ii)
An alien who is the spouse, married and unmarried sons and daughters, and parents of an alien in possession of critical reliable information concerning either criminal activities or terrorist operations.	8 U.S.C. 1101(a)(15)(S)
Individuals who have suffered substantial physical or mental abuse as victim of criminal activity.	U-1
An alien who is the spouse, child, unmarried sibling or parent of the victim of the criminal activity above.	U-2, U-3, U-4, U-5
An alien who are the spouses or children of an alien lawfully admitted for permanent residence and who have been waiting since at least December 2000 for their visa application to be approved.	V-1, V-2, V-3

For a complete table of the USCIS Class of Admission (COA) Codes log into the SAVE system and click on the “Online Resources” tab.

Note: There is no change in MA or BC+ eligibility policy for individuals in any other status or for those who are undocumented.

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8 MEDICAL SUPPORT

8.1 MEDICAL SUPPORT

8.1.1 Medical Support Introduction
8.1.2 Recovery of Birth Costs
8.1.3 Referral to CSA

8.1.1 Medical Support Introduction

Medical Support refers to the obligation that a parent has to pay for his or her child's medical care, either through the provision of health insurance coverage or direct payment of medical bills. The Child Support Agency (*CSA*) is responsible for establishing Medical support orders for some children receiving Medicaid who have an absent parent. The CSA is also responsible for establishing paternity and establishing medical support obligations for unpaid and ongoing medical support (including recovery of birth costs.)

8.1.2 Recovery of Birth Costs

When the non marital father of the unborn child is not included in the Medicaid group at the initial eligibility determination he could be held responsible for repayment of birth costs.

8.1.3 Referral to CSA

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services. At confirmation, CARES automatically sends a referral to the CSA for all Medicaid applications and person adds that include minors, unless the referral field on the Absent Parent Page is answered 'No'. The information on the Absent Parent Page must be filled out completely and accurately.

Note: A Referral to Child Support form (DWSP 3080) only needs to be completed when the absent parent page cannot be completed in CWW.

BC+ Note: While IM agencies are to continue referring the following individuals who are receiving BC+, the CSA's will be determining on their own, which cases will be provided Child Support Services. Not all BC+ recipients will qualify for free Child Support services and be required to cooperate with CSA's.

The following individuals (including minors) for whom Medicaid is requested or being received, must be referred to the local CSA unless an exception is noted:

1. Pregnant woman who is unmarried or married and not living with her husband.

   Pregnant women are not required to cooperate with the CSA during the pregnancy and for two months after the end of pregnancy. The woman's eligibility for Medicaid will continue during this period, regardless of her cooperation.
2. Child receiving *SSI* only if the caretaker requests child support services for the child. Do not sanction this caretaker if s/he does not cooperate with the CSA.
3. Non-Marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when:
   a. A Statement of Paternity has been completed,
   b. Both parents are in the home.

   Exception: Do not refer parents to the CSA when both parents are in the home and the father's paternity has been legally established. (Paternity is legally established by a court order or by a Voluntary Paternity Acknowledgment Form signed on or after May 1, 1998 and filed with the Wisconsin Vital Records office.)

   Note: If a father's name appears on a Wisconsin Birth Certificate for a child born after 5/11/1998, it means paternity has been established.

4. Natural or adoptive parent(s) not living in the household.

   Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because s/he is in the military.

5. Married natural parents in the home, but:
   a. Child was born prior to their marriage, and
   b. Paternity was not established by court action, or the birth was not legitimized after their marriage.

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8.2 MEDICAL SUPPORT/ CSA COOPERATION

8.2.1 Medical Support / Child Support Agency (CSA) Cooperation
8.2.2 Failure to Cooperate

8.2.1 Medical Support / Child Support Agency (CSA) Cooperation

Unless the person is exempt, or has good cause for refusal to cooperate (see 8.3 Claiming Good Cause), each *applicant*/*member* that is referred, must, as a condition of eligibility, cooperate in:

1. Establishing the paternity of any child born out of wedlock for whom Medicaid is requested or received, **and**
2. Obtaining medical support for the applicant and for any child for whom Medicaid is requested or received.

Cooperation includes any relevant and necessary action to achieve the above. As a part of cooperation, the applicant may be required to:

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the applicant.
2. Appear as a witness at judicial or other hearings or proceedings.
3. Provide information, or attest to the lack of information, under penalty of perjury.
4. Pay to the *CSA* any court-ordered medical support payments received directly from the absent parent after support has been assigned.
5. Attend office appointments as well as hearings and scheduled genetic tests.

Note: The applicant or member is only required to cooperate if the child under their care is eligible for benefits funded under Title XIX. If the child's Medicaid benefit is funded through any other source (Title XXI or GPR) the caretaker is not required to cooperate and can not be sanctioned for non-cooperation. Check the Medical Status codes to determine funding source. The CSA will monitor the child's Medicaid funding source.

8.2.2 Failure to Cooperate

The CSA determines if there is non-cooperation for individuals required to cooperate. The IM agency determines if good cause exists (see 8.3.7 Claiming Good Cause> Determination). If there is a dispute, the CSA makes the final determination of cooperation. The member remains ineligible until s/he cooperates, establishes good cause, or cooperation is no longer required.

The following individuals are not sanctioned for non cooperation:

1. Pregnant women.
2. Minors.
3. Caretakers, while family income is over 150% of the FPL.
4. Caretakers while the family is in a BC+ Extension.

For a pregnant woman, failure to cooperate cannot be determined prior to the end of the month in which the 60th day after the termination of pregnancy occurs.

Note: If the local CSA determines that a parent is not cooperating because court ordered birth costs are not paid, the parent or caretaker is not sanctioned.

Example 1: Mary, a disabled parent, is applying for Medicaid for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for Medicaid and EBD Medicaid.

Mary is not eligible for EBD Medicaid or Medicaid, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for Medicaid.

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8.3 CLAIMING GOOD CAUSE

8.3.1 Claiming Good Cause Introduction
8.3.2 Notice

8.3.3 Good Cause Claim
8.3.4 Circumstances
8.3.5 Evidence
8.3.6 Investigation
8.3.7 Determination
8.3.8 Good Cause Found
8.3.9 Good Cause Not Found
8.3.10 Review

8.3.1 Claiming Good Cause Introduction

Any parent or other caretaker relative who is required to cooperate in establishing paternity and obtaining medical support may claim good cause. S/he must:

1. Specify the circumstance that is the basis for good cause, **and**
2. Corroborate the circumstance according to the evidence requirements in 8.3.5 Evidence

8.3.2 Notice

The IM agency must provide a Good Cause Notice (DWSP 2018) to all applicants and to members whenever a child is added to the Medicaid case. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support.

The IM worker and the parent or caretaker must sign and date the notice. File the original in the case record and give the *applicant*/*member* a copy. The *CSA* refers anyone who wants to claim good cause back to the IM Agency for a determination of whether or not good cause exists.

8.3.3 Good Cause Claim

The Good Cause Claim form (DWSP 2019) must be provided to any Medicaid parent or caretaker who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the claim in the presence of an IM worker or a notary public. The applicant/member's signature initiates the claim.

The original copy is filed in the case record, a copy is given to the parent or caretaker and a copy is attached to the referral document when a good cause claim is made at application.

A copy of good cause claims must be sent to the CSA within two days after a claim is signed. When the CSA is informed of a good cause claim, they will

immediately suspend all activities to establish paternity or secure medical support until notified of your final determination.

8.3.4 Circumstances

The IM agency must determine whether or not cooperation is against the best interests of the child. Cooperation is waived only if:

1. The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to the:
    a. Child. This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected, **or**
    b. Parent or Caretaker. This means the impairment is of such a nature or degree that it reduces that person's capacity to adequately care for the child.

2. At least one of the following circumstances exists and it is reasonably anticipated that proceeding to establish paternity or secure support or both would be detrimental to the child:
    a. The child was conceived as a result of incest or sexual assault, **or**
    b. A petition for the child's adoption has been filed with a court, **or**
    c. The parent or caretaker is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

8.3.5 Evidence

An initial good cause claim may be based only on evidence in existence at the time of the claim. There is no limit to the age of the evidence. Once a final determination is made, including any fair hearing decision, any subsequent claim must be based on new evidence.

The following may be used as evidence:

1. Birth certificates or medical or law enforcement records that indicate that the child may have been conceived as a result of incest or sexual assault.
2. Court documents or other records which indicate that a petition for the adoption of the child has been filed with a court.
3. Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records which indicate that the alleged father or absent parent might inflict physical or emotional harm on the member or the child.
4. Medical records which give the emotional health history and present emotional health status of the member or the child.
5. A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the member or the child.

6. A written statement from a public or private social agency that the agency is assisting the parent to decide whether or not to terminate parental rights.
7. A sworn statement from someone other than the member with knowledge of the circumstance on which the claim is based.
8. Any other supporting or corroborative evidence.

When a claim is based on emotional harm to the child or the member, the IM agency must consider the:

1. Person's present emotional state, **and**
2. Person's emotional health history, **and**
3. Intensity and probable duration of the emotional impairment, **and**
4. Degree of cooperation required, **and**
5. Extent of the child's involvement in the paternity or the support enforcement activity to be undertaken. If the member submits only one piece of evidence or inclusive evidence, you may refer him/her to a mental health professional for a report relating to the claim.

When a claim is based on his/her undocumented statement that the child was conceived as a result of incest or sexual assault, it should be reviewed as one based on emotional harm.

The IM agency must conduct an investigation when a claim is based on anticipated physical harm and no evidence is submitted.

The member has 20 days, from the date the claim is signed, to submit evidence. The IM agency, with supervisory approval, may determine that more time is needed.
There must be at least one document of evidence, in addition to any sworn statements from the member.

The IM agency should encourage the provision of as many types of evidence as possible and offer any assistance necessary in obtaining necessary evidence.

When insufficient evidence has been submitted:

1. The member must be notified and the specific evidence needed must be requested, **and**
2. The IM agency must advise that person on how to obtain the evidence, **and**
3. The IM agency must make a reasonable effort to obtain specific documents that are not reasonably obtainable without assistance.

If the parent or caretaker continues to refuse to cooperate or the evidence is still insufficient, a 10-day notice must be sent informing the parent or caretaker that if no further action is taken within ten days from the notification date, good cause will not be found and that s/he may first:

1. Withdraw the claim and cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request a hearing, **or**
4. Withdraw the application or request that the case be closed.

If no option above has been taken when the ten days have expired the IM worker will deny Medicaid to the applicant or disenroll the member from Medicaid. The sanctions remain in effect until there is cooperation or until it is no longer required.

8.3.6 Investigation

The IM agency must investigate all claims based on anticipated physical harm both when the claim is credible without corroborative evidence and when such evidence is not available.

Good cause must be granted when both the member's statement and the investigation satisfy you that s/he has good cause.

Any claim must be investigated when the member's statement together with any corroborative evidence does not provide a sufficient basis for a determination.

In the course of the investigation, neither the IM agency nor the CSA may contact the absent parent or alleged father without first notifying the member of your intention. Once notified the parent or caretaker has ten days from the notification date to:

1. Present additional supporting or corroborative evidence of information so that contact is unnecessary, **or**
2. Exclude allowable individuals, **or**
3. Withdraw the application or request that the case be closed, **or**
4. Request a fair hearing.

When the ten days have expired and no option has been taken the IM Agency will deny Medicaid to the applicant or remove the member from the Medicaid card, and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

8.3.7 Determination

The IM staff must determine whether or not there is good cause. This should be done within 45 days from the date a claim is signed. The time may be extended if it is documented in the case record that additional time is necessary because:

1. The IM agency cannot obtain the information needed to verify the claim within the 45 days, **or**
2. The parent or caretaker does not submit corroborative evidence within 20 days.

The good cause determination and all evidence submitted filed in the case record along with a statement on how the determination was reached.

If there is no evidence or verifiable information available that suggests otherwise, it must be concluded that an alleged refusal to cooperate was, in fact, a case of cooperation to the fullest extent possible.

If the parent or caretaker is cooperating in furnishing evidence and information, do not deny, delay, or discontinue Medicaid pending the determination.

If a fair hearing is requested on a good cause determination, Medicaid certification is continued until the decision is made.

The 45-day period for determining good cause is not used to extend an eligibility determination. The 30-day limit on processing an application is still a requirement.

The IM must notify the applicant/member in writing of the final determination and of the right to a fair hearing. Send the CSA a copy. The CSA may also participate in any fair hearing.

8.3.8 Good Cause Found

When good cause is granted, the IM must direct the CSA to not initiate any or to suspend all further case activities.

However, when the CSA's activities, without the member's participation are reasonably anticipated to not result in physical or emotional harm, the IM agency must:

1. First notify the person of the determination and the proposed directive to the CSA to proceed without his/her participation.
2. S/he has ten days from the notification date to:
    a. Exclude allowable individuals, **or**
    b. Request a hearing, **or**
    c. Withdraw the application, or request that the case be closed.
3. At the end of the ten days, direct the CSA to proceed if no option was taken. The CSA may decide to not proceed based on its own assessment.

The IM agency determination to proceed without the member's participation must be in writing. Include your findings and the basis for the determination. File it in the case record.

8.3.9 Good Cause Not Found

When good cause is not granted, the IM agency must notify the parent or caretaker. It must be stated in the notice that s/he has ten days from the notification date to:

1. Cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request a hearing, **or**
4. Withdraw the application or request that the case be closed.

When the ten days have expired, and if none of the options listed above has been taken, the IM agency must deny Medicaid to the applicant or terminate the member's Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

8.3.10 Review

The IM agency does not have to review determinations based on permanent circumstances. Review good cause determinations that were based on circumstances subject to change when there is new evidence or at redeterminations.

The parent or caretaker must be notified when it is determined that good cause no longer exists. It must be stated in the notice that s/he has ten days from the notification date to:

1. Cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request that the case be closed, **or**
4. Request a hearing.

When the ten days have expired, and if none options listed above has been taken, the IM agency must deny the individual's Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

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8.4 COOPERATION BETWEEN IM & CSA

8.4.1 Information
8.4.2 Medicaid Discontinued
8.4.3 Fraud

The relationship between the IM agency and the *CSA* requires ongoing cooperation.

8.4.1 Information

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists

them in providing medical support services. Therefore, the CSA may request information from the IM agency in addition to that included in the referral and as contained in the case record.

CARES automatically shares information with KIDS so it is important to enter the data accurately.

8.4.2 Medicaid Discontinued

The CSA is notified through CARES when Medicaid is discontinued.

8.4.3 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action (IMM 11.1 Public Assistance Faud Program).

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9 THIRD PARTY LIABILITY (TPL)

9.1 THIRD PARTY LIABILITY (TPL)

9.1.1 Third Party Liability Introduction
9.1.2 TPL Cooperation
9.1.3 TPL Cooperation Requirements
9.1.4 TPL Good Cause Claim
9.1.5 Assignment Process

9.1.1 Third Party Liability Introduction

Third Party Liability (*TPL*) refers to the obligation a third party (not Wisconsin Medicaid program or the Medicaid *member*), has to pay the bills for a Medicaid member's medical services. Medicaid is the payer of last resort for the cost of medical care. This means that if a Medicaid member also has coverage under a private health insurance plan, that plan is to be billed first for any medical services. Medicaid then pays any amount remaining after the private insurer has paid what they owe, up to the Medicaid reimbursement rate. Another common example of third party liability is when someone receives an insurance settlement resulting from an accident. If Medicaid paid for any medical services resulting from that accident, the Medicaid program is to be reimbursed the cost of those medical services from the proceeds of the insurance settlement. Third party payers include health insurers, court ordered medical support, and any other third party that has a legal obligation to pay for medical services.

9.1.2 TPL Cooperation

All Medicaid members must assign to the State of Wisconsin their rights to payments for medical services from third party payers. A member complies with this requirement by signing the application form. The assignment includes all unpaid medical support and all ongoing medical support obligations for as long as Medicaid is received. In addition, Medicaid members must cooperate in identifying and providing information to assist the State in pursuing third parties who may be liable to pay for care and services, unless the individual establishes good cause for not cooperating. If a member fails to cooperate with TPL requirements s/he could be sanctioned.

9.1.3 TPL Cooperation Requirements

The Medicaid member must cooperate in providing TPL information unless s/he is exempt or there is good cause for refusing to cooperate. TPL information could include the name and address of an insurance company, insurance policy number, and the name and address of the policy owner.

If an *adult* refuses, without good cause, to provide health insurance information for themselves, or anyone for whom they are legally responsible and is receiving Medicaid, the adult is ineligible until s/he cooperates.

Do not sanction the following for non-cooperation:

1. Minors, including *minor* caretakers.
2. A parent or caretaker requesting child support services for a child receiving *SSI*.
3. Pregnant woman – She may not be sanctioned during the pregnancy, or for two months after the pregnancy has ended, if the TPL source is the absent parent of her child(ren).

9.1.4 TPL Good Cause Claim

When good cause is claimed (See 8.3 Claiming Good Cause), the IM agency must review the circumstances and decide on whether it is an appropriate claim of good cause. The appropriate entry on the Medical Coverage page in CWW regarding the good cause determination must be made, and the reason for the decision must be documented in case comments.

TPL good cause reasons are the same as those for Medical Support.

9.1.5 Assignment Process

At application, the Income Maintenance Agency must give a Notice of Assignment (DWSP-2477) to each *applicant*. If the applicant refuses to sign this form, the Income Maintenance Agency must complete the lower portion of the form and file it in the case record. This must be done no later than at the time of the interview. The applicant must be given a copy of the notice. Processing a Medicaid application must not be delayed while waiting for the form to be signed. The member should not be penalized for not signing this form. The original copy must be filed in the case record.

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9.2 NURSING HOME AND HOSPITAL INSURANCE

9.2.1 Nursing Home and Hospital Insurance Introduction
9.2.2 Assignment
9.2.3 Recovery of Payments

9.2.1 Nursing Home and Hospital Insurance Introduction

All members must cooperate in providing Third Party Liability (*TPL*) coverage and access information for nursing home and hospital insurance policies. All members must:

1. Sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (See 9.2.2 Assignment)
2. Turn over any payments to the State of Wisconsin (See 9.2.3 Recovery of Payments) that s/he received from nursing home or hospital insurance while receiving Medicaid.

Any nursing home or hospital insurance payments that exceed the amount that Medicaid has paid in benefits for that *member* will be refunded to him/her.

Terminate Medicaid eligibility for the individual who is not cooperating in providing TPL insurance information (See 9.1.2 TPL Cooperation), unless they have good cause (See 9.1.4 TPL Good Cause Claim).

9.2.2 Assignment

To assign hospital or nursing home insurance payments, the member must provide a statement in writing to the insurance company requesting that all future

payments be made to the State of Wisconsin. Request a copy of the member's letter to the insurance company and send it to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

The assignment includes all ongoing payments for as long as Medicaid is received. Terminate Medicaid eligibility for the individual that refuses to sign over these payments.

9.2.3 Recovery of Payments

In some cases, payments can only be signed over to the patient. The member must cooperate in turning over these payments to the State of Wisconsin, or his/her eligibility will end for not cooperating with providing TPL coverage and access information.

The member must write on the back of the check "Pay to the order of the State of Wisconsin" and sign the check.

Collect the payments monthly from the members along with the corresponding Explanation of Benefits (EOB), and send them to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the member refuses to turn over the payments.

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9.3 HEALTH INSURANCE RISK SHARING PLAN (HIRSP)

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 Blue Cross/Blue Shield know immediately when they begin Medicaid eligibility. To do this, contact:

Plan Administrator
Wisconsin Health Insurance Risk
Sharing Plan
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

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

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9.4 HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

9.4.1 Cost Effective
9.4.2 Participation in HIPP
9.4.3 Cooperation
9.4.4 Exceptions
9.4.5 Not Cost Effective

HIPP pays the employee's portion of the employer subsidized health care coverage. EDS determines if it is cost effective to buy the employer's insurance.

9.4.1 Cost Effective

If it is cost-effective to buy the employer-subsidized insurance, the HIPP Unit will notify those members who are required to enroll in an employer's health plan and provide additional information related to enrollment, coverage, and cooperation.

HIPP may pay the premium for a non-Medicaid family *member* if that member needs to enroll in the group health plan in order to obtain coverage for the Medicaid member. Medicaid will only pay for the premiums of the ineligible family member(s) and not any of their other cost sharing expenses (e.g. prescription co-pays). Medicaid will continue to cover the employer's health insurance premium, deductibles and co-insurance for the Medicaid member.

9.4.2 Participation in HIPP

Members participating in HIPP will have Medicaid as a backup. If the employer's health insurance does not cover something that Medicaid does, then Medicaid will pick up the payment.

9.4.3 Cooperation

To remain eligible for *MAPP*, the *adult* whose employer can provide insurance must:

1. Cooperate in providing information necessary to assess cost-effectiveness, and
2. Agree to enroll and actually enroll in the employer's health care plan if the plan is determined to be cost-effective.

Failure to cooperate or enroll in the employer's plan is non-cooperation. The adult who could get insurance coverage is not eligible for MAPP. If one adult fails to cooperate, it does not affect the *spouse* or children's Medicaid eligibility.

The EDS HIPP unit worker will communicate HIPP non-cooperation directly to you. Enter the non-cooperation and the ineligible adult will close after the next *adverse action*.

Beginning October 1, 2009, parents may no longer be sanctioned for failing to cooperate with the HIPP program when other family members are in BadgerCare Plus. This policy applies to both current members and new applicants.

9.4.4 Exceptions

Listed below are two exceptions to participating in HIPP:

1. Members who are enrolled in a Special *Managed Care* Program (*SMCP*).

   Some examples of SMCP's are Independent Care Program, Elder Care Option Program, and Wraparound Milwaukee. Do not consider the member non-cooperative if s/he refuses to participate in HIPP while enrolled in a SMCP. The HIPP Unit will monitor the member's enrollment in SMCP's to determine the member's responsibility for HIPP participation.

2. A member who is unable to enroll in an employer's health plan on their own behalf.

   An example of this situation would be when a MAPP member's spouse is unwilling to enroll the member in their employer based health plan. Since the member's spouse has the cost-effective employer's health plan, but chooses not to enroll the MAPP member, the coverage under that plan is considered unavailable to the member.

9.4.5 Not Cost Effective

If it is not cost-effective to buy the employer-subsidized insurance, the member will remain eligible for MAPP.

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9.5 CASUALTY CLAIM PROCESS (SUBROGATION)

9.5.1 Casualty Claims (Subrogation) Introduction
9.5.2 Reporting Accident or Injury Claims

9.5.1 Casualty Claims (Subrogation) Introduction

Casualty claims are those claims for Medicaid benefits resulting from an accident or injury for which a third party may be liable.

Example 1: Mike receives treatment for injuries suffered when he was hit by a car. The vehicle owner is the third party and may be responsible for reimbursing Medicaid for those benefits. If Mike is working with an attorney or insurance agency to settle the claim, he is legally obligated to give notification to the local agency.

Medicaid members should report any casualty claims before the case is settled. The Medicaid ID number of the Medicaid *member*, date of the accident, and the insurance company or name of the attorney to bill should be included with the referral.

9.5.2 Reporting Accident or Injury Claims

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:
    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 EDS at 608-

221-4567 or call at 608-221-4746 EXT 80062 with MA#, date of accident and insurance/attorney to bill.

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9.6 OTHER HEALTH INSURANCE

9.6.1 Other Health Insurance Introduction
9.6.2 Policies Not To Report

9.6.1 Other Health Insurance Introduction

The IM Agency should collect insurance coverage information about applicants and members at application, review, person add, or when insurance changes and enter it into the Medical Coverage Page in CWW. The fiscal agent will complete an insurance search and return verified insurance information through the CWW / MMIS interface. This is because Medicaid is usually the payor of last resort, and any other insurance coverage will be billed before the Medicaid program.

9.6.2 Policies Not To Report

The following policies should not be entered on the Medical Coverage Page in CWW or reported to the fiscal agent on the Health Insurance Information form (F-10115).

1. HMOs for which the State pays all or part of the premium.

2. Health Insurance Risk Sharing Plans (HIRSP).
3. Medicare (enter in CWW on the Medicare Page).
4. General Assistance Medical Program (*GAMP*).
5. Indian Health Service (*IHS*). IHS is the exception to the rule that Medicaid is the payer of last resort. For Native Americans who are Medicaid members, IHS is the payer of last resort. Do not enter these policies on CARES.
6. Policies that pay benefits only for treatment of accidental injury.
7. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's *disability*.
8. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease s/he is insured against and if the benefits are assignable.
9. Life Insurance.
10. Other types of insurance types that do not cover medical services.

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9.7 THIRD PARTY LIABILITY (TPL) ENDING

When EDS verifies a major medical policy has ended, EDS automatically updates CARES and sends an alert. The worker should:

1. Ask the *member* if the insurance has ended,
2. If the member says that the insurance listed has not ended, the information is considered questionable. Verify the insurance information and update the CWW Medical Coverage page, **and**
3. Run eligibility.

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9.8 DOUBLE PAYMENT

Sometimes EDS finds that services have been paid for by both Medicaid and a third party that is not listed in the Medicaid file. When this happens, the worker may receive a Coverage Discrepancy Report from EDS.

If you receive this notice, review your files and contact the *member* to find out the *TPL* status of the Medicaid group members. If you find there is private health insurance available to any of the members, update CARES.

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9.9 HEALTH INSURANCE FORM

9.9.1 Health Insurance Information Form Introduction
9.9.2 Section A
9.9.3 Section B
9.9.4 Section C
9.9.5 Section D
9.9.6 Where to Send

9.9.1 Health Insurance Information Form Introduction

If CARES is not available, the Health Insurance Information Form (F-10115) can be used to collect insurance information. Complete a separate form for each insurance policy if a person has more than one. Listed below are some instructions for filling out this form.

IM/CS Blocks. If you can complete the form in its entirety, check IM. Do not check this box if you refer the form to Child Support for completion.

Added. Check the "Added" box when the policy in question has never been sent to EDS, and is not on their file. Complete the entire form.

Changed or Ended. Check the "Changed or Ended" box when altering information that is already on EDS's file and complete these items:

1. The shaded area on the top.
2. Medicaid ID numbers and names of only those case members affected by the change. Date of birth is required. Relationship is not.
3. The insurance company name in Box 1.
4. The policy number in Box 6.
5. The policy start date in Box 9.
6. The information you want to change. For example, to report the date on which coverage terminated, enter the end date in Box 10.

Deleted. Check the "Deleted" box when removing insurance information. Do not use a delete transaction in place of a change transaction when valid insurance coverage ends. Use it only if:

1. The insurance data put on the file was not valid during a period of Medicaid eligibility, **or**
2. The information should never have been put on the file because, for instance, it is life insurance.

To change the policy number, the insurance company billing address, or the start date of coverage, send EDS:

1. A (F-10115) marked "Delete" (on which you have deleted the incorrect information), **and**
2. A second (HCF 10115) marked "Add" (on which you have added the correct information).

Staple the forms together. Mark on the delete copy in red "1 of 2". Mark on the add copy in red "2 of 2".

When you are submitting a delete form with an add form, complete the add form in its entirety.

For the delete transaction, complete the shaded area on the top.

9.9.2 Section A

In Section A, list the Medicaid ID numbers and the names of only those case members affected by the delete and their date of birth.

1. Enter the insurance company name in Box 1.
2. Enter the policy number in Box 6.
3. Enter the policy start date in Box 9.

9.9.3 Section B

Policy Number. If the insurance ID card contains nothing but a group number, put the insured person's Social Security Number (SSN) in this space.

Policy Start Date. Use the effective date of the policy listed on the insurance ID card. If the date is not available, make the start date equal to or earlier than the start date of eligibility.

9.9.4 Section C

The policyholder’s SSN is voluntary. Failure to provide your SSN may result in a processing delay.

9.9.5 Section D

If a retired *member* has insurance through a former employer, list that former employer and the address, if available.

9.9.6 Where to Send

Send the original to:

EDS - *TPL* Unit
P.O. Box 7636
Madison, WI 53707-7636

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10 SSN

10.1 SSN REQUIREMENTS

10.1.1 SSN Requirements Introduction
10.1.2 Emergency Services
10.1.3 SSN Mismatches
10.1.4 SSN Fraud
10.1.5 Failure to Provide SSN

10.1.1 SSN Requirements Introduction

Medicaid applicants must provide a Social Security Number (SSN) or be willing to apply for one. Assist the *member* in applying for an SSN for any group member who doesn't have one. Non-applicants are not required to provide SSN Numbers.

Do not deny benefits pending issuance of a SSN if you have any documentation that an SSN application was made

An *applicant* does not need to provide a document or social security card. S/he only needs to provide a number, which is verified through the CARES SSN validation process.

10.1.2 Emergency Services

Do not require or verify SSNs of member's who receive emergency services only.

10.1.3 SSN Mismatches

If the SSN validation process returns a mismatch record, then the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN s/he must be willing to apply for one.

Inform the member if the SSN validation process suggests that another individual is using the same SSN. Advise the member to contact the Social Security Administration. The member may request Social Security Administration to conduct an investigation. Do not provide the member with any information that would identify the individual who is using the member's SSN.

10.1.4 SSN Fraud

If the Social Security Administration finds that the SSN has been used fraudulently it may:

1. Recommend further action be taken, and/or
2. Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

10.1.5 Failure to Provide SSN

If the caretaker is unwilling to provide or apply for the SSN of a *minor* or 18-year-old, the person who does not have the SSN is ineligible.

Medicaid applicants and members who belong to a recognized religious sect that conscientiously opposes applying for or using a social security number are exempt from meeting the SSN requirements. A person who refuses to apply for or use a social security number due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

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11 PREMIUM OR COST SHARE

11.1 PREMIUM OR COST SHARE

Nonpayment of a *MAPP* premium will result in nonfinancial ineligibility. See 26.1 MAPP Introduction for more information.

Nonpayment of a Family Care or Home and Community Based Waivers cost share will result in nonfinancial ineligibility. See 28.1 Home and Community Based Waivers Long Term Care Introduction and 29.1 Family Care Long Term Care (FCLTC)Introduction for more information.

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12 CHANGE REPORTING

View History

12.1 CHANGE REPORTING INTRODUCTION

Clients must report to the Income Maintenance agency, within 10 days of the occurrence, a change in address, income, assets, need, medical expenses or living arrangements which may affect eligibility.

Some changes may be reported through the ACCESS website (access.wisconsin.gov).

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13-14 RESERVED

13 - 14 RESERVED

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FINANCIAL (CHS. 15 - 19)

15 INCOME

15.1 INCOME INTRODUCTION

15.1.1 EBD Fiscal Group
15.1.2 Special Financial Tests for Disabled Minors
15.1.3 Income
15.1.4 EBD Related Test
15.1.5 Availability
15.1.6 Countable Income
    15.1.6.1 Migrant Workers

15.1.1 EBD Fiscal Group

An EBD fiscal group includes the individual who is non financially eligible for Medicaid and anyone who lives with them, who is legally responsible for them. Spouses who live together are in each other's fiscal group. This means that the *income* and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled *minor* (or dependent 18 year old), living with their parents would be a one person fiscal group. Special instructions for deeming parental income to the disabled minor are described in 15.1.2 Special Financial Tests for Disabled Minors.

Another exception to the fiscal group policy involves *SSI* recipients. If one *spouse* is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's fiscal group. For this situation you would again have a one person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual living in a medical institution for 30 or more consecutive days would be a one person fiscal group. If the institutionalized person is married, refer to chapter 18.1 Spousal Impoverishment for special instructions regarding *spousal impoverishment* procedures.

15.1.2 Special Financial Tests for Disabled Minors

A blind or disabled minor (or dependent 18 year old) would have their Medicaid eligibility determined according to the following special procedures when the disabled minor fails Family Medicaid financial tests. This process essentially

deems parental income to the disabled minor. The deemed parental income is added to the disabled minor's income when determining the disabled minor's financial eligibility for EBD Medicaid.

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household *member* and therefore not included in any of the following procedures.

An ineligible child in this section is a minor child who is neither disabled nor blind.

An eligible child in this section is a minor child who is disabled or blind or both.

Calculate the countable income of everyone in the Household using the following 6 steps. Count all of the person's income except that which is exempt or unavailable. See Chapter 15.1 Income Introduction.

1. For each ineligible child in the household:

    a. Subtract the ineligible child's unearned & earned income from the EBD Deeming Amount to an Ineligible Minor (39.4.2 EBD Deductions and Allowances).

    b. The remainder is the amount to be allocated to the ineligible child from parental gross unearned income.

    If there is not enough parental unearned income, allocate the rest from parental gross earned income.

    Go to #2.

2. Subtract $20, the general income exclusion, from any remaining parental unearned income.

    If there is not enough unearned income to subtract the full $20, subtract the rest of the $20 from parental earned income.

    Go to #3.

3. Subtract $65 & 1/2 from the remaining parental earned income.

    Go to # 4.

4. Add:

    a. Remaining parental unearned income resulting from step 03, and

b. Remaining parental earned income resulting from step 04

Go to #5.

5. From the total parent income resulting from #5, subtract:

a. The Parental Living Allowance (39.4.2 EBD Deductions and Allowances for a couple if both parents (or one parent and his/her spouse) live in the household; or

b. The Parental Living Allowance (39.4.2 EBD Deductions and Allowances) for an individual if only one parent lives in the household.

The remainder is the total parental income to be deemed to the eligible child(ren).

Go to #6

6. Divide the parental deemed income equally among the eligible children. Use the EBD-Related Determination worksheet (40.1 Worksheet 6) to calculate each child's Medicaid eligibility.

Example 3: Mr. and Mrs. Darwin have two children. Matthew, eight years old, is disabled, and is the eligible child. Jenny, 10 years old, is the ineligible child. Neither child has income. The Darwins have no unearned income. Parental earned income is $2,524 a month. The parents' earned income of $2,524 EBD minus $337 (deeming amount to an ineligible minor, see 39.4.2) = $2,187.

Remaining earned income $2,187.
General income exclusion -20.00
Remainder $2,167.
Earned income exclusion -65.00

Remainder $2,102
1/2 remaining earned income -$1,051

Remaining earned income $1,051
Parental living allowance -$1,011

Income deemed to eligible child = $40

Example 4: Lawrence has three children. One is disabled. None has any income. His monthly income is $1,950 earned, $290 unearned.

Lawrence's unearned income $ 290.00

EBD Deeming Amount for 2 ineligible minors -$674.00
Excess allocation $ -384
Lawrence's earned income $1,950.00
Excess allocation $ -384

Lawrence's remaining earned income $1,566
General income exclusion -20.00

Remainder $1,546
Earned income exclusion -65.00
Remainder $1,481
1/2 remaining earned income -$740.50

Remaining earned income -$740.50
Parental living allowance $ -674.00

Income deemed to eligible child $66.50

15.1.3 Income

See 39.4 EBD Assets and Income Tables for EBD income limits. See 39.5 FPL Table for all other Medicaid income limits. Chapters for each type of MA explain how to determine the income that you compare to the income limits.

See 39.4.2 EBD Deductions and Allowances for *TB*-Related income limits.

15.1.4 EBD Related Test

When doing manual EBD income eligibility determinations, use the EBD Related Determination worksheet. Apply the income disregards in the order in which they appear on the worksheet. The 65 & ½ earned income *disregard* and $20.00 SSI general income disregard are applied to the fiscal group's income. They are not applied separately to each individual fiscal group member's income. Special Exempt Income is also an allowable income deduction and a list of Special Exempt Income types can be found in chapter 15.7.2 Special Exempt Income.

The EBD categorically needy income limit consists of two components; an income amount plus a shelter/ utility amount. The EBD fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in 39.4 EBD Assets and Income Tables The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount (39.4 EBD Assets and Income Tables), and this total becomes

the EBD categorically needy income limit. A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid EBD categorically needy income test.

If an EBD related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in 39.4 EBD Assets and Income Tables. If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid EBD medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 24.2 Medicaid Deductible Introduction for more information about Medicaid Deductibles and to chapter 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid Deductible.

15.1.5 Availability

General Rules:

1. Only count income when it is available (see 15.1.5 Availability)
2. Some income is disregarded (see 15.3 Disregarded Income)
3. Always use *gross income* when calculating income.
4. Some income, even though it is unavailable income must be counted. (e.g. garnishments)

Income is available when:

1. It is actually available, and
2. The person has a legal interest in it, and
3. The person has the legal ability to make it available for support and maintenance.

Note: Available income can include more than a person actually receives if amounts are withheld from earned or unearned income because of a garnishment, or to pay a debt or any other legal obligation.

Examples of income sources that someone can make available are social security and unemployment compensation. This includes income increases such as Cost-of-Living Adjustments (COLAs).

When it is known that a member of the assistance group is eligible for some sort of income or an increased amount of income:

1. Count the income if the amount is known. Count it as if the person is receiving it.
2. Ignore the income if the amount is not known.

Example 5: Ms. M. is entitled to *OASDI* benefits of $450. However, she declined a $20 *COLA* increase, and her check is only $430. Since the full entitlement amount is known, available income is $450.

Income is unavailable when it will not be available for 31 days or more. The person must document that it will not be available for 31 days or more.

Unavailability is usually documented by a letter from an agency stating when the person will receive the benefit. Thus, if s/he has just applied for benefits, do not add it to his/her income yet. The income is not ignored; it is only suspended until it becomes available. Schedule an eligibility review for no later than the 60th day.

15.1.6 Countable Income

Countable income is the prospective gross monthly amount used in the eligibility determination and post-eligibility calculations.

15.1.6.1 Migrant Workers

Annualize migrant workers income. See 25.8 Migrant Workers.

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15.2 PROSPECTIVE INCOME

15.2.1 Prospective Budgeting
15.2.2 Prorating Income
15.2.3 Fluctuating Income

15.2.1 Prospective Budgeting

Budget the gross monthly earned and unearned income amount. See Process Help 16.3 for instructions on budgeting unearned income when other programs are requested along with Medicaid.

Verification is required for all sources of non-exempt income for EBD Medicaid applicants and recipients at the time of application, review or change in income source or amount.

Use all available data exchanges to verify income.

Note: The Employment Wage Match Query should not be used to verify current income. The income displayed on this match is the total income for a past quarter. It does not verify current monthly wages.

15.2.2 Prorating Income

Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, must be converted to a monthly amount or prorated.

Prorate means "to distribute proportionately."

Example 1: Sally receives a $1,500 Tribal Distribution Payment quarterly. This payment should be prorated for the months between payments. $1,500 is distributed over three months by dividing the amount of money by the number of months between payments. The prorated amount is $1,500/3= $500 a month.

Prorating is applied to a member's income when the income is received less often than monthly. By prorating, income is distributed evenly over the number of months between payments

Farm and self-employment income (See 15.6 Self Employment Income) is either averaged or prorated.

When an assistance group applies, do not count the prorated income until it is received.

Example 2: Joe receives semiannual land contract installments of $900. This equals a monthly income of $150 ($900 prorated over six months). He becomes eligible in May. He receives payments in January and July each year. Do not budget any prorated income until July, the first month of receipt after Joe becomes eligible.

If the group becomes ineligible and reapplies before they receive the next installment, use the same prorated amount as before.

Prorated Income is an Unavailable Asset
A source of income which is received in a particular month cannot also be counted as an asset for that same month. This policy also applies to income which has been prorated and will be budgeted over the appropriate prorated period (e.g. 12 months). The client is expected to use this prorated income for their personal needs over an extended period of time. Therefore, any unbudgeted balance is an unavailable asset during the period of time for which the prorated income is being counted. The amount of the unavailable asset will decrease with each month in which the prorated income is budgeted.

Example 3: Jay regularly receives a $1200.00 annual payment from a wealthy relative every January. This income is prorated over 12 month so $100 per month is counted as unearned income beginning in January. The initial $1200 payment and any remaining unbudgeted balance is an unavailable asset during the 12 month budgeting period. In January the entire $1200.00 is considered unavailable. In February, $1100.00 is considered unavailable. The unavailable amount will decrease with every month that income from this source is counted.

15.2.3 Fluctuating Income

If the amount or frequency of regularly received income is known, average the income over the period between payments. If neither the amount nor the frequency is predictable, do not average; count income only for the month in which it is received.

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15.3 EXEMPT/DISREGARDED INCOME

15.3.1 Adoption Assistance
15.3.2 Agent Orange Settlement Fund
15.3.3 Combat Pay
15.3.4 Crime Victim Restitution Program
15.3.5 Disaster and Emergency Assistance
15.3.6 Dottie Moore Payments
15.3.7 Foster Care
15.3.8 General Income Disregard
15.3.9 IDA Payments
15.3.10 Inconsequential
15.3.11 Kinship Care
15.3.12 Life Insurance
15.3.13 Nutrition Benefits
15.3.14 Payments to Native Americans
15.3.15 Payments to Nazi Victims
15.3.16 Radiation Exposure Compensation Act
15.3.17 Refugee "Reception and Placement" (R&P) payments
15.3.18 Refugee Cash Assistance (RCA)

15.3.19 Reimbursements
15.3.20 Relocation Payments
15.3.21 Repayments
15.3.22 Special Programs
15.3.23 Spina Bifida Child
15.3.24 Susan Walker Payments
15.3.25 Travel Tickets
15.3.26 VA Allowances
15.3.26.1 Residents of the State Veterans Home
15.3.27 Wartime Relocation of Citizens
15.3.28 W2 Payments
15.3.29 The American Recovery and Reinvestment Act (ARRA) of 2009
15.3.30 Subsidized Guardianship Payments.

”r;*Disregard*” and "exempt" in this instance means ”r;do not count.” When you are calculating the total amount of income a person has received, disregard the following kinds of income:

15.3.1 Adoption Assistance

Disregard adoption assistance payments.

15.3.2 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling "In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)".

Apply this disregard retroactively to January 1, 1989 and continue to disregard these payments for as long as they are identified separately.

15.3.3 Combat Pay

Disregard combat zone pay that goes to the household that is in excess of the military person's pre-deployment pay. The exclusion lasts while the military person is deployed to the combat area.

If the amount of military pay from the deployed absent family *member* is equal to or less than the amount the household was receiving prior to deployment, count all of the income to the household. Any portion of the military pay that exceeds the amount the household was receiving prior to deployment to a designated combat zone should be excluded when determining the household’s income.

Example 1: John's wife Bonnie and their daughter have an open Medicaid case. John is in the military stationed overseas, his monthly income is $1,000. John sends his wife $1,000 every month.

When John is deployed to a combat zone his pay is increased to $1,300 a month, which is deposited into a joint account. Because the $300 is combat zone pay, it is exempt income and not counted in the determination. The pre-combat pay of $1,000 is budgeted as unearned income for Medicaid.

15.3.4 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime.

15.3.5 Disaster and Emergency Assistance

Disregard major disaster and emergency assistance payments made by federal, state, county, and local agencies, and other disaster assistance organizations.

15.3.6 Dottie Moore Payments

Disregard any penalty payment paid as a result of the Dottie Moore lawsuit.

These court-ordered $50-$200 penalty payments can be imposed when the IM Agency or Child Support Agency (*CSA*) does not correctly process child support refunds.

15.3.7 Foster Care

Disregard *foster care* payments. Foster care payments are considered to be the income of the child or *adult* who is receiving foster care and these payments are exempt income for the foster care recipient. However in some situations the foster care recipient uses these payments to pay the foster parent for their room and board expenses. The room and board payments that are received by the foster parent are not disregarded and should be counted as non-exempt earned income (See 15.5.15) for the foster parent's Medicaid eligibility determination.

15.3.8 General Income Disregard

Disregard $20 from the EBD fiscal test group's net income.

15.3.9 Individual Development Account (IDA) Payments

Disregard Individual Development Account (IDA) payments that are made in the form of matching funds to buy a home, start a business, or to complete post-secondary education.

15.3.10 Inconsequential

Disregard income which is infrequent, irregular, and has no appreciable effect on ongoing need.

Infrequent income is defined as income that an individual receives only once during a calendar quarter from a single source, and which the individual did not receive in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not those payments occur in different calendar quarters.

Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

Exclude the following amount of income which is received either infrequently or irregularly:

- The first $30 per calendar quarter of earned income; and
- The first $60 per calendar quarter of unearned income.

15.3.11 Kinship Care

Disregard kinship care payments.

15.3.12 Life Insurance

Disregard life insurance policy dividends.

15.3.13 Nutrition Benefits

Disregard benefits received from the following:

1. Emergency Food and Shelter National Board.
2. Federal Emergency Management Assistance (FEMA).
3. FoodShare coupon allotment.
4. Home produce for household consumption.
5. National School Lunch Act.
6. Supplemental food assistance under the Child Nutrition Act of 1966.
7. Title VII Nutrition Program for the *Elderly*, Older Americans Act of 1965.
8. USDA Child Care Food Program.
9. USDA donated food and other emergency food.
10. WIC - the supplemental food program for women, infants, and children.

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments.
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims.
3. Payments under the Alaskan Native Claims Settlement Act.

4. Payments under the Maine Indian Claims Settlement Fund.
5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000.
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000.
7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge Munsee Indian Community of Mohicans.
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.
10. For EBD Medicaid cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds.
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan.
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, MN, reservations.
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.
15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000.
16. 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 BadgerCare Plus and all Medicaid subprograms for elderly, blind, or disabled persons **except:**

Senior Care and Long Term Care programs such Institutional Medicaid, Family Care (FC) and Home and Community Based Waivers (HCBW) including Partnership and Pace. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.3.15 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

15.3.16 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death due to exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000). The federal Department of Justice reviews the claims and makes the payments. If the affected person is dead, payments are made to his/her surviving *spouse*, children, parents, or grandparents.

Apply this disregard retroactively to October 15, 1990 and continue to disregard these payments for as long as they are identified separately.

15.3.17 Refugee Cash Assistance (RCA)

Disregard cash payments from the Refugee Cash Assistance (RCA) program. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

15.3.18 Refugee "Reception and Placement" (R&P) payments

Disregard federally funded "Reception and Placement" (R &P) payments made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/family or to a vendor.

15.3.19 Reimbursements

A reimbursement is a payment which a person receives for out-of-pocket expenses. Disregard reimbursements for expenses an assistance group member has incurred or paid. Do not disregard reimbursements for normal household living expenses (rent, clothing, or food eaten at home).

Here are some examples of reimbursements you should disregard:

1. For job or training related expenses. The expenses may be for travel, food, uniforms, and transportation to and from the job or training site. This includes travel expenses of migrant workers.
2. For volunteers' out-of-pocket expenses incurred during their work.
3. Medical or dependent care reimbursements.
4. Reimbursement from the Indianhead Community Action Agency (Ladysmith) under its JUMP Start Program for start-up costs to set up an in-home child care business in the person's home.
5. Reimbursements received from the Social Services Block Grant Program for expenses in purchasing Social Services Block Grant services, for example, transportation, chore services, and child care services.

The reimbursement payment should not be more than the person’s actual out-of-pocket expenses. If it is more, count the excess amount as unearned income.

15.3.20 Relocation Payments

Under s. 32.19, Wis. Stats., relocation payments are available to displaced persons. The following are examples of costs which the relocation payments are intended to cover: moving expenses, replacement housing and property transfer expenses. Disregard the amounts paid by any governmental agency or organization listed in s. 32.02, Wis. Stats. Disregard Title II, Uniform Relocation Assistance and *Real Property* Acquisition Policies Act payments. Its purpose is to treat persons displaced by federal and federally aided programs fairly so that they do not suffer disproportionate injuries as a result of programs designed for the public's benefit.

Disregard Experimental Housing Allowance Program (EHAP) payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

For Medicaid applicants/members, disregard housing assistance payments received under the following Acts:

1. United States Housing Act of 1937.
2. The National Housing Act.
3. Section 101 of the Housing and Urban Development Act of 1965.
4. Title V of the Housing Act of 1949.
5. Section 202(h) of the Housing Act of 1959.

15.3.21 Repayments

A repayment is money the member has received from an income maintenance program and must give back because of a program error or violation. Since s/he is not entitled to the money, s/he must repay it. Therefore it should not be counted as income to the member.

Disregard the following repayments:

1. Money withheld from an economic assistance check due to a prior overpayment.
2. Money from a particular income source that is voluntarily or involuntarily paid to repay a prior overpayment received from that same source of income.

If money from a particular income source is mixed with money from other types of income, disregard only an amount up to the amount of the current payment from the particular source.

Example 2: Richard receives $50 a month from the Veterans Administration (VA) and $250 from Social Security. The income from the two sources is

mixed together in one lump of $300. If the VA overpays Richard by $200, he can pay back to the VA only the $50 a month he receives from the VA. If he repays more, for instance, $75 a month, disregard only $50.

3. Social Security income used to repay an overpayment previously received from the Social Security Administration, whether *SSA* or *SSI*.

15.3.22 Special Programs

Disregard income from all of the following:

1. Active Corp. of Executives (ACE).
2. All wages paid by the Census Bureau for temporary employment related to Census 2010.
3. Emergency Fuel Assistance.
4. Foster Grandparents Program.
5. Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing HUD housing rent.
6. *Homestead Tax Credit.*
7. Low Income Energy Assistance Program.
8. Programs funded under Title V of the Older Americans Act of 1965 (15.5.14 Title V - Older Americans Act of 1965), except wages or salaries, which are counted as earned income.
9. Retired Senior Volunteer Program (RSVP).
10. Service Corp. of Retired Executives (SCORE).
11. University Year for Action Program (UYA).
12. Volunteers in Service to America (VISTA).
13. Wisconsin's Family Support Program (s. 46.985, WI Stats.) This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.
14. Senior Companion Program.

15.3.23 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any *disability* resulting from the child's spina bifida.

15.3.24 Susan Walker Payments

Disregard payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products.

15.3.25 Travel Tickets

In Medicaid cases, disregard the value of any commercial transportation ticket which the member, his/her spouse or parents (if the member is a *minor*) receives as a gift if it is:

1. For travel among the 50 states, District of Columbia, American Samoa, Guam, Northern Mariana Island, Puerto Rico, and the Virgin Islands, and
2. Not converted to cash.

15.3.26 VA Allowances

Disregard the following VA allowances:

1. Unusual medical expenses that are received by a veteran, their surviving spouse, or dependent.
2. Aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses.

Unusual medical expenses, aid and attendance, and housebound allowances for institutionalized and community waiver cases, in eligibility and post-eligibility determinations, except for residents of the State Veterans Homes at King or Union Grove (see 15.3.26.1 Residents of a State Veterans Home).

Example 3: Jack is a single veteran living in his home. He is disabled (as determined by the VA) and receives VA pension benefits in the amount of $1,450 per month. Because he requires assistance with his daily living tasks, Jack receives an aid and attendance allowance which is part of the $1,450. The aid and attendance allowance that Jack receives is $589 per month. Aid and attendance is disregarded income.

$1,450 VA pension
- 589 aid and attendance allowance (disregarded income)
$ 861 budgetable income

Example 4: Donald is a married veteran living with his wife and two children. He is disabled (as determined by the VA) and receives VA compensation benefits in the amount of $2,600 per month. He does not receive aid and attendance, housebound, or unusual medical expense allowances.

The full $2,600 is budgetable income to the household.

15.3.26.1 Residents of a State Veterans Home

For any veteran who resides at a State Veterans Home at King or Union Grove, in the eligibility determination, exempt the amounts identified by the VA as unusual medical expenses, aid and attendance, and housebound allowances.

In the post eligibility test, exempt $90 for those who meet the following conditions:

1. S/he receives aid and attendance, unusual medical expense or housebound allowance payments in an amount greater than $90, **and**
2. S/he is a veteran who has no spouse or child or is a childless surviving spouse of a veteran.

Example 5: John is a veteran residing at the State Veterans Home at King. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded in eligibility and post eligibility determinations. The personal needs allowance for institutionalized members is deducted from the $55 annuity payment. John's remaining budgetable income in the Medicaid post-eligibility determination is $10, and that $10 will be applied to his patient liability.

Example 6: Scott is a veteran residing at the State Veterans Home at King. His total monthly income consists of a $590 VA pension ($200 of which is for unusual medical expenses) and a $50 annuity payment. The portion of the VA pension for unusual medical expenses is totally disregarded in the Medicaid eligibility test. The $50 annuity payment and remaining $390 of the VA pension is non-exempt income. For the post-eligibility test, only $90 of the VA pension is disregarded. The patient liability calculation includes the personal needs allowance, so Scott will have to contribute $505 to his patient liability.

Eligibility Calculation
$590 VA Pension
+ 50 Annuity
$640
-200 (exempt income)
$440 countable income

Liability Calculation
$590 VA Pension
+ 50 Annuity
$640
- 90 (exempt income)
- 45 (personal needs)
$505 patient liability

15.3.27 Wartime Relocation of Citizens

Disregard restitution payments under PL 100-383 to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during WW II. There is no child support and maintenance disregard for Medicaid.

15.3.28 W2 Payments

Disregard Wisconsin Works (W2) payments for Transitional Jobs and Community Service Jobs. Do not disregard payments for Trial Jobs.

15.3.29 The American Recovery and Reinvestment Act (ARRA) of 2009

Disregard the one time payments of $250 sent to SSI, Veterans, Railroad Retirement, and Social Security recipients as a result of The American Recovery and Reinvestment Act of 2009.

15.3.30 *Subsidized Guardianship* Payments.

Disregard Subsidized Guardianship payments.

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15.4 UNEARNED INCOME

15.4.1 Income from Trusts
15.4.2 Sick Benefits
15.4.3 Unemployment Compensation (UC)
15.4.4 Retirement Benefits
15.4.5 General Relief and Charity
15.4.6 Gifts
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15.4.9 Interest Income
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15.4.17 Federal Match Grants for Refugees
15.4.18 Gambling winnings
15.4.19 Payments to Native Americans
15.4.20 First Time Home Buyer Tax Credits
15.4.21 Alimony, Maintenance, and Other Spousal Support Payments

Unearned income is income that the *member* receives from sources other than employment. Unless it is disregarded income (15.3 Disregarded Income) or an income deduction (15.7 Income Deductions), count gross unearned income in the person's income total.

When two payments from the same income source are received the same month due to mailing cycle adjustments, count each payment only for the month it is intended. Income sources commonly affected by such mailing cycle fluctuations

include general assistance, other public assistance programs, *SSI*, and *SSA* benefits.

Note: Occasionally, a regular periodic payment (e.g. title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.4.1 Income from Trusts

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term ”r;trust” includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The Medicaid member.
2. The *spouse* of the Medicaid member.
3. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member’s spouse. This includes a power of attorney or guardian.
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member’s spouse. This includes relatives, friends, volunteers or authorized representatives.

All payments (including interest, and dividends,) from a trust to the beneficiary are unearned income to the beneficiary. See (15.4.9 Interest Income) for instructions on counting interest.

If the beneficiary does not receive payments (including interest and dividends) from the trust, but they are added back to the trust principal, do not count them as income to the beneficiary if the beneficiary is *elderly*, blind or disabled.

Note: If the grantor is an institutionalized person, or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (17.13 Trusts).

15.4.2 Sick Benefits

Sick benefits are payments received from insurance such as income continuation.

15.4.3 Unemployment Compensation (UC)

Count normal UC that is received. Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars. Do not count the temporary supplemental benefit of $25 per week as issued under section 2002(h) of the ARRA. These supplemental benefits are issued between March 16, 2009 and June 30, 2010.

15.4.4 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends. Examples of retirement benefits include:

- Pension *disability* or retirement plans administered by an employer or union
- Accounts owned by the individual, such as Individual Retirement Accounts (IRA)
- Plans for self-employed individuals, sometimes referred to as KEOGH plans.

Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

Any periodic payments from individually owned accounts (e.g., IRA) should not be counted as income in the month of receipt. They are considered the same as withdrawals from an applicant's savings account.

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 1: Mike withdraws $2,000 he has in an IRA, and deposits it into a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another.

15.4.5 General Relief and Charity

Count unrestricted General Relief and charitable payments as follows:

1. Subtract the process month's Family Allowance from the Assistance Standard for this size fiscal group.
2. Multiply the difference by 12 to get the maximum payment you can *disregard*.
3. Ignore any payment that is less than the maximum.

4. Subtract from the maximum the amount of any payment that is greater than the maximum.
5. Count the remainder as unearned income.

15.4.6 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is unearned income only in the month of receipt. Count the gift as an asset in the months following the month of receipt

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less, for each assistance group member, for each calendar quarter.

15.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. Do not count the principal as income, because it is the conversion of one asset form to another. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

If the income is received less often than monthly, prorate the income to a monthly amount. Do not begin budgeting this monthly amount until the person first receives a payment after becoming eligible.

Example 2: Bob receives land contract payments from Farmer Brown twice a year, one $500 payment in March and another $500 payment in September.

If Bob is applying in February prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a $500 land contract payment, divide the total income ($500) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month ($500/6 months = $83.33). Begin budgeting this amount in March.

15.4.8 Loans

If an AG member makes a loan (except a land contract), treat the repayments as follows:

1. Count the interest as unearned income in the month received. In the months following the month the interest payment was received, count the interest payment as an asset.

2. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.
3. 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.

15.4.9 Interest/Dividend Income

15.4.9.1 EBD Interest/Dividend Income
15.4.9.1.1 Excluded Sources of Interest or Dividend Income
15.4.9.1.2 Interest and Dividends Income not excluded for EBD

15.4.9.1 EBD Interest/Dividend Income

Most interest and dividend earnings are considered excluded income and not counted when determining Medicaid eligibility. See 15.4.9.1.1 for excluded sources of interest or dividend Income and 15.4.9.1.2 for Interest and Dividend Income not excluded for EBD.

Most interest and dividend income from a resource excluded under SSI rules (and therefore exempt resource for Medicaid), will be an excluded source of income for all Medicaid Eligibility and post- eligibility determinations. The are, however, some exceptions (See 15.4.9.1.2)

15.4.9.1.1 Excluded Sources of Interest or Dividend Income

Do not count the following sources of interest or dividend payments:

1. Interest or dividend income from a non-exempt resource, such as savings accounts, checking accounts, stocks, bonds, etc.
2. Medicaid resources that are exempt by federal statute other than the Social Security Act:
    - Agent Orange Settlement Payments.
    - Austrian Social Insurance Payments.
    - Corporation for National Community Service (CNCS) (formerly ACTION) Programs.
    - Interests of Individual Development Accounts (IDAs) - TANF Funded.
    - Individual Development Accounts (IDAs) - Demonstrated Project.
    - Japanese-American and Aleutian Restitution Payments.
    - Low Income Energy Assistance.
    - Payments to Victims of Nazi Persecution.
    - Netherlands WUV Payments to Victims of Persecution.
    - Department of Defense (DOD) Payments to Certain Persons Captured and Interned by North Vietnam.
    - Radiation Exposure Compensation Trust Fund.

- Ricky Ray Hemophilia Relief Fund.
- Payments to Veterans' Children with Certain Birth Defects.

3. Interest and dividends that accrue to revocable and irrevocable trusts.
4. Interest and dividends from a life insurance policy.

15.4.9.1.2 Interest and Dividends Income not excluded for EBD

Count the following interest and dividends income for Medicaid:

1. Interest earned on the unspent portion of Earned Income Tax Credits.
2. Interest earned on the unspent portion of Child Tax Credits.
3. Interest and dividends on gifts to children with life threatening conditions.
4. Interest earned on the unspent portion of federal, state, or local relocation assistance payments.
5. Interest earned on the unspent portion of retroactive Social Security or SSI Payments.
6. Interest earned on the unspent portion of Crime Victim's Compensation Payments.
7. Interest portion on repayments of promissory notes or other loan agreements as non-exempt unearned income.
8. Count interest and dividend payments from a revocable or irrevocable trust as non-exempt unearned income, only when the trustee makes an actual payment of the interest or dividend to the trust beneficiary.

Count the interest and dividend income listed above as unearned income when it:

1. Is received regularly and frequently, and
2. Is more than $20 a month.

When income is received less often than monthly, prorate (See 15.2.2 Prorating Income) it to a monthly amount. Wait until the person first receives it after becoming eligible, and then begin prorating with the month in which the payment is received.

If the prorated amount is $20 or less, disregard it as inconsequential income. If more than $20, budget it as unearned income.

Example 5: In a Medicaid application, made June 16, 2009, a group member receives interest payments of $54 every three months. The next interest payment date is July 30, 2009. Do not count any of this interest income during June. Prorate the payment over July, August, and September. The interest is: $54/3 = $18. Since $18 is less than $20, do

not count the interest.

When interest or dividends are paid regularly, but the amount fluctuates, average the payments to get a monthly amount.

When you discover that interest has accumulated in an account, count all of the accumulated interest as unearned income. Do not count these interest dollars as an asset.

Example 6: In May, $12 is posted to an account as monthly interest on principal of $800. May income is $12 and the May asset is $800. In June, $12.50 is posted as interest on a balance of $812. June income is $12.50 and the June asset is $812.

If interest or dividends are not paid regularly (neither you nor the member can reasonably predict when it will be available), count the interest as unearned income in the month in which it is received.

15.4.10 Social Security Benefits

Count Social Security Benefits as unearned income in the month received.

15.4.11 Property Settlement

See 16.7.10 Property Settlement

15.4.12 Lump Sum Payments

See 16.7.11 Lump Sums Payments

15.4.13 Money for School

15.4.13.1 Total Disregards
15.4.13.2 Partial Disregards
15.4.13.3 Workforce Investment Act (WIA)

For elderly/disabled cases, apply the disregards listed in 15.4.13.1 Total Disregards & 15.4.13.2 Partial Disregards But count all other money that is derived from any other student loan or grant not listed below. Use the Student Financial Aids Report (F-16021) to obtain the type and amount of the student's aid package. Also use it to inform the student financial aids office of assistance granted.

See 15.4.13.3 Workforce Investment Act (WIA) for instructions on how to treat income that is earned under the Workforce Investment Act (WIA) .

15.4.13.1 Total Disregards

For elderly/disabled cases, totally disregard all of the following sources of money for education or training:

1. Supplemental Educational Opportunity Grant (SEOG),
2. Perkins Loans (formerly NDSL),
3. Federal Direct Student Loan Program (Formerly GSL & FFELP),
4. Wisconsin Direct Student Loan (WDL),
5. Talent Incentive Program/State Student
6. Incentive Grant (TIP/SSIG),
7. College Work Study Program (CWSP), and
8. Basic Educational Opportunity Grants (BEOG or PELL).
9. Wisconsin Indian Grant (WIG), and
10. Bureau of Indian Affairs Grant (BIAG).
11. Any other undergraduate loan or grant made or insured under any program administered by the U.S. Commissioner of Education.
12. Any other loans and grants obtained and used under conditions that prevent their use for current living costs.
13. County training program allowances granted by the IM agency.

15.4.13.2 Partial Disregards

For elderly/disabled cases, partially disregard all other money for education or training as follows:

1. Determine the cost of tuition, fees, books, transportation essential to education or training, and day care.
2. Subtract the total in "1" from the grant, loan, scholarship, etc. total.
3. Count any remaining money as unearned income:
   a. Only as of when the student gets the money; **and**
   b. Over the months the money is intended to cover.

Example 1: The remaining $600 of a grant is intended to cover January through June.

If it's received in:

- May, count $100 in each of the income months of May and June;
- July, budget $0;
- December, count $100 in each of the income months of January through June.

15.4.13.3 Workforce Investment Act (WIA)

For both Family & *Elderly*/Disabled MA cases, disregard all unearned income from WIA to any *adult* or *minor* participating in WIA, including:

1. "Need-based payments" paid to persons as allowances to enable them to participate in a training program.

2. "Compensation in lieu of wages" paid to persons in "tryout employment". This is arranged when private-for-profit opportunities aren't available and is generally limited to persons under age 22. Ask any *applicant* under age 23, or the local WIA staff if s/he is participating in "tryout employment". If s/he is, count this as unearned income.

3. "Payments for supportive services" paid to persons in training programs who aren't able to pay for training related expenses (e.g., transportation, health care, child care, meals).

Earned WIA income is paid in the form of wages from on-the-job training (OJT) and work experience activities. Disregard all earned WIA income of a minor for up to a total of 6 months per calendar year. Negotiate with the MA group which 6 months of income to disregard. The 6 months need not be consecutive. Budget WIA income earned by a minor in other than these 6 months according to (15.5.9. Student Income)

Count the **earned** WIA income of adult participants.

The **Job Corps Program** is a part of WIA. Consider a minor who's participating in the Job Corps a student when you calculate the income disregards for full-time students, and part-time students who are not employed full-time.

Consider Job Corps payments to adult participants as unearned WIA income.

15.4.14 Child Support

Count child support income as unearned income.

Child support payments (including arrearage payments) made to or on behalf of a disabled child are counted as unearned income to the child.

One-third of the amount of a child support payment made to or for a disabled child by an absent parent is excluded as income. This income exclusion applies to both court ordered and voluntary child support payments.

This exclusion only applies to payments made by an absent parent. Sometimes a family is reunited, and the parent is still making child support payments, in compliance with a court order, even though that parent is now living with the child. Under these circumstances, the one third income exclusion is not allowed, since the parent is no longer considered to be an absent parent.

The one third income exclusion described above, only applies to EBD Medicaid eligibility determinations; it does not apply to BC+ eligibility determinations.

15.4.15 Profit Sharing

Count profit sharing income as unearned income.

15.4.16 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives, not related to gainful employment, as unearned income even if the compensation is turned over to the order.

Count the compensation as earned income if it meets the criteria in 15.5.13 Income Received by Members of a Religious Order.

15.4.17 Federal Match Grants for Refugees

Some refugee resettlement agencies have grants available for refugees for their second, third, and fourth month after arrival in the U.S. These are cash grants and can vary in the amount issued. Count these payments as unearned income. Budget as "OT" on AFUI and document the grant in case comments.

15.4.18 Gambling winnings

Gambling winnings are counted as unearned income in the month of receipt. Gambling losses cannot be used to offset the winnings.

15.4.19 Payments to Native Americans

Disregard the first $500 of the monthly income from Tribal Per Capita payments from gaming revenue. 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 BadgerCare Plus and all Medicaid subprograms for elderly, blind, or disabled persons **except**:

Senior Care and Long Term Care programs such Institutional Medicaid, Family Care (FC) and Home and Community Based Waivers (HCBW) including Partnership and Pace. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.4.20 First Time Home Buyer Tax Credits

Effective 01/01/10

Count actual payments made to the member as unearned income in the month of receipt.

15.4.21 Alimony, Maintenance, and Other Spousal Support Payments

Count all Alimony, Maintenance, and Other Spousal Support Payments.

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15.5 EARNED INCOME

15.5.1 Income In Kind
15.5.2 Contractual Income
15.5.3 Rental Income
15.5.4 Jury Duty Payments
15.5.5 Wage Advances
15.5.6 Worker's Compensation
15.5.7 Governor's Central City Initiative
15.5.8 Income Tax Refunds
15.5.9 Student Income
15.5.10 AmeriCorps
15.5.11 Census 2010
15.5.12 Severance Pay

15.5.13 Income Received by Members of a Religious Order
15.5.14 Title V – Older Americans Act of 1965
15.5.15 Room and Board Income
15.5.16 Earned Income Tax Credit (EITC)
15.5.17 Make Work Pay Credit
15.5.18 Special Tax Credit for Certain Government Retirees

Earned income is income from gainful employment. The gross earned income before any deductions are taken out is counted. Count earned income only for the month in which it is received, except when the average number of payments increase due to mailing cycle adjustments.

Note: Occasionally, a regular periodic payment (e.g., wages, title II,or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.5.1 Income In-Kind

Count in-kind benefits as earned income if they are:

1. Regular, and
2. Predictable, and
3. Received in return for a service or product.

Do not count:

1. Meals and lodging for armed services members.
2. In-kind services that do not meet all three of the above criteria.

To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits.

15.5.2 Contractual Income

This provision applies primarily to teachers and other school employees.

When an employed Medicaid group *member* is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, determine the period of the contract and then prorate the income from the contract over that period. For example, if the contract is for 18 months, prorate the contract's income over 18 months no matter the number of installments made in paying the income. Do this even if:

1. There are predetermined vacation periods, or
2. S/he will only be paid during work periods, or

3. S/he will be paid only at the end of the work period, season, semester or school year.

15.5.3 Rental Income

When a Medicaid group member reports rental income to the Internal Revenue Service (IRS) as self-employment income, see15.6.3 Self Employment Income and Assets.

If s/he does not report it as self-employment income, add "net rent" to any other unearned income on the appropriate worksheet. Determine "net rent" as follows:

1. When the owner is not an occupant, "net rent" is the rent payment received minus the interest portion of the mortgage payment, and other verifiable operational costs. Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering, and replacing broken windows.

   Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring or cabinets, paving a driveway.

   If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

   When a life estate (See 16.8.1.5 Life Estate) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. Net rental income is the gross rental income minus taxes, insurance, and other operational costs. The operational costs are the same as the costs the holder was liable for when living on the property

2. When s/he receives income from a duplex, triplex, etc. and lives in one of the units, determine "net rent" as follows:
   a. Add the interest portion of the mortgage payment and other verifiable operational costs common to the entire operation.
   b. Multiply the number of rental units by the total in "a."
   c. Divide the result in "b." by the total number of units. This is the proportionate share.
   d. Add the proportionate share "c." to any operational costs paid by the member that are unique to any rental unit. The result is the total member expense.

e. Subtract the total member expense "d." from the total rent payments to get "net rent."

15.5.4 Jury Duty Payments

Count any portion of a jury payment that is over and above expenses as earned income for the month in which it is received.

15.5.5 Wage Advances

Count advances on wages as earned income in the month received.

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.

15.5.7 Governor's Central City Initiative

Count hourly income from the Governor's Central City Initiative as earned income. This program is only in Milwaukee County.

15.5.8 Income Tax Refunds

Effective 01/01/10
Income tax refunds are disregarded income. See 16.7.7 Income Tax Refunds.

15.5.9 Student Income

Disregard a member's income if s/he:

1. Meets the definition of a *dependent 18-year-old* , **or**
2. Is under age 19 and enrolled as a full-time student, **or**
3. Is under age 19 and enrolled as a part-time student working less than 30 hours per week.

Count the earned income of anyone under age 19 who does not meet any of the criteria listed above.

15.5.10 AmeriCorps

Count the living allowance or stipend as earned income. Disregard any child care allowance to the extent is was used to meet child care expenses to participate in AmeriCorps. Disregard any basic health insurance policy, child care services, auxiliary aid and services to people with disabilities and the

national service educational award of $4,725 for each year of completed service.

15.5.11 Census 2010

Disregard all wages paid by the Census Bureau for temporary employment related to Census 2010.

15.5.12 Severance Pay

Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee's request or through a mutual agreement with his/her employer as earned income when s/he would have received the amount had it not been deferred.

15.5.13 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives as earned income if the compensation is for gainful employment, even if the compensation is turned back over to the order.

Count the compensation as unearned income if it is not earned through gainful employment.

15.5.14 Title V – Older Americans Act of 1965

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to:

1. Green Thumb.
2. Experience Works.
3. The National Urban League.
4. National Senior Citizens Education and Research Center (Senior Aides).
5. National Indian Council on Aging.
6. U.S.D.A. Forest Service.
7. Wisconsin Senior Employment Program (WISE).
8. Community service employment programs, such as the Older Americans Community Service Program.

Identify programs funded under the Title V of the Older Americans Act using documents provided by the member, contacts with the provider, or a local council on aging.

Do not count reimbursements (See 15.3.19 Reimbursements).

15.5.15 Room and Board Income

Calculate net amount by deducting one of the following from the gross amount received from each roomer/boarder: $15 roomer only, $111 boarder only, $126 roomer and boarder.

15.5.16 Earned Income Tax Credit (EITC)

Effective 01/01/10
Disregard EITC payments.

15.5.17 Make Work Pay Credit

Effective 01/01/10
Disregard actual payments made under Make Work Pay..

15.5.18 Special Tax Credit for Certain Government Retirees

Effective 01/01/10
Disregard actual payments made under the Special Tax Credit for Certain Government Retirees.

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15.6 SELF EMPLOYMENT INCOME

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15.6.1 Definitions

15.6.1.1 Income

Self-employment income is income directly from one's own business rather than as an employee with a specified salary or wages from an employer.

15.6.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

15.6.1.3 Operating

A business is operating when it is ready to function in its specific purpose. The period of operation begins when the business first opens and generally continues uninterrupted up to the present. A business is operating even if there are no sales and no work is being performed. Thus a seasonal business operates in the off season unless there's been a significant change in circumstances (15.6.5.3 Anticipating Earnings).

A business is not operating when it cannot function in its specific purpose. For instance, if a mechanic cannot work for 4 months because of an illness or injury, he may claim his business was not in operation for those months.

15.6.1.4 IM Income

IM income is self-employment income that is counted in determining income maintenance eligibility and benefits.

15.6.1.5 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

15.6.1.6 Non-real Property

Non-real property means all property other than real property.

15.6.2 Ways to Identify

15.6.2.1 By Organization
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15.6.2.3 Employee Status

Identify a farm or other business according to the following criteria.

15.6.2.1 By Organization

A farm or other business is organized in one of the following ways:

1. A sole proprietorship, which is an unincorporated business owned by one person.
2. A partnership, which exists when 2 or more persons associate to conduct business. Each person contributes money, property, labor, or skills, and expects to share in the profits and losses. Partnerships are unincorporated.
3. A corporation is a legal entity authorized by a state to operate under the rules of the entity's charter. There may be one or more owners. A corporation differs from the other forms because a corporation:

a. Is taxed as a separate entity rather than the owners being taxed as individuals, and
b. Provides only limited liability. Each owners' loss is limited to their investment in the corporation while the owners of unincorporated business is also personally liable.

15.6.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return with the IRS. A person who will owe more than $400 in taxes at the end of the year must file quarterly estimates.

IRS tax forms for reporting self-employment income are listed below.

1. Form 1065 - Partnership
2. Form 1120 - Corporation
3. Form 1120S - S Corporation
4. Form 4562 - Depreciation & Amortization
5. Form 1040 - Sole Proprietorship
    a. Schedule C (Form 1040) - Business (non-farm)
    b. Schedule E (Form 1040) - Rental and Royalty
    c. Schedule F (Form 1040) - Farm Income
    d. Schedule SE (Form 1040) - Social Security Self-Employment

15.6.2.3 Employee Status

A person is an employee if s/he is under the direct "wield and control" of an employer. The employer has the right to control the method and result of the employee's service. A self-employed person earns income directly from his/her own business, and all of the following applies:

1. Does not have federal income tax and FICA payments withheld from a paycheck.
    Note: A baby sitter who works in someone else's home is considered an employee of that household, even if the individual employing him/her does not withhold taxes or FICA.
2. Does not complete a W-4 for an employer.
3. Is not covered by employer liability insurance or worker's compensation.
4. Is responsible for his/her own work schedule.

Examples of self-employment are:

1. Businesses that receive income regularly (for example, daily, weekly or monthly):

a. Merchant,
b. Small business,
c. Commercial boarding house owner or operator, or
d. Owner of rental property

2. Service businesses that receive income frequently, and possibly, sporadically:

   a. Craft persons,
   b. Repair persons,
   c. Franchise holders,
   d. Subcontractors,
   e. Sellers of blood and plasma, or
   f. Commission sales persons (such as door-to-door delivery).
3. Businesses that receive income seasonally:
   a. Summer or tourist oriented business,
   b. Seasonal farmers (custom machine operators),
   c. Migrant farm worker crew leaders,
   d. Fishers, trappers, or hunters, or
   e. Roofers.
4. Farming, including income from cultivating the soil, or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time or hobby farming.

15.6.3 Self Employment Income Assets

15.6.3.1 Business Assets
15.6.3.2 Bank Accounts
15.6.3.3 Disallowed Expenses

15.6.3.1 Business Assets

Business assets are generally income producing property. Exclude assets directly related and essential to producing goods or services.

In EBD cases, all real and non-real business property is exempt if the business is currently operating (15.6.1.3 Operating) for the self-support of the EBD individual. There is no profitability test.

Note: See 16.9 Non-Home Property Exclusions.

Ask the EBD person to furnish the documents needed to:

1. Describe the business, its properties, and its assets.
2. Show the number of years it has been operating.
3. Identify any co-owners.
4. Show the estimated gross and net earnings for the current tax year.

If the property is not currently operating, exempt it if there is reasonable expectation it will resume operating within the next 12 months. Base your reasonable expectation on the following information:

1. Date of last use.
2. Reason property is not in current use.

3. Estimated date the person expects to resume use.

If s/he decides not to resume, the property becomes a countable asset in the month after the decision not to resume.

Extend the 12 months only when a disabling condition prevents the person from resuming business use of the property.

15.6.3.2 Bank Accounts

With corporations you can easily distinguish between personal and business checking and savings accounts. A corporation is a separate legal entity and the accounts it owns must be in the corporation's name. Accounts in the name of the owners are personal accounts.

For partnerships and sole-proprietorships, a cash account is a business account if the person claims that it is a business account. *Disregard* a business account, if the profitability test is passed, even if a partner or sole-proprietor makes withdrawals from the account for personal use. You don't need a profitability test for EBD cases.

15.6.3.3 Disallowed Expenses

Expenses that are allowed self-employment deductions on the IRS business tax forms are allowed expenses for Medicaid. Some specific expenses that have been identified as not allowed in the calculation of Self Employment Income on the IRS tax forms and therefore not allowed for Medicaid are:

1. Net loss carryover from previous periods,
2. Federal, State, and local income taxes,
3. Charitable donations,
4. Work-related personal expenses, such as transportation to and from work,
5. Work-related personal expenses such as pensions, employee benefit and retirement programs and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not), **or**
6. Principal payments on loans for the purchase price of income producing real estate, capital assets/equipment, and durable goods.

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.

Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to IRS, you must judge whether or not it is self-employment income.

Self-employment income sources are:

1. **Business**. Income from operating a business.
2. **Capital Gains**. Income from selling securities and other property.
3. **Rental**. Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income.

Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.

When the owner is not an occupant, net rental income is the rent payment received minus the interest portion of the mortgage payment and other verified operational costs.

When a life estate (16.8.1.5 Life Estate) holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

When the owner lives in one of the units of a multiple unit dwelling, compute the annual net rental income as follows:

1. Add the annual interest portion of the mortgage payment and other annual operational costs (including taxes) common to the entire operation.
2. Divide the result in step 1 by the *total* number of units to get the proportionate share.
3. Multiply the amount in step 2 (the proportionate share) by the number of *rental* units. Rental units means the total number of units minus the unit the owner lives in.
4. This equals total expenses.
5. Subtract total annual expenses from the total annual rental income to get net annual rental income.
6. Divide the net annual rental income by 12 to get the net monthly rental income. Budget this amount.

Example 1: George owns a 4 unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is $9,765. His operational expenses, including taxes on the house from the most recent taxes is $12,359. This totals $22,124. This amount divided by 4 units = a proportionate share of $5,531.

$5,531 * 3 rental units = $16,593. This represents his total budgetable annual expenses. His total annual rental income = $28, 800 ($800 per unit per

month).

$28,800
-$16,593
$12,207

$12,207 / 12 = **$1,017.25** net monthly rental income.

Royalties. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

15.6.5 Calculating IM Income

15.6.5.1 IRS Tax Forms
15.6.5.2 Worksheets
15.6.5.2.1 Depreciation
15.6.5.3 Anticipated Earnings

IM income (15.6.1.1 Income) is anything you receive in cash or in-kind that you can use to meet your needs for food, clothing, and shelter by either:

1. Using IRS tax forms completed for the previous year, or
2. Anticipating earnings (15.6.5.3 Anticipated Earnings)

15.6.5.1 IRS Tax Forms

Do not fill out any IRS tax forms (or the F-00107 Self-Employment Income Report Form) yourself. This is the responsibility of the *member*.

Consult IRS tax forms only if:

1. The business was in operation at least one full month during the previous tax year, and
2. The business has been in operation six or more months at the time of the application, and
3. The person does not claim a change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (15.6.5.3 Anticipating Earnings)

15.6.5.2 Worksheets

If you decide to use IRS tax forms, use them together with the self-employment income worksheets (F-16034 , F-16035 , F-16036 and F-16037).

The worksheets identify net income and depreciation by line on the IRS tax forms.

For each operation, select the worksheet you need and, using the provided tax forms and/or schedule, complete the worksheet. These are:

1. *Sole Proprietor - Farm and Other Business*

a. IRS Schedule C (Form 1040) &endash; Non-farm Business Income
b. IRS Schedule E (Form 1040) - Rental and Royalty Income
c. IRS Schedule F (Form 1040) - Farm Income
d. IRS Form 4797 - Capital & Ordinary Gains

2. Partnership
   a. IRS Form 1065 - Partnership Income
   b. IRS Schedule K-1 (Form 1065) - Partner's Share of Income
3. Corporation
   IRS Form 1120 - Corporation Income
4. Subchapter S Corporation

a. IRS Form - 1120S - Small Business Corporation Income
b. IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

Next, divide IM income by the number of months that the business was in operation during the previous tax year.

The result is monthly IM income. Add this to the fiscal test group's other earned and unearned income. If monthly IM income is a loss, add zero to the non self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Don’t apply a loss from unearned income to a gain in earned income. Losses from self-employment can’t be used to offset other earned or unearned income.

If you use more than one worksheet because there is more than one operation, combine the results of each worksheet into one monthly IM income amount before adding that total to any other income. Remember that while a salary or wage paid to a *FTG* member is an allowable business expense, you must count it as earned income to the payee.

Continue to process the group through the balance of the handbook, including some additional work-related expenses that IRS doesn't allow as business expenses (See 15.7.5 $65 and ½ Earned Income Deduction).

15.6.5.2.1 Depreciation

EBD cases must deduct depreciation from their self-employment income. The amount of the depreciation deduction is the same as the amount they claim on their tax forms.

15.6.5.3 Anticipated Earnings

If past circumstances don't represent present circumstances, calculate self-employment income based on anticipated earnings. A change in circumstances is any change that can be expected to affect income over time. It is the person's responsibility to report changes.

The date of an income change is the date you agree that a change occurred. You must also judge whether the person's report was timely to decide if the case was over or underpaid. Changes are then effective according to the normal prospective budgeting cycle. Don't recover payments made before the agreed on date.

Other instances when you would use anticipated earnings:

1. The business wasn't operating at least one full month during the previous tax year.
2. The business wasn't operating six or more months at the time of the interview.

Examples of changed circumstances are:

1. The owner sold or simply closed down the business.
2. The owner sold a part of his business (e.g., one of two retail stores).
3. The owner is ill or injured and will be unable to operate the business for a period of time.
4. A plumber gets the contract on a new apartment complex. The job will take nine months and his/her income will increase.
5. A farmer suffers unusual crop loss due to the weather or other circumstances.
6. There's a substantial cost increase for a particular material such that there will be less profit per unit sold.
7. Sales, for an unknown reason, are consistently below previous levels. The relevant period may vary depending on the type of business (consider normal sales fluctuations).

The Self-Employment Income Report Form (SEIRF) (Self-Employment Income Report Form- F-00107) simplifies reporting income and expenses when earnings must be anticipated. It's modeled after IRS Form 1040, Schedule C, and can be used to report income for any type of business with any form of organization. However, some, especially farm operators, may find it easier to complete the IRS tax form when income and expense items are more complex.

To compute anticipated earnings, the person must complete a SEIRF for those months of operation since the change in circumstances occurred following the guidelines below (remember, the beginning of a business is a change in circumstances). S/he may complete the SEIRF for each month separately or combine the months on one SEIRF.

When a new self-employment business is reported or when a change in circumstance occurs and the past circumstances no longer represent the present, recalculate self-employment income:

1. When two or more months of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information beginning from the date self employment began or the date of the significant change. See example 1.
2. When at least one full month but less than two full months of actual self-employment income information is available, calculate a monthly net income average using the actual net income received in any partial month of operation, the one full month of operation and an estimate of net income for the next month. See example 2.
3. When there is less than one full month of actual income information available, calculate a monthly net self-employment income average using the actual net income received in the partial month (since the change in circumstance occurred) and estimated income and expenses for the next two months. See example 3.

Use the average until the person's next review or if a significant change in circumstances is reported between reviews.

Example 1: Bonnie applies for CC and Medicaid on April 5, 2007. She reports that she started self-employment in January 2007. The agency uses a SEIRF for January, February and March to determine the prospective self-employment income estimate for Bonnie's Medicaid and CC certification period (April 2007 &endash; March 2008).

On Bonnie's September SMRF, no change in self-employment income is reported and the worker continues to use the average determined at the time of application.

Example 2: Ricardo is applying for FS and Medicaid eligibility on February 5, 2007. He started self-employment on December 15th. To calculate his prospective self-employment income, he completes a SEIRF for December, January, and February including his actual and expected income and expenses for three months. The worker divides this total by three to determine an anticipated monthly average income amount. This amount is used until a change in self-employment is reported, or until Ricardo completes a new application or a review.

Example 3: Jenny is a Medicaid and CC recipient who has been self-employed as a hair dresser since 2002. Jenny's Medicaid and CC certification period is December 2008 to November 2009. The worker used Jenny's 2007 tax return to establish a monthly income amount.

In March 2009 Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she'll be able to return to work, but it will not be until at least May. The worker has Jenny complete a SEIRF for February 17- February 28 (actual income since the change in circumstance occurred) and for March and April using the best estimate of income to establish her prospective self-employment income. The worker will use these three months to determine a prospective self-employment income estimate for the remainder of the certification period. Jenny does not need to submit any additional SEIRFs.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a change in circumstances .

15.6.6 Verification

Self employment income is not available through data exchange and therefore must be verified (20.4.1 Questionable Items Introduction #7).

Completed and signed IRS tax forms (15.6.2.2 By IRS Tax Forms) are sufficient verification of farm and self-employment income. A completed and signed SEIRF is sufficient verification.

It isn't necessary to collect copies of supportive items such as receipts from sales and purchases. However, you can require verification when the information given is in question. Document the reason for the request.

15.6.7 Self-Employment Hours

Count the time a self-employed person puts in on business related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

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15.7 INCOME DEDUCTIONS

15.7.1 Maintaining Home or Apartment
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15.7.3 Medical/Remedial Expenses (MRE)
15.7.4 Impairment Related Work Expenses (IRWE)
15.7.5 $65 and ½ Earned Income Deduction

15.7.1 Maintaining Home or Apartment

If an institutionalized person has a home or apartment, deduct an amount from his/her income to allow for maintaining the home or apartment that does not exceed the *SSI* payment level plus the E supplement for one person (See 39.4.1). The amount is in addition to the personal needs allowance (See 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.

Make the deduction only when the following conditions are met:

1. A physician certifies (verbally or in writing) that the person is likely to return to the home or apartment within six months, and
2. The person's *spouse* is not living in the home or apartment.

Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six month continuance. A physician must again certify that s/he is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time as long as the person is institutionalized. It is not limited to the first six months of institutionalization.

Example 1: Bob was institutionalized in June 2007 as a private pay patient. In June 2008, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2008. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of care, starting in June 2008.

15.7.2 Special Exempt Income

Special exempt income includes:

1. Income used for supporting others (15.7.2.1 Support Payments).
2. Court-ordered attorney fees (15.7.2.3 Fees to Guardians or Attorneys.
3. Court-ordered guardian and guardian ad litem fees (15.7.2.3 Fees to Guardians or Attorneys).
4. Expenses associated with establishing and maintaining a guardianship. (15.7.2.3 Fees to Guardians or Attorneys)
5. Expenses associated with a Self-Support Plan (15.7.2.2 Self-Support Plan).
6. Impairment Related Work Expenses (IRWE) (15.7.4 Impairment Related Work Expenses (IRWE)
7. Maintaining a home or apartment (15.7.1 Maintaining Home or Apartment)
8. Costs associated with *real property* listed for sale (16.2 Assets Availability)

For specific exemptions see 15.3 Disregarded Income.

15.7.2.1 Support Payments

Support payments are payments which an Medicaid *member* makes to another person outside of the *FTG for the purpose of supporting and maintaining that*

*person. Support payments are either court-ordered (*15.7.2.1.1 Court-Ordered or non-court-ordered (15.7.2.1.2 Non-court-Ordered).

Include the support payment amount as part of an institutionalized person's monthly need (See 27.6 ILTC Monthly Need) and cost of care (See 27.7 ILTC Cost of Care Calculation).

A person in the fiscal group who has legal responsibility for a person in a nursing home may be paying that person's patient liability. If so, deduct this amount from the group's income.

15.7.2.1.1 Court-Ordered

The income deduction for monthly court ordered support expenses is the amount that the member is "obligated" to pay as stipulated in the court order. Do not allow payments for *arrearages* and annual R & D expenses.

Actual payments may be deducted for court ordered lying in costs for the costs of the birth of the child. Unlike monthly court ordered expenses, actual payments for lying in costs are frequently paid at various times and are usually not tied to a regular payment schedule.

Note: If the court order stipulates that the individual must pay a monthly amount toward lying in costs, allow the court ordered amount (obligated amount) as an income deduction. If the member is required to pay lying in costs, but no specific monthly amount is ordered, allow actual payments for lying in costs as an income deduction.

15.7.2.1.2 Non-court-Ordered

Include non-court-ordered support payments only if they are paid to the following:

1. Institutionalized spouse. The maximum amount that can be included is the AFDC Cat Needy income limit for a group size of one (See 39.3 AFDC Related Income Table) minus the spouse's net income.
2. *Minor child who is living with a non-legally responsible relative (NLRR). The maximum amount that can be included is the AFDC cat needy income limit for a group size of one plus the child's medical expenses minus the child's net income.*

Do not include non-court-ordered payments if they are to:

1. A spouse or minor child who receives SSI, or
2. A spouse who is eligible for SSI but refuses to apply for it.

15.7.2.2 Self-Support Plan

A member whose eligibility is based on blindness or *disability* may deduct income that is received under an approved self-support plan. This allows a handicapped person to receive income and accumulate resources for training or purchasing equipment necessary for self support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the member must perform in accordance with the plan. The plan must:

1. Be specific, current, and in writing.
2. Be approved by the county or tribal agency.
3. Specify the amount to be set aside, and the expected cost and time required to accomplish the objective.
4. Provide for identification and segregation of goods and money accumulated and conserved.

15.7.2.3 Fees to Guardians or Attorneys

15.7.2.3.1 Countable

Count as available income any payments an institutionalized person makes to:

1. A legal guardian or attorney, which are not court-ordered payments. Do not include such payments in the person's monthly need, and do not deduct them from his/her monthly income.
2. A third party to reimburse a prepayment the third party made of a guardianship fee. Count the payment even if the third party obtained a court order to recoup the pre-payment.

Exception: Deduct this third party prepayment if:

a. The third party was the county acting as guardian ad litem. A guardian ad litem is someone appointed by the court to represent the best interests of a juvenile or disabled person during a particular court proceeding, and
b. The prepayment was to an attorney who was not a county employee at the time the services were delivered, and
c. A court ordered the institutionalized person to reimburse the county's prepayment.

15.7.2.3.2 Not Countable

Do not count the following as available income:

1. Court-ordered guardian and/or attorney fees paid directly out of the person's monthly income.
2. Expenses paid by the person for establishing and maintaining a court-ordered guardianship or protective placement for him/herself.

15.7.3 Medical/Remedial Expenses (MRE)

Medical and Remedial Expenses (MRE) are used in:

1. the home and community-based waiver programs ,
2. patient liability calculations for residents of a medical institution, and
3. cost share and Medicaid Purchase Plan (*MAPP*) premium calculations.

Medical expenses are anticipated incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

1. Deductibles and co-payments for Medicaid, Medicare, and private health insurances.
2. Health insurance premiums.
3. Bills for medical services which are not covered by the Wisconsin Medicaid program.
4. For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid. (Past medical bills cannot be used for MAPP premium calculations.)

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

1. Case management.
2. Day care.
3. Housing modifications for accessibility.
4. Respite care.
5. Supportive home care.
6. Transportation.
7. Services recognized under s.46.27, Wis. Stats.
8. Community Options Program, that are included in the person's service plan.

Remedial expenses do not include housing or room and board services.

15.7.4 Impairment Related Work Expenses (IRWE)

Impairment Related Work Expenses (IRWE) are expenses used to determine eligibility for Medicaid, MAPP eligibility and premium calculations. IRWEs are anticipated incurred expenses by the member related to the member's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as Medicaid, private insurance, or the member's employer. If an anticipated IRWE is later paid by an unanticipated source it is still allowable for past months in which it was budgeted, but not for future months.

Example 2: On March 25, Cecil was told by Harvey's Auto Repair Shop that his wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of $2,000 for the repairs. The $2,000 estimate was determined to be a standard charge for this type of repair in the community.

On March 26, Cecil applied for Medicaid in Milwaukee County. At this time the anticipated expense of the van repair was deducted from Cecil's income.

Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his IM worker.

Cecil's IM worker should not deduct the anticipated cost of the van repairs for any subsequent eligibility and premium determinations.

Deduct any EBD person's expenses which:

1. Do not exceed his/her gross monthly earned income (plus room and board income, if any).
2. Are reasonably related to his/her earned income. Expenses which are reasonably related to earned income include those incurred in performing on the job and improving the person's ability to do the job.

Bills from months prior to the months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the member's community. If you count an expense as an IRWE, do not also use the expense as a Medical/Remedial Expense (MRE).

Some examples of IRWEs are: Modified audio/visual equipment, typing aides specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the member's disability.

Exceptions: Always count the expenses of getting to and from work and the child care expenses as an IRWE for blind individuals.

15.7.5 $65 and ½ Earned Income Deduction

The $65 and ½ earned income deduction is an EBD fiscal test group deduction.

To calculate the $65 and ½ earned income deduction, subtract $65 from the member's monthly earned income. Divide the result by two, and add $65. This is the earned income deduction.

Example 3: Michelle has monthly income of $1,240. Her $65 and ½ earned income deduction is

$1,240.00
&endash; 65.00
$1,175.00

$1,175.00/2 = $587.50 Countable Income

$ 587.50
+ 65.00
$ 652.50 Earned Income *Disregard*

Michelle's earned income deduction amount is $652.50.

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16 ASSETS

16.1 ASSETS INTRODUCTION

Effective 10/01/2009, children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including *MAPP*, Community Waivers, FamilyCare, etc.

Do not count income as an asset in the month it was received when determining the countable asset amount.

Example 1: Mr. Johnson has $2600.00 in his checking account for the month of March. Of that amount, $700.00 is unearned income that he received in March. His countable asset amount is $1900.00.

Add together all countable, available (See 16.2 Assets Availability), assets the fiscal group owns including:

1. Joint accounts. (16.4.1 Joint Accounts)
2. Burial Assets (16.5 Burial Assets)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (16.7.2 Loans)
8. Life Insurance (16.7.5 Life Insurance)
9. Non- Burial Trusts (16.6 Non-Burial Trusts)
10. Land Contract (16.7.12 Land Contract)

11. Mortgage (16.7.13 Mortgage)
12. Trailer Home (16.8.1.2 Non-Motorized Trailer Homes)
13. Nonhome *Real Property*. (16.8 Real Property)

Use the EBD Related Determination worksheet when doing manual eligibility determinations for non institutionalized EBD Medicaid applicants and recipients. The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any *member* of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate EBD medically needy asset limit are ineligible for Medicaid.

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16.2 ASSETS AVAILABILITY

16.2.1 Assets Availability Introduction
16.2.2 Real Property

16.2.1 Assets Availability Introduction

An asset is available when:

1. It can be sold, transferred, or disposed of by the owner or the owner's representative, and
2. The owner has a legal right to the money obtained from sale of the asset, and
3. The owner has the legal ability to make the money available for support and maintenance, and
4. The asset can be made available in less than 30 days.

Consider an asset as unavailable if:

1. The *member* lacks the ability to provide legal access to the assets, and
2. No one else can access the assets, and
3. A process has been started to get legal access to the assets.

or

When the owner or owner's representative documents that the asset will not be available for 30 days or more.

Use the criteria above to determine whether an asset was available in a backdate month unless an asset is deemed unavailable in the month of application because it will not be available for 30 or more days (considered unavailable in any or all backdate months).

Example 1: Sylvia has life insurance that she cannot convert to cash within 30 days. She has a letter from the insurance company stating when she will receive the money. It becomes available the day she receives the money. Schedule an eligibility review, for no later than the 60th day after the date of application.

16.2.2 Real Property

Non-exempt *real property* (See 16.8 Real Property) is unavailable when:

1. The person who owns the property lists it for sale with a realtor. See 16.9 Non-Home Property Exclusions.
2. A joint owner who is outside the fiscal test group refuses to sell the property.

When the member is a co-owner of the property with someone outside the fiscal group, you must determine whether s/he is a joint owner or an owner-in-common.

Joint ownership has a right of survivorship. That is, upon the death of one joint owner, the other inherits the share of the deceased. A joint owner's share may not be sold without forcing the sale of the entire property.

Ownership-in-common has no right of survivorship. An owner-in-common may bequeath his/her share of the property to anyone s/he chooses. S/he may also sell his/her share during his/her lifetime.

If an institutionalized person owns property that's unavailable because it's listed for sale, s/he can use some of her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. Do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.

Allow these minimal maintenance costs for as long as the person is making a good faith effort to sell the property at current market value.

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16.3 SEPARATE AND MIXED ASSETS

When an Medicaid group keeps an exempt asset in:

1. A separate account or an account with other exempt assets, exempt the exempt asset:
   a. Indefinitely, for example, most payments to Native Americans (15.3.14 Payments to Native Americans), **or**
   b. For as long as the exemption can be applied to the asset, for example, EITC (See 16.7.8 Earned Income Tax Credit (EITC)), which is exempt only through the month following the month of receipt.

2. An account mixed with other assets (some of which are non-exempt), exempt only the portion that is considered the exempt asset:
   a. For six months from the date the exempt asset was mixed with the non-exempt assets, **or**
   b. If the exempt asset has been prorated as income, exempt it for the period over which it is prorated.

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16.4 ACCOUNTS

16.4.1 Joint Accounts
16.4.1.1 EBD Medicaid Applicant/Member EBD co-owner
16.4.1.2 EBD Medicaid Applicant/Member Non EBD Co-Owner
16.4.1.3 Exception to Joint- Accounts policy
16.4.2 Jointly Held Real Property

16.4.1 Joint Accounts

Account means a deposit of funds with a financial institution (bank, savings and loan, credit union, insurance company, etc.).

Apply the following policy to savings, checking and share accounts, certificates of deposit, NOW accounts, and similar arrangements where the holders have equal access to the funds.

Deem amounts from joint accounts differently depending upon whether or not the account is shared with an EBD Medicaid *applicant*/*member*.

EBD Medicaid applicant/ members also include any of the Medicare Beneficiary programs *QMB*, *SLMB*, SLMB +, and *QDWI*.

SeniorCare applicant/members are not considered an EBD related applicant/member when deeming joint accounts.

16.4.1.1 EBD Medicaid Applicant/Recipient EBD co-owner

When an EBD Medicaid applicant/member shares a joint account with a co-owner who is another EBD applicant/member, deem an “equal share” to each account holder.

“Equal Share” means an amount in proportion to the number of EBD-related applicant/member account holders. If there are three holders, an equal share means each is deemed 1/3 of the account balance

16.4.1.2 EBD Medicaid Applicant/Recipient Non EBD Co-Owner

When an EBD Medicaid applicant/member shares an account with an individual or individuals who are not EBD Medicaid applicant(s)/member (s) deem the full share to the EBD Medicaid applicant/member.

Full share" means an amount equal to the account balance. The account balance is the total of the principle and any interest retained in the account, minus any withdrawal penalties or charges.

Applying the preceding policy may result in considering available to a fiscal test group more money from a joint account than is actually in that account. If that occurs, deem an equal share to each account holder who is in the fiscal test group.

Example 1: Joe is an EBD Medicaid member who shares a $4000 account with his *spouse* Connie. Joe and Connie reside together and are therefore in the same Fiscal Test Group (*FTG*). Rather than assigning $4000 from this account as Joe's asset and $4000 as Connie's asset, which would result in $8000 being counted as the fiscal test group's asset, deem an equal share to each account holder who is in the FTG so that only $4000 would be counted as the group's total asset.

16.4.1.3 Exception to Joint Accounts policy

Don't apply Joint Accounts policies (16.4.1 Joint Accounts) to the following kinds of joint accounts:

1. Accounts established for business , charitable or civic purposes.
2. Trust or restricted accounts. A trust or restricted account is one in which the person named as holder of the account has no access or limited access to the funds in it.
3. Special purpose accounts. A special purpose account has at least one holder acting as the power-of-attorney, guardian or conservator for at least one of the other holders of the account.
4. Convenience accounts. The following policy applies only to joint accounts of persons who are not married to one another:

When a person's name appears on a joint account, assume s/he is part owner of the assets in the account. Inform the member that s/he has a right to present evidence showing s/he did not deposit any assets into the account.

To show that s/he does not own or co-own any assets in the account, s/he must present all of the following:

1. A signed statement explaining:

a. Who owns the funds in the joint account.
b. The reason for establishing it.
c. Who made the deposits to the account.

2. A signed corroborating statement from the co-holder of the account.
3. A copy of the change in the account which removes his/her name or restricts his/her access.

If the co-holder is incompetent or a *minor*, obtain a statement from a knowledgeable third party. Then, decide whether to accept the person's statement. If you decide s/he is not a co-holder, apply the decision retroactively as well as prospectively. When no third party is available, document the reason.

16.4.2 Jointly Held Real Property

Apportion an equal share of any *real property* or any income derived from real property to each owner. To apportion, the equity or income must be available.

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16.5 BURIAL ASSETS

16.5.1 Burial Trusts

16.5.2 Burial Insurance
16.5.3 Life Insurance Funded Burial Contracts (LIFBC)
16.5.3.1 Irrevocable Assignment of LIFBC
16.5.3.2 Revocable Assignment of LIFBC
16.5.4 Spaces
16.5.5 Burial Funds
16.5.6 Wisconsin Funeral Trust Program
16.5.6.1 Statement of Funeral Goods & Services
16.5.6.2 Cash Advances

16.5.1 Burial Trusts

Exempt all burial trusts made in Wisconsin that are irrevocable by Wisconsin law, as noted in the trust agreement. If made in another state, exempt all that are irrevocable by the laws of that state. Refer any question about any state's law to your corporation counsel.

Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, they are a countable asset.

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. Any principal amount over $3,000 is a countable asset. (See 18.4 Spousal Impoverishment Assets for information about burial assets for persons with a *community spouse*.)

16.5.2 Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than the payment of the insured's burial expense. It is an insurance product sold by a state licensed insurance company, and is typically funded with an annuity or life insurance policy.

The following are not burial insurance policies:

1. If a policy has *cash surrender value* to which the member has access, the policy is not burial insurance it is life insurance.
2. If a burial policy calls for any excess proceeds to be paid to secondary beneficiary (other than the deceased person's estate), it is life insurance, not burial insurance.
3. Similarly, if a policy calls for the proceeds to be paid to a private party who is expected but not legally required to use the funds for the burial costs of the insured, the policy is life insurance.

The ownership of the annuity or life insurance policy is irrevocably assigned by the policyholder to a funeral expense trust established by the insurance company. The trustee or trust administrator is required to pay all trust proceeds toward the policy holder's funeral expenses at the time of the policy holder's death. If a trust's proceeds exceed burial costs, the excess must revert back to the deceased person's estate.

A burial insurance policy is unavailable if:

1. It includes language that says it is irrevocable, and
2. It states that all of the proceeds must be used for burial expenses.

The purchase of a burial insurance policy that meets the above conditions is not a divestment because the purchaser is presumed to receive fair market value.

16.5.3 Life Insurance Funded Burial Contracts (LIFBC)

A life insurance funded burial contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Death benefits which exceed the actual costs of burial expenses must be paid to the insured’s estate or the insured’s beneficiary.

A burial contract that is funded with a life insurance policy must be in writing and must contain all of the following:

1. Name of funeral home and the insurer.
2. Statement of funeral goods and services.
3. Effect of canceling or surrendering the insurance policy.
4. Effect of changing the assignment of the policy proceeds.
5. Nature and extent of any price guarantees for goods and services.

The assignment option (revocable or irrevocable) chosen by the customer impacts the determination of countable asset and/or divestment amount.

16.5.3.1 Irrevocable Assignment of LIFBC

An irrevocably assigned *LIFBC* is an unavailable asset because the member no longer owns it.

If a member has chosen irrevocable assignment of his/her LIFBC the burial space exemption (See 16.5.4 Spaces) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (See 16.5.5 Burial Funds).

If the *face value* of the burial funds portion of the contract exceeds $1,500, it offsets the burial fund exclusion described in 16.5.5.

If the face value of the burial funds portion does not exceed $1,500, determine the cash surrender value (CSV) of the LIFBC at the time that it was assigned and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in 16.5.5 Burial Funds to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by items #1 and #2 above, purchased at *fair market value*.
4. Apply divestment policy to any remaining CSV (17.13.2 Trusts).

Example 1: Mr Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (See 16.5.5 Burial Funds), and so $1,500 of this LIFBC will be considered his exempt burial fund. The $1,300 casket does not reduce the burial fund exclusion (see 16.5.5 Burial Funds and is not a countable asset because it is a purchase of a burial space.

Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 divestment (17.13.2 Trusts).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash surrender value (of the LIFBC at the time that it was assigned) and apply the divestment policy (17.13.2 Trusts). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the *divested amount*.

Example 2: Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurred, because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

16.5.3.2 Revocable Assignment of LIFBC

When a member has chosen revocable assignment of their LIFBC, use the following procedures to determine the countable asset amount.

Identify all other burial assets and life insurance policies the customer may have. Use burial fund logic (See 16.5.5 Burial Funds) to determine what portion of the LIFBC is a countable asset.

The value of the burial contract is equal to the cash surrender value (CSV) of the life insurance policy. If the face value of all life insurance policies is $1,500 or less, exempt the CSV under the life insurance exclusion.

If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion (See 16.5.5 Burial Funds), if applicable.

If one or more burial spaces are included in the statement of funeral goods and services, the burial space exclusion (See 16.5.4 Spaces) does not apply. This is because the provider has not received payment and therefore no purchase of burial space(s) has been made.

Example 3: Mrs. White has a revocably assigned LIFBC and no other burial assets or life insurance policies. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (16.5.4) does not apply to Mrs. White's contract, but $1,500 of the CSV is exempt under the burial funds exclusion (16.5.5 Burial Funds). The remaining $200 of the CSV is a countable asset.

Example 4: Mrs. White has a revocably assigned LIFBC. She additionally has a burial plot already paid for and a whole life insurance policy with a face value of $1,500 and cash surrender value (CSV) of $1,000. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (16.5.4) does not apply to Mrs. White's contract. No portion of the CSV is exempt under the burial funds exclusion (16.5.5), because the face value of her whole life insurance policy is $1,500. The burial plot is exempt, because it is paid for. The entire value of the LIFBC ($1,700) is a countable asset.

16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include the following, if they have been paid for:

1. Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons, and
2. Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques, and
3. Arrangements for opening and closing the gravesite.

Exempt multiple spaces of any value under the following conditions:

1. The space(s) must be owned by the EBD person, that person's *spouse*, or, when the EBD person is a *minor*, by the minor's parents.
2. Both a plot and a mausoleum space cannot be exempted for the same person.
3. Each person may have more than one type of space.
4. The space(s) must be for the use of the EBD member or one of the following:
    a. *Spouse*.
    b. Minor or *adult* natural, adoptive, or stepchild.
    c. Brother or sister.
    d. Natural or adoptive parent.
    e. Spouse of any of the above.

Example 5: Bob, age 12, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: #1 is for Bob, #2 and #3 are for his parents, #4 is for his older brother, who does not live at home, and #5 is for Bob's uncle. All the plots and spaces are exempt except #5.

16.5.5 Burial Funds

Burial fund exemptions apply only to EBD Medicaid fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD Medicaid members and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add:

1. The face value of the person's irrevocable burial trusts.
2. The face value of all of his/her life insurance policies whose cash value is exempt.
3. The face value of his/her exempt burial insurance (See 16.5.2 Burial Insurance).
4. The cash surrender value of revocably assigned life insurance funded burial contracts (LIFBC) (See 16.5.3.2 Revocable Assignment of LIFBC).
5. The burial funds portion of irrevocably assigned LIFBC (See 16.5.3.1 Irrevocable Assignment of LIFBC).

If the total value of above items is $1,500 or more, do not exempt any more burial funds. If the total is less than $1,500, subtract the total from $1,500. The result is the amount of his/her burial fund total that is exempt.

Example 6: Mrs. Smith, age 74, applies for EBD Medicaid. She has a $1,600 savings account designated as a burial fund, a $1,300 irrevocable burial trust, and two life insurance policies. The combined face values of the life insurance policies total $900. Add up the values of exempted assets. The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed $1,500.

$1,300 Irrevocable burial trust
+900 Face value life insurance
$2,200

The total is more than $1,500 so no portion of the burial fund (savings account) is exempt.

Example 7: This time, Mrs. Smith, in addition to her $1,600 savings account designated as a burial fund, has a $300 irrevocable burial trust and two life insurance policies with a combined face value of $900.

$ 300 Irrevocable trust
+ 900 Face value life insurance
$1,200

The total is less than $1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund.

$1,500 Maximum burial fund exclusion
- 1,200
$ 300

Mrs. Smith can exempt $300 from her savings account as a burial fund. The remaining $1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which s/he first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.

The fund set aside for burial must be identifiable, but not necessarily segregated from other funds.

16.5.6 Wisconsin Pre-Need Funeral Trust Program

The Wisconsin Funeral Trust is a single trust owned and operated by the Wisconsin Funeral Directors Association (WFDA). It was established and maintained according to the rules of the Wisconsin Department of Financial Institutions. It is available for use by all WFDA members statewide. Funds placed in the Trust will be invested in accordance with applicable state law.

WFDA has created 2 preneed funeral contracts; one is for a guaranteed price and another is for a non-guaranteed price. These contracts are available to all individuals, not just those who are or may be EBD Medicaid applicants/recipients.

The agreement by the purchaser with the funeral home constitutes a purchase, even if revocable in whole or part. The contract nearly always includes burial spaces, which are excluded assets. The contract is not:

1. An installment burial contract.
2. An insurance funded burial contract.
3. Divestment as the funds transferred are in exchange for equal amounts of goods and/or services.

In determining countable asset value:

1. Deduct first the amount identified as irrevocable under Wisconsin law.
2. Deduct next the amount equal to the value of all burial spaces purchased by the contract. Remember that "burial spaces" includes caskets and outer burial containers vaults, liners, etc.
3. Deduct any amount that can be included in the applicant's/recipient's burial fund.
4. The remainder is the countable asset.

Example 8:

Total Contract Value	=	$5,200
Amount Designated as Irrevocable	=	- $3,000
		$2,200
Value of Excluded Burial Spaces	=	- $1,300
		$900
Amount of Excluded Burial Funds*=		- 0
Countable Asset	=	**$900**

* The amount of funds that may be excluded as the $1,500 "burial fund" is reduced by any amount of cash value in his/her life insurance and the amount of irrevocable burial trust. Whenever the burial contact specifies $1,500 or more as irrevocable, no funds can be excluded as "burial fund."

Example 9:

Total Contract Value	=	$4,200

Amount Designated as Irrevocable	=	- $1,300
		$2,900
Value of Excluded Burial Spaces	=	- $1,300
		$1,600
Amount of Excluded Burial Funds*	=	- 200**
Countable Asset	=	**$1,400**

**This example assumes that the person has not identified another insurance or irrevocable burial funds toward his/her "burial fund". $1,500 maximum burial fund allowance, less the $1,300 this contract makes irrevocable, leaves room for an additional $200 to be allocated to the "burial fund". Note that in example 1, the purchaser was able to achieve a higher exemption.

16.5.6.1 Statement of Funeral Goods & Services

The US Federal Trade Commission (FTC) requires funeral directors nationwide to use a "Statement of Funeral Goods and Services" as a way of indicating to their customers what is being purchased and their charges. This form looks a great deal like the first page of the WFDA preneed funeral contract. WFDA has advised their members to complete and provide to the family a copy of the Statement of Funeral Goods and Service along with the preneed funeral contact as a service to their customers and in compliance with FTC rules.

16.5.6.2 Cash Advances

On both the WFDA preneed funeral contract and the FTC's Statement of Funeral Goods and Services is an area called "Cash Advance Items". These are expenses for services and goods not provided by the funeral home but often related to the funeral.

Usually, the funeral home asks the purchaser/family to reimburse it dollar-for-dollar equal to what was advanced. A funeral home can, however, charge additional sums for their service in making cash advances on behalf of the deceased's family. For example, a funeral home may advance a $175.00 payment for an obituary charge to the local newspaper; when billing the family, the funeral home adds a $20.00 service fee for a total of $195.00. By FTC rule, whenever the funeral home bills for more than the actual amount of the cash advance, it must identify this to the purchaser/family with a standard phrase added to the Statement of Funeral Goods and Services; the phrase is "We charge you for our services in obtaining...". This phrase appears on the WFDA preneed agreement and comes into effect whenever the small box to the left of each line under "Cash Advance Item" is marked.

Amounts identified on a preneed agreement under "Cash Advances Items" are not disregarded and are part of the "Total Contract Value" in the asset

calculations (see the formula above) for EBD Medicaid . This is true whether there is an additional charge on the cash advance item or not.

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16.6 NON-BURIAL TRUSTS

16.6.1 Non-Burial Trusts Introduction
16.6.2 Trust Principal
16.6.3 Revocable Trusts
16.6.4 Irrevocable Trusts
    16.6.4.1 Trust Established with resources of a third party
    16.6.4.2 Trust established with resources of the Individual or Spouse
16.6.5 Special Needs Trust
16.6.6 Pooled Trusts
16.6.7 Ho-Chunk Tribal Trusts

16.6.1 Non-Burial Trusts Introduction

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or

administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term ”r;trust” includes any legal instrument or device or arrangement, which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The EBD Medicaid *member*,
2. His/her *spouse*,
3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or the member’s spouse. This includes a power of attorney or a guardian, **or**
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member’s spouse. This includes relatives, friends, volunteers or authorized representatives.

If the principal of a trust includes assets of the *applicant*/recipient or spouse, and the assets of any other person or persons, apply the policies in 16.6.3 Revocable Trusts and 16.6.4 Irrevocable Trusts to the portion of the trust attributable to the assets of the applicant/recipient or spouse.

16.6.2 Trust Principal

The trust principal is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

16.6.3 Revocable Trusts

A *revocable trust* is a trust which can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

The trust principal of a revocable trust is an available asset.

16.6.4 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

16.6.4.1 Trust Established With Resources of a Third Party

If the resources of someone other than the individual or their spouse (i.e. a third party),were used to form the principal of an irrevocable trust, the trust principal is

not an available asset unless the terms of the trust permit the individual to require that the trustee distribute principal or income to him or her.

16.6.4.2 Trust Established With Resources of the Individual or Spouse

If the resources of the individual or the individual's spouse were used to form all or part of the principal of the trust, some or all of the trust principal and income may be considered a non-exempt asset, available to the individual. If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual at any time no matter how distant, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered non-exempt assets, available to the individual.

This treatment applies regardless of:

- the purpose for which a trust is established;
- whether the trustees have or exercise any discretion under the trust;
- any restrictions on when or whether distributions may be made from the trust; **or**,
- any restrictions on the use of distributions from the trust.

Example 1: Doug is a 65 year old Medicaid applicant. Several years ago, Doug transferred his life savings of $60,000 to an irrevocable trust, naming himself as the beneficiary. Doug's brother, Jim was appointed as the trustee. Under the terms of the trust, Jim could disburse up to $10,000 annually, from either trust principal or trust income, either directly to Doug or indirectly to provide some benefit for Doug. The trustee had sole discretion as to when and how these trust disbursements would be made, but under no circumstance could they exceed $10,000 in a 12 month period. Because the entire *corpus* (principal of the fund) could eventually be distributed, $60,000 would be considered an available non-exempt asset for Doug's Medicaid eligibility determination, even if the trustee decides not to make any actual disbursements.

Example 2: Al is a 65 year old Medicaid applicant. Six years ago, Al sold his farm for $300,000 and put the entire proceeds from the sale into an irrevocable trust, naming himself as the beneficiary. Al's friend, Scott was appointed as the trustee. Under the terms of the trust, Scott could disburse any amount of trust principal or trust income, at any time, either directly to Al or indirectly to provide some benefit for Al. The trustee had sole discretion as to when and how disbursements would be made as well as the amount that could be disbursed. Therefore $300,000 would be considered an available non-exempt asset for Al's Medicaid eligibility determination, even if the trustee never makes an actual disbursement.

Example 3: Dave is a 65 year old Medicaid applicant who won a $250,000

lottery several years ago and put the entire amount into an irrevocable trust, naming himself as the beneficiary. Dave appointed his brother Don as the trustee. Under the terms of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed.

The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4: In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution.

The half of the generated income that is paid to Don would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note: If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (See 17.13 Trusts) and (17.13.4 Exceptions).

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts described in chapters 16.6.5 Special Needs Trust and 16.6.6 Pooled Trusts . The policies described above also do not apply to irrevocable trusts created by a will, unless the terms of the trust permit the individual/beneficiary to require that the trustee distribute principal or income to him or her.

16.6.5 Special Needs Trust

Disregard special needs trusts whose sole beneficiary is under age 65 and totally and permanently disabled (under SSI program rules) if it meets these conditions:

1. The trust must be established for the sole benefit of the disabled person by his/her parent, grandparent, legal guardian or a court, and
2. Contain a provision that, upon the death of the beneficiary, the Wisconsin Medicaid program will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

The exception continues after the person turns 65, provided s/he continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

16.6.6 Pooled Trusts

Disregard pooled trusts for disabled persons managed by:

1. WISH Pooled Trust
2. WisPACT Trust I

Note: Contact the CARES CALL Center for instructions on treating any other pooled trusts.

The WISH Pooled Trust and the WisPACT Trust I must meet the following conditions:

1. Are established and managed by a non-profit association. The pooled trust can contain funds that hold accounts funded by third parties for the benefit of the disabled person's own assets or income.
2. Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a *disability* .
3. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court. If the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/recipient.
4. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.

    - This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid MA program after subtracting a reasonable amount for administrative costs.
    - This requirement can also be satisfied when the pooled trust account includes *real property*, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid MA recipient who is disabled (as established under SSI rules) or *elderly* (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid recipient.

<u>Note</u>: The assets that have been placed in a potential pooled trust pending a disability determination are unavailable assets until the disability determination

has been made. If the individual has been determined disabled by DDB, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.

16.6.7 Ho-Chunk Tribal Trusts

The Ho-Chunk Tribe, under it's tribal ordinances and in conjunction with the Indian Gaming Regulatory Act establishes irrevocable trusts for tribal members who are minors or determined to be legally incompetent. These irrevocable trusts are funded primarily with per capita distribution payments derived from gaming revenue. The Department of Health Services has determined that funds placed in these trusts, for the benefit of minors and individuals who are legally incompetent are considered to be owned by the Ho-Chunk Tribe and not the trust beneficiary. Therefore, the irrevocable Ho-Chunk Tribal Trusts established for minors or legally incompetent tribal members are considered to be unavailable assets for the tribal member's Medicaid eligibility determination.

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16.7.1 Personal Property

16.7.1.1 Household Goods

Do not count household goods as an asset.

Household goods include:

1. Items of personal property, found in or near the home, that are used on a regular basis; **and**
2. Items needed by the household for maintenance, use and occupancy of the premises as a home.

Examples of household goods include but are not limited to:

1. Furniture,
2. Appliances,
3. Electronic equipment such as personal computers and television sets,
4. Carpets,
5. Cooking and eating utensils, **and**
6. Dishes.

Note: Items that are acquired or held because of their value or as an investment are not considered household goods (see 16.7.1.3 Other Personal Property).

16.7.1.2 Personal Effects

Do not count personal effects as an asset.

Personal effects are:
1. Items of personal property originally worn or carried by the individual, **or**
2. Articles otherwise having an intimate relation to the individual.

Examples of personal effects include but are not limited to:
1. Personal jewelry including wedding and engagement rings,
2. Personal care items,
3. educational or recreational items such as books or musical instruments,
4. Items of cultural or religious significance to an individual, such as ceremonial attire, **or**
5. Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs.

Note: Items that are acquired or held because of their value or as an investment are not considered personal effects.

16.7.1.3 Other Personal Property

Personal property that an individual acquires or holds because of its value or as an investment:
1. Is a countable resource (asset); **and**
2. Is not considered to be a household good or personal effect.

Other personal property items include, but are not limited to:
1. Gems acquired or held because of their value or as an investment,
2. Jewelry that is not worn or held for family significance, and
3. Collectibles acquired or held because of their value or as an investment.

Example 1: Mr. Hollenback received $10,000 from an insurance settlement. Mr. Hollenback paid back creditors with $7,000 and purchased $3,000 in jewelry. Mr. Hollenback does not wear the jewelry. The IM workers must determine whether the jewelry is excluded from resources as a personal effect

or is a countable resource in the form of other personal property. Mr. Hollenback's statements establish that the jewelry has no family significance and that he purchased the jewelry for its value as a means to spend down the $10,000. The IM workers correctly determines that the jewelry is not an excludable personal effect because an item purchased for its value cannot be a personal effect.

The IM worker correctly determines the jewelry as a countable asset.

16.7.2 Loans

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.

If an AG member makes a loan (except a land contract), treat the repayments as follows:

1. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.
2. Count any interest payment on the loan as unearned income in the month received, and as an asset in the months following the month it was received.

16.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, which is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died, or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month received and thereafter. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

16.7.3 HUD Payments

Disregard reimbursements resulting from federal regulatory changes in computing U.S. Department of Housing and Urban Development (HUD) housing rent as income in the month paid and assets in the next month.

16.7.4 Annuities

An annuity is a written contract under which, in return for payment of a premium or premiums, an individual will receive a series of payments at regular intervals for a specified time period.

The annuitant is the person entitled to the payments. A purchaser can name himself/herself or another person as the annuitant. The purchaser may also name a beneficiary to receive annuity payments after the annuitant's death.

16.7.4.1 Annuities Purchased After March 1, 2004

(For annuities purchased before March 1, 2004 refer to subsection 16.7.4.2) Treat Annuities purchased after March 1, 2004 as available assets in accordance with the following:

16.7.4.1.1 Annuities That Can Be Surrendered:

If the annuity's cash value is available for withdrawal (minus any penalty) the annuity can be "surrendered."

To determine the value of annuities that can be surrendered (for example, an annuity in the accumulation phase), use the following formula:

1. Total deposits made to the annuity.

Plus

2. Earnings on the deposits not previously paid out.

Minus

3. Withdrawals and surrender costs charged for withdrawal.

Equals

4. Annuity's value

16.7.4.1.2 Annuities That Cannot Be Surrendered (this subsection effective 03-01-09)

It has been established that a market exists for annuities that cannot be surrendered. Some companies have purchased such annuities. Check the annuity contract to see if it can be sold. If it is capable of being sold, consider it to be an available asset unless the *applicant* or recipient demonstrates that s/he has made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.

If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity, that amount will be considered an available asset.

The annuity will be considered to be an unavailable asset if documentation is provided from the company stating that it places no value on the annuity. Payments from an annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must

also be evaluated for possible divestment, in accordance with 17.11 Annuities.

Example 2: Cynthia is 83 years old and applying for Medicaid. She owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferable. The agency has the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia's annuity contract at $82,000. Cynthia's annuity is therefore considered to be an available asset with a value of $82,000 which is the amount used to determine Cynthia's Medicaid eligibility.

Example 3: Sam is 66 years old and applying for Medicaid. He owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility.

16.7.4.2 Annuities Purchased before March 1, 2004

Annuities that can be surrendered (In the accumulation phase)
The accumulation phase of an annuity is the period when the purchaser puts money into the annuity. During the accumulation phase, an annuity is an available asset because the annuitant can cash it in for its cash value.

Cash value (also known as surrender value) equals:

1. Total deposits made to the annuity.
   +
2. Earnings on the deposits not previously paid out.
   -
3. Withdrawals and surrender costs charged for withdrawal.

In determining the cash value, do not deduct income tax withheld or tax penalties for early withdrawal.

Annuities in the Pay-Out Phase (can not be surrendered)
The pay-out (annuitization) phase begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It

involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

An annuity becomes an unavailable asset on the date the settlement option is made final. This means even if the payment starts months later, it is unavailable on the date the settlement option is made final.

16.7.5 Life Insurance

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. 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 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.

Life insurance policies always have a face value, but do not always have a cash value. Term life insurance is limited to a defined time period as stated in the policy and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value. An endowment insurance plan generally has cash value.

Note: In calendar year 2000, some VA Term Life Insurance Policies were assigned a cash value. The Department of Veteran's Affairs put into effect a regulation to provide paid-up life insurance on term policies. When the veteran chooses this option to purchase paid-up insurance with their term insurance, the policy at that point has a *cash surrender value*. The cash value amount is a countable asset.

16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees

A Continuing Care Retirement Community (CCRC) or Life Care Community (LCC) typically provides a variety of living arrangements, from independent living through skilled nursing care. Potential residents frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Effective January 1, 2009, entrance fees paid by an individual to a CCRC or LCC are counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when **all** of the following conditions apply:

1. The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care. It

is not necessary for the CCRC or LCC to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met,

2. The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community. It is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies, **and**
3. The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community. An ownership interest generally means the right to possess and convey property, but recognize that it might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not they have an ownership interest in the CCRC or LCC by presenting documentation from the facility to that effect. If the CCRC or LCC confirms that the entrance fee does not confer an ownership interest to the resident, then this third condition is met.

Entrance fees which meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the *elderly*, blind, and disabled, regardless of whether or not the individual is requesting long term care services. An entrance fee which does not meet all three conditions described above is an unavailable asset.

For Medicaid eligibility determinations, all normal *spousal impoverishment* rules regarding income and asset allocations for a *community spouse* are applicable to married couples who reside in a CCRC or LCC, when one spouse resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in a more independent living setting. CCRC and LCC contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse, before determining the amount of resources that a resident must spend on his or her own care.

This provision must be applied to all Medicaid applications and eligibility reviews that occur on or after January 1, 2009, regardless of when the entrance fee was actually paid.

16.7.7 Income Tax Refunds

Federal and state income tax refunds are available assets.

16.7.8 Earned Income Tax Credit (EITC)

Disregard all Earned Income Tax Credit (EITC) in the month received and for 9 months following the month of receipt.

After the 9 month disregard period has passed, count any remaining EITC payments as available, non-exempt assets.

16.7.9 Vehicles (Automobiles)

Vehicle or automobile means any registered or unregistered vehicle used for transportation. Vehicles used for transportation include but are not limited to cars, trucks, motorcycles, boats, snowmobiles. A temporarily broken down vehicle used for transportation meets the definition of an automobile.

16.7.9.1 Determining Equity Value

Equity value is:

1. The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book), or the value as estimated by a sales representative at a local dealership,
2. Minus any encumbrances (loans or mortgages) that are recorded on the vehicle’s title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the fiscal test group, others not. To find what the fiscal test group’s equity value in the vehicle is, do the following:

1. Find the vehicle’s wholesale value.
2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle’s title. The result is the equity value.
3. Divide the equity value by the total number of owners.
4. Add up the prorated equity values of the owners who are in the fiscal test group. The result is the fiscal test group’s equity value in the vehicle.

16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

1. One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. Assume the automobile is used for transportation, absent evidence to the contrary.

2. When an individual owns more than one automobile apply the exclusion as follows:

    a. Apply the exclusion in the manner most advantageous to the individual.
    b. Apply the total exclusion to the automobile with the greatest equity value if the eligible individual/couple own more than one automobile used for transportation of the eligible individual/couple or a member of the individual's/couple's household.
    c. The equity value of any automobile, other than the one wholly excluded is a resource when it:
        - Is owned by an eligible individual/couple; **and**
        - Cannot be excluded under another provision (e.g. property essential to self-support, plan to achieve self-support.)

Do not apply the vehicle exclusion to the following vehicles:

a. A vehicle that has been junked;
b. A vehicle that is used only as a recreational vehicle (e.g., a boat used for pleasure).

The equity value of such a vehicle is a resource.

3. When an individual owns two or more automobiles, apply the following rules:
    a. If only one automobile is used for transportation, totally exclude the value of that automobile.
    b. If more than one automobile is used for transportation, totally exclude the automobile with the greatest equity value.

For any automobile that cannot be excluded for transportation reasons, consider excluding it under the provisions for property essential to self-support, plan to achieve self support. If the automobile does not qualify for the exclusion, count the equity value of the automobile as a resource.

4. If an individual who owns an automobile that is temporarily inoperable (e.g., needs repairs) and states that the automobile will be repaired and used for transportation within the next twelve calendar months, exclude the total value of the automobile.

If an individual states that the vehicle will not be repaired and used for transportation in the next 12 calendar months, count the equity value of the automobile as a resource.

16.7.10 Property Settlement

Money received as a property settlement is always an asset regardless of whether it is paid in one payment or in installments. It is never income.

16.7.11 Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, sale of property, Railroad Retirement, Unemployment Compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

16.7.11.1 Retroactive SS Payments

The unspent portion of retroactive *SSI* and Retirement Survivors *Disability* Insurance (RSD)I benefits received on or after March 2, 2004 is excluded from resources for the nine calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or nine months following the month the payment is received. A retroactive payment means it is paid later than the month in which it is due. After nine months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received before March 2, 2004 is excluded from resources for the six calendar months following the month in which the individual received the benefits.

16.7.12 Land Contract

When a land contract is executed, the purchaser builds equity in the property through the payments s/he makes. The seller keeps legal title to the property until it is paid for. The seller's interest in the land contract is personal property, not real property.

The seller's legal title to the property can be sold and converted to cash for support and maintenance. To determine the value of the seller's legal interest in the land contract:

1. Find the original sale price or the *fair market value* (as determined by a qualified real estate appraiser). Of these two amounts choose the one which more accurately reflects the contract's true value on the date it was originated.
2. From this amount subtract:
    a. Payments which the purchaser has already made on the principal.

Example 5: The fair market value of the land contract is $50,000. The purchaser has already paid $10,000 on the principal.

$ 50,000	Fair Market Value
-10,000	Already Paid
$ 40,000	Outstanding Balance

b. Encumbrances on the contract, for example, a personal loan.
c. The amount lost to a discount.

Example 6: Milton Rokeach wants to buy up Mr. Graham's land contract. He asks for a 10% discount.

$40,000	Outstanding Balance
- 4,000	10% Discount Given by Mr. Graham to Milton Rokeach
$36,0000	Value of Mr. Graham's Interest in the Land Contract

3. The remainder, after subtracting a., b., and c. from the original sale price, is the value of the seller's interest in the land contract. Count this as an available asset.

If the land contract is not an available asset, the person must document its unavailability by showing that either:

a. The terms of the land contract prohibit its sale, **or**
b. No one is willing to purchase it from him/her

When the claim is that no one will purchase the land contract, it must be offered for sale to at least one individual or organization active in the land con-tract purchasing market. A written statement from the individual or organization that they will not buy it is sufficient to establish the land contract as an unavailable asset.

Notice that if it has been offered only to an individual or organization that never purchases land contracts, it remains an available asset.

16.7.13 Mortgage

Treat any mortgage held by and owed to a member the same as a land contract.

16.7.14 Wisconsin Higher Education Bonds

The State of Wisconsin sells Wisconsin Higher Education Bonds to the public as a way to save for higher education. To determine their net value, subtract broker's fees from market value.

The bonds may be sold back to the State, under certain time restraints:

1. Before the maturity date, a portion of their value is withheld. The amount withheld equals the school's tuition and fees. Any excess goes to the person.
2. On or after the maturity date, the value is the total amount received.

The bonds may be sold on the "secondary" bond market at any time. Since they can be disposed of on the market with no time limit they are an available asset. To determine their net value, subtract broker's fees from market value. (Verify the amounts through a broker.)

16.7.15 Wartime Relocation of citizens

Disregard restitution paid under PL 100-383 to Japanese-Americans and Aleuts or their survivors who were interned or relocated during World War II.

16.7.16 Agent Orange Settlement Fund

Disregard payment received from the Agent Orange Settlement Fund or any other fund established in settling ”r;In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)”. Disregard as income in the month received and as an asset thereafter.

16.7.17 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death resulting from exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000).

When the affected person is dead, payment is made to his/her surviving *spouse*, children, parents, or grandparents. The federal Department of Justice reviews the claims and makes the payments.

Apply this disregard retroactively to October 15, 1990 and continue to disregard the payment for as long as it is identified separately.

16.7.18 Institutionalized Person’s Assets

An institutionalized person 's personal allowance may accumulate to where s/he may lose eligibility due to excess assets. To prevent this, s/he can spend money on personal needs or make a refund to Medicaid. The refund should be paid to the IM agency. If s/he chooses to make a refund , calculate what a year's accumulation will be and work out a payment schedule. When the payments equal Medicaid benefits received, have the person stop the payments until s/he receives more benefits.

If the person refuses to refund, discontinue eligibility when the asset limit is exceeded. S/he remains ineligible until the assets are again at or below the limit. At that point s/he may reapply.

These instructions apply to all institutionalized Medicaid recipients, whether certified by your agency or by the Social Security Administration.

16.7.19 Blind/Disabled Set-Aside

Disregard the following for a blind or disabled person:

1. Assets essential to the continuing operation of her/his trade or business.
2. Other income-producing property.
3. Assets set aside to carry out an approved self-support plan (See 15.7.2.2 Self-Support Plan). The set-aside must be segregated from other funds. Disregard interest that accumulates, provided the set-aside does not exceed the provisions of the plan.

16.7.20 Replacing and Repairing Exempt Assets

Vehicles and homes are examples of exempt assets. If an exempt asset is lost, stolen, or damaged, disregard any cash (and interest earned) or in-kind replacement received from any source to repair or replace it.

The cash or in-kind payment must be used within nine months of the date it is received. After the end of the ninth month, count as an asset leftover cash not used for the repairs or replacement.

Extend the nine-month period for up to another nine months if the person has good cause for not repairing or replacing the thing. Good cause means circumstances beyond the person's control to prevent repair or replacement. This includes not being able to contract it out. When there is good cause, count as an asset any amount not used for repairs or replacement. Begin with the month after the end of the extension.

If, during a good cause extension, the person no longer intends to replace or repair the exempt asset, count the amount for replacement or repair as an asset. Begin with the month the person reports his/her change of intent.

16.7.21 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends (e.g. pension disability or retirement plans administered by an employer or union).

Other examples of retirement funds include accounts owned by the individual, such as Individual Retirement Accounts (IRA) and plans for self-employed individuals, sometimes referred to as KEOGH plans.

1. Employment related pension plans should be treated as follows.
   a. If an applicant/recipient has the ability to cash in a work related benefit, the net amount of the benefit (after any penalties but before any tax withholding) available to the applicant/recipient should be treated as an available asset. Some retirement benefit plans allow employees to cash in their benefits as a lump sum payment when they leave their job instead of waiting until they reach retirement age to get the pension. However, do not count retirement funds as an available asset if the applicant/recipient has to quit a job to get at the retirement funds, or if the applicant/recipient is receiving periodic payments from the retirement benefit plan.
   b. If the applicant/recipient does not have access to the account's principal in his/her retirement benefit plan, the principal should be treated as an unavailable asset.
   c. Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

2. Individually owned retirement funds, such as IRA's Keogh plans, etc., that are owned by the applicant/ recipient should be counted as available non-exempt assets (minus any early withdrawal penalty) for the Medicaid applicant/recipient. The applicant/recipient always has access to the principal in these accounts, subject to an early withdrawal penalty.

   Any periodic payments from these accounts should not be counted as income in the months of receipt. These payments are considered assets. They are considered the same as withdrawals from an applicant's saving account. Only interest earned on the funds in a retirement fund is to be counted as income (15.4.9.1 EBD Interest/Dividend Income).

3. Disregard work-related retirement benefit plans or individually owned retirement accounts, such as IRAs or Keoghs, of an ineligible spouse in an EBD case. This policy includes the disregard of retirement funds held by the community spouse in spousal impoverishment cases.

   Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 7: Mike withdraws $2,000 he has in an IRA, and deposits it into a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.

16.7.22 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is income in the month of receipt. It is an asset in the months after the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less, for each assistance group member, for each calendar quarter.

16.7.23 U.S. Savings Bonds

Count the cash value of a U.S. Savings Bond unless it is unavailable. A bond is unavailable only if the Medicaid group proves it tried to cash the bond and was refused.

16.7.24 Make Work Pay

Disregard Make Work Pay payments as income and disregard them as an asset for the month of receipt and 2 months following the month of receipt.

16.7.25 Indian Judgment Fund Purchases

Disregard assets purchased with Indian judgment funds (See 15.3.14 Payments to Native Americans, #10). But do not disregard:

1. Proceeds from the sale of these initial purchases.
2. Subsequent purchases made with the proceeds from the sale of these initial purchases.

16.7.26 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

16.7.27 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

16.7.28 Uniform Gifts to Minors Act

Do not count funds held in an account for the benefit of a *minor* that are the result of transfers under the Uniform Gifts to Minors Act. This act is also called the

Uniform Transfers to Minors Act. There is no asset test for minors for EBD eligibility determinations.

16.7.29 Individual Development Accounts (IDA) Programs

Individual Development Accounts (IDA) are restricted accounts owned by low-income people. The IDA program provides matching funds for buying a home, starting a business, or post-secondary education. Member savings and interest are a countable asset if the IDA was established using the Assets for Independence Act or Refugee Assistance Act funds. However, if W-2 or Community Reinvestment funds support the IDA program, the assets are exempt.

16.7.30 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime. These payments are an excluded resource for 9 months following the month of recipient.

16.7.31 The American Recovery and Reinvestment Act (ARRA) of 2009

Do not count the one-time $250 payment under the ARRA as an asset either in the month of receipt or nine months following the month the payment is received.

16.7.32 First Time Home Buyer’s Tax Credit

Count the First Time Home Buyer's Tax Credit payments as unearned income in the month of receipt. Any amount that is retained is counted as a non-exempt asset starting with the month following the month of receipt.

16.7.33 Special Tax Credit for Certain Government Retirees

Disregard the Special Tax Credit for Certain Government Retirees as an asset for the month of receipt and 2 months following the month of receipt.

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16.8 REAL PROPERTY

16.8.1 Home/Homestead Property
- 16.8.1.1 Multiunit Dwelling
- 16.8.1.2 Non-Motorized Trailer Homes
- 16.8.1.3 Exempt Home Property
- 16.8.1.4 Home Equity over $750,000.00
- 16.8.1.5 Sale of Home Property
- 16.8.1.6 Life Estate

Real property means land and most things attached to the land, such as buildings and vegetation.

16.8.1 Home/Homestead Property

A home is a place of abode and lands used or operated in connection with it. In urban situations the home usually consists of a house and lot. A home can consist of a house and more than one lot. As long as the lots adjoin one another, they are considered part of the home.

Homestead property may have more than one building or house on it. This applies to urban home owners as well as farm families. In farm situations the home consists of the house and buildings together with the total acreage property upon which they are located that is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the home.

Land should be considered part of the home property if it is not completely separated from the home property by land in which neither the individual nor his/her *spouse* has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

If land is completely separated from the home property by land in which neither the individual nor his/her spouse has ownership interest it should not be considered part of the homestead property.

16.8.1.1 Multi-unit Dwelling

When a Medicaid fiscal group *member* lives in one unit of a multi-unit dwelling and owns all of the units, exempt all of the units and the property they are on. Consider the whole multi-unit dwelling as the group member's home.

16.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered *real property*, regardless of whether or not the member owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (16.8.1 Home/ Homestead Property) if the member currently lives in it or had lived in it before entering an institution, **or**

If the member owns the land that the non-motorized home is sitting on, consider it and any other buildings on that land as part of the homestead.

2. Non-home property if the member does not live in it or had not lived in it prior to entering an institution.

If the non-motorized trailer home is listed for sale, it is considered unavailable (See 16.2 Assets Availability).

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (See 17.2.3.1 Homestead Property).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while s/he continues to reside there.

Institutionalized Person. When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His/her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.
2. The institutionalized person expresses his/her intent to return to the home. If s/he is able to form an intent but unable to express it, determine his/her intent through other available evidence. Other evidence includes:
   a. His/her written statements.
   b. His/her oral statements made before incapacitation. Accept reports of these statements made by family members.
   c. Accept reports of his/her intent made by an *authorized representative*. If there is no evidence s/he disagrees with the statement, accept the authorized representative's statement.

   If s/he appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his/her intent.

   If s/he has been judged incompetent, accept the intent statement of his/her guardian. Use the guardian's intent statement even if it differs from the member's.

   If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

16.8.1.4 Home Equity over $750,000.00

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e. Institutional, Community Waivers, Family Care, Partnership or PACE) are not eligible for LTC services if the equity interest in their home is greater than $750,000. S/he is still eligible for card services if all other eligibility requirements are met.

This restriction does not apply if a spouse, *minor* or disabled child resides in the home.

The $750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an "undue hardship" for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines outlined in 17.17 Undue Hardship.

The equity value of a home is the current *fair market value* (*FMV*) minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant*/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 1: Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of $760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob's health deteriorates and he applies for a Community Waiver program. That application is denied because Bob's equity interest in his home exceeds the LTC eligibility limit by $10,000.

On December 15, 2009 Bob reapplies for a Community Waiver program and reports that on December 1, 2009, he took out a $12,000 home equity loan and used the entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob's December 15, 2009 application for Community Waivers is approved because Bob's equity interest in his home is now $748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 2: Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of $1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the $750,000 LTC eligibility limit, his wife resides in the home, which negates the $750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e. nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals who are current recipients of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC recipient who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the $750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

16.8.1.5 Sale of Home Property

Money from the sale of real property is an asset. When the property that is sold is a homestead, disregarded the proceeds if they are placed in an escrow account and used to purchase another home within three months.

16.8.1.6 Life Estate

A life estate allows an individual to gift a home or other possession but retain certain property rights for his/her lifetime. Generally a life estate provides an individual the right to possess and use a gifted property, and to make money from it. The person does not have the title to or the right to sell the property. S/he usually may not pass it on to his/her heirs as an inheritance. S/he also has the right to sell his/her interest in it. S/he is liable for all costs of the property such as taxes and repairs, unless the will (or *deed*) states otherwise.

When property is conveyed to one person for life (life estate holder) and to another person (the remainder man), both a life estate interest and remainder interest are created. When the life estate holder dies, the remainder man holds full and unconditional title to the property and can dispose of it as s/he wishes (fee simple). Life estate values need to be determined for divestment calculation.

Example 1: Sidney gifted away his $100,000.00 home to his nephew Frank, but retained a $30,000.00 life estate, the *divested amount* is $70,000.00.

The life estate interest is an unavailable asset when determining Medicaid asset eligibility for Sidney. However, the remainder interest is an available non-exempt asset for Frank, the remainder person, for Medicaid eligibility determinations.

Determine the value of the remainder interest for the date you are determining Medicaid eligibility. To do this use the age of the life estate holder on the date that you are determining eligibility for the remainder person. Also use the property's FMV as of that same date. Then select the remainder multiplier (the one that corresponds to the age of the life estate holder) from the life estate table and multiply the FMV by that number. The result should be the value of the property's remainder interest for the remainder person as of the date that eligibility for Medicaid is being determined for that person.

To determine the value of a life estate or remainder interest:

1. In the Life Estate and Remainder Interest Table (See 39.1 Life Estate and Remainder Interest) find the line for the person's age as of the transaction date.
2. Multiply the figure on that line in the Life Estate or Remainder column times the fair market value to determine the value of the life estate or remainder interest.

When a life estate holder moves off the property and the property is rented, follow the instructions in 15.5.3 Rental Income for counting the rental income.

If a remainder person sells the property for which a life estate is retained, the life estate holder is not entitled to any of the payments.

However, if the life estate holder gives up his/her life estate to secure the sale of the property, then the life estate holder would be entitled to some portion of the proceeds from the sale of the property. Treat money received as a result of property settlement as an asset (16.7.10 Property Settlement).

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16.9 NON-HOME PROPERTY EXCLUSIONS

Non-home property is any countable asset other than a *homestead*. See 17.4 Exceptions for divestment. Exclusions of non-home property in EBD cases include:

1. *Real property* that is listed for sale with a realtor at a price consistent with its *fair market value*.
2. Property excluded regardless of value or rate of return. Property used in a trade or business is in this category. See 15.6.3.1 Business Assets.
3. Property excluded up to $6,000, regardless of rate of return. This category includes non-business property used to produce goods or services essential to self-support. Any portion of the property's equity value in excess of $6,000 is not excluded.

   Non-business property essential to self-support can be real or personal property. It produces goods or services essential to self-support when it is used, for example, to grow produce or livestock solely for personal consumption, or to perform activities essential to the production of food solely for home consumption.

4. Property excluded up to $6,000 if it is non-business property that produces a net annual income (either cash or in-kind income) of at least 6%.

If the excluded portion produces less than a 6% return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a 6% return, continue to consider the first $6,000 in equity as excluded.

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16.10 INDIAN LANDS

Exclude a Native American's interest in or possession of land which is held by an individual Native American or tribe, and which can only be disposed of with the approval of other individuals, the tribe, or the Federal government.

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17 DIVESTMENT

17.1 DIVESTMENT INTRODUCTION

Divestment can affect the eligibility for Long Term Care Medicaid. If it is determined that divestment occurred some time in the past, the *applicant* or recipient may be found ineligible for Long Term Care Medicaid for a period of time. Divestment does not affect eligibility for Medicaid card services.

Note: Effective 10/1/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a Medicaid case for a child.

The definitions and general rules found in sections 17.2- 17.5 apply to all divestments. The special situations in 17.6 - 17.13, while falling under the same definitions and general rules, require extra treatment because of their complexity.

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17.2 DIVESTMENT DEFINITIONS

17.2.1 Divestment
17.2.2 Transfer
    17.2.2.1 Date of Transfer
17.2.3 Nonexempt Assets
    17.2.3.1 Homestead Property
17.2.4 Institutionalized Person
17.2.5 Community Spouse
17.2.6 Fair Market Value
17.2.7 Divested Amount
17.2.8 Net Market Value
17.2.9 Value Received
17.2.10 Unavailability

17.2.1 Divestment

"Divestment" is the transfer of income, non-exempt assets, and *homestead* property (See 17.2.3.1 Homestead Property), which belong to an institutionalized person or his/her *spouse* or both:

1. For less than the *fair market value* of the income or asset by:
    a. An institutionalized person, or
    b. His/her spouse, or
    c. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse, or
    d. A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the

person's spouse. This includes relatives, friends, volunteers, and authorized representatives.

2. It is also divestment if a person takes an action to avoid receiving income or assets s/he is entitled to. Actions which would cause income or assets not to be received include:
    a. Irrevocably waiving pension income.
    b. Disclaiming an inheritance.
    c. Not accepting or accessing injury settlements.
    d. Diverting tort settlements into a trust or similar device.
    e. Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.
    f. Refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate. Count the action as a divestment only if:
        - The value of the abandoned portion is clearly identified, and
        - There is certainty that a legal claim action will be successful.

This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of his/her spouse's estate. If the institutionalized person does not contest his/her spouse's will in this instance, the inaction may be divestment.

3. The purchase of certain types of assets, even at the fair market value, may be considered a divestment, including :
    a. The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser resides in the home for a period of at least 12 consecutive months after the date of purchase. See 17.10.3
    b. The purchase of a promissory note, loan or mortgage, on or after January 1, 2009 is a divestment unless such note, loan or mortgage meets several criteria. See 17.12.2
    c. The purchase of certain annuities may be considered a divestment. See 17.11.2

17.2.2 Transfer

"Transfer" is the act of changing the legal title or other right of ownership to another person. Converting an asset from one form to another is not divestment. For example, buying a race horse for $12,000 and keeping the race horse is not divestment.

17.2.2.1 Date of Transfer

If the Medicaid *member* has transferred *real property* , such as a homestead, the official date of transfer is the date the Quit Claim *Deed* was signed. It is not the date the transfer was recorded with the county Register of Deeds.

Example 1: When Mrs. Puzo entered a nursing home and applied for Medicaid on September 15, 1997, she indicated that she had divested her homestead to a nephew. When questioned about the date, she said it was about three years ago. The IM worker called the county Register of Deeds. She learned that the transfer was recorded on September 1, 1994. This was within the 36 month lookback period. Fearing that Mrs. Puzo might be subject to a divestment penalty, the IM worker asked when the Quit Claim Deed was signed. It was signed August 1, 1994, which was before the 36-month lookback period began. Therefore, Mrs. Puzo was not subject to a divestment penalty.

17.2.3 Nonexempt Assets

"Nonexempt assets" are those that are counted in *SSI*-related asset tests. Assets that aren't counted in these tests are called exempt assets. An available asset (See 16.1 Assets Introduction) can be either exempt or nonexempt.

17.2.3.1 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the Medicaid divestment policy. Homestead divestments are permitted only under the circumstances described in 17.4 Exceptions, #7.

17.2.4 Institutionalized Person

See 27.4 ILTC Definitions.

17.2.5 Community Spouse

See 18.2.1 Community Spouse.

17.2.6 Fair Market Value

"Fair market value" is an estimate of the prevailing price an asset would have had if it had been sold on the open market at the time it was transferred.

17.2.7 Divested Amount

"*Divested amount*" is the net market value minus the value received.

17.2.8 Net Market Value

"Net market value" is the fair market value at the time of the transfer minus any outstanding loans, mortgages, or other encumbrances on the property.

17.2.9 Value Received

"Value received" is the amount of money or value of any property or services received in return for the person's property. The value received may be in any of the following forms:

1. Cash.
2. Other assets such as accounts receivable and promissory notes (both of which must be valid and collectible to be of value), stocks, bonds, and both land contracts and life estates which are evaluated over an extended time period.
3. Discharge of a debt.
4. Prepayment of a bona fide and irrevocable contract such as a mortgage, shelter lease, loan, or prepayment of taxes.
5. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment.

17.2.10 Unavailability

If an Medicaid member or his/her spouse uses an asset in a way that makes it unavailable and doesn't receive *FMV*, treat that asset as divestment. An example is using an asset as collateral for someone else's loan.

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17.3 LOOK BACK PERIOD

17.3.1 Look Back Period Introduction
17.3.2 Divestments Prior To January 1, 2009
17.3.3 Divestments On or After January 1, 2009

17.3.1 Look Back Period Introduction

The lookback period is a period of time prior to application or entry into an institution. A divestment that has occurred in the lookback period or any time thereafter can cause the *applicant* or recipient to be ineligible.

The look back period begins when an individual is both institutionalized and has applied for Long Term Care Medicaid or has applied for one of the Home and Community Based Waiver or Managed Long Term Care programs.

Look back from the:

1. Institutionalized person's date of application or review, or
2. Medicaid recipient's date of entry into the institution.

When you count backward, start counting with the month before the date of application or entry into the institution as month 1. When determining which date to use, use the most recent date.

"Date of application" is the date the applicant or his/her representative signs the application. If s/he does not sign the application, it is not a complete application and no divestment penalty can be imposed.

17.3.2 Divestments Prior To January 1, 2009

For divestments made prior to January, 1, 2009, the look back period is 36 months for non-trusts and 60 months for divestments involving trusts.

17.3.3 Divestments On or After January 1, 2009

The look back period for all divestments made on or after January 1, 2009 is 60 months. The 60 month look back period for non-trust divestments was effective January 1, 2009. Because the policy can only be applied back to January 1, 2009 there is a phased in approach to the 60 month look back for these non-trust divestments.

From January 1, 2009 to January 1, 2014 the look back period for non-trust divestments is:

- 36 months until 1/1/12
- 37-59 months between 1/1/12- 12/31/13
- Effective 1/1/14, 60 months

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17.4 EXCEPTIONS

A divestment that occurred in the lookback period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment wasn't made with the intent of receiving Medicaid.

The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that s/he was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

Any of the following circumstances are sufficient to establish that the *applicant*/*member* transferred resources without an intent to qualify for Medicaid.

- The applicant/member had made arrangements to provide for his/her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

  An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his/ her long term care services for his/her remaining life expectancy.

  To measure "sufficient resources' use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets and insurance held by the individual at the time of the divestment, **or**

- Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**

- If an individual had a pattern of charitable gifting, or gifting to family members (i.e. birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15% of the individual's or couple's annual gross income. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a

pattern of giving to assist family members with educational or vocational goals, **or**

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for IRS tax purposes, or otherwise provide more than 50% of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

2. The *community spouse* divested assets that were part of the community *spouse* asset share.

   a. 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.

Example 1: When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. After Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share.

   b. If the community spouse receives assets from the eligible institutionalized spouse that were not part of the community spouse asset share, s/he cannot give them to anyone except persons listed in 17.4, #8. Giving them to someone other than these persons could cause the institutionalized person to become ineligible.

Example 2: Ralph is an institutionalized Medicaid recipient. He recently inherited $25,000, and immediately transferred it to Edith, his community spouse. This $25,000 is not part of the community spouse asset share. Therefore, Edith cannot transfer the money to anyone except "a child of any age of either spouse who is

either blind or permanently and totally disabled or both" (17.4, #8). If she transfers it to anyone else, Ralph's eligibility for institutional services may be affected.

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. The community spouse's divestment of homestead property after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.

Example 3: When Ralph applied for institutional Medicaid, he and Edith owned a home together. Homestead property is not counted as part of the community spouse asset share. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. Edith can divest the part of the homestead which Ralph gave to her without affecting Ralph'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.

Example 4: After Ralph entered the nursing home and became eligible for Medicaid, Edith inherited $12,000 from a favorite uncle. She gave it to a favorite nephew. This divestment does not affect George's eligibility because the money, even though not part of the community spouse asset share, did not come from Ralph.

Note: While these examples show that in some circumstances the community spouse's divestments 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.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession aren't divestment.

5. The person intended to dispose of the asset either at *fair market value* or other valuable consideration.

Example 5: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03,

unaware that it was worth more. The friend sold it to a stamp dealer for $7300. When Gary applies for Medicaid, this divestment will be disregarded.

6. The agency termines that denial of eligibility would result in undue hardship for the person. (See 17.17 Undue Hardship)

7. The institutionalized person or his/her spouse divests homestead property to his/her:

   a. *Spouse*
   b. Child who meets at least 1 of the following conditions/situations:
      - Under 21 years of age

      OR

      - Blind

      OR

      - Permanently & totally disabled

      OR

      - Been residing in the institutionalized person's home for at least 2 years immediately before the person became institutionalized, and provided care to him/her which permitted him/her to reside at home rather than in the institution. This care must have been provided for the entire 2 years immediately before the person became institutionalized. Get a notarized statement that the person was able to remain in his/her home because of the care provided by the child.

      Note: The statement must be from his/her physician or from someone else who has personal knowledge of his/her living circumstances. A notarized statement from the child does not satisfy these requirements.

   c. Sibling who:

      - Was residing in the institutionalized person's home for at least 1 year immediately before the date the person became institutionalized.

      Verify that the sibling was residing in the institutionalized person's home for at least 1 year immediately before the person became institutionalized. Don't require a specific type of verification. Some examples of verification are written statements from nonrelatives,

social services records, tax records, and utility bills with the address and the sibling's name on them.

and

- Has a verified equity interest in the home.

"Equity interest" means an ownership interest in a homestead.

Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

8. The institutionalized person or his/her community spouse divests a nonhomestead asset or assets to:

a. A spouse

b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

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17.5 PENALTY PERIOD

17.5.1 Penalty Period Introduction
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17.5.2.1 Penalty Period for divestments prior to January 1, 2009
17.5.2.2 Penalty Period for divestments on or after January 1, 2009
17.5.3 Penalty Period Begin Date For Applicants
17.5.3.1 Divestments That Occurred Prior to January 1, 2009
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17.5.4 Penalty Period Begin Date For Recipients
17.5.5 Recalculation of Penalty Periods
17.5.5.1 Full Refund
17.5.5.2 Partial Refund
17.5.5.3 Divestments During a Penalty Period

17.5.1 Penalty Period Introduction

If there was a divestment during the lookback period or any time after, and if none of the above exceptions apply, the institutionalized person must be determined ineligible for a period of time.

During this penalty period Medicaid will not pay the institutionalized person's daily care rate in the nursing home. A Community Waivers applicant or recipient is ineligible for Community Waivers. S/he may, however, still be eligible for Medicaid card services (See 17.15 Medicaid Card Services)

17.5.2 Calculating the Penalty Period

17.5.2.1 Penalty Period for Divestments prior to January 1, 2009

For divestments prior to January 1, 2009, the penalty period is calculated by dividing the divested amount by the average nursing home cost to a private pay patient ($6,216).Round all fractions downward. For example, 8.6 = 8 months, .7 = 0 months.

Example 1: Jeff transferred $83,512 in cash, CDs, and stocks to The Green

Tree Brethren, Inc on December 20, 2008. $83,512 divided by $6,216 is 13.43 Jeff is ineligible for 13 months.

17.5.2.2 Penalty Period for divestments on or after January 1, 2009

For divestments on or after January 1, 2009, the divestment penalties are calculated in days, using the average daily nursing home cost to a private pay patient. The average daily rate is computed by multiplying the average monthly rate by 12 and dividing by 365. (6,216 x 12 = 74,592 divided 365 = 204.35)

Example 2: Jeff applied for FC on February 5, 2010. In January 2009 Jeff transferred $18,500 in cash to his son. At the time of application Jeff is otherwise eligible for FC. $18,500 divided by 204.35 = 90.53 days. Jeff is ineligible for 90 days.

Once you have determined the number of days that will constitute the individual's divestment penalty period, use the following website to establish when the penalty period will end and the exact date on which eligibility for Long Term Care Services can begin:

http://cgi.cs.duke.edu/%7Edes/datecalc/datecalc.cgi.

This website contains two date calculators. Use the one that "calculates the date some number of days from an initial date." Enter the penalty period begin date (17.5.3) and the number of days of the penalty period. When you hit the submit button you will receive the first date the person can be eligible.

17.5.3 Penalty Period Begin Date For Applicants

17.5.3.1 Divestments That Occurred Prior to January 1, 2009
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

For divestments that occurred prior to January 1, 2009, the penalty period for applicants for both Institutional Medicaid and Home and Community Waivers/FC begins with the month the divestment occurred.

Example 3: Jeff applied for MLTC in February 2010. In December 2008 Jeff transferred $98,611 in cash to his son. $98,611 divided by $6,216 is 15.86. Jeff is ineligible for 15 months beginning with the month he transferred the assets. His penalty period starts December 2008. He would be eligible again in March 2010.

For divestments that occurred **on or after January 1, 2009**, the penalty period for an **applicant** for Institutional LTC Medicaid begins on the day the applicant:

- Is institutionalized and
- Has applied for Medicaid and
- Is otherwise eligible for Medicaid

17.5.3.2 Divestments That Occurred On or After January 1, 2009

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

Example 4: Jeff applied for FC on February 5, 2010. In January 2009 Jeff transferred $18,500 in cash to his son. At the time of application Jeff is otherwise eligible for FC. $18,500 divided by 204.35 = 90.53 days. Jeff is ineligible for 90 days from the date he applied for Family Care. His penalty period begins on Feb 5, 2010. He will be eligible on May 6, 2010.

Example 5: Joan enters a nursing home on March 1, 2010 and applies for Medicaid on March 4, 2010. On her application, Joan reported that on February 2, 2010, she gave her adult daughter a $100,000 cash gift, which is determined to be a divestment. Joan meets all other Medicaid eligibility requirements therefore Joan's divestment penalty period will begin on March 1, 2010. If Joan had been over the asset limit at the time of application she would not have been "otherwise eligible for Medicaid" so her divestment penalty period would not start until she was under the asset limit.

Example 6: John applies for a HCBW program on April 7, 2010. He indicates on his application that he gave his adult son a $60,000 cash gift on February 15, 2010. John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He resides in a county that doesn't have any available waiver slots and he is therefore put on a waiting list. The $60,000 cash gift was determined to be a divestment. John is therefore ineligible for HCBW for the length of the penalty period. His penalty period would begin on April 7, 2010.

Example 7: Jeff enters a nursing home on March 1, 2010. He applies for Medicaid on April 15, 2010 and requests that his eligibility be backdated to March 1, 2010. John meets all other Medicaid eligibility requirements in March and April 2010, however he reports transferring $100,000 in stocks and bonds to his brother on February 14, 2010. John's divestment penalty period begins on March 1, 2010, which is the date that he is institutionalized, has applied for

Medicaid Long Term Care, and is otherwise eligible for Medicaid except for the imposition of the divestment penalty.

17.5.4 Penalty Period Begin Date For Recipients

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).

Example 8: Divestment that was reported timely:
On February 9, 2009, Alice, an institutionalized recipient, reports a divestment that occurred on January 31, 2009. The divestment results in a 165 day penalty period. The penalty period will begin on January 1, 2009 and end on June 14, 2009.

Because *Adverse Action* (AA) notice needs to be provided before coverage of long term care ends, the benefit will terminate effective March 1st if the worker processes the divestment prior to AA in February. If the worker processes the divestment after adverse action in February, the long term care benefit will terminate effective April 1, 2009. Because Alice reported the change timely, none of the Long Term Care benefits paid during the required adverse action notice period are subject to benefit recovery.

Example 9: Divestment that was not reported timely:
On March 1st, Edith, an institutionalized recipient, reports a divestment that occurred on January 2, 2009. The divestment results in a 165 day penalty period. The penalty period will begin on January 1, 2009 and end on June 14, 2009. If the worker processes the divestment prior to adverse action in March, Medicaid will discontinue paying for long term care on April 1, 2009.

If the divestment had been reported timely, the long term care benefits could have been terminated effective February 1, 2009. The long term care payments made in January are not considered an overpayment, however the payments made for the months of February and March are recoverable overpayments

17.5.5 Recalculation of Penalty Periods

17.5.5.1 Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if s/he met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 10: Scott gave a $10,000 certificate of deposit to his adult son on March 10, 2009. On October 1, 2009, Scott entered a nursing home and applied for Medicaid. Due to his prior divestment, Scott was ineligible for Medicaid coverage for the cost of his institutional care for 47 days. The divestment penalty period started on October 1, 2009 and ended on November 20, 2009. Scott was certified for Medicaid LTC on November 21, 2009.

Scott's son had already cashed in the CD but on December 5, 2009, he returned $10,000 in cash to Scott as a refund of the prior gift from his father. Since the equivalent value of Scott's previously transferred asset has been returned, Scott is now potentially eligible for Medicaid LTC services for the period of October 1, 2009 through November 20, 2009. Scott met all other eligibility requirements during that retroactive period and he is certified for Medicaid LTC services for that same period. The $10,000 that Scott received and reported on December 5, 2009 is counted as an asset beginning in December and would make him ineligible for Medicaid, effective January 1, 2010, unless his assets are reduced to program limits prior to January 1, 2010.

17.5.5.2 Partial Refund

Individuals who are currently serving a divestment penalty may receive 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.

Example 11: Dale resides in a nursing home and is currently serving a 97-day penalty period due to a $20,000 divestment that he made to his brother last month. Dale receives a partial refund of $6,000 from his brother which he promptly uses to purchase $6,000 worth of lottery tickets. When Dale reports the receipt of the refund and describes what he did with it, there is no adjustment to the original 97-day penalty period because Dale didn't use the partial refund to pay for care that was previously provided to him by the nursing home.

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.

Example 12: In the example 11 above, if Dale had verified that he paid the $6,000 to the nursing home for past care provided, which he was legally obligated to pay, his penalty period would have been reduced. The original divested amount of $20,000 would have been reduced to $14,000, which would have ultimately resulted in the 97-day penalty period being reduced to a 68-day penalty period ($14,000 divided by $209.16).

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

17.5.5.3 Divestments During a Penalty Period

If another divestment occurs when a penalty period is in effect, another penalty period must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The new penalty period will not begin until the existing period has expired. The penalty periods cannot run concurrently.

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

Example 13: Jeff had a penalty period that lasted until July 25th. In June he transferred another $40,000 to friends. $40,000 divided by 204.35=195.74. The divestment penalty period is 195 days. The new divestment period of 195 days begins July 26th, the day after the original divestment penalty period has ended. The new divestment penalty period does not run concurrently with the original divestment period.

The divestment report doesn't register divestment penalty changes. If it is necessary to remove a divestment penalty or change an existing penalty period in iChange, update the Transfer/ Divestment of Assets page, run eligibility, and confirm. Then contact EDS (608) 221-4746 extension x80221). Provide EDS with the date that the divestment penalty was removed or the new end date. The level of care 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.

Reminder: The divestment notices are inaccurate. Send a manual notice explaining eligibility for card services, the reason for service reduction, and the number of months in the penalty period when a case receives a divestment penalty. Include the legal citation [49.453 Wis. Stats.].

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17.6 MULTIPLE DIVESTMENTS

Multiple divestments are two or more separate divestments made within the lookback period or at any time thereafter.

For multiple divestments that occurred prior to January 1, 2009:

1. Add together all the divested amounts of transfers in the lookback period or any time thereafter that are connected in any of the following ways:
    a. Transfers that occur in the same month.
    b. Transfers that occur in both months of a period of any two consecutive months.
    c. Transfers with a penalty period (17.5 Penalty Period) that extends into a month in which there is another transfer.
    d. Transfers with a penalty period (17.5 Penalty Period)) that extends into the month immediately preceding a month in which there is another transfer.

2. Calculate the penalty period (17.5 Penalty Period)).

If there are divestments prior to January 1, 2009 in the lookback period which are not connected in any of the ways described above, treat them as separate and calculate a separate penalty period for each.

For multiple divestments that occur on or after January 1, 2009, all transfers made by the institutionalized individual or his/her *spouse* that occur during the look-back period must be added together, to arrive at a total divestment amount. That total will be used to calculate the appropriate divestment penalty period. For these divestments it doesn't matter if the divestments were made in sequential months, have penalty periods that overlap, or penalty periods that extend into a month immediately preceding a month in which there was another transfer.

Note about penalty period begin date for multiple transfers:
When an *applicant* or *member* has penalty periods from transfers that occurred prior to January 1, 2009, and transfers that occurred on or after January 1, 2009, the penalty period for the transfers in 2009 may not begin until the month after the earlier penalty period ends.

Example 1: Ernie entered a nursing home and applied for Medicaid on June 3, 2010. He meets all the financial and non-financial criteria for Medicaid except he divested both prior to and after January 1, 2009. In the 36-month look-back period he made the following transfers:
06/01/2008 $20,000 cash to a friend
09/01/2008 $35,000 bond to his son
10/01/2008 $50,000 bond to grandson
11/01/2008 $50,000 bond to grandson
12/01/2008 $25,000 bond to grandson

These Transfers were made prior to 1/1/09 so the worker would use the policy

for multiple transfers prior to 1/1/09 to determine the penalty period. The 06/01/2008 transfer has a penalty period of three months. Since it goes to 08/31/08, it extends into the month that immediately precedes the month of another transfer, the 09/01/09 transfer. Each of the later transfers, the 10/01/09 11/01/09, and 12/01/09, occur in consecutive months so the worker will add together all of the divested amounts from 06/01/2008 through 12/01/2008 to calculate the penalty period. From these divestments Ernie has a 28 month penalty period (180,000 divided by 6,362) with a begin date of 6/01/08 and an end date of 9/30/2010.

2/1/2009 $5,000 cash to his nephew
4/1/2009 $10,000 CD to his son

Since these transfers were made on or after 1/1/09 the divested amounts are totaled and divided by the daily nursing home rate of pay to determine the penalty period. The penalty period for these divestments is 71 days (15,000 divided by 209). Because this penalty period can't start until the penalty period imposed for the transfers prior to 1/1/09 is over, the begin date of this penalty period will be 10/1/10.

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17.7 JOINTLY HELD ASSETS

When an institutionalized person owns an asset in common with another person and when s/he or the other person or any person acting on their behalf transfers the asset during the lookback period or anytime thereafter, s/he may be penalized for divestment if the transfer:

1. Reduces or eliminates the institutionalized person's ownership or control of the asset, or
2. Limits the institutionalized person's right to sell or otherwise dispose of the asset.

"Holding an asset in common" means holding it through joint tenancy, tenancy in common, joint ownership, or partnership.

Example 1: For many years Debra held a joint account with her daughter, Donna. On October 15, 1996, Donna withdraws $13,000 from it. On December 3, 1996, Debra enters a nursing home and applies for Medicaid. The $13,000 withdrawal is a divestment. A penalty period must be calculated and imposed.

If placing another individual's name on the account, or asset actually limits the individual's right to sell or otherwise dispose of the asset, such placement would constitute a transfer of assets. For example, the addition of another individual's name requires that the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 2: John bought a piece of property with his nephew, Carl. Three months later John requested to participate in the community waivers program. John explained that his nephew, Carl, refused to sell the property and, therefore, it was unavailable and should not be counted as an asset. The IM worker agreed with John that the land wasn't available and wouldn't be counted as an asset. But, the purchase of the property and the nephew's refusal to make it available (through liquidation) to meet John's needs was divestment. Therefore, John is subject to a penalty period starting from the 1st of the month in which the jointly owned property was purchased.

When a person's name appears as co-owner of a jointly held asset, assume s/he is part owner of the property. However, you must inform him/her that s/he has a right to present evidence showing she is not an owner (See 16.3 Separate and Mixed Assets).

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17.8 DIVESTING BY PAYING RELATIVES

17.8.1 Divesting by Paying Relatives Introduction
17.8.2 Room & Board

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/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 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:

1. The services directly benefited the institutionalized person.
2. The payment did not 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.

Example 1: Ms. Rain applies for community waivers on 1-10-95. She paid her son $3,500 to remodel her bathroom the previous month. She shows that her son installed new tile and fixtures. You check with a local contractor who estimates the he would charge $4,000 for the same job. Since Ms. Rain received *FMV*, it's not divestment.

Example 2:. Ms. M. enters a nursing home on 12-12-95 and applies for Medicaid. She reports she paid her daughter $7,000 in December for coming to her house each evening and fixing dinner for the previous 2 months. You check with a local agency that provides meals to homebound persons. They charge $2 for each meal. Ms. M.'s daughter provided 61 meals. The fair market value of the meals was $122. You determine Ms. M overpaid her daughter. The *divested amount* is $6,878 ($7000-$122).

3. If the amount of total payment exceeds 10% of the *community spouse* asset share (See 18.4.3 Calculate the CSA), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:

   a. Specify the service and the amount to be paid, **and**
   b. Exist at the time the service is provided.

Example 3: Ms. A enters a nursing home and applies for Medicaid on 11-1-96. When asked if she has transferred any assets in the past 36 months, she reveals that she has. She paid her daughter $10,000 in exchange for personal care which her daughter had provided to her the past 2 years. This $10,000 payment would ordinarily be counted as a divestment, since it is above 10% of Ms. A's community *spouse* asset share.

But she shows you a written, notarized statement, dated 10-09-94, in which she promises to pay $10,000 to her daughter for the

specified care. Therefore, there is no divestment.

If there is no community spouse, use 10% of the highest possible CSAS in 18.4.3 Calculate the CSA.

17.8.2 Room & Board

If an institutionalized person has made room & board payments to a relative, *disregard* them if:

1. The payments do not exceed fair market value of the room & board, **and**
2. Are for periods when the institutionalized person was receiving the room & board.

If the room & board is paid after the person has been institutionalized, treat the payment as divestment unless:

1. The payment is only for the month immediately preceding the month s/he entered the institution, **or**
2. S/he provides a written lease that existed during the time s/he was receiving room & board from the relative.

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17.9 INCOME DIVESTMENT

Income received by an institutionalized person and transferred in the month of receipt is considered divestment.

Example 1: Mr. M. resides in a nursing home. He receives a pension check of $3,000 a month. Mr. M. immediately signs the check over to his son. This is a divestment.

Unless there is reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of living.

However, there may be divestment if the person transferred amounts of regularly scheduled income which s/he ordinarily would have received. Such a transfer usually takes the form of a transfer of the right to receive income.

When you find the institutionalized person has transferred income or the right to receive income, calculate a penalty period based on the total amount of income transferred.

Example 2: Donald transfers his rights to his $325,000 pension to his daughter. The *divested amount* is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

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17.10 LIFE ESTATES

17.10.1 Life Estates Introduction
17.10.2 Joint Owners
17.10.3 Purchase of a Life Estate in the Home of Another Person

17.10.1 Life Estates Introduction

A life estate is created when a property holder transfers ownership of the property to someone else and retains the right to live on the property and the income from it. The new owner of the property is referred to as the remainder person.

Because s/he no longer owns the property the life estate holder does not have the right to sell or dispose of the property. Because s/he can't sell or dispose of

the property it is not counted as an available asset to the life estate holder. If the remainder person applied for EBD Medicaid and did not live in the home, the property, minus the value of the life estate, would be counted as an available asset to him or her (the remainder interest).

The value of the life estate is also not considered an available asset to the life estate holder.

If the property holder transferred the property to the remainder person for less than fair-market-value (*FMV*), a divestment has occurred. The *divested amount* is the FMV of the property at the time of the transfer minus the life estate value. To find the life estate value, multiply the FMV of the property by the number from the 39.1 Life Estate and Remainder Interest table which corresponds to the age of the life estate holder at the time the property was transferred.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant*/*member* agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

There can also be divestment if the life estate is terminated and the life estate holder is not paid for the value of the life estate. To calculate the divested amount multiply the FMV of the property at the time the life estate was terminated by the number from the 39.1 Life Estate and Remainder Interest table which corresponds to the age of the life estate holder at the time the life estate was terminated.

Example 1: Marion gave her home to her son John in December 2006. She was 83 at the time. The FMV of the house at the time of the transfer was $87,000. Marion retained a life estate. In January 2009 she applied for Family Care. Since the transfer of her home occurred in the look back period the worker will have to determine a divestment penalty period. The divestment amount is the FMV of the house as of December 2006 minus the life estate value.

To determine the life estate value, multiply $87,000 by .38642. (the number from 39.1 Life Estate and Remainder Interest that corresponds to age 83.)

The divested amount is $87,000 - .$33,618.54 = $53,381.46. $53,381.46 divided by 6,362 = 8.39 months. Marion would have been ineligible from December 2006 through July 2007. She was determined eligible beginning January 1, 2009.

Example 2: In June 2009, John sold the home for the current FMV of $102,000 and Marion terminated the life estate. He took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate so a divestment has occurred. The divestment amount is the life estate value at the time the life estate was terminated.

To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from table 39.1 Life Estate and Remainder Interest that corresponds to Marion's age, 86, at the time the life estate was terminated.)

$102,000 X .33764 = $ 34,439.28

The divested amount is $34,439.28. The average daily nursing home cost of care as of June 2009 was $209.16. Marion's penalty period is 164 days. She is ineligible from June 2009 through 11/12/2009.

Since this is an open/ongoing case you have to give timely notice to end her Institutional Medicaid. If the divestment has been reported timely you would close her case using *adverse action* logic.

If the divestment were not reported timely you would have to calculate an overpayment for the months she would have been ineligible if the change would have been reported timely. (See 22.2.2.2 Overpayment Amount)

Example 3: James sold his home to his son Robert on December 1, 2006. James was 75 years old and the home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149).(See 39.1 Life Estate and Remainder Interest for this value.) Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, there is not divestment.

In February 2007, James moved to a *CBRF* and the home was rented out and James continued to retain the life estate. The home is not an available asset to James even though he is no longer living in the home. Because he holds a life estate on the home, James is entitled to any income produced by the property. The net rent from the home is countable income for James. (See 15.6.4 Self-Employed Income Sources)

17.10.2 Joint Owners

When two or more people hold a life estate on a property, determine the life estate value for each individual by dividing the FMV of the property by the number of life estate holders to find each individual's share of the FMV. Then calculate the life estate value by multiplying the individual share of the FMV by the number in the 39.1 Life Estate and Remainder Interest table that corresponds with the individual's age at the time of the transfer or termination of the life estate.

Example 4: In June 2006 Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The FMV of the home at the time of the transfer was $140,000. At the time George was 82 and Marie was 68. In February 2007, George applied for FC. Since the transfer occurred in the look back period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment the worker must first determine the life estate values.

$140,000 divided by two = $70,000

George's age at the time of the transfer was 82. Multiply 70,000 x .40295 (See 39.1 Life Estate and Remainder Interest for this value.)= 28,206.50
Marie's age at the time of transfer was 68. Multiply 70,000 X .63610 = 44,527.00

The total life estate value for both Marie and George is $72,733.50.

The divested amount is the FMV minus the life estate value. ($140,000 - $72,733.50 = $67,266.50)

To calculate the penalty period, divide the divested amount by the average nursing home cost of care at the time of application. ($67,266.50 divided by $5584) George has a 12 month penalty period so will be ineligible from June 2006 through May 2007.

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

The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser:

- Resides in the home for a period of at least 12 consecutive months after the date of purchase; **and**
- Received fair market value for the purchase.

Residency
Apply the following rules to determine whether a person has resided in the home for 12 consecutive months:

- The 12-month period may start immediately after the purchase or at any time after the purchase.

- Absences from the life estate home for less than 30 consecutive days will not affect the 12-month determination.

Example 5: Ralph purchases a life estate interest in his brother's home on January 5, 2009 and moves into that home on the same date. He goes to Florida on January 20, 2009 and returns to the home on February 10, 2009. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

Absences from the life estate home for 30 days or more for vacations, trips or to stay elsewhere result in the 12-month period starting over.

Example 6: Vicki purchases a life estate interest in her sister's home on January 20, 2009 and moves into that home on the same date. On March 3, 2009 Vicki goes to Bermuda for a family vacation and returns on April 15, 2009. Since Vicki was absent from the home for 30 or more consecutive days, the consecutive month of residency string is broken. Vicki's 12-month residency clock is reset with April 2009 being her "new" first month of residency.

Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count towards the 12 consecutive months. However, such absences do not result in the 12-month period starting over.

Example 7: Jim purchases a life estate interest in his cousin's home on January 20, 2009 and moves into that home on the same date. Jim continues to reside in the home until April 10, 2009 at which time he is hospitalized as a result of an auto accident. Jim remains in the hospital until August 5, 2009 when he is discharged and returns home. Jim continues to reside in the home from August 5, 2009 until December 24, 2010.

Jim's residency in the home for the months of January, February, March, and part of April count as four consecutive months of residency. The months of May, June, and July are not included in the consecutive month count because he is absent from the home for those full calendar months. However the absence from the home for those months does not cause the 12-month clock to be restarted because Jim's absence was the result of his hospitalization. When Jim returns to the home on August 5, 2009, August counts as the fifth month of continuous residency. Jim will meet the 12 months of continuous residency requirement in March of 2010.

If the 12-month residency requirement has not been met at the time of the application for LTC Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until the penalty period ends or the date the individual meets the 12 month residency requirement, whichever occurs first. There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

Fair Market Value

If the 12-month residency requirement has been met at the time of the application for LTC, the local agency must also determine whether the applicant paid the fair market value (FMV) for the life estate. The FMV of the life estate is determined using the age of the life estate holder on the date that the life estate was created and the property's FMV on that date. Multiply the FMV by the life estate multiplier on the Life Estate and Remainder Interest Table (See 39.1). The result is the value of the property's life estate interest as of that date. If the applicant paid more than the life estate interest value, the difference is the divested amount.

Example 8: Joyce, age 75, has $200,000 in her savings account. On February 3, 2009, she gives $200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of February 3, 2009 was $300,000. Joyce moved into her son's home on March 5, 2009 and has resided there continuously for more than 12 consecutive months. On April 9, 2010 Joyce applies for a Community Waiver program, meets the functional screen and all other Medicaid eligibility requirements. Joyce also establishes that as of her application date for Community Waivers, she has resided in her son's home for more than 12 consecutive months.

The divestment issue that now needs to be resolved is whether or not Joyce received FMV for the $200,000 that was used to purchase the life estate. Using the Life Estate Table in Chapter 39.1 it is determined that Joyce's life estate interest was worth $156,447 at the time of the purchase. Since Joyce paid $200,000 for a life estate that was worth $156,447, the divested amount is $43,553. Joyce is ineligible for Community Waiver beginning on the date of her Community Waiver application

When a couple jointly holds a life estate, the institutionalized *spouse* must reside in the home for 12 consecutive months or his/her portion of the life estate value will be considered a divestment. See 17.10.2 Joint Owners for instructions on calculating the spouse's portion of the life estate value.

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17.11 ANNUITIES

17.11.1 Annuities Purchased Prior to 1/1/09
17.11.2 Annuities Purchased On Or After 01/01/09 Or Had Transactions To Them On Or After 01/01/09
- 17.11.2.1 Disclosure
- 17.11.2.2 Remainder Beneficiary Designation
- 17.11.2.3 Additional Divestment Criteria For Unavailable Annuities Owned By The Institutionalized Applicant/ Member

17.11.1 Annuities Purchased Prior to 1/1/09

It is divestment if an institutionalized person transfers assets or income to an annuity (See 16.7.4 Annuities) when any of the following conditions exist:

1. S/he chooses a settlement option that has a pay-out schedule extending beyond his/her life expectancy.

   The *divested amount* is the total of all payments scheduled after the month in which the person's age exceeds his/her life expectancy.

   Determine the person's life expectancy as follows:

   a. Find his/her age on the date s/he chose the settlement option.
   b. Consult 39.8 Life Expectancy Table for his/her life expectancy.

   Example 1: A 76-year-old man purchases an annuity and chooses a settlement option on January 1, 1994. The annuity will make $100 payments to him beginning January 1, 1994 and ending December 31, 2010. His life expectancy is age 86 (See 39.8 Life Expectancy Table. He will turn 87 on December 1, 2004. Total the payments from January 1, 2005 through December 31, 2010. The total is the divested amount.

   The life expectancy value can be adjusted based on a medical condition diagnosed by a physician before the person transferred funds to the annuity or trust.

2. S/he purchases an annuity that has no cash or surrender value, and s/he does not choose a settlement option.

The divested amount is the amount the institutionalized person paid for the annuity. (If there is a cash or surrender value, count it as an available asset.)

3. S/he purchases an annuity in which neither s/he nor his/her *spouse* nor a blind or permanently disabled child of any age of either spouse is named the annuitant.

4. S/he purchases an annuity in which there are not fixed, periodic payments made within his/her life expectancy.

17.11.2 Annuities Purchased On Or After 01/01/09 Or Had Transactions To Them On Or After 01/01/09

17.11.2.1 Disclosure

Beginning January1, 2009, all applicants for Medicaid long term care services and all recipients of Medicaid long term care services undergoing an eligibility review are required to disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouses have an interest. This requirement also applies to annuities purchased before January 1, 2009, if any action is taken by the individual that changes either the course of payment from the annuity or the treatment of the income or principal of the annuity. These transactions include:

- additions of principal,
- elective withdrawals,
- requests to change the distribution of the annuity,
- elections to annuitize the contract,
- a change in ownership, **or**
- any other non-routine action not listed below

The following types of changes and events would not subject an annuity purchased prior to January 1, 2009 to treatment under the new policy rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;
- Changes that occur based on terms of the annuities which existed prior to January 1, 2009 and which do not require a decision, election or action to take effect; **or**
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A separate annuity disclosure form (Annuity Information - Disclosure F-10192) must be completed by applicants for each annuity owned by the *applicant* or the applicant's community spouse in order to meet the disclosure requirement. This form must also be sent to *SSI* recipients who are applying for HCBW and MLTC programs. The Disclosure form must be sent to all applicants and recipients who indicate that they have an annuity. A copy of the completed form and any documents verifying the status of the annuity must be scanned into the electronic case file (ECF).

The Wisconsin Medicaid for the *Elderly*, Blind, and Disabled Application (F-10101) has been updated to collect additional information about annuities and provide information about the requirement to designate the State as a remainder beneficiary of the annuities owned by applicants for LTC Medicaid or their spouses. The new version of the application will be available with the next printing. Forms Coordinators will be notified when the updated version is available.

If the applicant/*member* or his/her spouse (or representative) refuses to disclose the required information related to the annuity, the applicant/member is ineligible for Medicaid for the failure to cooperate in providing requested information.

17.11.2.2 Remainder Beneficiary Designation

Annuities purchased on or after January 1, 2009 by an individual who is applying for Medicaid Long Term Care Services (or his/her spouse) must name the "Wisconsin Department of Health Services Estate Recovery Program" (hereafter referred to as "the State") as a remainder beneficiary. The requirement to name the State as a remainder beneficiary also applies to annuities purchased prior to January 1, 2009 if certain transactions (those described above) involving the annuity were made by the individual or spouse on or after January 1, 2009. This requirement applies to all annuities, regardless of whether they are considered revocable or not.

An annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual, unless there is a community spouse and/or a *minor* or disabled child. A child is considered disabled if he or she has been determined disabled by the DHS *Disability* Determination Bureau, or receives Supplemental Security Income (SSI) or Social Security Disability Insurance (*SSDI*) benefits. If there is a community spouse and/or any minor or disabled child, the State must be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the State has been named as a remainder beneficiary after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than *fair market value*, the State must then be named in the first position. For example, this might apply if the community spouse or child changes the annuity beneficiary during the recipient's lifetime.

The IM agency must determine if the annuity transaction or purchase occurred prior to January 1, 2009. If so, it is subject to pre-DRA divestment policy. If the annuity transaction or purchase occurs on or after January 1, 2009, the State must be designated as a remainder beneficiary. To do this, a separate annuity beneficiary designation form (Annuity Beneficiary Designation, F-10191) must be completed and signed by all applicants (or spouses), for each annuity that must have the state designated as the remainder beneficiary.

This form must also be sent to SSI recipients who are applying for HCBW and MLTC programs. The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, F-10190) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.
When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days, the IM agency must contact the issuer by phone and request that the issuer respond within 10 days. If the issuer does not respond 40 days after the Notice of Obligation form was sent, contact the CARES Call Center for further guidance.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, contact the CARES Call Center for further guidance.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation (F-10190).

Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,
- Verification has been received that the beneficiary designation change is in process,
- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, **or**
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

We have attached a flow chart to guide eligibility workers on the entire process of getting the disclosures, the designation of the state as a beneficiary and informing the annuity issuers of the state's interest and their reporting obligation.

17.11.2.3 Additional Divestment Criteria For Unavailable Annuities Owned By The Institutionalized Applicant/ Member

The following policy changes do not apply to annuities that are considered to be available resources. Annuities that are considered "unavailable" and purchased on or after January 1, 2009, by or on behalf of an annuitant who has applied for Medicaid coverage of Long Term Care Services, as well as annuities purchased prior to January 1, 2009 and for which certain transactions (see above) were made on or after January 1, 2009 are subject to the following divestment rules.

The annuities described in this section only refer to annuities purchased by or on behalf of an annuitant who is an applicant for or recipient of Medicaid Long Term Care Services. These divestment rules do not apply to annuities for which the community spouse is the annuitant. The annuity will not be treated as a divestment if the annuity meets **any of the following conditions:**

1. The annuity is considered either:
    - An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), **or**
    - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC),

    or

2. The annuity is purchased with proceeds from one of the following:
    - A traditional IRA (IRC Sec. 408a);
    - Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c));
    - A simplified retirement account (IRC Sec. 408 §(p));
    - A simplified employee pension (IRC Sec. 408 §(k)); or
    - A Roth IRA (IRC Sec. 408A).

or

3. The annuity meets all of the following requirements:
    - The annuity is irrevocable and non-assignable;
    - The annuity is actuarially sound; and
    - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 1 and 2 above, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the institutionalized individual (or his/her representative) to produce this documentation.

To determine if an annuity is actuarially sound, use the life expectancy tables, from Social Security at http://www.ssa.gov/OACT/STATS/table4c6.html which is compiled from information published by the Office of the Actuary of the Social Security Administration. The guarantee payout period of the annuity cannot be longer than the annuitant's life expectancy. If the individual is not expected to live longer than the guarantee payout period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place.

For any annuity which does not meet the above conditions, the amount of the transfer is the amount spent to purchase the annuity and the date of transfer is the date of the purchase or the date of the most recent transaction for this annuity.

An annuity that meets the requirements above is not considered a divestment, but it must still be disclosed and the state designated as the remainder beneficiary. Failure to disclose results in ineligibility and failure to designate the state as a remainder beneficiary on the annuity results in a divestment penalty period.

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17.12 PROMISSORY NOTES

17.12.1 Promissory Notes Prior to 01/01/09
17.12.2 Promissory Notes On or After 01/01/09

17.12.1 Promissory Notes Prior to 01/01/09

It is divestment if an institutionalized person signs a promissory note prior to January 1, 2009 that has at least one of the following:

1. A provision that forgives a portion of the principal,
2. A balloon payment,
3. Interest payments only, with no principal payments, **or**
4. An inadequate interest rate (relative to current market rates) at the time the promissory note was signed.

17.12.2 Promissory Notes On or After 01/01/09

The purchase of a promissory note, loan or mortgage, on or after January 1, 2009 is a divestment unless such note, loan 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, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the Social Security Administration (*SSA*). The standards are found in a table (called the Period Life Table), which can be found on the following SSA Web page: 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, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that s/he would receive payment in full during his/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 or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically cancelled 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 or mortgage contains language to cancel the balance upon the death of the lender, the note, loan or mortgage can be amended to remove this language and avoid a divestment penalty, **and**

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

Example 1: On February 1, 2009, Mary gave her *adult* daughter $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of $100 per month for the first 47 months and a $45,300 payment in the 48th month. Twelve months later, on February 1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid long term care services (February 1, 2010), Mary's daughter has repaid her mother only $1,200, and the outstanding balance on the note is $48,800. Mary's divested amount is $48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 2: John purchased a $60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid long term care services is $40,000. The divested amount that will be used in calculating John's divestment penalty period is $40,000.

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17.13 TRUSTS

17.13.1 Trusts Introduction
17.13.2 Revocable Trusts
17.13.3 Irrevocable Trusts
17.13.4 Exceptions

17.13.1 Trusts Introduction

"Trust" is any arrangement in which a person (the "grantor") transfers property to another person with the intention that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary"). The term “trust” includes any legal instrument or device that is similar to a trust.

"Legal instrument or device similar to a trust" means any legal instrument, device, or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary. For purposes of this section, an individual shall be considered to have established a trust if assets of the individual are used to form all or part of the *corpus* (principal) of the trust.

"Grantor" may be:

1. The Medicaid *member*.
2. His/her *spouse*.
3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or his/her spouse. This includes a power of attorney or a guardian.
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or his/her spouse. This includes relatives, friends, volunteers or authorized representatives.

17.13.2 Revocable Trusts

A *revocable trust* is a trust that can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

1. The trust principal of a revocable trust is an available asset. "Trust principal" is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.
2. All payments from the trust to or for the benefit of the institutionalized person are income.
3. All payments from the trust that are not to or for the benefit of the institutionalized person are divestment.

17.13.3 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

The following actions are divestment if they took place during the lookback period (17.3 Look Back Period) or any time after:

1. An irrevocable trust was created. The *divested amount* is the total amount of the created trust.

   Sometimes revocable trusts contain a clause that causes them to become irrevocable at a later date in the life of the trust. Divestment occurs on the date the trust changed from revocable to irrevocable.

Example 1: In 1998 Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July, 2008. He divested the total amount of the trust on February 2, 2007.

2. Funds were added to the irrevocable trust. The *divested amount* is the amount of the added funds.

If either of these actions took place before the lookback period, apply the following rules:

1. Payments to the institutionalized person from trust income or from the body of the trust are income.
2. Payments that could be disbursed to the institutionalized person from trust income or from any portion of the body of the trust but that are not disbursed are available assets.
3. Payments from the trust to anyone other than the institutionalized person are divestment.

17.13.4 Exceptions

The policies described in this trusts section do not apply to any of the following trusts.

1. Annuities (17.11 Annuities).

2. Irrevocable burial trusts (16.5.1 Burial Trusts).
3. Trusts established by a will.
4. Special Needs Trusts - A trust containing assets of an individual under age 65 who is totally and permanently disabled (under *SSI* program rules). *Disregard* the trust if it meets these conditions.
   a. The trust must be established for the sole benefit of the disabled person by his/her parent, grandparent, legal guardian or a court, **and**
   b. Contain a provision that, upon the death of the beneficiary, the Wisconsin Medicaid program will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

The exception continues after the person turns 65, provided s/he continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

5. Pooled trusts (Effective 09-01-08).
   Pooled Trusts Not Subject to Divestment
   Pooled Trusts Subject to Divestment
   Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled

I. **Pooled Trusts Not Subject to Divestment**

These are trusts for disabled persons as determined by SSI rules. Disregard them if they meet the following conditions:

a. Are established and managed by a non-profit association, **and**
b. Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a *disability*, **and**
c. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court. If the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid *applicant* /recipient, **and**
d. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.

v. This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.

vi. This requirement can also be satisfied when the pooled trust account includes *real property*, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid recipient who is disabled (as established under SSI rules) or *elderly* (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid recipient, and

g. The trust was established with the funds of a disabled individual of any age. These would be considered "self-funded" trusts, and the age of the disabled individual at the time the trust was created, is irrelevant.

II. **Pooled Trusts Subject to Divestment**

A pooled trust established with the funds of a third party on or after September 1, 2008 for a disabled individual, age 65 or over will not be exempt from the divestment penalty provisions, if the third party subsequently applies for Medicaid. The divestment penalty is applied to the third party who created the pooled trust unless the trust beneficiary is the third party's disabled child. Similarly, contributions/additions to a pooled trust by a third party, made after the disabled beneficiary turns 65 will also be subject to divestment penalty provisions if the third party (trust grantor) subsequently applies for Medicaid.

III. **Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled**

Third party funded pooled trusts for individuals applying for disability status are not subject to divestment if:

a. they have placed their assets in a potential pooled trust, and
b. they meet all of the conditions in 5 I above, and
c. the potential disabled individual has initiated the disability determination process prior to 09/01/08, and
d. they are over age 65.

"Initiating the disability determination process" means that the individual must have asked either the county agency, the Social Security Administration, or *DDB* for a disability determination.

6. Trusts for Disabled Individuals. A trust for disabled individuals is a trust established with an individual's funds solely for the benefit of his/her disabled child (regardless of the child's age), or solely for the benefit of any other disabled individual who is under 65 years of age. The disability status is the same as that which is determined under SSI rules. The exception continues after the person turns age 65, provided s/he continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns age 65, unless the beneficiary is his/her disabled child. Anything added to the trust after the beneficiary turns age 65 (except for a beneficiary who is the grantor's disabled child) is a divestment. Money added before the beneficiary turns age 65 is not a divestment.

Note: Unlike Special Needs and Pooled Trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" which becomes effective upon the death of the beneficiary.

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17.14 BOTH SPOUSES INSTITUTIONALIZED

If the *community spouse* made a divestment that resulted in a penalty period for the institutionalized *spouse* (see 17.4 Exceptions 2b), apportion the penalty period between the spouses at the time the community spouse enters an institution and applies for Medicaid.

Example 1: Joe Penner is in a nursing home. Mrs. Penner is his community spouse. Joe inherited $84,000 and immediately transferred it to Mrs. Penner. This $84,000 was not part of the community spouse asset share. Mrs. Penner gave it to her church. This divestment resulted in a penalty period of 26 months for Joe Penner. Now Mrs. Penner is entering the nursing home and applying for Medicaid. The time that remains on Joe Penner's penalty period must be apportioned to both spouses.

Apportion the penalty period as follows:

1. Find the *divested amount* that was used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
   a. Multiplying the average nursing home private pay rate x the number of
      - complete months of the penalty period already served for divestments prior to 1/1/09, **or**
      - the days of the penalty period already served for divestments on or after 1/1/09
   b. Subtracting the result from the original divested amount.

c. Calculate the penalty period for the remaining divested amount.

d. Divide the new penalty period equally between the 2 spouses.

If either spouse leaves the institution or dies, add the remainder of his/her penalty period to the other spouse's penalty period.

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17.15 MEDICAID CARD SERVICES

17.15.1 Nursing Home
17.15.2 Community Waivers

Medicaid card services are all the Medicaid covered services (21.1 Benefits Introduction) except *SNF*/*ICF* Intermediate Care Facility payments and ancillary services (Wis. Ad. Code 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid recipients by a nursing home and that are reimbursed within the daily care rate.

17.15.1 Nursing Home

A person who, because of divestment, isn't eligible for services reimbursed within the daily institutional care rate is still eligible for Medicaid card services.

17.15.2 Community Waivers

Community waivers (CW) members who have divested cannot receive CW benefits and can't use CW eligibility criteria. They may be eligible for Medicaid card services. Determine eligibility using regular Medicaid methodology.

Send a notice to the CW case manager telling him/her of the member's ineligibility for waiver services.

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17.16 GAMBLING

Gambling losses at a casino, racetrack or in some other type of regulated gambling is not divestment. It is divestment if the *member* makes personal bets with friends or relatives or has losses from unregulated gambling.

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View History

17.17 UNDUE HARDSHIP

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17.17.1 Introduction

A divestment penalty period must be waived when the imposition of the penalty period deprives the individual of:

- Medical care such that the individual's health or life would be endangered; **or**
- Food, clothing, shelter, or other necessities of life.

17.17.2 Hardship Waiver Request Process

At the same time that the worker issues the manual Negative Notice of Decision (F-16001) to the *applicant* or recipient informing the person of the divestment penalty period, the following forms must also be completed and mailed with the Negative Notice of Decision:

- Divestment Penalty and Undue Hardship Notice (F-10187).
- Undue Hardship Waiver Request form (F-10193) to the Hardship Notice, including the Case Name and Number.

17.17.3 Valid Request

The completed Undue Hardship Waiver Request form (F-10193) must be submitted to the Income Maintenance (IM) agency. A written and signed request that fulfills the minimum request requirements is also acceptable.

The Long Term Care (LTC) facility in which the individual is residing may also file an undue hardship request on behalf of the institutionalized individual. However, the LTC facility must have the client or their authorized representative's written permission, using the Undue Hardship Waiver Request form (F-10193) to file the undue hardship request.

The LTC facility can also represent the institutionalized individual in any subsequent fair hearing activity involving an undue hardship request/denial, as long as the facility has the *member* (or his/her representative's) written permission to do so. This can also include the actual request for a fair hearing.

17.17.4 Effective Date of Approved Hardship Waivers

17.17.4.1 Timely Request- Received Within 20 days After Notification Is Mailed

If the valid request for an undue hardship waiver is received by the local agency within 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice (F-10187), and the request is approved, the effective date of the waiver will be the initial date of the penalty period.

Example 1: Amy receives a notice dated February 10, 2009 that her January 20, 2009 application for Community Waivers is being denied and that she will have a 100-day divestment penalty period beginning January 20, 2009. Amy submits an undue hardship request to the IM agency, which is received on February 15, 2009. The undue hardship request is ultimately approved by the IM agency and Amy's penalty period is waived. Amy is subsequently certified for Community Waiver Medicaid beginning January 20, 2009.

17.17.4.2 Untimely Request- Received Later Than 20 days After Notification Is Mailed

A request may be submitted later than 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice (F-10187), (for example, when there is a change in circumstances), but if approved, the waiver effective date will not be earlier than the date of the request.

Example 2: Alice receives a notice dated February 10, 2009 that her January 20, 2009 application for Community Waivers is being denied and that she will have a 350-day divestment penalty period beginning January 20, 2009. In June 2009, Alice's health deteriorates and her monthly income decreases by 60%. Alice submits an undue hardship request to the IM agency, which is received on June 25, 2009. The undue hardship request is ultimately approved by the IM agency and Alice's remaining penalty period is waived. Alice is subsequently certified for Community Waiver Medicaid beginning June 25, 2009.

17.17.5 Required Documentation

The applicant (or his/her representative) must submit the following verification of hardship:

1. A statement signed by the individual (or his/her representative) which describes whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets, **and**
2. Proof that an undue hardship would exist if the penalty period is applied (as follows).
   - If the ***member is currently institutionalized***, s/he must submit a copy of the notification sent from the LTC facility which states both the date of involuntary discharge and alternative placement location or other proof that if the hardship waiver is not granted, the individual will be deprived of medical care such that the individual's health or life would be endangered; or deprived of food, clothing, shelter, or other necessities of life.
   - If the ***member is applying for Community Waivers COP, FamilyCare,, IRIS, PACE or Partnership***, s/he must submit an estimate of the cost of the LTC services needed to meet his/her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing and other necessities of life.

Compare the two estimates to the individual or couple's income and assets. If the IM agency determines that the individual does not have enough income and/or assets to pay for his or her LTC and other needs (i.e. food, shelter, etc.), consider the individual's health to be endangered.

If the required documentation is not submitted with the request for an undue hardship waiver, send a written request for verification. If the applicant/member fails to submit the required verification within 10 days after the request is mailed, deny the undue hardship waiver request and notify the individual with the Undue Hardship Decision Notice (F-10188). Extend the deadline to submit the required documentation for up to ten days when the individual communicates a need for additional time or assistance in obtaining it.

17.17.6 Determination Process Timeframe

A decision about whether to grant an undue hardship waiver shall be made by the local IM agency within 30 days after receipt of the request. Send the member/applicant the appropriate manual Positive or Negative Notice of Decision based on the IM agency's decision.

If an undue hardship is approved, a new hardship request does not have to be done at review. Once an undue hardship request is approved, either the entire penalty period is waived, or the remaining penalty period is waived, depending upon whether or not the client makes a timely or untimely undue hardship waiver request. If the undue hardship request is denied, the client has the right to make another subsequent request, if and when their circumstances change.

17.17.7 Bed Hold Payments and Notification

When a hardship waiver request is received by an IM agency from an institutionalized individual, the agency will send the institution the Undue Hardship Bed Hold Notice (F-10189) to inform them that the request was received. The Notice will inform the institution that a "r;bed hold" payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 days.

Use the Undue Hardship Waiver Decision (F-10188) form to notify the institution of the agency's decision about the undue hardship waiver and the availability of the bed hold payment (when applicable).

If the request for an undue hardship waiver is approved, the penalty period will be waived and the need for a bed hold payment is therefore unnecessary. If the undue hardship waiver request is denied, indicate on the Waiver Decision form the dates for which the State will make the bed hold payments. Attach a copy of the Waiver Decision form to the manual Negative Notice of Decision that you send the member/applicant.

The Negative Notice must include the agency's reason for the denial, "r;You have not proven that the divestment penalty will create an undue hardship for you." The Notice must also inform the member/applicant that Medicaid/Forward Health will pay for LTC services received during the bed hold period. Manually certify the bed hold period by completing a manual Medicaid certification form (F-10110 - formerly DES 3070 - See PH 81.3) and sending it to the fiscal agent for processing.

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e. nursing homes, etc.) who are requesting an undue hardship determination. They will not be made for Community Waivers or Family Care applicants.

17.17.8 Fair Hearing Rights

If the request for an undue hardship waiver is denied, the individual has the right to appeal the decision through a written request to the Division of Hearings & Appeals (See the IMM Ch. 3). The individual has 45 days from the date of the notice issuance to file the appeal. These same hearing rights are also applicable to the facility in which the individual resides, as long as the facility has the institutionalized individual's written permission to represent him/her in the appeal process.

17.17.9 Referral

If a Power of Attorney (POA) or other *authorized representative* transferred the asset, the IM agency must consider making a referral to the local *Adult*-at-Risk agency for investigation of possible financial exploitation of an *elderly*, blind, or disabled individual.

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18 SPOUSAL IMPOVERISHMENT

18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular MA financial limits. Spousal impoverishment policy applies to institutionalized persons (See 18.2.3 Institutionalized) and their *community spouse* (18.2.1 Community Spouse).

The policy's purpose is to prevent impoverishment of the community *spouse*. Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, s/he is allowed to have substantial assets and income without liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See 2.5.3 Spousal Impoverishment MA Signatures for application and review signature requirements..

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18.2 SPOUSAL IMPOVERISHMENT USEFUL TERMS

18.2.1 Community Spouse
18.2.2 Community Spouse Asset Share
18.2.3 Institutionalized

18.2.1 Community Spouse

A "*community spouse*" is:

1. Married to an institutionalized person **and**
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community *spouse* is not an institutionalized person, his/her living arrangement can have no effect on his/her asset share (See 18.2.2 Community Spouse Asset Share below) or income allocation (See 18.6 Spousal Impoverishment Income Allocation).

Example 1: Joe is an institutionalized person living in a nursing home. His wife, Carla, is in prison. Carla is entitled to the community spouse asset share and to any allowable income which Joe chooses to allocate to her.

18.2.2 Community Spouse Asset Share

The community spouse asset share (CSAS) is the amount of countable assets above $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for MA. Once the institutionalized spouse is determined eligible, the assets of the community spouse are unavailable.

18.2.3 Institutionalized

"Institutionalized person" means someone who:

1. Participates in Community Waivers, **or**
2. Has resided in a medical institution for 30 or more consecutive days, **or**
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30 day period is that a resident of an IMD (27.1.2 Institutions for Mental Disease) is considered an institutionalized person until s/he is discharged. The 30 day period includes situations in which the person resides in more than 1 medical institution during 30 or more consecutive days.

If a person relocates from one institutional living arrangement to another, consider him/her to be in a continuous period of institutionalization, provided s/he does not live in a non-institutional living arrangement between the two periods of institutional living.

Example 2: Mr. Wunder's niece moved him from his community waiver placement in Bayfield County to an *SNF* nursing home in Eau Claire County. This is a continuous period of institutionalization. If he had gone to live with his niece for a while, and then gone to the Eau Claire nursing home, his arrival at the Eau Claire nursing home would have been considered a new period of institutionalization.

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18.3 SPOUSAL IMPOVERISHMENT REQUIREMENTS

All institutionalized persons applying for Medicaid must meet the same nonfinancial requirements. *Spousal impoverishment* policy introduces no changes in Medicaid nonfinancial tests.

On the financial side:

1. **Assets**. The assets of both the institutionalized person and his/her *spouse* are counted in the asset test.
2. **Income**. The income limit is the same as that for non-spousal impoverishment institutionalized persons. But, after the institutionalized person becomes eligible, s/he is allowed to allocate some of his/her income back to his/her *community spouse* and family.

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18.4 SPOUSAL IMPOVERISHMENT ASSETS

18.4.1 Spousal Impoverishment Assets Introduction
18.4.2 Asset Assessment
18.4.3 Calculate the CSAS
18.4.4 Asset Test
18.4.5 Undue Hardship
18.4.6 Asset Transfer
- 18.4.6.1 Asset Transfer Period
  - 18.4.6.1.1 Leaves Institution or becomes ineligible during the 12 month transfer period.
- 18.4.6.2 Institutionalized Spouse is Eligible after the 12 month transfer period
  - 18.4.6.2.1 Leaves Institution for 30 or more days then Re-institutionalized
  - 18.4.6.2.2 Loses Medicaid Eligibility But Remains Institutionalized

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his/her *community spouse*. (**Note**: *Disregard* prenuptial agreements. They have no effect on spousal impoverishment determinations.) Add together all countable, available (See 16.1 Assets Introduction) assets the couple owns.

Do not count the following assets:

1. *Homestead* property. If the institutionalized person and the community *spouse* each owns home property and meets the criteria in 16.8.1.3 Exempt Home Property exempt the institutionalized person's home, but not the community spouse's home.

Example 1: One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home, but exempt the spouse's home. Both homes cannot be exempt simultaneously.

2. One vehicle, regardless of value or purpose. If the AG has more than one vehicle, disregard one vehicle totally, regardless of value or purpose. Then, for the remaining vehicles, follow the EBD rules for vehicles (See 16.7.9 Vehicles).

3. Any/all assets designated for burial purposes are exempt. Any unreasonable amount should be supported by documentation of the burial related costs or contract.

   Do not allow applicants and recipients to simply state that they are setting aside an unreasonable amount of cash (e.g., $1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

   For example, ask the *member* to document that they have arranged to purchase a $100,000 casket or that a funeral home will provide them with a $75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

   This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (See 16.5 Burial Assets).

4. Household goods and personal items, regardless of their value.

5. All assets not counted in determining EBD MA eligibility.

6. IRA's of an ineligible community spouse (See 16.7.21 Retirement Benefits).

18.4.2 Asset Assessment

The IM Agency must make an assessment of the total countable assets of the couple at the:

1. Beginning of the person's first continuous period of institutionalization of 30 days or more, **or**
2. Date of the first request for community waivers, whichever is earlier.

Complete an asset assessment using the F-10095 "Medicaid Asset Assessment" when someone applies, even if s/he had one done in the past, to get the most current asset share.

If the member was not married on the first date of institutionalization or waivers request, apply the policy from the point s/he is married. If s/he has remarried

since the first date of institutionalization or waivers request, apply the policy from the date s/he got married to his/her current spouse.

The IM agency must also do an asset assessment at any other time the institutionalized person or his/her spouse requests it.

The IM agency should inform the person for whom an assessment is being made what documentation is required. S/he must document ownership interest in and the value of any available assets the couple had at the time of his/her first period of continuous institutionalization. The same documentation procedures are used as when an application is filed (See 20.1 Verification Introduction).

18.4.3 Calculate the CSAS

The community spouse asset share (CSAS) is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for MA.

IF the total countable assets of the couple are:	THEN the CSAS is:
$219,120 or more	$109,560.00
Less than $219,120 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

CARES will send each member of the couple a letter that states the couple's total countable assets, the CSAS, how much the institutionalized spouse must transfer to the community spouse, the date by which the transfer must be made, and the institutionalized person's asset limit.

18.4.4 Asset Test

When the institutionalized person applies for MA, compare the total countable assets of the couple to $2,000 plus the greater of:

1. CSAS, **or**
2. An amount ordered by a court, or fair hearing.

If assets at the time of application are equal to or less than this amount, the institutionalized person is eligible. If they are more, s/he is not eligible.

18.4.5 Undue Hardship

The institutionalized person will not be denied MA if the IM Agency determines that the ineligibility caused by excess assets creates undue hardship for him/her. Undue hardship means an immediate, serious impairment to the institutionalized person's health.

18.4.6 Asset Transfer

After the institutionalized person is found eligible, s/he may transfer assets to the community spouse. The maximum amount s/he can transfer is the CSAS (or a greater amount ordered by a court or a fair hearing). If the community spouse already has some assets, the institutionalized person can transfer assets which when added to the community spouse's assets equal the CSAS (or an amount ordered by a court or a fair hearing).

S/he isn't allowed to transfer assets for less than *fair market value* to anyone other than the community spouse.

18.4.6.1 Asset Transfer Period

The institutionalized spouse must transfer the assets to the community spouse by the next regularly scheduled review (12 months). If his/her assets are above $2,000 on the date of the next scheduled review, s/he will be determined ineligible. S/he will remain ineligible until his/her assets no longer exceed the $2000 Medicaid asset limit.

Example 2: Robert was first institutionalized September 2006. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2006. The couple's total combined assets were $42,000, $32,000 of which were owned solely by Robert. Robert had until the next scheduled review (September 2007) to get his total assets under the $2000 Medicaid asset limit.

By September 2007 Robert had only transferred $23,000 to Lucinda. Robert still had $9,000 in assets. Robert became ineligible October 2007, and will remain ineligible as long as his assets remain over $2000.

18.4.6.1.1 Leaves Institution or becomes ineligible during the 12 month transfer period.

If the institutionalized spouse during the 12 month transfer period:

1. Leaves the institution for 30 days or more and becomes institutionalized again, **or**
2. Becomes ineligible for Medicaid and then becomes eligible for Medicaid once again.

The time allowed to transfer assets does not start over again.

18.4.6.2 Institutionalized Spouse is Eligible after the 12 month transfer period

18.4.6.2.1 Leaves Institution for 30 or more days then Re-institutionalized

If the institutionalized spouse remains in the institution and MA eligible after the expiration of the 12 month transfer period, but then leaves the institution for 30 days or more, and subsequently becomes institutionalized once again for 30 days or more, s/he would be subject to all *spousal impoverishment* rules upon becoming re-institutionalized.
Including:

- An asset assessment (See 18.4.2 Asset Assessment) would be required for the purpose of determining the community spouse asset share, **and**
- The couple would have to once again pass a joint asset test, **and**
- The institutionalized spouse would get another 12 month period to transfer all of his/her assets in excess of $2000 to their community spouse.

Example 3: Peter was institutionalized and determined MA eligible in March of 2002. Janice, Peter's wife, remained in the community. In February 2003 Peter's assets were below $2000. Peter remained MA eligible and institutionalized through May 2003. In June 2003, Peter left the nursing home and joined Janice in their home in the community. His Medicaid eligibility ended on June 30, 2003.

In August 2003 Peter inherited $100,000. In September 2003, Peter's condition worsened and he was institutionalized again and applied for MA. All spousal impoverishment rules would be applied to Peter's September 2003 application. His eligibility would be based on a joint asset test, and if eligible he would have12 months to transfer assets in his name that exceed $2000 to his wife.

18.4.6.2.2 Loses Medicaid Eligibility But Remains Institutionalized

If the institutionalized spouse remains in the institution and remains Medicaid eligible after the 12 month transfer period but subsequently becomes ineligible and remains institutionalized, spousal impoverishment asset rules would not be applicable if s/he should reapply.

If the institutionalized person reapplies for Medicaid, her/his asset limit would be $2000 and the spouse's assets would not be counted.

If eligible, s/he would still be allowed to allocate some of her/his income to the community spouse.

Example 4: Gregory was institutionalized in December 2007. Gregory and his wife, Marcia, who remained in the community, passed the joint asset test. Gregory was found eligible and allowed until November 2008 to get under the $2000 asset limit. By November 2008 Greg had transferred enough assets to Marcia to get under the asset limit.

In March 2009, while Gregory remained institutionalized, he refused to sign over to Medicaid a health insurance payment check. His Medicaid eligibility was discontinued March 31, 2005 for failure to cooperate with *TPL* requirements. Greg has never left the institution and now reapplies for Medicaid on June 3, 2009. Since Greg never left the institution for 30 days or more since his original Medicaid spousal impoverishment application was approved (December 2007), the assets of his community spouse are not counted when determining eligibility for the application filed June 2009. Greg's asset limit for this application is $2000.00.

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18.5 SPOUSAL IMPOVERISHMENT INCOME

18.5.1 Nontrust Income
18.5.2 Trust Income

The income limit is the same as for institutionalized persons who don't have a *community spouse*. See 39.4 EBD Assets and Income Table.

18.5.1 Nontrust Income

Count non-trust income as belonging to the person who receives the payment.

1. If the payment is received in both spouses' names, count half for each.
2. If the payment doesn't specify the payee, count half for each *spouse*.
3. If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him/her, whether voluntarily or under a court order.

18.5.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him/her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it isn't assigned to a specific family *member*, divide it equally between those who receive it.

18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION

18.6.1 Spousal Impoverishment Income Allocation Introduction
18.6.2 Worksheet 7 Section A -- Community Spouse Income Allocation
18.6.3 Worksheet 7 Section B -- Family Member Income Allowance
18.6.4 Worksheet 7 Section C -- Cost of Care

18.6.1 Spousal Impoverishment Income Allocation Introduction

After the institutionalized person is found eligible, s/he may allocate some of his/her income to the *community spouse* and dependent family members living with the community *spouse*. Income that is allocated for the community spouse must actually be given to the community spouse each month, in order for it to be allowed as a post eligibility income deduction for the institutionalized spouse. However income that is allocated for a dependent family does not have to be actually given to the dependent family *member*.

Dependent family members include:

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

The institutionalized person must decide how much income to allocate. S/he may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or s/he may choose to allocate a lesser amount.

Since s/he may have medical costs that aren't covered by MA, s/he may wish to keep some income and not allocate it all.

Example 1: Caroline has monthly income of $400. She transfers $310 to her community spouse, keeping only her personal needs allowance (39.4.2 EBD Assets and Income Table) and $45 to pay as her monthly patient liability. She incurs $80 in non-covered medical expenses each month. Those expenses will be charged first to her patient liability. But she must pay the remaining $35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.

Use the *Spousal Impoverishment* Income Allocation Worksheet (See WKST 07) to determine how much of the institutionalized spouse's income:

1. May be allocated to his/her spouse (Section A).
2. Will be deducted, regardless of whether or not s/he actually allocated it to other dependent family members (Section B).
3. Will be paid toward his/her cost of care (Section C).

On the Spousal Impoverishment Income Allocation Worksheet (See WKST 07), do the following:

18.6.2 Worksheet 7 Section A -- Community Spouse Income Allocation

1. Enter on Line 1 the community spouse maximum income allocation. Unless a larger amount is ordered by a fair hearing or court, the maximum allocation is the lesser of:

   a. $2,739.00 **or**
   b. $2,428.33 plus excess shelter allowance. (See 39.4.2)

   "Excess shelter allowance" means shelter expenses above $728.50. Subtract $728.50 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,428.33. (See 39.4.2)

   Community spouse shelter costs include the community spouse's expenses for:

   i. Rent.
   ii. Mortgage principal and interest.
   iii. Taxes and insurance for principal place of residence. This includes renters insurance.
   iv. Any required maintenance fee if the community spouse lives in a condominium or cooperative.
   v. The standard utility allowance established under the FoodShare program:

If *Community Spouse* pays:	Add
Heat and utilities	$419
Utilities only	$292
Telephone only	$29
If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard	

utility allowance by the amount of utility expenses included in the maintenance fee.

For Community Waivers cases, follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:

- If the waiver person's community spouse lives with him/her, do not add the excess shelter cost to the income allocation.
- If the waiver person's community spouse does not live with him/her, add the excess shelter cost to the income allocation.

A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his/her necessary and basic maintenance needs with the amount allocated.

If a court or a fair hearing decision orders a larger Community *Spouse* Income Allocation, enter the court or fair hearing ordered amount on Line 1.

2. Enter on Line 2 the community spouse's monthly gross income. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.

3. Do the math from Line 1 through Line 3. The result on Line 3 is the maximum amount of income the institutionalized spouse may allocate to his/her community spouse.

If the institutionalized spouse does not allocate the maximum amount, the amount s/he retains counts as income in determining the amount contributed to the patient liability.

18.6.3 Worksheet 7 Section B -- Family Member Income Allowance

1. Enter $607.08 on Line 1 under the name of each dependent family member who lives with the community spouse.
2. Enter the gross monthly income of each dependent family member under his/her name. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.
3. Do the math from Line 1 through Line 3.
4. Add the Line 3 amounts together and enter the total on Line 4. Deduct the amount on Line 4 from the institutionalized spouse's income.

18.6.4 Section C -- Cost of Care

1. Enter the institutionalized person's gross monthly income on Line 1. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.
2. Enter his/her personal allowance on Line 2:

a. Personal Needs Allowance (39.4.2 EBD Deductions and Allowances) for a person in a medical institution, **or**

b. Personal Maintenance Allowance for a person in community waivers. This is the Community Waivers Basic Needs Allowance (39.4.2 EBD Deductions and Allowances) plus other applicable deductions (28.8.3.1 Personal Maintenance Allowance) up to the EBD Maximum Personal Maintenance Allowance amount (39.4.2 EBD Deductions and Allowances).

3. Enter on Line 4 the income allocation amount (Section A, Line 3) that is actually allocated to the community spouse.
4. Enter on Line 6 the dependent family member allowance from Section B, Line 4.
5. Enter on Line 8 any court-ordered guardian or attorney fees (27.6.6 Fees to Guardians or Attorneys).
6. Enter on Line 10 the institutionalized person's medical/remedial expenses and the cost of his/her health insurance premiums.

7. Do the math from Line 1 through Line 11. The result on Line 11 is the amount the institutionalized spouse must pay toward cost of care.

Example 2: Harry, a MA recipient, resides in a nursing home. He has unearned income of $3,600 a month. His wife, Edith, gets $200 a month from Social Security. Her sisters, Mabel and Maxine, whom she claims as dependents on her IRS tax forms, live with her. Mabel has no income. Maxine receives $20 a month from her son.

Community Spouse Income Allocation

Harry's community spouse, Edith, has shelter costs of $756.00 a month. Her excess shelter costs are $756.00 minus $728.50= $27.50. $27.50 plus $2,428.33 = $2,455.83. $2,455.83 is less than $2,739.00, so the maximum allocation amount to Harry's spouse is $2,455.83. (See 39.4.2)

$2,455.83 (maximum income allocation)
-200.00 (Edith's monthly income)
$2,255.83 (spousal income allocation)

Family Member Income Allowance

$ 607.08 (maximum income allowance) (18.6.3)
-0.00 (Mabel's income)
$607.08 (Mabel's income allowance)

$607.08(maximum income allowance) (18.6.3)
-20.00 (Maxine's income)
$ 587.08 (Maxine's income allowance)

$607.08 (Mabel's income allowance)
+$587.08 (Maxine's income allowance)
$1194.16 total family member income allowance)

Payment Toward Cost of Care

$ 3,600.00 (Harry's income)
-45.00 (personal needs allowance) (39.4.2 EBD Deductions and Allowances)
- $2,255.83 (spousal income allocation)
-$1,194.16 family member income allowance)
$ 105.01 (nursing home liability amount)

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18.7 SPOUSAL IMPOVERISHMENT EFFECTIVE DATE

This income allocation policy applies to persons who:

1. Were institutionalized persons (18.2.3 Institutionalized) on or after September 30, 1989. *Disregard* the length of time they were already institutionalized.

Example 1: John had been continuously institutionalized for 23 years on September 30, 1989. Apply the income allocation policy to John.

Example 2: Mildred has been continuously institutionalized since September 30, 1989. Apply the income allocation policy to Mildred.

Example 3: George lived in the community most of the time, but he was frequently institutionalized for short periods. He was in a continuous period of institutionalization on September 30, 1989. Apply the income allocation policy to George.

2. Became institutionalized person's (18.2.3 Institutionalized) on or after September 30, 1989 and were eligible for MA on the date of admission. The date of admission is the effective date for these persons.

Backdating: When requested by the *member*, test for Medicaid eligibility in the three months prior to the application month. Apply the Medicaid policies in effect during the backdate period. For backdate months, do not deduct the spousal income allocation amount from the institutionalized person 's income unless it was actually transferred to the *community spouse* in the backdate period. Calculate the income amount and the dependent family member income allocation in the same way as for current months.

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18.8 SPOUSAL IMPOVERISHMENT NOTICES

After the institutionalized person has been determined MA eligible, the following notices are sent to both spouses:

1. Notice of Medicaid Income Allocation (F-10097). This notice contains the amount of income allocated to the *community spouse*, and the amount of the institutionalized person's cost of care contribution.
2. Medicaid Recipient Asset Allocation Notice (F-10098). This notice specifies the amount of assets the recipient must transfer to the community *spouse* in order to retain MA eligibility. It also specifies the date by which the transfer must be made.

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18.9 COMMUNITY SPOUSE'S MEDICAID APPLICATION

Community spouses who apply for Medicaid must apply on a separate application from that of the institutionalized person. Count assets and income allocated and transferred to them by the institutionalized person when determining the community spouse's Medicaid eligibility. Beyond these, count only the assets and income belonging to the *community spouse*.

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19 RESERVED

CH. 19 RESERVED

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PROGRAM ADMIN. (CHS. 20 - 23)

20 VERIFICATION

20.1 VERIFICATION INTRODUCTION

20.1.1 Verification Definition
20.1.2 Documentation
20.1.3 Verification Receipt Date

20.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances. Documentation is a method by which you accomplish verification.

You will ask the questions needed to determine eligibility, but only need to verify mandatory and questionable items.

If the *member* is applying for other programs of assistance or if you are looking for sources of verification, see the specfic verification chapters for those programs in their respective handbooks.

20.1.2 Documentation

Case comments in CARES provide documentation. Your notes report what happened in collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed. There is no requirement to photocopy and file verification items.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate Income Maintenance agency or the next business day if verification is delivered after the agency's regularly scheduled business hours. Income Maintenance agencies must stamp the receipt date on each piece of verification provided.

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20.2 GENERAL RULES

1. Apply these verification instructions only to Medicaid
2. Only verify items necessary to determine eligibility for Medicaid.
3. If an item is not mandatory or questionable, do not verify it.

4. Do not over-verify. Requiring excessive pieces of evidence for any one item is over-verification. If you have all the verification you need, do not continue to require additional verification.
5. Do not verify information already verified unless you believe the information is fraudulent or differs from more recent information. If you suspect fraud exists, determine if you should make a referral for fraud or front-end verification (See 20.6 Front End Verification). Fraud in other programs of assistance does not affect MA verification.
6. Do not exclusively require a particular type of verification when various types are possible.
7. Do not target special groups or persons on the basis of race, religion, national origin or migrant status for special verification requirements.
8. Do not harass the *member* or violate his/her privacy, personal dignity, or constitutional rights. Respect personal rights.
9. If a member chooses to provide you missing but needed verification directly, do not require him/her to sign a release form. If s/he provides you with the required verification without a release and it is sufficient to establish eligibility, accept the verification.

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20.3 MANDATORY VERIFICATION ITEMS

20.3.1 Mandatory Verification Items Introduction
20.3.2 Social Security Number
    20.3.2.1 Emergency Services
20.3.3 Alien Status
20.3.4 Disability
20.3.5 Assets
    20.3.5.1 Divestment
20.3.6 Medical Expenses
20.3.7 Power of Attorney and Guardianship
20.3.8 Income

20.3.1 Mandatory Verification Items Introduction

Verify the following mandatory items:

1. SSN (20.3.2 Social Security Number).
2. Alien Status (7.3 Immigrants).
3. *Disability* and Incapacitation (5.2 Determination of Disability).
4. Assets for the *Elderly*, Blind and Disabled (16.1 Assets Introduction).
5. Divestment, for EBD (17.1 Divestment Introduction).
6. Medical Expenses, for deductibles only (24.7 Meeting the Deductible).
7. Documentation for Power of Attorney and Guardianship (20.3.7 Medical Expenses)
8. Migrant workers eligibility in another state (25.8.4.1 Migrant Workers Simplified Application), if applicable.
9. Physician certification (verbally or in writing) that the person is likely to return to the home or apartment with-in 6 months for institutionalized persons maintaining a home or property (15.7.1 Maintaining Home or Apartment) and is entitled to a home maintenance allowance.
10. Income
11. Citizenship and Identity (7.2 Documenting Citizenship and Identity).

Accept self declaration for all other items, unless you document them as questionable.

20.3.2 Social Security Number

Social Security Numbers (SSNs) need to be furnished for household members requesting Medicaid, but are not required from non-applicants.

SSNs should be recorded in CARES if obtained voluntarily from the *member*, or if the information is available through other information sources (e.g. bank statement).

An *applicant* does not need to provide a document or social security card. S/he only needs to provide a number, which is verified through the CARES SSN validation process.

If the SSN validation process returns a mismatch record, then the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN s/he must be willing to apply for one.

Inform the member if the SSN validation process suggests that another individual is using the same SSN. Advise the member to contact the Social Security Administration. The member may request Social Security Administration to conduct an investigation. Do not provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may:

1. Recommend further action be taken, **and/or**
2. Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

20.3.2.1 Emergency Services

Do not require or verify SSNs of members who receive emergency services only.

20.3.3 Alien Status

A member who indicates s/he is not a citizen must provide an official government document that lists his/her alien registration number. Verify the individual's alien status by using the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for BCPP (See the BC+ Handbook) and persons applying for EMA who do not provide proof of alien/immigration status can still qualify for those benefits.

An alien that presents documentation of his/her alien status and meets all other eligibility criteria is presumptively eligible. Begin benefits and determine, through SAVE, that s/he is in a satisfactory immigration status.

Verification of alien status is not needed if the person already provided proof when s/he applied for an SSN.

Do not re-verify alien status unless the member reports a change in citizenship or alien status.

20.3.4 Disability

For any person who wants to be considered disabled for Medicaid, including the Medicaid Purchase Plan (*MAPP*), *DDB* must complete a disability determination (5.3 Disability Application Process). There is no need to re-verify after the initial determination. Disability reviews are scheduled by DDB and they will send any new information to you. Receipt of *SSI* or *OASDI* benefits is verification of disability.

20.3.5 Assets

Verification of assets is mandatory for members requesting the following Medicaid subprograms:

1. EBD (categorically and medically needy).
2. EBD Special Status (503, Disabled *Adult* Child, Widow/widowers).
3. Medicaid Purchase Plan (MAPP).
4. Institutional Medicaid.
5. Community Waivers, including PACE and Partnership.
6. Family Care.
7. Medicare Premium Assistance Programs.

Also verify assets of community spouses for community waivers, institutional Medicaid and Family Care non-Medicaid. If reported assets exceed the asset limit, do not pursue verification.

Do not verify exempt assets.

Example 1: An EBD Medicaid member's burial plot is not counted in determining his/her Medicaid eligibility. Do not require verification of its value in determining the group's Medicaid eligibility.

Do not verify cash on hand.

20.3.5.1 Divestment

Verify if a member or *spouse* has divested assets when determining eligibility for institutional Medicaid and community waivers (17.1 Divestment Introduction).

20.3.6 Medical Expenses

Verify medical expenses if they are used to meet a deductible. Verify the expense and date of service.

20.3.7 Power of Attorney and Guardianship

Verify power of attorney and any guardianship type as specified by the court. Ask for any documentation regarding durable power of attorney or court-ordered guardianship. For applications and other relevant applicant information, refer to Power of Attorney as "Power of Attorney for Finances".

The IM Agency must determine the guardianship type specified by the court. Only the person designated as "guardian of the estate," "guardian of the person and estate," or "guardian in general" may attest to the accuracy of the information on the application form and sign it. Do not require a "conservator" or "guardian of the person" to sign the application form.

20.3.8 Income

Verify all sources of non exempt income for EBD Medicaid applicants and recipients. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/recipient is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e. checkstubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

a. Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member);
b. Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.
c. Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment, pensions, retirement income, etc.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e. check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if s/he has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance. In this situation, continue to attempt to obtain the verification. Once the

verification is received, benefits may need to be adjusted based on the verified information.

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20.4 QUESTIONABLE ITEMS

20.4.1 Questionable Items Introduction

20.4.2 Tuberculosis
20.4.3 Farm and Self-employment Income

20.4.1 Questionable Items Introduction

Information is questionable when:

1. There are inconsistencies in the group's oral or written statements.
2. There are inconsistencies between the group's claims and collateral contacts, documents, or prior records.
3. The *member* or his/her representative is unsure of the accuracy of his/her own statements.
4. The member has been convicted of Medicaid recipient fraud or has legally acknowledged his/her guilt of recipient fraud. Do not require a member to provide verification for the sole reason that they have acknowledged or been convicted of fraud in any other public assistance or employment program.
5. The member is a *minor* who reports that s/he is living alone. This does not apply to minors applying solely for FPW.
6. Unclear or vague (i.e., information provided, but not clear).

20.4.2 Tuberculosis

See 25.7 Tuberculosis for appropriate verification items if information provided is questionable.

20.4.3 Farm and Self-employment Income

See 15.6.6 Verification for appropriate verification items if information provided is questionable.

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20.5 MEMBER RESPONSIBILITY

Assist the *Member*
The IM worker has a responsibility to use all available data exchanges to verify information, but the *member* has primary responsibility for providing verification. The member must likewise resolve questionable information. Do not deny eligibility when the member does not have the ability to produce verification.

Assist the member in obtaining verification if s/he has difficulty in obtaining it.

Use the best information available to process the application or change within the time limit and issue benefits when the following two conditions exist:

1. The member does not have the power to produce verification, **and**
2. Information is not obtainable timely even with your assistance.

In this situation, seek verification later. When you have received the verification, you may need to adjust or recoup benefits based on the new information. Explain this to the member when requesting verification.

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20.6 FRONT END VERIFICATION

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. Refer a group for FEV only when it's characteristics meet a designated profile. See 3.2.2 of the IMM Fraud Prevention/ Front End Verification.

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20.7 WHEN TO VERIFY

20.7.1 Application and Review
20.7.1.1 Application
20.7.1.2 Eligibility Reviews
20.7.2 Changes

Verify mandatory and questionable items at application, review, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. Do not reverify one time only verification items.

Exception: Veterans benefits, including allowances for Aid and Attendance, Housebound, and Unusual Medical Expenses usually increase only once a year, in January. If an IM agency verifies the January veterans benefit increase, it does not have to re-verify the veteran benefit income at the time of the next scheduled eligibility review, which occurs later in that same year. If another change in the veterans benefit does occur between January and the next scheduled eligibility review, that income change will have to be verified. This exception is being adopted to reduce the verification workload for both the IM

agency and Veterans Administration staff, who routinely pursue and provide veterans benefit income verification every January.

20.7.1 Application and Review

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days. Advise the *applicant* of the specific verifications required within the 30 day processing time. Give the applicant a minimum of ten calendar days to provide any necessary verification.

Do not deny eligibility for failure to provide the required verification until the later of:

1. the 11th day after requesting verification, **or**
2. the 31st day after the application filing date.

If you request verification more than ten days prior to the 30th day you must still allow the applicant 30 days from the application filing date to provide the required verification.

20.7.1.2 Eligibility Reviews

Do not deny the group's eligibility for failure to provide the required verification until the 11th day after requesting verification or the end of the review month, whichever is later.

Example 1: Fred's eligibility review is due in April. He submits a mail-in review form on April 10th. The eligibility worker requests verification of his income on April 11th. If the verification is not submitted by April 30th, his eligibility will end on April 30th.

Example 2: Shannon's eligibility review was due in June. At *Adverse Action* in June a notice was sent to Shannon to let her know her Medicaid eligibility would end June 30th because she had not yet completed her review. A telephone interview was conducted on June 30th. A request for verification, with a July 10th due date, was sent to Shannon. Because the required verification (including signature) was not submitted by July 11th, her eligibility beginning July 1st was denied

20.7.2 Changes

Advise the recipient of the specific verification required and allow a minimum of ten days to provide it.

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20.8 ACTIONS

20.8.1 Positive Actions
20.8.2 Delay
20.8.3 Negative Actions

20.8.1 Positive Actions

Begin or continue benefits when:

1. The *member* provides requested verification within the specified time limits and is otherwise eligible.
2. Requested verification is mandatory, but the member does not have the power to produce the verification and s/he is otherwise eligible.

20.8.2 Delay

Notify the member of a processing delay when:

1. Verification is needed, and
2. S/he has the power to produce the verification, and
3. The minimum time period allowed for producing the verification has not passed.

CARES provides a verification checklist, to notify the member of the reason for the delay, the specific verification required, and the date the verification is due.

20.8.3 Negative Actions

Deny or reduce benefits when all of the following are true:

1. The member has the power to produce the verification.
2. The time allowed to produce the verification has passed.
3. The member has been given adequate notice of the verification required.
4. You need the requested verification to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility.

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20.9 RELEASE OF INFORMATION

You need someone's written release to get information from a verification source only when the source requires it.

When a source requires a written release:

1. Explain the requirement to the *member*.
2. Ask the member, his/her *spouse*, or another appropriate *adult* in the household to sign the necessary release form(s). The form may be:
    a. The CARES-generated or alternate pre-printed application forms.
    b. Release to *Disability* Determination Bureau form (F-14014)

Deny, discontinue or reduce benefits only when:

1. No appropriate person will sign the release form, and
2. The missing verification is necessary to determine eligibility, and
3. The member is unwilling or unable to provide the verification directly, and
4. The source requires a release, and
5. The release is the only way you can obtain the verification.

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20.10 VERIFICATION RESOURCES

Workers can access many sources of information through data exchanges such as income, Social Security (SS), Unemployment Compensation (UC), and birth

records. See the CARES Guide, Chapter 10 for instructions. See the IM Manual, Ch. 1, Part D, 4.0.0 for instructions on the SAVE (Alien Verification) System.

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21 BENEFITS

21.1 BENEFITS INTRODUCTION

Medicaid covers many health care services. However, limitations apply that ensure only medically necessary services are provided.

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

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21.2 FULL-BENEFIT MEDICAID

Those subprograms of Medicaid that are eligible to receive full- benefit Medicaid services include:

1. Katie Beckett Medicaid (25.6 Katie Beckett).
2. Home and Community Based Waivers Long Term Care (28.1 HCBWLTC Introduction).
3. Institutions Medicaid (27.1 Institutions).
4. BC+ and BC+ Extensions Standard Plan (See the BC+ Handbook)
5. EBD Medicaid (cat or med needy).
6. BC+ Continuously Eligible Newborn (CEN) (See the BC+ Handbook)
7. Foster Care Medicaid (See the BC+ Handbook)
8. Adoption Assistance Medicaid
9. Medicaid Met Deductibles (24.2 Medicaid Deductible Introduction)
10. Medicaid Purchase Plan (*MAPP*) (26.1 MAPP)
11. Wisconsin Well Woman Medicaid (See the BC+ Handbook)
12. *SSI*-Medicaid

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21.3 LIMITED BENEFIT MEDICAID

Limited benefit subprograms of Medicaid includes:

1. Medicare Buy-In Programs (32.1 Medicare Beneficiaries Introduction).
2. Emergency Services for Non-Qualifying Aliens
3. Tuberculosis-Related Medicaid (25.7 Tuberculosis).
4. Presumptively Eligible Pregnant Women (See the BC+ Handbook)
5. Family Care Non-MA (See the BC+ Handbook)
6. SeniorCare (33.1 SeniorCare Introduction)
7. Family Planning Waiver (See the BC+ Handbook)
8. BadgerCare Plus Benchmark Plan
9. BadgerCare Plus Core Plan

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21.4 COVERED SERVICES

21.4.1 Covered Services Introduction
21.4.2 Transportation
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21.4.1 Covered Services Introduction

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.

Examples of Medicaid covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. Federally Qualified Health Center (FQHC) services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment – ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.
8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.

11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    a. under 21 years of age.
    b. under 22 years of age and received services immediately before reaching age 21.
    c. 65 years of age or older.
12. Intermediate care facility services, other than services at an institution for mental disease.
13. Laboratory and X-ray services.
14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services).
32. *TB* (tuberculosis) services.
33. Transportation to obtain medical care.

If you or the member have additional questions, contact Member Services at 1-800-362-3002.

21.4.2 Transportation

Federal regulations require that Medicaid programs provide transportation to members who need to obtain Medicaid services. Transportation by ambulance, specialized medical vehicle (SMV) or IM agency approved common carrier is a covered Medicaid service when provided in accordance with the appropriate sections below.

21.4.2.1 Ambulance

Ambulance transportation is a covered service if it is provided by a Medicaid certified ambulance provider, and the member is suffering from an illness or injury that rules out other forms of transportation, and only if it is for:

1. Emergency care when immediate medical treatment or examination is needed to deal with or guard against a worsening of the person's condition.
2. Non-emergency care when authorized in writing by a physician, physician assistant, nurse midwife or nurse practitioner.

IM is not responsible for prior authorization for ambulance services.

21.4.2.2 Specialized Medical Vehicle (SMV)

A Specialized Medical Vehicle (SMV) is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of a SMV must have first aid training and CPR certification.

SMV transportation is a covered service if the person is legally blind, or indefinitely or temporarily disabled as documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner. The documentation from the provider must indicate why the person's condition prevents him/her from using a common carrier or private vehicle. In the case of a temporary *disability* , the documentation must indicate the expected length of time SMV services will be necessary, as well as why the person cannot use common carrier transportation.

SMV services are available only for transportation to a Medicaid covered service (including community waiver services if transportation is included in the per diem). A member's age, place of residence, lack of parental supervision, or lack of a driver's license are not qualifying criteria for SMV services.

The IM agency is not responsible for prior authorization for SMV services, but may refer a member who is unable to use common carrier to a Medicaid certified SMV provider.

Managed Care

Medicaid HMOs and special managed care programs authorize and reimburse transportation providers for ambulance and specialized medical vehicle services. Care Management Organizations (CMOs) do not cover common carrier or ambulance service, but do contract for SMV services. If a member is not in a HMO, s/he can call 1-800-362-3002 with questions on ambulance or SMV providers.

21.4.2.3 Common Carrier

Common carrier means any mode of transportation approved by an IM agency, except an ambulance or a SMV. Common carrier transportation is a covered service if the IM agency (or a designated agency) authorizes the transportation.

21.4.2.3.1 Transportation to Out-of-State Providers

Except for services provided by Medicaid-certified "border-status" providers, all non-emergency out-of-state services require prior authorization from the Medicaid program. According to s. HFS 101.03, a border-status provider is, "a provider located outside of Wisconsin who regularly gives service to Wisconsin recipients and who is certified to participate in Medicaid."

If the Medicaid program approves a request for out-of-state health care services, the transportation to receive the service may be covered if authorized by the IM agency. The IM agency may approve a request for the transportation only if prior authorization has been granted for the health care service that the recipient will be receiving from the out-of-state provider. The IM agency should not approve requests for out-of-state transportation if the Medicaid program has not authorized the out-of-state health care service.

As with other travel, approve the least expensive means of transportation, which the member can use, and which is reasonably available when the service is required. The IM agency may provide reimbursement up to the charges of the common carrier, for mileage expenses or a contracted amount the IM agency or its designated agency has agreed to pay the transportation provider. Related travel expenses may be covered as described below. The IM agency may request verification of expenses, or documentation that the trip occurred.

21.4.2.3.2 Transportation Administration

When providing common carrier transportation, the IM agency should use the most cost-effective mode of transportation possible. The IM agency reimburses transportation by common carrier. Members may contact the IM agency with questions on common carrier reimbursement.

Common carrier transportation requires authorization by the county/tribal agency prior to departure. The member or someone acting on his/her behalf may request the authorization. The request can be made by phone, in person, or in writing to the IM agency. Denials must be in writing and must explain why the request was denied. The county/tribal agency may delegate common carrier authorization to another county/tribal, or other local agency, provided members are assured of transportation to Medicaid covered services.

Issue authorizations and denials with reasonable promptness. For authorizations, specify the means of transportation authorized. If recurring

medical care is needed, you may authorize all of the trips needed for a specific time period.

21.4.2.3.3 Reimbursement

Follow these guidelines when approving or reimbursing transportation services:

1. Approve the least expensive means of transportation, which the member can use, and which is reasonably available when the service is required. If neighbors, friends, relatives or voluntary organizations have routinely provided transportation at no cost, the county or tribal agency does not have to approve that transportation.

2. Do not restrict approval according to the type of covered service. For example, you may not limit reimbursement for transportation to only urgent medical services or physician provided services.

3. Reimburse transportation only to and from a location where the member receives a Medicaid covered service.

   The IM agency may request documentation that a Medicaid covered service was provided:

   a. provision of covered services is questionable **or**
   b. The member was unable to obtain prior approval.

4. The county/tribal agency may limit reimbursement for mileage to the nearest provider if the member has reasonable access to health care of adequate quality from that provider.

Example 1: There is a pharmacy 11 miles from the member's home that could have filled his/her prescription. But s/he went to one 32 miles from home. Reimburse him/her on the basis of the shorter distance. The county or tribal agency may require provider documentation of the need for a specialized service at the location requested.

5. The IM agency may reimburse members who use their own vehicle up to $0.24 a mile, and may bill up to $0.26 a mile and keep up to $0.02 a mile for administration.

   If the vehicle is lift/ramp equipped, you may reimburse up to $0.50 a mile. The IM agency may bill $0.52 a mile and keep up to $0.02 a mile for administration.

6. A volunteer driver (someone who provides service to another person) may be reimbursed up to $0.33 a mile. If they carry more than one

member on a single trip, volunteer drivers may be reimbursed up to $0.35 a mile. The county or tribal agency may bill up to $0.36 a mile ($0.38 for more than one member on a single trip) and keep up to $0.03 a mile for administration.

7. You may reimburse public carriers, such as taxis and buses for non-contracted trips, up to their usual and customary charges to the general public. Reimburse the provider directly, or have the member pay for the transportation and reimburse him/her.

8. When no alternative transportation arrangements are available or when it is the most cost effective alternative, the IM agency may contract with SMVs or Human Service Vehicles (HSVs).

Limit reimbursement to no more than $1.05 per loaded mile for each member. Loaded mileage is the mileage driven when the member is on board.

When an agency contracts with a SMV, HSV, taxi company or similar entity, the agency may charge administrative costs of up to five percent of the amount paid. The amount paid must not exceed $1.05 per loaded mile for each member.

9. County or tribal agencies may operate their own program to transport members. They may claim reimbursement as follows:
    a. Car. Up to the rate per mile allowed for state employees who use their own car, and keep up to 3 cents per mile for administration.
    b. Van. Up to $.0.50 per mile and keep up to $0.05 per mile for administration. If the agency hires a driver for transporting members exclusively, it may claim up to $1.05 per mile. Do not claim additional amounts for the driver's salary or for administrative expenses.

    For the most current state rates, refer to http://dhs.wisconsin.gov/bfs/pdf/APP/Travel/trav10.pdf should be updated annually.

10. The county or tribal agency may not use common carrier transportation funds to pay drivers while they are not actively providing direct transportation services. Do not claim reimbursement for the cost of purchasing the vehicle.

11. The county or tribal agency may cover travel-related expenses if the travel is "other than routine." Travel that is other than routine may be

defined as trips that are significantly beyond the distances typically traveled to obtain health care services in a particular locality.

Related travel expenses may also include the cost of meals and commercial lodging en route to and from, and while receiving, a Medicaid-covered service. Related travel expenses may also include the cost of an attendant to accompany the member if, the member's age and/or physical condition warrants an attendant. If the member is age 16 years or older, the need for an attendant must be determined and documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner.

Only reimburse the cost of one attendant, unless the physician, physician assistant, nurse midwife, or nurse practitioner documents in writing, that the recipient's condition requires the physical presence of more than one attendant. The IM agency or its designated agency must maintain the statement of need.

Parking fees are not reimbursable as a "related travel expense."

12. An attendant is a person, in addition to the driver, that is specifically trained in procedures that are necessary for care and transportation of the member. An attendant's costs may include transportation, lodging, meals, and a salary.

When the attendant is a member of the member's family, limit reimbursable costs to transportation, commercial lodging and meals. A member's family consists of the member, his/her *spouse*, parent, stepparent, foster parent, sibling, half-siblings, the member's natural, adoptive, and stepchildren, grandparent, and grandchildren.

County/tribal agencies may approve up to four weeks of expenses without DHFS approval. A request for attendant care over four weeks requires prior authorization by DHFS. Send prior authorization requests to:

Transportation Policy Analyst
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Reimbursement for the member's and/or attendant's meals and lodging must be no greater than the amounts paid by the state to its employees for those expenses. Reimburse multiple night stays at state rates for employees. The minimum salary for an attendant must be the minimum

federal hourly wage. For the most current state rates, refer to http://www.dhs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf
The information in this page should be updated annually.

13. The county/tribal agency may establish their own procedures for cash advances to members.

14. Apply these reimbursement guidelines for members who are retroactively certified for Medicaid. They are entitled to request reimbursement of medical transportation costs that occurred during the retroactive period.

15. Medicare beneficiaries who are ineligible for Medicaid are not eligible for Medicaid transportation reimbursement.

16. For common carrier transportation, Medicaid will reimburse IM agency's for transportation costs that have prior authorization. The IM agency may also work with an HMO to coordinate the common carrier transportation.

Medicaid encourages IM agency's that choose not to contract with an HMO for transportation to work with the HMO so that the enrollee's transportation needs can be met.

21.4.2.3.4Transportation Waiver

When you deny a request for transportation expenses, tell the member that s/he can ask for a waiver. If s/he asks for a waiver, write up the waiver request.

In your waiver request

1. Refer to the Administrative Rule permitting waivers (HFS 106.13).

2. If the denial is for a family member's attendant services, note the waiver request is to waive Administrative Rule HFS 107.23 (3).

3. Describe the specific case situation.

4. Give your reason(s) for requesting the waiver. An example of a reason would be that enforcement of the requirement would result in unreasonable hardship for the person.

5. Sign the request and send it to:

Transportation Policy Analyst
Division of Health Care Financing
P.O. Box 309

Madison, WI 53701-0309

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21.5 CO-PAYMENT

A EBD Medicaid *member* may be required to pay a part of the cost of a service. This payment is called a “co-payment” or “co-pay”.

Members who do not have to pay a co-payment are:

1. Children under age 18 whose income is at or below 100% of the FPL,
2. Pregnant Women,
3. Children that are members of a federally recognized Tribe, **and**
4. Nursing Home Residents

Medical services exempt from co-payments are:

1. Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
2. Services related to pregnancy.
3. Family planning services and supplies.
4. Common carrier transportation, if provided through or paid for by a county/tribal human or social services department.
5. Home health services.
6. Personal care services.
7. Case management services.
8. Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.
9. Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year.
10. Hospice care services.
11. Substance abuse (alcohol and other drug abuse) day treatment services.
12. Respiratory care for ventilator-assisted members.

13. Community Support Program (CSP) services.

Providers are required to make a reasonable effort to collect the co-payment. Co-payments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a co-payment.

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21.6 HMO ENROLLMENT

21.6.1 HMO Enrollment Introduction
21.6.2 Exemptions
21.6.3 Change of Circumstances
21.6.4 Disenrollment
21.6.5 EDS Ombuds

21.6.1 HMO Enrollment Introduction

Most Medicaid members who are eligible for Family Medicaid and reside in a Medicaid HMO service area must enroll in a HMO.

Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the member's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.

This is the enrollment process:

1. Members residing in a HMO service area receive a HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose a HMO and how to find out if a provider is affiliated with a HMO.
2. If the *member* does not choose a HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in a HMO.
3. If the member has not chosen a HMO after four weeks, and lives in an area covered by two or more HMO's, s/he will be assigned a HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

4. S/he will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, s/he should contact the Enrollment Specialist at 1-800-291-2102.

21.6.2 Exemptions

A member may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.

If the member believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at 1-800-291-2102. The number is also in the enrollment materials they receive.

21.6.3 Change of Circumstances

Members who lose Medicaid eligibility, but become eligible again may be automatically re-enrolled in their previous HMO.

If the member's eligibility is re-established after the six-month period, s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.

21.6.4 Disenrollment

Members are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a non-Family Medicaid subprogram.
2. They become eligible for Medicare.
3. They lose eligibility.
4. They move out of the HMO's service area.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member's new area, s/he remains *fee-for-service*.

21.6.5 EDS Ombuds

Members with questions about their rights as HMO enrollees may call 1-800-760-0001 or write:

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823

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21.7 FORWARD HEALTH CARDS

21.7.1 Medicaid Cards Introduction
21.7.2 Appeals
21.7.3 Homeless
21.7.4 Lock-in Program
21.7.5 Temporary Cards
    21.7.5.1 Green Cards
    21.7.5.2 Tan Cards
21.7.6 Lost/Stolen Cards

21.7.1 Medicaid Cards Introduction

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.

Each person in the family who is eligible for Medicaid receives his/her own card. The cards do not display eligibility dates. All Medicaid services are paid for under the Medicaid ID number on the card. For newborns that do not have a Medicaid ID, Medicaid pays for all services within the first ten days of the baby's birth under the mother's Medicaid ID number. The baby need not be determined eligible for the claims to be paid. If the baby has a Medicaid ID, services are billed under that number. If the baby does not have a Medicaid ID, CARES will assign a pseudo ID number. EDS assigns a pseudo ID if the newborn is reported to them by a Medicaid HMO or hospital, and the newborn has not yet received an SSN.

Members will know if they are eligible based on positive and negative notices sent from the IM agency. Members who receive a notice that they are no longer eligible for Medicaid should keep their ForwardHealth cards. Cards should not be thrown away. If a *member* becomes eligible again, they will use the same ForwardHealth card originally issued. If they have questions regarding their eligibility status, they can call you or Member Services at 1-800-362-3002.

21.7.2 Appeals

Keep an Medicaid case in appeal status open if the member makes a request prior to the closure date. The member can continue to use their ForwardHealth card until a decision is made regarding his/her eligibility.

21.7.3 Homeless

Make ID cards available to homeless Medicaid members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

21.7.4 Lock-in Program

A program called 'Lock-in' is available in cases of benefit misuse. The member is assigned to a particular provider for services. When a member receives health care, the providers are told of the member's restriction(s) when verifying eligibility. If you have information that your member may be misusing benefits or his/her ForwardHealth card, send the member's name, address, card number, and a summary of the facts and any documentation to:

Division of Health Care Financing
Bureau of Health Care Program Integrity
P.O. Box 309
Madison, WI 53701-0309

Or call providers services at (800) 947-9627 or (608)221-9883 .

21.7.5 Temporary Cards

The following cards are the only paper Medicaid cards:

1. Green Cards
2. Tan Cards

21.7.5.1 Green Cards

EDS does not issue temporary cards. The IM Agency issues them. Each agency must issue a temporary card if the member does not already have a Forward Health card and needs health care within the two to three days before s/he receives one in the mail. The green temporary card is the only way the member may be able to receive services without having to pay out-of-pocket, since eligibility is not on MMIS yet for the provider to verify.

Order the green temporary Medicaid ID card stock from:

Medicaid Eligibility Maintenance
P.O. Box 7636
Madison, WI 53707-7636
Phone: (608) 221-4746
Fax: (608) 221-0885

When ordering, indicate the agency, contact person, and number of blank cards desired.

Include the following on each temporary ID card you issue:

1. Medicaid ID number.
2. Agency code.
3. Medical status code.

4. Member's full name.
5. Member's date of birth.
6. Member's sex (M or F).
7. Member's address.
8. Valid dates: Do not use future dates beyond the current benefit month.
9. Other insurance coverage. If private insurance, include the name. If Medicare, include the Medicare number as it appears on the member's Medicare card with "A" for Part A and/or "B" for Part B.

Do not issue a temporary card to members who would not normally receive a Forward Health card. Members in the following categories do not get a Forward Health card, so should not be issued temporary cards:

1. AE – Alien Emergency services. No card is necessary because only services directly related to the emergency are reimbursable by Medicaid.
2. FC - Family Care Non-Medicaid. Medicaid does not cover services provided to members in this category. If the member is enrolled in a Family Care *CMO*, limited services are provided entirely by that CMO.
3. *Medicare Premium Assistance* Programs
    a. SB – *SLMB* only
    b. SLMB+ – Qualified individual, group 1
    c. ALMB – Qualified individual, group 2
    d. QW – *QDWI*

Medicaid pays for these members' Part A and/or Part B Medicare premiums. No health care services are payable by Medicaid.

21.7.5.2 Tan Cards

Temporary tan cards are provided to the member from the PE provider after having completed a presumptive eligibility application and the provider has found the member eligible for PE. The provider sends the completed PE application to EDS. Once EDS receives the PE application from the provider and applies the PE eligibility to MMIS, a Forward Health card is sent to the member.

21.7.6 Lost/Stolen Cards

If a member needs a replacement card, s/he or an *authorized representative*, including the IM worker, should call Member Services at 1-800-362-3002. A new Forward Health card will be issued and will be sent out the following business day. The 16-digit number on the card is unique to each card. If a new card is issued, it will have a new card number to help prevent fraud and monitor card stock.

Replacement cards are issued automatically when:

1. The member's name changes.

2. The card was returned as undeliverable and the member's address changes.

A replacement for any other reason must be requested through Member Services, 1-800-362-3002.

You cannot request replacement cards using a F-10110 (formerly DES 3070) or CARES.

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21.8 WAIVER OF MEDICAID BENEFIT LIMITATIONS

Someone who is eligible for Medicaid but has been refused a specific Medicaid benefit by the provider can be given a waiver. The waiver lifts the limitation and allows the *member* to receive the benefit.

The provider of the service must request the waiver. The request goes to the Division of Health Care Financing (DHCF).

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21.9 THIRD PARTY COVERAGE

See 9.1 Third Party Liability.

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21.10 GOOD FAITH CLAIMS

21.10.1 Definition of Good Faith Claims
21.10.2 Denials
21.10.3 Causes and Resolutions
21.10.4 Process
21.10.5 Instructions

21.10.1 Definition of Good Faith Claims

A Good Faith claim is a claim that has been denied by Medicaid with an eligibility-related Explanation of Benefits (EOB) code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to EDS to be processed as a Good Faith claim. If the eligibility file has been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, EDS will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith form (F-10111) is used for this purpose. A Good Faith claim cannot be reimbursed until the EDS recipient file is updated.

21.10.2 Denials

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a Good Faith claim .

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not

	eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.
614	Medicaid number doesn't match recipient's first name.

21.10.3 Causes and Resolutions

Causes and A Good Faith claim can occur when:

1. A recipient presents an ID card that is invalid because:
    a. You issued a temporary ID card for a prior period or manually determined case and didn't update CARES or send EDS a to update the recipient's eligibility file. EDS will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the recipient is eligible for the dates on the card. The letter will include instructions on how to complete a (F-10111) and the information that is needed.
    b. The provider suspects the recipient of misusing or abusing a Medicaid ID card (i.e. using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and EDS can tell that it was altered, EDS will contact you to verify the recipient was eligible or forward it to the Division of Health Care Access and Accountability (DHCAA) for review.

2. The recipient's name has changed since the card was issued. EDS can usually resolve claims that are denied with code "029" and "614". If necessary, EDS will contact you to confirm the information.

With the implementation of the ForwardHealth ID cards, providers are less likely to receive one of the eligibility-related denials used for Good Faith claims submission. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When the provider verifies the member's eligibility, they are getting the most current information available on the MMIS. Therefore, it is unlikely that they will be told the *member* is eligible when s/he is not.

The most likely reason a Good Faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill Medicaid before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case,if the member presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the Good Faith claim , EDS will update the member's eligibility file with a good faith segment and pay the claim immediately.

EDS will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider doesn't send a copy of the ID card with the claim, EDS must confirm eligibility with you before the claim can be paid.

The definition of a 'valid' card is either a:

1. ForwardHealth card that indicates eligibility for the dates of service through the EVS.
2. A temporary paper card showing dates of eligibility.

21.10.4 Process

EDS initiates the Good Faith claim process by sending you a Good Faith form (F-10111) that they have partially completed, and one or two letters, depending on what documentation of eligibility the provider included with their claim. Complete the F-10111 form if this is a new member (cert. 1) or return a new F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

EDS
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed 3070 forms to:

1. Mail: EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: veds3070@wisconsin.gov

3. Fax: (608) 221-8815

21.10.5 Instructions

Agency Denial
If the member identified on this Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Recipient Did Not Have ID Card After Date of Service

Place an “X “in this box if you are certain that the member did not possess a valid Medicaid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible
Place an “X” in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found
Place an “X” in this box if the member has never been eligible for Medicaid in your agency.

Dates of Services
EDS enters the dates of service for the claim.

Partial Deny
Use this field only if the member had eligibility for some of the dates of service. Enter the “from” and “to” dates which cover the portion of the dates of service for which the member did not have eligibility.

Type of Certification
EDS will check one of these boxes:

1. Initial Certification
   EDS will place an “X” in this box when the member and Medicaid number submitted on the claim cannot be found on the eligibility master file.

2. 2. Amended Certification
   EDS will place an “X” in this box when the member is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number
EDS will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number
EDS will enter the known or suspected MMIS case number (primary person’s SSN + tie-breaker) of the member listed on the provider’s claim.

Action Date
EDS enters the date they completed the Good Faith form.

Medical Status Code
When EDS receives the provider’s claim along with a photocopy of an ID card, a hard copy response received through EVS or a transaction log number from the

Automated Voice Response (AVR). EDS compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, EDS enters a “71” medical status code and pays the claim immediately. EDS then enters the eligibility dates for the entire month in which services were provided.

If the member was eligible for the entire period of certification shown on the Good Faith form (F-10111) , remove the “71” medical status code and write in the correct code. Attach a F-10110 (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the member was eligible for Medicaid.

Period of Certification
If EDS has entered the suspected period of certification to be added to the recipient master file, check it for accuracy. Then complete a F-10110 (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth
EDS will enter the suspected control name and year of birth (YOB) for the member. This control name must be the first four letters of the member’s last name. The YOB is the last two digits in the member’s year of birth. Both of these items must match the information currently in the member’s EDS file.

Current ID Number
EDS will enter the member’s current Medicaid ID number.

Date of Birth
EDS completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate as MM/DD/CCYY.

Signature of Agency Director
Good Faith forms must have an authorized signature for initial certifications.

Worker ID
On initial certifications, enter the six-digit worker code of the certifying IM worker.

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22 ADMINISTRATION

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22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid home health and long-term care benefits by:

1. Liens against a home
2. Claims against estates
3. Affidavits
4. Voluntary recoveries

These procedures are the Estate Recovery Program (*ERP*). No ERP recovery may be made for Medicaid services provided before 10-01-91.

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the member's age and residence when s/he received the benefit.

Following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995 consisting of:
    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members 55 or older on or after April 1, 2000.
4. All home and community-based waiver services (COP Community Options Program Waiver, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver and Community Supported Living Arrangements) received by members age 55 or older on or after July 1, 1995 and:

a. Prescription/legend drugs received by waiver participants.
b. Benefits paid associated with a waiver participant's inpatient hospital stay.

These include inpatient services that are billed separately by providers and Services that are non-covered hospital services.

5. In pilot counties, Family Care services received by members age 55 or older on or after February 1, 2000 and:
    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.
6. Costs that may be recovered through a *lien* are:
    a. Medicaid costs for services received on or after October 1, 1991 during a nursing home stay.

b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000 by members 55 or older as of the date of the service.

22.1.2.1 QMB

Payments for 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.

22.1.3 Nursing Home Definition

For ERP purposes, "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes skilled nursing (*SNF*) and intermediate care facilities (*ICF* Intermediate Care Facility), in-patient psychiatric facilities and facilities for the developmentally disabled (FDD). "Nursing home" does not include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.
2. A hospice, as defined in §50.90(1) Wis. Stats., that directly provides inpatient care.
3. Community Waiver residence.
4. Institutions for mental disease (IMD Institute for Mental Disease) .

22.1.4 Liens

22.1.4.1 Notice of Intent to File a Lien
22.1.4.2 Out of State Property
22.1.4.3 Returns Home to Live
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22.1.4.5 Special Cases
22.1.4.6 Adjustment for Burial Trust
22.1.4.7 Administrative Hearing: Liens
22.1.4.8 Homes Placed in Revocable Trusts

DHS will not file a lien on:

1. Nonhome property.
2. Life estates.
3. *Homestead* property sold by land contract.

4. Property outside Wisconsin (See 22.1.4.2 Out of State Property).
5. A mobile home or the land it sits on when the *member* does not own the land.

DHS may file a lien on:

1. A home and all property used and operated in connection with that home.
2. A mobile home and the land it sits on, when the member owns the land.
3. A home placed in a *revocable trust* (See 22.1.4.8 Homes Placed in Revocable Trusts.

When a home is sold, DHS uses the lien to recover certain payments for Medicaid services provided as listed in 22.1.2 Recoverable Services. The lien's value is "open ended." The lien's value increases as the amount of recoverable Medicaid services paid accumulates.

Payment of the lien is made directly to DHS. Do not accept any payments relating to liens filed by DHS.

Contact the ERP Liens Specialist if the member's home is sold within 45 days after the Notice of Intent to File a *Lien* is completed.

The lien has no effect until filed.

Example 1: Mr. A applies for Medicaid on 03-06-95. He has a home and his circumstances require a lien. The IM agency sends a Notice of Intent to File a Lien on 03-10-95. ERP staff can not file a lien until 04-24-95 because of the required 45 day waiting period. Mr. A's legal representative sells the property on 04-10-95. Recovery of Mr. A's Medicaid payments by a lien on that property is not possible as the property was sold before a lien was filed. The IM agency contacts the ERP Lien Specialist to report on the home's sale.

22.1.4.1 Notice of Intent to File a Lien

Complete a Notice of Intent to File a Lien (F-13038 paper form) when an Medicaid member meets all the following criteria. S/he:

1. Lives in a nursing home or inpatient hospital and is required to contribute to the cost of care.
2. Has a home (16.1 Assets Introduction).
3. Is not expected to return to live at that home.

   Base this decision on the person's medical condition. His/her physician's statement that s/he can reasonably be expected to return home is sufficient support for the person's claim that s/he will return.

The physician's statement should include a description of the diagnosis and prognosis for the member. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the member, family, guardian, power of attorney, or physician, that the person will return home, consult with the Estate Recovery Program's Lien Specialist. Do NOT file a Notice of Intent to File a Lien until ERP staff have checked with the Department of Health and Family Services' medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.

4. None of these relatives of the member reside in that home.
   a. *Spouse*.
   b. Child who is:
      - Under age 21, **or**
      - Blind, **or**
      - Disabled.
   c. Sibling, if the sibling:
      - Has an equity interest in the home; **and**
      - Lived in the home continuously beginning at least 12 months before the member's nursing home or hospital admission.

When you have completed the Notice:

1. Mail or give the original to the member or his/her authorized representative.
2. Send a copy to the ERP office.
3. Attach a legible copy of the latest property tax bill or a copy of the property *deed* (if available) for any homestead property reported. This gives ERP staff the information necessary to obtain the legal description needed to file a lien.
4. File a copy in the case record.

ERP staff delays further action until the period given the member to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

22.1.4.2 Out of State Property

If an Medicaid member has property outside Wisconsin that would be subject to a lien if located in Wisconsin, provide the same data you would provide on Wisconsin property. Do not give a Notice of Intent to File a Lien.

DHS may not file liens against out-of-state properties. However, ERP staff wants data on these cases to assist in negotiating lien agreements with other states.

22.1.4.3 Returns Home to Live

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live, the lien must be released. Notify the ERP. ERP staff will release the lien.

22.1.4.4 Change in Circumstances

At review and other times, at local option, reexamine the circumstances of the member's home. If conditions change such that a lien must be filed, complete a Notice of Intent to File a Lien.

22.1.4.5 Special Cases

ERP staff applies special consideration for the following two case situations:

1. When a child (age 21 or older) of the member lives in the home, DHS is able to file a lien. It will not enforce the lien until that child moves or the home is sold if s/he:
    a. Lived in the home with the member for at least two years before the resident's admission to the nursing home or hospital, **and**
    b. Assisted the parent such that s/he helped delay the member's admission.
2. When a sibling of the member (other than a sibling described in 22.1.4.1 Notice of Intent to File a Lien) lives in the home, DHS is able to file a lien. It will not enforce the lien until that sibling moves or the home is sold if the sibling resided in the home for at least 12 months before the member's admission to the nursing home or hospital.

Alert the ERP when your member meets either of these two case situations.

22.1.4.6 Adjustment for Burial Trust

DHS may adjust the amount of its lien to allow a member to use proceeds from the sale of the home to establish or supplement a burial trust. ERP staff will review each situation individually. Refer any questions regarding lien satisfaction amounts or lien releases to the ERP staff.

22.1.4.7 Administrative Hearing: Liens

A member or his/her representative may request an administrative hearing if s/he feels the statutory requirements for imposing the lien have not been met. The IM Agency attends the hearing to explain the decision to file the Notice of Intent to File a Lien. The only issue at the hearing will be whether the following requirements were satisfied:

1. The member has an ownership interest in a home.
2. The member resides in a nursing home or hospital.
3. The member cannot **reasonably** be expected to be discharged from the nursing home or hospital and return home to live.
4. None of the following lawfully reside in the home:
    a. The member's *spouse*.
    b. The member's child who is:
        - Under age 21, **or**
        - Disabled, **or**
        - Blind.
    c. The member's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the member was admitted to the nursing home or hospital.

The request for an administrative hearing must be made in writing directly to the Division of Hearings and Appeals (DHA) at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request must be clearly marked "Medicaid Lien" and must be filed within 45 days of the mail date on the Notice of Intent to File a Lien. The date the written request is received by DHA is the date the hearing request is considered filed.

22.1.4.8 Homes Placed in Revocable Trusts

If a Medicaid member places his/her home in a revocable trust (16.1 Assets Introduction); s/he retains an ownership interest in the home. Complete a Notice of Intent to File a Lien if the member meets the conditions for a lien to be filed (See 22.1.4.1 Notice of Intent to File a Lien).

22.1.5 Estate Claims

22.1.5.1 Waiver of Estate Claim
22.1.5.2 Notice of Hardship Waiver Rights
22.1.5.3 Administrative Hearings: Hardship Waivers
22.1.5.4 Personal Representative's Report
22.1.5.5 Home as Part of the Estate

22.1.5.6 Affidavits in Small Sum Estates
22.1.5.7 Patient Fund Account
22.1.5.8 Voluntary Recovery (ERP)

DHS recovers Medicaid benefit costs from the member's estate. No claim is made on the member's spouse's estate for a Medicaid member's costs.

When DHS learns of the death of a member, it files a claim at probate court in the amount of Medicaid recoverable benefits.

The probate court will not allow a claim on the estate to be paid if any of the following survives the member:

1. A spouse.
2. A child, if the child is:
    a. Under age 21, **or**
    b. Blind, **or**
    c. Disabled.

Do not negotiate a settlement, accept any funds, or sign any release for estate claims that have been filed by DHS. ERP staff should be notified if a claim is filed by the county against an estate for recovery of overpayments or incorrect Medicaid benefits, for those 55 years of age or older or for any member who has resided in a nursing home.

Refer any questions about specific estate claims to the ERP staff.

22.1.5.1 Waiver of Estate Claim

In estates of members who die on or after April 1, 1995, an heir or beneficiary of the deceased member's estate may apply for a waiver of an estate claim filed by ERP. To be successful, the person applying for the waiver must show one of these three hardships exist:

1. The waiver *applicant* would become or remain eligible for AFDC, *SSI*, FS or Medicaid if ERP pursued the estate claim.
2. The deceased member's *real property* is part of the waiver applicant's business (for example, a farm) and the ERP recovery claim would affect the property and result in the waiver applicant's loss of his/her means of livelihood.
3. The waiver applicant is receiving general relief or veteran's benefits based on need under §45.351(1) Wis. Stats.

The waiver application must be made in writing within 45 days after the day:

1. ERP mailed its recovery claim to the probate court or its affidavit to the heir, **or**
2. ERP mailed its notice of waiver rights, whichever is latest.

The waiver application must include these points:

1. Relationship of the waiver applicant to the deceased member.
2. The hardship under which the waiver is requested.

ERP staff must issue a written decision granting or denying the waiver request within 90 days after the waiver application is received by ERP. In determining its decision, ERP must consider all information provided to it within 60 days of its receipt of the waiver application.

22.1.5.2 Notice of Hardship Waiver Rights

ERP will provide notice of the waiver provisions to the person handling the deceased member's estate. If ERP is not able to determine who that person is, the notice will be included with the claim when ERP files it with the claim court.

The person handling the estate is then responsible for notifying the decedent's heirs and beneficiaries of the waiver provisions.

22.1.5.3 Administrative Hearings: Hardship Waivers

If a waiver application is denied, the waiver applicant may request an administrative hearing. ERP staff will attend the hearing to defend their denial of the hardship waiver.

The hearing request must be made within 45 days of the date the ERP decision was mailed.
The hearing request must:

1. Be made in writing.
2. Identify the basis for contesting the ERP decision.
3. Be made to the Division of Hearings and Appeals (DHA) at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The date the request is received at DHA is used to determine the timeliness of the request.

ERP staff will maintain DHS' claim in the estate pending the administrative hearing decision. If collections are made and the waiver is ultimately approved, those funds will be returned.

To introduce evidence at a hearing not previously provided to DHS, the applicant must mail that evidence to DHS with a postmark at least seven working days before the hearing date.

22.1.5.4 Personal Representative's Report

The personal representative of the estate of an Medicaid member must notify DHS that the estate is being probated [§859.07(2), Wis. Stats.]. The notification must be by certified mail and include the date by which claims against the estate must be filed.

22.1.5.5 Home as Part of the Estate

When a home **is part of the estate**, the court may impose a lien equal to the Medicaid payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example 2: Mr. A dies. A claim on his estate is filed and the estate includes his home. His spouse is deceased and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. A's home. A lien is placed on the home but cannot be enforced because the *minor* child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased member:
   a. Resides in the member's home, **and**
   b. That child resided in that home for at least 24 months before the member entered the nursing home, hospital, or received home and community-based waiver services, **and**
   c. That child provided care that delayed the member's move to the nursing home, hospital, or his/her receipt of home and community-based waiver services.
2. A sibling of the deceased member:
   a. Resides in the member's home, **and**
   b. Resided in that home for at least 12 months before the date the member entered a nursing home, hospital, or received home and community-based services.

The lien filed in one of these two instances will be payable at the death of the child or sibling or when the property is transferred, whichever comes first.

However, if the child or sibling sells the home covered by the DHS lien, and uses the sale proceeds to buy another home to be used as that child's or sibling's primary residence, then:

1. DHS will transfer the lien to the new home if the amount of the child or sibling's payment or down payment for the new home is equal to or greater than the proceeds from the original home.
2. If the down payment on the new home is less than the proceeds from the sale of the original home, DHS will recover the amount of the proceeds above the down payment, but no greater than the lien amount. If there is an amount in the lien still not satisfied, DHS will file a lien for the remaining amount on the new home.

22.1.5.6 Affidavits in Small Sum Estates

Heirs of a deceased Medicaid member must notify ERP before transferring any of the deceased funds through a Transfer by Affidavit ($20,000 and Under) (§867.03, Wis. Stats.). The heir must send a copy of the affidavit to ERP by certified mail, return receipt requested. S/he must wait ten days from the delivery date on the return receipt card before transferring the deceased's funds. Property considered to be the home of a Medicaid member who passed away after September 1, 2001 and is being transferred by an affidavit is subject to a lien if the state's claim cannot be satisfied through available liquid assets Liquid assets are defined as cash or assets which can readily be converted to cash. Examples include: bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/recipient and negotiable; etc.. The DHS may not enforce the lien while any of the following survive:

1. Spouse,
2. Child who is:
    a. Under age 21, **or**
    b. Blind, **or**
    c. Disabled.

If an heir claims the patient account fund or transfers the deceased's funds from a financial institution, ERP will send an affidavit to the heir to recover any funds remaining after burial and estate administration costs have been paid. Funeral costs are limited to those expenses connected with the funeral service and burial. A marker for the grave is considered a burial cost. Memorials and/or donations to churches, organizations, persons, or institutions are not considered burial costs.

ERP will recover any funds that remain from a burial trust after costs have been paid.

Direct specific questions about questionable allowable costs to ERP staff.

22.1.5.7 Patient Fund Account

Nursing homes are required to notify ERP when a Medicaid member dies with money left in his/her nursing home patient fund account if s/he has no surviving spouse or minor or disabled child.

ERP will claim from the nursing home any funds remaining in the patient account after payment of funeral and burial expenses and outstanding debts from the last month of illness that are not chargeable to Medicaid.

22.1.5.8 Voluntary Recovery (ERP)

When a member age 55 or older wishes to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce a potential claim in an estate, forward the payment to ERP. First check, BVCI to make sure there is not an outstanding Medicaid claim for an overpayment since the money should be applied to an overpayment first. Voluntary payments, except for prepayment of a deductible may only be up to the amount of Medicaid paid to date. (See 22.1.10 Voluntary Recovery (Not ERP) for voluntary recoveries for members under age 55.)

The check or money order should be made payable to DHS.

Mail the payment to:

Estate Recovery
6406 Bridge Road
Madison, Wisconsin 53784-0013

With the payment, include:
1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.
3. Name and address of the person who should receive the receipt.

These refunds will be credited to the member and will be used to offset any claim that may be filed in the member's estate.

Incentive payments of 5% will be paid to the IM Agency for refunds.

Advise heirs and beneficiaries of deceased members who wish to make a voluntary refund to call ERP staff.

22.1.6 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form and data received through the *SSA* State Data Exchange (SDX) tape (for SSI/Medicaid members) is on the database.

The database is compared to the death record files of the Division of Health Care Financing, Vital Records and State Registrar Section.

When a match shows an Medicaid member or his/her surviving spouse has died, a report record is produced. ERP staff check the report against lists of new probate proceedings sent monthly by county registers in probate. This is a back up to the requirement that DHS be notified of the last date for filing claims.

22.1.7 Notify Members

Provide a copy of the Wisconsin Medicaid Estate Recovery Program brochure (PHC 13032) to every Medicaid member 54 1/2 years old or older or institutionalized at application and review. Have each member or his/her representative read the notice of liability on the CAF Combined Application Form ("Recovery of Medical Benefits"). S/he acknowledges understanding of this notice when signing the CAF.

22.1.8 Disclosure Form

Complete an Estate Recovery Program Disclosure Form whenever a Medicaid member:

1. Enters or resides in a nursing home, **or**
2. Enters or resides in an inpatient hospital and is required to pay a Medicaid cost of care liability, **or**
3. Becomes 55 years old.

Do this even if s/he has zero assets.

Complete the form with information about the member, his/her spouse, and his/her children that are blind, disabled, and under age 21.

Attach a legible copy of the latest property tax bill or a copy of the property deed for any homestead property reported if possible. This may give ERP staff the property's legal description needed to file a lien.

Request the member or his/her agent to sign the completed form. If s/he will not sign the form:

1. Sign the form at the "Member Signature" line.
2. Note near your signature that you reviewed the data with the person or his/her agent. Indicate:

a. That s/he did or did not agree the data was accurate.
b. The reason s/he did not sign.

In a mail-in application situation, document if the form was not returned or was returned without a signature.

Send the completed form to the ERP. File a copy in the case record.

You need not update this form unless there is a substantial change in circumstances (for example, an inheritance).

22.1.9 Estate Recovery Program (ERP) Contacts

The ERP address is:

Estate Recovery Program Section
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer members to Member Services at 1-800-362-3002.

Direct case-specific questions about:

1. Estate recovery disclosure forms and liens to the Lien Specialist, (608) 264-6758.
2. For estates of $20,000 or less, provide the phone number of the "Affidavit Help Line," (608) 264-6756, to heirs of a deceased members who have questions about ERP. The Help Line provides recorded messages that answer the most frequently asked questions regarding small sum estates. It also provides the caller with an opportunity to either leave a message or talk to ERP staff.
3. Probated estate claims and voluntary ERP payments to the appropriate Estate Recovery Specialist. For the counties listed contact:

Estate Claims Specialists	
(608) 264-6757	**(608) 266-6777**
Bad River Tribal	Adams
Calumet	Ashland
Chippewa	Barron
Clark	Bayfield
Columbia	Brown
Crawford	Buffalo
Eau Claire	Burnett
Jackson	Dane
Jefferson	Dodge
Juneau	Door
Kenosha	Dunn
Kewaunee	Florence
Lac du Flambeau Tribal	Fond du Lac
LaCrosse	Forest
Lafayette	Grant

Langlade Lincoln Milwaukee Racine Richland Rock Rusk Sauk Sawyer Shawano Sheboygan St. Croix Stockbridge-Munsee Tribal Walworth Washburn Washington Waukesha Waupaca Waushara Winnebago Wood	Green Green Lake Iowa Iron Manitowoc Marathon Marinette Marquette Menominee Monroe Oconto Oneida Oneida Tribal Outagamie Ozaukee Pepin Pierce Polk Portage Price Red Cliff Tribal Taylor Trempeleau Vernon Vilas

22.1.10 Voluntary Recovery (Not ERP)

Accept payments from a member under age 55 made for purposes of Medicaid eligibility or prepaying a Medicaid deductible.

Instruct the member to make the payment payable to your IM Agency. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

22.1.11 Incentive Payments

DHS will return to local agencies 5% of collections made through a lien, voluntary payments and probated estate recoveries. We will pay this incentive to the last county/tribal agency certifying the member for Medicaid.

The payments are discretionary. DHS will make them based on county/tribal compliance with program requirements.

22.1.12 Other Programs

ERP also recovers for Community Options Program (COP Community Options Program), Wisconsin Chronic Disease Program (WCDP), Medicaid and non-Medicaid Family Care, and Partnership. ERP does not recover for PACE.

22.1.13 Recoverable Services Chart

	Nursing Home Resident Medicaid	**Hospital Inpatient Medicaid**	**Community Resident Medicaid**	**Medicaid Waiver**	**FC Medicaid FC-Non Medicaid**	**Partn**
Age	Any age	Any age	55 years of age or older	55 years of age or older	55 years of age or older Any age NH/Hospital	55 yea or olde Any ag NH/Ho
Services on or after	10/01/91	07/01/95	07/01/95	07/01/95	2/1/00	3/1/09
Recoverable Services	All Medicaid benefits paid while residing in nursing home	All Medicaid benefits paid while residing as an inpatient in a medical institution (hospital)	• Home health skilled nursing • Home health aide services • Home health therapy and speech patholog y • Private duty nursing • Personal care services (receive d on or after 4/1/00)	• Home health skilled nursing • Home health aide services • Home health therapy and speech pathology • Private duty nursing • All waiver services • Prescription/ legend drugs • Benefits paid associated with an inpatient hospital stay • Personal care services (received on or after 4/1/00)	• CMO's actual costs of services as reported to DHS • Prescription/ legend drugs • Benefits paid associated with an inpatient hospital	• H h s n • H h s • H h th s p • P n • A s • P le d • B p a w in h • P c s

Effective 4/1/00: If the recipient meets all of the following:

1. Resides in a nursing home, or hospital.
2. Is required to contribute to the cost of care.

3. Is not reasonably expected to return home to live.
4. A lien is filed on their home.

All services listed above that were received on or after 4/1/00 may be recovered through the lien, except Family Care services which may be recovered as of 2/1/00.

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22.2 CORRECTIVE ACTION

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22.2.1 Overpayments

22.2.1.1 Recoverable Overpayments
22.2.1.2 Non-Recoverable Overpayments

An “overpayment” occurs when Medicaid (Medicaid) benefits are paid for someone who was not eligible for them, or when Medicaid payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the Medicaid benefits incorrectly provided. Some examples of how overpayments occur are:

1. Concealing or not reporting income.
2. Failure to report a change in income or assets.
3. Providing misinformation, at the time of application, regarding any information that would affect eligibility.

22.2.1.1 Recoverable Overpayments

Initiate recovery for a Medicaid overpayment if the incorrect payment resulted from one of the following:

1. *Member* Error

Member error exists when an *applicant*, recipient, or any other person responsible for giving information on the member’s behalf, unintentionally misstates (financial or non-financial) facts, which results in the *member* receiving a benefit that s/he is not entitled to or more benefits than s/he is entitled. Failure to report non-financial facts that impact eligibility or cost share amounts is a recoverable overpayment effective July 27, 2005. For ongoing cases, September 1, 2005 is the earliest a claim can be established for failure to report a non-financial change. For applications on/after July 27, 2005, overpayment claims can be established effective with the application date.

Member error occurs when there is a:

a. Misstatement or omission of facts by a member, or any other person responsible for giving information on the member’s behalf, at a Medicaid application or review, **or**
b. Failure on the part of the member, or any person responsible for giving information on the member’s behalf, to report changes in financial (income, assets, expenses, etc.) or non-financial information that affects eligibility, premium, patient liability or cost share amount.

A Medicaid member is responsible for notifying his/her IM worker of changes within 10 days of the occurrence.

An overpayment occurs if the change would have adversely affected eligibility benefits or the post eligibility contribution amount (cost share, patient liability).

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 2: Sally, determined eligible for waivers in January with a cost share, experienced a reduction in her health insurance expense in July, but did not report that to her worker until her November review. The worker made the changes in CARES and increased her cost share for December.

What can now be recovered ?
Had Sally reported timely, her cost share would have increased beginning in August. Since the new policy is effective 7/27, August is the first month the agency can recover. The overpayment is the difference between the new cost share and the old cost share for August, September, October and November.

Example 3: Shana was determined eligible for Well Woman Medicaid (WWWMA) in February. She had private insurance, but due to a waiting period for preexisting conditions, her treatments weren't covered. The waiting period ended July 31st, and the private insurance began to cover Shana's treatment effective August 1st. Shana did not report this to her worker so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30. Since her case would have closed August 31st if she had reported the change timely, Shana has an overpayment for September through November. What can now be recovered – Giving AA notice, WWWMA would have closed August 31, 2005. The Fee For Service claims paid for September, October and November are recoverable.

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.

2. Fraud

Fraud is also known as Intentional Program Violation (IPV).
Fraud exists when an applicant, recipient, or any other person responsible for giving information on the member's behalf does any of the following:

1. Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
2. Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
3. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
4. Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

If there is a suspicion that fraud has occurred, see 22.2.4 Refer to District Attorney for information about referral to the District Attorney (DA).

3. Member Loss of an Appeal

Benefits a member receives due only to a fair hearing order can be recovered if the member loses the appeal.

A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount.

22.2.1.2 Non-Recoverable Overpayments

Do not initiate recovery for a Medicaid overpayment if it resulted from a non-member error, including the following situations:

1. The member reported the change timely, but you could not close the case or reduce the benefit due to the 10-day notice requirement.
2. Agency error (keying error, math error, failure to act on a reported change, etc).
3. Normal prospective budgeting projections based on best available information.
4. A change in the Medicaid category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

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.

22.2.2 Overpayment Calculation

22.2.2.1 Overpayment Period
22.2.2.2 Overpayment Amount
22.2.2.2.1 Institutional Overpayments
22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact
22.2.2.3 Deductible
22.2.2.4 Premiums
22.2.2.4.1 Overpayments for Individuals Eligible for FPW Benefits
22.2.2.4.2 Overpayments for QMB cases
22.2.2.5 Determining Liable Individual

22.2.2.1 Overpayment Period

If the overpayment is a result of a misstatement or omission of fact during an initial Medicaid application, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (22.2.2.2 Overpayment Amount).

The ineligible period should begin with the application month.

For ineligible cases, if the overpayment is a result of failure to report a change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date

the case would have closed or been adversely affected allowing for proper notice. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.

22.2.2.2 Overpayment Amount

Use the simulation function in CARES to determine a member's eligibility, nursing home liability, premium or cost share (if applicable) based on the corrected information (CARES Guide Chapter VIII, 1.4.1). Use the actual income received by the member in determining if an overpayment has occurred.

To calculate the overpayment amount, use the RC (recipient claims) screen on MMIS. The overpayment amount depends on the Medicaid category and whether the case is *fee-for-service* or enrolled in a HMO.

If a case was ineligible due to excess income recover :

1. The lesser of FFS services Medicaid paid or the amount the member would have paid toward a deductible (If eligible for a deductible)

or

2. The lesser of what the member paid or would have paid toward the deductible and the amount Medicaid has spent on HMO capitation payments.

If a case/individual was ineligible for reasons other than excess income or not eligible for a deductible) recover the:

1. Amount paid for the medical services provided if the case is fee-for-service.

or

2. *Managed care* organization's capitation rate, less any contribution made by the member (ex. premium, cost share) if the case members are enrolled in a Medicaid managed care organization. The capitation rate is the monthly amount Medicaid pays to the member's managed care organization.

For the overpayment amounts for institutional (22.2.2.1 Overpayment Period), waiver (22.2.2.1 Overpayment Period), BadgerCare (22.2.2.3 Deductible), Medicaid Purchase Plan (22.2.2.3 Deductible), deductible (22.2.2.2 Overpayment Amount) and Family Planning Waiver (FPW) cases see the appropriate sections.

22.2.2.2.1 Institutional Overpayments

The overpayment amount for an institutional case is the amount Medicaid paid.

Note: Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.

22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact

If a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability/cost share amount and the one the member originally paid is the overpayment amount.

Do not send a F-10110(formerly DES 3070) to retroactively increase the patient liability on MMIS.

Family Care

For Family Care (FC) cases in which an omission of fact results in an increased Family Care liability or cost share, complete the following:

1. Recalculate the cost share or FC liability for any months that would have been affected.
2. Calculate the difference between the paid cost share or FC liability amount and the new cost share or FC liability amount.
3. Send the member a notice indicating the correct cost share for the months in question. Indicate on the notice the cost share amount still owed to the Care Management Organization (*CMO*) for each month in question. Do not attempt to recover the overpayment.
4. Report the new cost share amount to the CMO.

It is the CMO's responsibility to collect the difference between the cost share already paid and the correctly calculated cost share amount. This amount is not an overpayment of Medicaid funds, but is the amount that the member owes the CMO directly.

22.2.2.3 Deductible

If a member error increases the deductible before the deductible is met, there is no overpayment. Recalculate eligibility and notify the member of the new deductible amount.

If the member met the incorrect deductible and Medicaid paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount or the amount of claims over the six month period (whichever is less) .

If the member was ineligible for the deductible, determine the overpayment amount. If the member prepaid his/her deductible, deduct any amount s/he paid toward the deductible from the overpayment amount.

22.2.2.4 Premiums

If a BadgerCare (BC) or Medicaid Purchase Plan (*MAPP* The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program.) case was still open for the timeframe in question, but there was an increase in the premium, recover the difference between the premium paid and the amount owed for each month in question. To determine the difference, determine the premium owed and view the premium amount paid on CARES screen AGPT.

BadgerCare
If the case was ineligible for BC, recover the amount of medical claims paid by the state and/or the capitation rate. Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount (22.2.2.2 Overpayment Amount).

The overpayment amount is the difference between the premium paid and premium owed even if the premium that was paid was $0.

Example 7: Tom and his family became eligible for BadgerCare in June 2004 without a premium. In his application Tom failed to disclose income from a second job which would have resulted in a $100 per month premium. This new information was discovered in July 2004.

Overpayment Calculation
$100 premium owed for June
+ $100 premium owed for July
$200 Total premium owed
- $ 0 premium paid
$200 Overpayment

MAPP
If the case was ineligible for MAPP, recover the amount of medical claims paid by the state. Deduct any amount s/he paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

22.2.2.4.1 Overpayments for Individuals Eligible for FPW Benefits

If an individual or case was ineligible for Medicaid or BC but would have been eligible for FPW benefits, the calculation of the ultimate Medicaid overpayment amount is as follows:

If the incorrect/overpaid Medicaid benefits were "fee for service" medical claims paid by the state, recover the amount of benefits that were actually paid by the state minus any premiums which the member may have paid and the amount of any actual FPW services that were provided.

If the incorrect /overpaid Medicaid benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the member may have paid and the "average" (currently $28.60) monthly cost of Medicaid FPW services.

22.2.2.4.2 Overpayments for QMB cases

The overpayment amount for *QMB* cases is:

1. Medicare Part A premium if paid by the state (some are free others are paid by the state).

plus

2. Medicare Part B premium

plus

3. Medicare deductibles

plus

4. Medicare Co-insurance

Use the MMIS RC screen to determine if any Medicare deductibles and co-insurance payments were made by the state.

22.2.2.5 Determining Liable Individual

Except for minors, collect overpayments from the Medicaid member, even if the member has authorized a representative to complete the application or review for him/her.

Example 8: Sofie applied for Medicaid in December, and at that time designated her daughter, Lynn, as her *authorized representative*. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for Medicaid. Sofie was determined to be ineligible for Medicaid from December through March. Recover from Sofie for any benefits that were provided to her from December through March.

If a *minor* received Medicaid in error, make the claim against the minor's parent(s) or legally responsible relative if the parent or legally responsible relative was living with the minor at the time of the overpayment.

22.2.3 Overpayment Process

22.2.3.1 Overpayment Process Introduction
22.2.3.2 Member Notice

22.2.3.1 Overpayment Process Introduction

Follow the instructions in Chapter VIII of the CARES Member Assistance for Re-employment & Economic Support Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered. You are responsible to:

1. Enter the claim into CARES.
2. Send a manual Medicaid Overpayment Notice (F-10093) indicating the reason for the overpayment and the period of ineligibility.
3. Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.
4. Record payments on CARES screen BVCP within five days of receipt.

CARES will:

1. Track the issuance of notices of non-payment and send automated dunning notices (i.e. past due notices).
2. Refer past due claims for further collection action (i.e. tax intercept) to the Central Recoveries Enhanced System (CRES).
3. Close the claim when the balance is paid.

22.2.3.2 Member Notice

Notify the member or the member's representative of the period of ineligibility, the reason for his/her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

22.2.4 Refer to District Attorney (DA)

See IMM Chapter 3, Public Assistance Fraud Program for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

22.2.5 Fair Hearing

The IM Agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

22.2.6 Agency Retention

The IM Agency can retain 15% of the payments recovered. See IMM Chapter 3.3.8 Local Agency Retention.

22.2.7 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his/her Medicaid from the date of the incorrect denial or termination through the time period that s/he would have remained eligible.

If the member was incorrectly denied or terminated for BC or MAPP The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program. with a premium obligation. Allow the member to pick which months s/he would like to receive benefits. Collect all premiums owed for all prior months before certifying the member for the months s/he chose.

If a member already paid for a Medicaid covered service, inform the member that s/he will need to contact his/her provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

22.2.8 Incorrect Member Contribution

22.2.8.1 Premiums
22.2.8.1.1 BadgerCare
22.2.8.1.2 Medicaid Purchase Plan (MAPP)

22.2.8.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BC or MAPP The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program. and would result in a refund for the member, determine the correct premium amount for each month in which it was incorrect.

When reporting the refund to the BadgerCare or MAPP Unit, include the:

1. The member's Social Security Number.
2. Months for which a refund needs to be issued.
3. New premium amount.
4. Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

22.2.8.1.1 BadgerCare

If the premium was recalculated and reduced for prior month(s), report the premium refund to the BadgerCare Unit by:

Telephone: 1 (888) 907-4455
Fax: (608) 251-1513

When submitting a fax, write "Attn: BC Premium Refunds".

22.2.8.1.2 Medicaid Purchase Plan (MAPP)

If the premium was recalculated and reduced for prior month(s), report the premium refund to the MAPP Unit by:

Telephone: 1 (888) 907-4455
Fax: (608) 251-8185

When submitting a fax, write "Attn: MAPP Premium Refund"

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22.3 INTERAGENCY CASE TRANSFER

A case transfer occurs when the primary person, receiving benefits from a county or tribal Income Maintenance agency for a particular month, applies for aid from another Income Maintenance agency for the same or next month. The primary person must be a *member* of a currently open Medicaid Assistance Group or one that has been closed for less than a calendar month.

The agency to which the member reports the move must collect information about the changes, for example, the new address. If the agency does not have sufficient information about the changed circumstances, it must request information from the member, according to the Medicaid verification policy (20.1 Verification Introduction).

CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.

Do not require a review or new application for case transfers, except in the following programs:

Community Wavers (28.1 HCBWLTC Introduction)
Family Care (29.1 Family Care Long Term Care (FCLTC) Introduction)
Deductible Met (24.11 Deductibles and Inter-Agency Transfers)

See 6.1 of the Process Help for information on how to process case transfers.

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23 RESERVED

CH. 19 RESERVED

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SUBPROGRAMS (CHS. 24- 38)

24 SSI RELATED MEDICAID AND DEDUCTIBLES

24.1 SSI RELATED MEDICAID INTRODUCTION

SSI related Medicaid is the original, basic Medicaid program for individuals who are *elderly*, blind, or disabled (EBD). SSI related individuals must meet all appropriate Medicaid nonfinancial eligibility requirements. SSI related Medicaid has the lowest income and asset limits (link to appropriate reference table) of all EBD Medicaid programs/categories. It has two income limits which are referred to as the Categorically Needy limit and the Medically needy limit.

When doing manual EBD income eligibility determinations, use the EBD Related Determination worksheet. Apply the income disregards in the order in which they appear on the worksheet. The 65 & ½ earned income *disregard* and $20.00 SSI general income disregard are applied to the fiscal group's income. They are not applied separately to each individual fiscal group member's income. Special Exempt Income is also an allowable income deduction and a list of Special Exempt Income types can be found in chapter 15.7.2 Special Exempt Income

The EBD categorically needy income limit consists of two components; an income amount plus a shelter/ utility amount. The EBD fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in chapter 39.4 Elderly, Blind, and Disabled (EBD) Assets & Income Tables. The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount (chapter 39.4), and this total becomes the EBD categorically needy income limit. A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid EBD categorically needy income test.

If an EBD related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in chapter 39.4. If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid EBD medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 24.2 Medicaid Deductible Introduction for more information about Medicaid Deductibles and to chapter 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid Deductible.

See 39.4 EBD Assets and Income Table

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24.2 MEDICAID DEDUCTIBLE INTRODUCTION

When a Medicaid *applicant* is ineligible for Medicaid solely because s/he has income that exceeds the Medicaid medically needy income limit, s/he can become eligible by meeting the Medicaid deductible. "Meeting the Medicaid deductible" means incurring medical costs that equal the dollar amount of the deductible.

The Medicaid deductible is the group's total excess monthly income over the 6 consecutive months of the Medicaid deductible period (See 24.3 Deductible Period).

"Excess monthly income" is the amount which is above the group's monthly medically needy income limit.

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24.3 DEDUCTIBLE PERIOD

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.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month of application.

Example 1: John applies for Medicaid in July. He can choose to begin his six month Medicaid deductible period in April, May, June, or July.

The applicant cannot choose an Medicaid deductible period which includes a month in which, if s/he had applied, s/he would have been ineligible due to excess assets.

Example 2: Doyle applies for Medicaid in July. He has excess income in July. He wants an Medicaid deductible period that goes from April through September. In addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the $5,000 on May 31, so he can begin his Medicaid deductible period in May.

Example 3: Clarice applies for Medicaid in July. She has excess income in July. She wants an Medicaid deductible period that goes from April through September.

In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31. Therefore, she cannot include May or any months prior to May in her Medicaid deductible period. She no longer had the $5,000 on June 30, so she can begin her Medicaid deductible period in June.

The applicant can choose an Medicaid deductible period which includes a month in which, if s/he had applied, s/he would have been ineligible for a non-financial reason. Although excess income is still calculated over a six month period, the individual can only be certified for Medicaid during the dates when he or she was non-financially eligible.

Example 4: Marion applies for Medicaid in July. She has excess income in July. She wants an Medicaid deductible period that goes from April through September.

Marion was incarcerated from April 30th through May 18th. She meets the deductible with a countable expense from April 10th, so she should be certified from April 10th through April 29th, and May 19th through September 30th.

Example 5: Janet applies for Medicaid in July and requests an Medicaid deductible period from April through September. She gave birth on June 30th. Janet paid the full deductible amount, so is certified from April 1st through June 30th.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his/her eligibility in the backdate month is determined by whether or not s/he had excess assets on the last day of the month.

Example 6: Jack applies for Medicaid in July. He wants an Medicaid

deductible period that goes back two months to include May and June. In May, he would have been eligible except for excess income. In June he had received a $10,000 gift. On June 29 he went to the track and lost the $10,000. Had he applied on June 30 he would have been eligible. Jack can include both May and June in his Medicaid deductible period.

Example 7: Mansour applies for Medicaid in July. He is found to be eligible. He had medical bills in April and May. He also had excess income in April and May. He wants an Medicaid deductible period that includes April and May. Unfortunately, he was the recipient of a $5,000 cash gift on June 29. It was several days before he was able to spend it on groceries and other legitimate purchases. Mansour will not be able to include April or May in the deductible period because on June 30, had he applied, he would have been determined ineligible.

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period. This will usually occur as a result of a recent decrease in their monthly income.

Example 8: Jeff applies for Medicaid on 1/1/04 and his monthly excess income is $100.00. His Medicaid deductible is $600.00 and his deductible period is January 01, 2004 through June 30, 2004. In April 2004, Jeff's monthly excess income decreases to $10.00 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have his worker recalculate the original $600.00 deductible which would then become a $330.00 deductible (three months of $100.00 excess income and three months of $10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2004 through September 30, 2004 with a $60.00 deductible obligation ($10.00 x 6 = $60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (See 24.6.1 Changes During the Deductible Period> Income Changes)

Individuals who have been certified for Medicaid after meeting a deductible, will have to complete a review to establish a new deductible period. CARES does not send a review notice to the *member* regarding the new deductible period if s/he did not meet the deductible for the current period.

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24.4 CHOOSING NOT TO HAVE A DEDUCTIBLE

An *applicant* who is ineligible for excess income in some backdate months, but has no excess income in others, does not have to choose to have an Medicaid deductible. S/he can choose to be certified in the months s/he is eligible and to accept the ineligibility of the other months where s/he has excess income.

Example 1: Horace applies for Medicaid in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants Medicaid eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets.

But in May and June he had excess income of $20 each month. He has 2 choices:

Choose an Medicaid deductible period of April through September. After meeting the Medicaid deductible of $40 he would be certified for Medicaid from April through September.

Not choose an Medicaid deductible period. He would not have to meet an Medicaid deductible. He could be certified immediately for April and July. But he would have to forego Medicaid for May and June because of the excess income in May and June.

If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, s/he does not have to include them in a deductible period. S/he can be certified for them immediately, and can begin the Medicaid deductible period with the month of application.

Example 2: Roslyn applies for Medicaid in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her Medicaid deductible period in July.

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24.5 CALCULATING THE DEDUCTIBLE

24.5.1 Fiscal Test Groups
24.5.2 Institution Cases
24.5.2.1 Backdating
24.5.2.2 Deductible
24.5.3 Deductible Examples

To calculate the dollar amount of the Medicaid deductible for a regular Medicaid fiscal test group:

24.5.1 Fiscal Test Groups

Determine the Medicaid deductible period (24.3 Deductible Period) for this fiscal test group.
Find the fiscal test group's total net income for each month in the deductible period.

For the months after the month of application, use prospective net income. (Income that may have been disregarded in the eligibility test which must now be counted, add back in, when determining the deductible period) (See 24.14 Medicaid Deductible, Cost of Care).

Compare the total net income of each month with the group's medically needy income limit. If the group is an:

SSI-related fiscal test group, see 39.4 EBD Assets and Income Table.

If a month's income is less than or equal to the medically needy limit, ignore it.

If a month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net in-come of that month.

Add together the excess income of the months in the deductible period. The result is the Medicaid deductible.

24.5.2 Institution Cases

24.5.2.1 Backdating

Institutionalized and non-institutionalized persons can be eligible back to the 1st of the month, 3 months prior to the month of application. Even if they are ineligible in the month of application, they may still be eligible for retroactive coverage. When an institutionalized person requests retroactive Medicaid, test him/her against the nonfinancial and financial standards that are appropriate to the month being tested. For the months s/he was not institutionalized, use the EBD asset and income limits (39.4 EBD Assets and Income Table). For the months s/he was institutionalized, use the institutional eligibility criteria found in 27.1 Institutions.

24.5.2.2 Deductible

For the months in which s/he was not institutionalized, s/he may be eligible in some, but ineligible in others, due to excess income. In this situation, s/he has 2 choices:

1. To be certified for the months s/he is eligible, and accept the ineligibility of the other months in which s/he has excess income, **or**
2. To meet a deductible. The deductible period begins in the backdate month that s/he chooses, and extends 6 months. Calculate the deductible for the full 6-month deductible period. Calculate the deductible by comparing his/her monthly income for each of the 6 months to the EBD medically needy income limit, not the institutional income limit.

Expenses which can be counted against the deductible are those listed in 24.7 Meeting the Deductible plus his/her cost of care (27.7 ILTC Cost of Care Calculation). Expenses that cannot be counted are listed in 24.7.2 Meeting the Deductible> Noncountable Costs.

When s/he meets the deductible, she can be certified to the end of the deductible period. At the end of the deductible period, redetermine his/her eligibility using the institutional financial tests.

24.5.3 Deductible Examples

Example 1: Artie Cobb applies for Medicaid in July. He wants to backdate his Medicaid three months. His Medicaid deductible period is April through September. In April, May, June, and July his AG had excess income of $50 each month. Its prospective excess income for August and September is $50 each month. 6 X $50 = $300. Artie's Medicaid deductible is $300.

Example 2: Clarice applies for Medicaid in July. She wants to backdate her Medicaid to May 1. Her Medicaid deductible period is May 1 through October 31. In May and June her AG had excess income of $100 each month. In July it has excess income of $200. Its prospective excess income for August, September, and October is $200 a month. Clarice's Medicaid deductible is

$1,000.

Example 3: Myron applies for Medicaid in July. He wants to backdate Medicaid to June 1. His Medicaid deductible period is June 1 through November 30. In June his AG had excess income of $50. In July it has no excess income. Its prospective excess income for August, September, October, and November is $0. Myron's Medicaid deductible is $50.

Example 4: Tillerman Tyler applies for Medicaid in July. He wants his Medicaid to begin July 1. His Medicaid deductible period is July 1 through December 31. In July his AG has $100 excess income. Its prospective excess income for August, September, October, November, and December is $100 each month. Tilly's Medicaid deductible is $600.

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24.6 CHANGES DURING THE DEDUCTIBLE PERIOD

24.6.1 Income Changes
24.6.2 Group Size Changes
24.6.3 Asset Changes
24.6.4 Non-Financial Changes

If there are income changes during the Medicaid deductible period, recalculate the Medicaid deductible amount.

24.6.1 Income Changes

1. Add together the monthly excess income of the months of the Medicaid deductible period that have already gone by.

2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.
3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.
4. Add the results of #1, #2, and #3.

Example 1: Cicely applied for Medicaid in July. She had excess income of $20 a month. Her Medicaid deductible was $120. In November she reports a pay increase of $10 a month. Now you must recalculate her Medicaid deductible.

1. Add together the excess income of months July through October. The result is $80.
2. Calculate her November excess income. The result is excess income of $30.
3. Prospective income for December is $30.
4. Cicely's new Medicaid deductible: $80 + $30 + $30 = $140.

If the income change results in **lower excess income** in the month of change, the *applicant* can choose to:

1. Recalculate the Medicaid deductible, **or**
2. Create a new deductible period.

Example 2: Winston goes from full time to part time employment in the fourth month of his Medicaid deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his Medicaid deductible or to have a new deductible period.

If he recalculates, the resulting deductible will be lower than the previous one.

His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he had met the previous deductible.

If the income change results in **no excess income** the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. **Begin eligibility immediately.**

Example 3: If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

24.6.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, you must recalculate the deductible. Compare the new group's income with the new group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes (24.6.1 Income Changes).

Example 4: John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group. On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be recalculated using the smaller group size (one person fiscal test group) as of March 1.

24.6.3 Asset Changes

If the fiscal group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible. End the deductible period.

24.6.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period excess income may still be calculated during the dates the individual is non-financially ineligible, however the individual can only be certified for Medicaid during the dates s/he is/was non-financially eligible.

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24.7 MEETING THE DEDUCTIBLE

24.7.1 Countable Costs
24.7.1.1 Countable Expenses
24.7.2 Noncountable Costs
24.7.3 Prepaying a Deductible
24.7.3.1 Payment of Entire Deductible Amount
24.7.3.2 Combination of Payment and Incurred Expenses
24.7.3.3 Combination of Payment and Outstanding Expenses
24.7.3.4 Calculation Errors
24.7.3.5 Insufficient Funds

The fiscal test group meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group does not meet the deductible within the deductible period, it can choose to begin a new deductible period. (24.3 Deductible Period)

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in 24.7.1 Countable Costs below.

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a *member* of the *applicant*/recipient's *FTG*.

Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example1: Sally's *minor* child Ida died of leukemia in April 2004. In September 2004, Sally requests that a medical bill incurred for Ida be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in (24.7.1.1 Countable Expenses)

3. Meet one of the following four conditions

   a. Still be owed to the medical service provider sometime during the current deductible period.

   Expenses which have been “deferred” by the provider are considered a countable cost still owed to the provider and can be used to meet a Medicaid deductible.

   - The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.

     - If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.

   - Many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 2: From May- July 2007 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2008, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for Medicaid on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred."

"Deferred", she explained, means that the member would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can use this "deferred" charge toward her deductible.

Example 3: Lestat applies for Medicaid in July, 2007. An Medicaid deductible of $700 is calculated for him. In 2006 he had a blood transfusion. The bill for the transfusion was $800. He never paid it and still owes it to the service provider. He can use the unpaid bill to meet his Medicaid deductible, but must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

b. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 4: Frank and Estelle apply for Medicaid on March 1, 2007, requesting that their deductible period begin January 1, 2007. Their deductible for the period January 1 - June 30th is $340. In April, they had a ten-year-old medical bill of $300 written off. They can count the $300 toward the January - June 2007 deductible because it was written off during the deductible period.

c. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 5: Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 6: Malcom is in his second deductible period which began March 1, 2007. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February 2006. He may not apply this toward his current deductible.

Example 7: Norah is in her second deductible period which began in September 2007. In June 2007, Norah met her deductible and was certified for Medicaid. After certification, and before the prior deductible period ended in August 2007, Norah paid for medical services that were not Medicaid covered services. Norah can apply these paid bills to the deductible period the

began in September 2007.

d. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 8: Mr. and Mrs. Avenue apply for Medicaid on August 10th, 2007, requesting that their deductible period begin on August 1, 2007. Their deductible for the period from August 2007 through January 2008 is $1500. On May 10th the couple paid off a $2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining $500 cannot be applied to future deductible periods.

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 24.7.1 Countable Costs:

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles and co-payments for Medicaid,for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

   Note: MMIS data may be used to calculate Medicaid co-payments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses are:
   a. Case management
   b. Day care.
   c. Housing modifications for accessibility.
   d. Respite care.
   e. Supportive home care.

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- Assistance with activities of daily living
- Attendant care
- Supervision
- Reporting changes in the participant's condition,
- Assistance with medication and medical procedures which are normally self-administered, or
- The extension of therapy services, ambulation and exercise.
- Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well being and care at home.

f. Transportation.

g. Community Based Residential Facility (*CBRF*), *Adult* Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

Remedial expenses do not include housing or room and board expenses.

CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation (21.4.2 Transportation , including attendant services (21.4.2.3.3 Transportation>Common Carrier>Reimbursement>Attendant).

4. Medical insurance premiums paid by a member of the fiscal test group or FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible..

Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).

6. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.

7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.

8. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in 24.7.1. # 3.

Examples include:

a. General Assistance
b. Community Options Program
c. AIDS Drug Assistance Program (ADAP)

Example 9: Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 10: Sally received a medical service in January 2008 which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January 2008. Sally has excess income and must meet a deductible. Since

the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in 24.7.1 # 3

Example 11: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 12: Charlie received a medical service in January 2008 which was paid by Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January 2008. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medicare Supplemental Medical Insurance (Plan B) premiums if they have already been deducted from the gross social security check.
3. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

Example 13: Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.

4. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in 24.7.1Countable Costs.

Example 14: The court orders a health insurer or other third party to pay for medical services.

Example 15: An applicant incurs a $300 medical bill. She applies the $300 toward her deductible even though s/he has not made any payments on the

bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the $300 bill. But she cannot use it to meet her current deductible because she already used it to meet the prior deductible.

24.7.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment **prior** to the begin date of the corresponding deductible period.

If the member is **55 or older**, forward the payment to:

Estate Recovery/Casualty Collections
6406 Bridge Road
Madison WI 53784-0013

Prepayment checks or money orders should be made payable to: "The Department of Health and Family Services."

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.

If s/he is **under 55**, instruct the member to make the payment payable to your IM Agency. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

24.7.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 16: Laura's deductible period is from March 1st through August 31st. The total deductible amount is $1,000. Laura submits payment of $1,000 on August 15th. Laura's Medicaid eligibility begins on March 1st.

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the

remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 17: Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is $1,800. Chad submits a medical bill with a March 8th date of service for $800. On July 15th, he submits payment of $1,000. Chad's Medicaid eligibility begins March 8th. Submit a Medicaid Remaining Deductible Update (F-10109) identifying the provider of service on March 8th and the $800 member share amount.

Enter the incurred medical expense first. Perform a PF23 sort. The remaining balance is the amount that can be paid to meet the deductible. Enter the payment date as the same date of the last incurred medical expense, which equals the balance of the deductible, on CARES Client Assistance for Re-employment & Economic Support screen AGTM. Complete and submit a Medicaid Remaining Deductible Update (F-10109) to EDS. Enter the deductible met date as the date of the last incurred medical expense. Enter the member share as the amount of the last incurred medical expense.

24.7.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 18: Roberta's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is $1,500. She submits an outstanding bill from January 10th for $500. On August 15th, she submits payment of $1,000. Roberta's Medicaid eligibility begins March 1st

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.4 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS.

24.7.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

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24.8 ORDER OF BILL DEDUCTION

24.8.1 Hospital Bills
24.8.2 Pregnancy Fees

When applying medical bills to the deductible, start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

24.8.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is difficult sometimes to know when the patient met the deductible.

For this reason, if the patient's hospital bill for one continuous stay in the hospital is equal to or above whatever the deductible was on the date of admission, count the deductible as having been met on the date of admission. Set that date as the begin date of Medicaid certification. Apply the hospital bill to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example 1: Linda submits a $2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for $2,500 with a date of service of July 12th. Apply the $2,000 hospital bill to the deductible first.

24.8.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

In determining whether these "global" pregnancy fees meet the deductible, treat them the same way as you would a hospital bill. If the "global" pregnancy fee is equal to or above the deductible, count the deductible as having been met as of the date an agreement was signed.

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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.

Fill out the Medicaid Remaining Deductible Update (F-10109) only if:

A Medicaid certified provider has provided the billed services.

The person, having met the deductible, is being certified. If s/he is not being certified, Medicaid will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the member is not eligible until s/he has met the deductible, s/he still owes for all bills prior to that date.

Do not send more than one bill. In the series of bills which the member may submit to you, there will be only one bill which is larger than the amount needed to meet the deductible. Medicaid will consider the remainder of the bill for payment.

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24.10 LATE REPORTING OF DEDUCTIBLE INFORMATION

If the client turns in late reports on income changes or medical costs, recalculate the deductible as of the date the change took place or the medical cost was incurred. See what would have been the deductible had s/he reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin Medicaid certification on that date.

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24.11 DEDUCTIBLES AND INTER-AGENCY TRANSFERS

When a Medicaid group, having met the deductible, moves to another county or tribal area, do not transfer the case to the new agency unless there is a change that requires a review.

Example 1: John Restless and family are receiving Medicaid after having met a deductible. John moves himself and his family from Waupaca County to Vilas County. There are no other changes in the case. Waupaca County keeps the case until the deductible period expires.

Example 2: The Sans Pareil family is receiving Medicaid after having met a deductible in Grant County. They move to Polk County after reporting a change in assets to their Grant County IM worker. Polk County must do the review and take over the case, even if the change does not affect the Sans Pareil's eligibility.

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24.12 CHANGES AFTER MEETING A DEDUCTIBLE

24.12.1 Changes After Meeting a Deductible Introduction
24.12.2 Income Changes
24.12.3 Asset Changes
24.12.4 Non-Financial Changes

24.12.1 Changes After Meeting a Deductible Introduction

When the fiscal group has met the deductible, it can be certified for Medicaid to the end of the deductible period.

24.12.2 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period.

24.12.3 Asset Changes

If the Medicaid group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue Medicaid eligibility.

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

The deductible period (24.3 Deductible Period) for which excess income is calculated may include a month(s) in which, if a *member* had applied, s/he would have been ineligible for a non-financial reason.

If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.

If an *adult* caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his/her name will appear on the Medicaid card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, the member may choose:

1. to continue with the current deductible period, **or**
2. to reapply and establish a new deductible period if his or her income still exceeds the appropriate Medicaid income limit.

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24.13 DEATH DURING A DEDUCTIBLE PERIOD

24.13.1 Death During a Deductible Period Introduction
24.13.2 Prepaid Deductible

24.13.1 Death During a Deductible Period Introduction

If the *member* dies during the deductible period, and is not already certified, look at all countable costs (24.7.1 Meeting the Deductible> Countable Costs) prior to death. If those countable costs meet the deductible, certify the dead person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

24.13.2 Prepaid Deductible

If the member prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the member prepays and dies before the deductible period starts, the deductible is refundable.

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24.14 MEDICAID DEDUCTIBLE, COST OF CARE

When you are calculating a Medicaid deductible, a patient liability amount, a community waivers cost share or a community waivers spenddown for a "503" AG, a DAC Disabled *Adult* Child, or a widow or widower, use the total income before any COLAs or *OASDI* (DAC or widow/widower) increases were subtracted.

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25 SPECIAL STATUS MEDICAID

25.1"503" ELIGIBILITY

25.1.1 503 Introduction
25.1.2 Identifying a "503" AG
25.1.3 Calculating the COLA Disregard

25.1.1 503 Introduction

Federal law requires that the IM Agency provide Medicaid (Medicaid) eligibility to any *applicant* for whom the following two conditions exist:

1. S/he is receiving Old Age, Survivors, Health and *Disability* Insurance (*OASDI*) Benefits .

2. S/he was receiving Supplemental Security Income (*SSI*) concurrently with OASDI but became ineligible for SSI.

Note: The notion "concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations where *SSA* recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits.

Example 1: Elmo Tanner was receiving SSI in February, 2006, the month he had a disabling accident. In February, after the accident, he applied for OASDI. In April, 2006, SSA notified him that he had been determined disabled. The notice informed him that his OASDI eligibility extended back to the onset date of his disability in February, 2006. Along with the notice was a check for retroactive OASDI benefits back to the February date. The amount of the OASDI check made him immediately ineligible for SSI. There was no period of time when he was actually receiving both SSI and OASDI benefits at the same time. Nevertheless, Elmo meets the requirement of concurrently receiving both SSI and OASDI benefits from February through April.

On the other hand, if Elmo had been receiving OASDI benefits, and was then granted retroactive SSI benefits for the same period, he would not meet the definition of "concurrent."

An assistance group (AG) with these two characteristics is often referred to as a "503" AG. The name comes from Section 503 of the Medicaid Law.

25.1.2 Identifying a "503" AG

When a "503" AG applies for Medicaid, *disregard* all OASDI COLAs the AG has received since the last month s/he was eligible for and received both OASDI and SSI benefits.

To identify a "503" AG, do the following:

1. Determine whether, after April 1977, there has ever been a month in which one of the following conditions existed:
   a. Was eligible for both OASDI and SSI (a person who received SSI fraudulently doesn't qualify as a 503 case), **or**
   b. Received an OASDI check or a retroactive OASDI check and a SSI check for the same month in which s/he was eligible for both OASDI (or retroactive OASDI) and SSI.

If "no", s/he is not a "503" AG. If "yes" and is no longer receiving SSI, do the following:

2. Determine if s/he is now receiving an OASDI check. If s/he is not, s/he is not a "503" AG. If s/he is, s/he is a "503" AG. S/he will receive a *COLA* disregard. Enter “Y” on the Individual Nonfinancial> Prior SSI page in the CWW.

If s/he was receiving SSI-E, the state SSI-E Supplement (39.4.1) will also be deducted.

SSI-E AGs are SSI recipients who receive a higher state supplement than regular SSI. Persons who receive SSI-E payments must live:

a. In substitute care of eight or fewer beds, or
b. At home and need more than 40 hours a month of primary long term support services.

25.1.3 Calculating the COLA Disregard

To calculate the Cost-of-Living Adjustment (COLA) disregard amount, do the following:

1. Find the AG's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.

   Do not include in the *gross income* any Medicare Plan B premiums, which the State has paid for the AG.

2. On the COLA *Disregard* Amount Table (39.6 COLA) find the last month in which the person was eligible for and eligible for and received a check for both OASDI (or retroactive OASDI) and SSI.

3. Find the decimal figure that applies to this month.

4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

Example 2: Newby's current gross OASDI income is $700. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI, and received benefits from both was April 1991. On the COLA Disregard Amount Table (39.6), April 1991 falls between January 1991 - December 1991.

Therefore, the decimal figure that applies to April 1991 is 0.239033048. Multiply 0.239033048 x $700 to find Newby's COLA disregard amount.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard again.

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25.2 DISABLED ADULT CHILD (DAC)

25.2.1 DAC Introduction
25.2.2 DAC Payment Disregard
25.2.3 COLA Disregard
25.2.4 Disregards For Individuals Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase In DAC Benefits.

25.2.1 DAC Introduction

A Disabled *Adult* Child (DAC) is:

1. At least 18 years old at the time *SSI* was lost.
2. Classified by the Social Security Administration as disabled before age 22.
3. Receives an *OASDI* (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.

   Note: Receipt of Railroad Retirement is not considered OASDI for this policy.

4. Was receiving SSI, but lost SSI eligibility because the OASDI (DAC) payment exceeded the SSI income limits.

25.2.2 DAC Payment Disregard

When a Disabled Adult Child applies for Medicaid, *disregard* all OASDI (DAC) payments which caused him/her to lose SSI eligibility.

Example 1: George is an SSI recipient. While his father worked, George received a monthly SSI payment of $686.78. When his father retired and began receiving $1000 a month in social security, George began receiving an OASDI (DAC) payment of $500 a month (50% of his father's social security payment). His monthly check is $706.78 ($500 DAC + $186.78 SSI + $20 SSI unearned income disregard).

When George's father dies, George begins receiving a DAC payment of $750 a month (75% of his father's social security payment). This puts him over the SSI income limit ($686.78 + $20 unearned income disregard = $706.78). He loses SSI.

When he applies for EBD Medicaid, disregard the total increase of $250 ($750 - $500 = $250).

Example 2: Harvey is an SSI recipient. While his father works, Harvey receives a monthly SSI payment of $686.78. When his father retires and receives $1800 per month in social security, Harvey begins receiving an OASDI (DAC) payment of $900 (50% of his father's Social Security payment). This $900 payment makes Harvey ineligible for SSI.

When Harvey applies for EBD Medicaid, the initial DAC payment of $900 will be disregarded when his EBD Medicaid eligibility is determined.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him/her again.

25.2.3 COLA Disregard

When a Disabled Adult Child applies for Medicaid, disregard all OASDI COLAs since the last month s/he was eligible for and received both OASDI and SSI benefits. Calculate the *COLA* disregard amount (25.1.2 Identifying a "503" AG).

If the Disabled Adult Child was receiving SSI-E, disregard both the state SSI-E Supplement (39.4 EBD Assets and Income Tables) and the COLA.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him/her again.

25.2.4 Disregards For Individuals Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase In DAC Benefits

An individual who loses their SSI eligibility due to the receipt of an initial DAC benefit or increase in their current DAC benefit is entitled to the following disregards when determining their eligibility for Medicaid:

1. The DAC payment, either initial or increase which made them ineligible for SSI.
2. The SSI-E supplement, if the individual was receiving the E supplement at the time they became ineligible for SSI.
3. All COLAs received since the last month that the individual was eligible for and received both OASDI and SSI benefits.

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25.3 WIDOWS & WIDOWERS

A widow or widower who lost *SSI* remains eligible for Medicaid if s/he meets all of these conditions:

1. Disabled.

2. Age 50 or older.
3. Either:
   a. Married to the deceased person at time of his/her death, or
   b. Married to deceased at least ten years, divorced from him/her, and now unmarried.

Receiving *OASDI* benefits as widow or widower (Section 202, Title II, Social Security Act).

4. Received SSI or a State Supplementary Payment (SSP) (39.4 EBD Assets and Income Tables) in the month before the month in which s/he began to receive OASDI payments.
5. Became ineligible for SSI or SSP.
6. Would be eligible for SSI or SSP except for the receipt of the OASDI payment. *Disregard* the entire OASDI amount.
7. Not entitled to Medicare Part A.

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25.4 MEDICAID DEDUCTIBLE, COST OF CARE

When calculating a Medicaid deductible, a patient liability amount, a community waivers cost share or a community waivers spenddown for a "503" AG, a DAC, or a widow or widower, use the total income before any COLAs or *OASDI* (DAC or widow/widower) increases were subtracted.

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25.5 1619 CASES

Section 1619 of the Social Security Act applies to severely impaired persons who work. If they would be ineligible for *SSI* because of their earnings, they keep their SSI Medicaid eligibility.

1619(a) - They are working individuals who continue to receive a small SSI check. They retain SSI Medicaid eligibility.

1619(b) - They are working individuals who do not receive a SSI check but are still eligible for SSI Medicaid. For the *COLA disregard* determination, use the date cash payments ended.

To determine the person's SSI status, contact the local Social Security Office. Social Security processes Medicaid eligibility for these members.

The SSI benefits of a 1619 person entering an institution continue for up to two months.

If a *member* loses 1619 status, but also is a widow/widower, DAC, or 503, s/he is entitled to all disregards that are appropriate for these special status cases when determining eligibility. Losing 1619 status is considered the same as losing SSI eligibility.

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25.6 KATIE BECKETT

The Katie Beckett program tests qualified blind and/or disabled minors for Medicaid. It does not deem assets and income from the natural or adoptive parents.

To qualify under the Katie Beckett program a blind or disabled *minor*:

1. Must require a level of care provided in a hospital, Skilled Nursing Facility (*SNF*), or Intermediate Care Facility (*ICF*), and
2. Can appropriately receive this care in his/her home, and
3. Would be non-financially eligible for Medicaid if s/he were in a hospital, SNF, or ICF.

If a minor child meets these requirements and if the parent wants him/her to remain in the home, contact:

Katie Beckett Program
Division of Supportive Living Services

Bureau of Developmental Disabilities
1 West Wilson Street, Room 418
Madison, WI 53707
Telephone (608) 266-3236

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25.7 TUBERCULOSIS

25.7.1 Non-Financial Requirements
25.7.2 Financial Tests
25.7.3 TB-Related Services
25.7.4 QMB, SLMB and QDWI
25.7.5 Aliens
25.7.6 Processing

Medicaid applicants who are infected with tuberculosis (*TB*) are non-financially eligible for TB-related Medicaid services.

25.7.1 Non-Financial Requirements

Consider these persons to be in a special category of Medicaid. They are non-financially eligible for TB-related Medicaid if they are infected with TB, even if they are not blind, disabled, or over age 65. "Infected with TB" means that a physician has examined them and found that one or more of the following diagnoses apply to them:

1. Infected with latent or active TB.
2. Positive TB skin test.
3. Negative TB skin test, but a positive sputum culture for the TB organism.
4. Negative test for TB, but a physician certifies that they require TB-related drug therapy or surgical therapy or both.
5. A physician certifies that they require testing to confirm the presence or absence of TB.

Accept the member's statement that they have one or more of the above conditions unless the information provided is questionable (20.4 Questionable Items). If questionable, accept any of the following as verification:

1. A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.
2. Wisconsin Tuberculosis Record (Form DPH 4756). This card identifies the person and the physician's diagnosis, and has on it the name and telephone number of the treatment provider.

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 $1,433 This is *gross income*. There is no net income test.

Deductible. TB-related AGs which fail the TB-related gross income test cannot become eligible for a Medicaid deductible.

If more than one person in the AG is TB-infected, test each person as a single individual with his/her own fiscal test group. Do not deem assets or income from any other *member* of the AG.

Example 1: Mary and her *spouse* George are both applying for TB-related Medicaid. Test Mary and George as separate fiscal test groups. Do not deem assets or income from Mary to George or from George to Mary. Test Mary's assets against the asset limit. Test her income against the income limit for one person. Test George's assets against the asset limit. Test his income against the income limit for one person.

Example 2: There are three children in the Kraan family. All of the children have TB. Consider each child to be a separate fiscal test group. Test each child using only his/her own assets and income. Each child's assets do not exceed the asset limit. Each child's income limit does not exceed the income limit. Do not deem assets or income from the child's parents or from any of his/her siblings.

If only one person in the AG is TB-infected, and that person is a:

1. TB-infected *minor* or 18-year-old:

   Test him/her in the Financial Tests for Disabled Minors. Add the parents' deemed assets and income to the minor or 18- year-old's assets and income. Test him/her against the asset limit and the gross income limit.

2. TB-infected *adult* with assets/income, and spouse with no assets/income:

   Test the TB-infected adult's assets/income against the asset limit and the gross income limit.

3. TB-infected adult with assets/income, and spouse with assets/income:

   Use the EBD-Related Determination Worksheet (WKST 06) to determine the spouse's assets and net income. Add these totals to the TB-infected

person's assets and gross income. Compare this total to the asset limit and the gross income limit.

4. TB-infected adult with no assets/income, and spouse with assets/income:

   Use the WKST 06 to determine the spouse's assets and net income. Compare these results to the asset limit and the gross income limit.

   When using the WKST 06, *disregard* items 16-18. Replace item 19 with the TB-related income limit. *Disregard* item 20.

25.7.3 TB-Related Services

Persons who become eligible for TB-related Medicaid receive an Medicaid card that identifies them as eligible for only the following Medicaid services:

1. Prescribed drugs.
2. Physicians' services.
3. Laboratory and X-ray services, including services to diagnose and confirm the presence of infection.
4. Clinic services and federally qualified health care (FQHC) services.
5. Targeted case management services.
6. Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients.
7. Services that are necessary as a result of the side effects of prescribed drugs for TB treatment.

25.7.4 QMB, SLMB and QDWI

QMB, *SLMB*, and *QDWI* recipients do not automatically qualify for TB-related Medicaid services. If they are eligible for EBD or Family Medicaid, they can receive TB-related services under regular Medicaid.

25.7.5 Aliens

TB-related services provided for the treatment of an emergency medical condition (34.1 Emergency Services) may be covered for persons who do not meet citizenship requirements (7.3 Immigrants).

25.7.6 Processing

Determine TB-related AGs manually in the following way:

1. Determine Medicaid eligibility for all other subprograms in CARES. Do not confirm unless there is eligibility for a category of Medicaid that is not QMB, SLMB, or QDWI.

If there is only QMB, SLMB, or QDWI eligibility, test the person against the TB-related financial tests. Complete and return a F-10110 (formerly DES 3070) to EDS:

a. Mail: EDS
P.O. Box 7636
Madison, WI 53707

b. Email: VEDS3070@wisconsin.gov

c. Fax: (608) 221-8815

2. If the member is eligible, certify him/her with a manual F-10110 (formerly DES 3070) form, medical status code of TR. Confirm all denials in CARES and allow the CARES generated notices to be sent. Send him/her a manual positive notice with the effective date of his/her eligibility for TB-related services.

3. If the person is not eligible for any Medicaid subprograms, including TB-related Medicaid, confirm all denials in CARES and allow the CARES generated notices to be sent. Send him/her a manual negative notice indicating that s/he is not eligible for TB-related Medicaid.

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25.8 MIGRANT WORKERS

25.8.1 Migrant Workers Introduction
25.8.2 Simplified Application
25.8.3 Regular Application
25.8.4 Reviews
25.8.4.1 Simplified Application
25.8.4.2 Regular Application

25.8.1 Migrant Workers Introduction

"Migrant worker" means any person who temporarily leaves a principal place of residence outside of Wisconsin and comes to Wisconsin for not more than ten months in a year to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading or storing of any agricultural or horticultural commodity in its unmanufactured state. "Migrant worker" does not include any of the following:

1. A person who is employed only by a state resident if the resident or the resident's *spouse* is related to the person as the child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, nephew, or the spouse of any such relative.
2. A student who is enrolled or, during the past six months has been enrolled, in any school, college or university unless the student is a *member* of a family or household which contains a migrant worker.

A migrant family includes the adults, including non-marital coparents, and their dependent children living in the migrant household.

25.8.2 Simplified Application

Use the following simplified application procedure to determine Medicaid eligibility for migrant workers and their families who have come into Wisconsin and who:

1. Have current Medicaid eligibility from another state. ("Current Medicaid eligibility" means eligibility that includes at least months one and two of the application process.) Or had Medicaid eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.
2. And have the same members or fewer in the case as there were when the case had eligibility in the other state.

The simplified application procedure is as follows:

1. For members with current Medicaid eligibility from another state, verify the eligibility and the end date. Accomplish the verification by copying the out-of-state Medicaid card or by contacting the other state.
2. For members previously eligible in Wisconsin find the CARES Member Assistance for Re-employment & Economic Support closure code and review date.

3. Ask if the same members, or fewer, are in the case compared to when the group was eligible in the other state.
4. Collect all non-financial information.
5. Do not collect any financial information.
6. Certify Medicaid benefits for the migrant family.

Example 1: A migrant family consisting of dad, mom, and their three children comes to Wisconsin. On September 3, 2008, dad applies for Medicaid in Wisconsin for himself and his family.

The family has current Medicaid eligibility from Texas. That is, eligibility extends beyond application months one and two.

The household composition of five members is the same as listed on the Medicaid card.

The fulfillment of these two conditions indicates that the case should be processed with the simplified application procedure.

The IM enters non-financial information into CARES, and completes the asset and income screens by answering "N" to all of the financial questions. S/he also makes sure to answer "Y" to the migrant question on ANDC for all family members.

CARES passes the case for MAOU eligibility with $0 assets and $0 income. The eligibility end date from Texas is November 30, 2008. The IM changes the review date on AGEC to November 30, 2008, to coincide with the end date from Texas.

Example 2: The same migrant family comes in for the November 2008 review. Verify all mandatory and questionable verification items. The family is determined eligible through October 31, 2009.

The family leaves Wisconsin in December, 2008. Medicaid closes for failure to reside in the state. In March 2009, the family returns. There have been no non-financial changes and no changes in household composition. The family should be processed with the simplified application procedure because their case closed only for failure to reside in Wisconsin.

25.8.3 Regular Application

If migrant workers and their families have no current Medicaid eligibility, or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular Medicaid application, with the following exception:

Use annualized earned income. “Annualized earned income” is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family’s income if it is anticipated that last year’s income is the best estimate of the current year’s prospective income.

25.8.4 Reviews

Offer the following three review choices for migrant families:

1. Mail.
2. Phone.
3. Face-to-face interview.

Income is always annualized.

See 2.2 for information on reviews.

25.8.4.1 Simplified Application

For migrant families that have been certified through the migrant simplified application process, the first review coincides with the date out-of-state eligibility ends. The next review is 12 months from the first review.

25.8.4.2 Regular Application

For migrant families that have been certified through the regular application process, the first review is 12 months from the month of application.

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26 MEDICAID PURCHASE PLAN (MAPP)

26.1 MEDICAID PURCHASE PLAN (MAPP) INTRODUCTION

The Medicaid Purchase Plan (*MAPP*) is a subprogram of the Wisconsin Medicaid Program. It allows disabled people who are working or want to work to become or remain Medicaid eligible, even if employed, since there are higher income limits.

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26.2 MAPP APPLICATION

26.2.1 Begin Month
26.2.2 Fiscal Test Group (FTG)

26.2.1 Begin Month

Certify applicants for *MAPP* retroactively for any or all, up to three prior months, if s/he met all of the eligibility criteria at that time. The *member* is responsible for any premium due for the previous months in which s/he elects coverage.

Clients can also choose to begin MAPP eligibility during any future month that can be processed in CARES.

Example 1: Jack applies for MAPP on September 30th and requests a retroactive determination of eligibility. His application is processed on October 21st. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November or December.

26.2.2 Fiscal Test Group (FTG)

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (AG). Enter them in CARES on the same application. The member's *spouse* is a countable member of the *FTG*. A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP *applicant* chooses not to disclose or verify assets, a case may fail for a higher Medicaid eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the member's spouse and test children in the FTG. Test children include the member's *minor* natural or adoptive children. Do not include the member's stepchildren in the FTG. Do not count the income or assets of the test children.

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26.3 MAPP NON-FINANCIAL REQUIREMENTS

26.3.1 MAPP Nonfinancial Requirements Introduction
26.3.2 Disability
26.3.3 Work Requirement
- 26.3.3.1 Self-Employment
- 26.3.3.2 Contractual Employment
- 26.3.3.3 Employment Ending
- 26.3.3.4 Temporary Employment

26.3.4 Work Requirement Exemption
26.3.5 Health and Employment Counseling Program (HEC)
- 26.3.5.1 HEC Processing
- 26.3.5.2 HEC Extension
- 26.3.5.3 HEC Participation Changes

26.3.6 Health Insurance Premium Payment (HIPP)
26.3.7 Spousal Impoverishment
26.3.8 Institutionalization
26.3.9 Community Waivers
- 26.3.9.1 Special Managed Care Programs

26.3.1 MAPP Nonfinancial Requirements Introduction

Clients must meet all of the following:

1. Meet general MA non-financial requirements (4.1 Who is Nonfinancially Eligible for Medicaid),
2. Be at least 18-years-old, (there is no maximum age limit).
3. Be determined disabled, presumptively disabled, or *MAPP* disabled by the *Disability* Determination Bureau (*DDB*) (5.2 Determination of Disability and 5.10 MAPP), and
4. Be working in a paid position or participating in a Health and Employment Counseling (HEC) program (26.3.4 Work Requirement Exemption) .

Note: Individuals who are receiving MA through SSI's 1619 (b) program are non financially eligible for MAPP. Those persons who are *SSI* eligible under 1619 (b) can be on SSI Medicaid and MAPP at the same time. These individuals are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. Because this group is the most likely to move from SSI Medicaid to MAPP, DHS has decided to allow them to be eligible for both at the same time.

26.3.2 Disability

DDB must certify disability (5.10 MAPP). There is no requirement that a *member* be a current or former SSI or *SSDI* beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If a member does not have a disability determination from *SSA*, a federal agency which administers the SSI, *OASDI*, and Medicare programs, complete the disability application process outlined in 5.3 Disability Application Process. The rest of the MAPP application must be completed at this time and MAPP eligibility pending only for the disability before the MADA will be sent to DDB through the automated process. (See the Process Help Chapter 12 Auotmated Medicaid Disability Determination)

Follow the rules in section 5.7 Redetermination on when to review disability determination.

Note: A current MAPP recipient who loses SSDI because s/he exceeds the Substantial Gainful Activity level remains MAPP eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with *adverse action* notice for the reason 'not MAPP disabled.

26.3.3 Work Requirement

To meet the work requirement, a member must engage in a work activity at least once per month, or be enrolled in a Health and Employment Counseling (HEC) program (See 26.3.4 Work Requirement Exemption). Consider a member to be

working whenever s/he receives something of value as compensation for his/her work activity.

This includes wages or in-kind payments. The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

26.3.3.1 Self-Employment

If a member engages in a self-employment activity that generates some compensation, at least once in the calendar month, the individual is employed for purposes of MAPP.

A member does not need to realize a profit from self-employment for it to be defined as work.

26.3.3.2 Contractual Employment

If an individual is under contractual employment for the entire year, s/he is employed for the purposes of determining MAPP eligibility for the entire year. Do not consider members employed for any months in which they do not have a contractual employment agreement.

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. Do not take action to terminate eligibility until one full calendar month has passed since employment ended.

26.3.3.4 Temporary Employment

If a member has signed up with a temporary service agency and is not actually working, s/he is not working for purposes of MAPP. If a member is engaged in work activity for which compensation will be received, at least once in a calendar month, s/he is employed for the purposes of determining MAPP eligibility in that calendar month.

26.3.4 Work Requirement Exemption

If there is a serious illness or hospitalization that causes the member to be unable to work, the work requirement can be suspended for up to six months. S/he can continue to be MAPP eligible. The member must contact the IM agency to request the exemption. Have the member complete the Medicaid Purchase Plan (MAPP) Work Requirement Exemption (F-10127). This provision is not available unless s/he:

1. Has been enrolled in MAPP for six months and has paid any applicable premiums prior to the request of an exemption.

2. Is expected to return to work in the next six months.
3. Provides an expected date of recovery.
4. Provides the reason that an exemption is needed (i.e., illness or hospitalization).
5. Has had no more than two exemptions (maximum of six months each) to the work requirement in a three-year time period. The two exemptions cannot be consecutive.

Based on criteria outlined above, the IM agency will approve or deny the request. If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

In the sixth month of an exemption, mail to the recipient a notice indicating the date the Medical Work Exemption will end as well as steps the member may take to continue MAPP eligibility.

26.3.5 Health and Employment Counseling Program (HEC)

Health and Employment Counseling Program (HEC) is a program certified by the Department of Health and Family Services (DHS) to arrange services that help a member reach his/her employment goals. HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months a member can re-enroll in HEC to meet the eligibility criteria for MAPP, as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

Clients who are not working can meet the MAPP work requirement if participating in a HEC program. If an *applicant* is not currently working and wants to meet with a HEC screener, pend the case for up to 30 days beyond the application processing period. For an ongoing case, pend the case for up to 30 days after the change is reported or eligibility review is completed. This allows time for the screener to determine if the person qualifies for HEC.

If a determination has not been provided by the HEC screener within the thirty days, deny the case. The member is responsible for reporting HEC participation to the IM agency. The IM agency is not responsible for tracking HEC participation.

26.3.5.1 HEC Processing

Give the member a blank MAPP Employment Plan form, a Medicaid Purchase Plan factsheet (PHC 10071) , and the list of HEC screeners in your area. The member needs to complete the Employment Plan and give it to the screener.

The screener and member meet to set employment goals. The screener approves or disapproves the Employment Plan and then sends it to the Department of Health and Family Services (DHS) MAPP Unit, where a final approval/disapproval decision is made within ten working days. Their address is:

Pathways to Independence
Room 951
1 W. Wilson St
Madison, WI 53701

If the plan is not approved, the member should be informed by the HEC counselor that s/he has appeal rights and has the right to file a fair hearing.

The DHS MAPP Unit sends an approval letter to the member and the screener. In order to receive MAPP, the member is responsible for providing the IM worker with a copy of the approval letter.

See 26.10 HEC Regional Screeners for a listing.

26.3.5.2 HEC Extension

A participant can extend a HEC period by contacting HEC to request an extension.

If the HEC period is ending prior to the member meeting his/her employment plan goals, but the goals can be met within the three months after the regular HEC period will end, the DHS MAPP Unit can extend the HEC participation for three months.

26.3.5.3 HEC Participation Changes

The HEC counselor/screener monitors the participation of the member as s/he pursues the goals described in his/her MAPP Employment Plan. Whenever a member notifies the IM agency that s/he has stopped participating in the HEC program, the eligibility will be terminated with an adverse action notice.

Whenever a HEC participant notifies the IM agency that s/he is now employed, information about the employment will be needed and eligibility redetermined.

26.3.6 Health Insurance Premium Payment (HIPP)

See 9.4 Health Insurance Premium Payment for information about Health Insurance Premium Payment (HIPP) and cooperation requirements.

26.3.7 Spousal Impoverishment

There are no *spousal impoverishment* protections for MAPP. An institutionalized member who was determined ineligible for Mediaid using the Medicaid Institutions tests can qualify for Mediaid through MAPP. However, because only the member's assets count in determining MAPP eligibility, do not apply the spousal impoverishment provisions for assets. Similarly, because there is no post-eligibility treatment of income and instead calculate a premium using only the member's income, there is no *community spouse* income allocation or family member maintenance allowance for MAPP.

26.3.8 Institutionalization

Clients in an institution may qualify for MAPP if they fail institutional Medicaid. If the member's income exceeds 150% of the FPL (39.5 FPL Table), s/he 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 exceeds 150% of the FPL (39.5 FPL Table), s/he is responsible to pay a monthly premium instead of a cost share.

26.3.9.1 Special Managed Care Programs

MAPP members are eligible for enrollment into specific Special Managed Care Programs (*SMCP*).

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26.4 MAPP FINANCIAL REQUIREMENTS

26.4.1 Assets
26.4.1.1 Independence Accounts
26.4.1.2 Independence Account Exemption Status
26.4.1.3 Pension or Retirement Accounts
26.4.2 Income

Follow EBD rules in Chapters 15.1 Income Introduction and 16.1 Assets Introduction to determine countable assets and income. The following are *MAPP* financial eligibility requirements.

26.4.1 Assets

Total countable assets of the *member* must be $15,000 or less. Only count the assets of the MAPP *applicant* for the MAPP asset eligibility test.

26.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account. These accounts are an exempt asset. There is no limit to the number of accounts, and no restriction on what the money can be used for.

Only assets deposited while MAPP eligible may be exempted. Deposits made between periods of MAPP eligibility are not exempt.

Example 1: Freda creates an Independence Account out of an existing pension account in January with a pre-existing $5,000 when she becomes MAPP eligible. In March, while MAPP eligible Freda deposits another $2,000 in her Independence Account. Freda became MAPP ineligible in April and deposited another $1,200 in her Independence Account. Freda became MAPP eligible again in July. In the second period of MAPP eligibility the Independence Account pre-amount would change from $5,000 to $6,200. The

only assets that can be exempted are the deposits made while MAPP eligible. In this case $2,000 would be exempt and $6,200 would be counted as an asset.

To qualify as an Independence Account, it must be:

1. Registered with the IM Agency. Completing the F-10121 Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency. Place the completed F-10121 in the recipient case file and a provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the exception of pension and retirement accounts (See 26.4.1.3 Pension or Retirement Accounts)

A member's deposits (earned or unearned) in an independence account may total up to 50% of gross earning over a 12-month period, without penalty. If the member's deposits, from actual (earned or unearned income), exceed 50% of his/her actual gross earnings over the same twelve-month period, a penalty is assessed (See 26.5.1.1 Penalty). Amounts withdrawn from a MAPP Independence Account during a twelve month period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 2: Fred earns $5000 gross from January - December 2003. Total deposits into the independence account were $3000 for the same period. A $500 withdrawal was made in December 2003 to pay for car repairs. The $500 withdrawal is ignored when determining the penalty. The penalty is based solely on total deposits which exceeded 50% of gross earnings over a twelve month period. The result in this example would be a $500 penalty. (See 26.4.1.3 Pension or Retirement Accounts)

26.4.1.2 Independence Account Exemption Status

If a member with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) is exempt for future MAPP application(s). The entire balance is a countable asset for all other Medicaid subprograms.

26.4.1.3 Pension or Retirement Accounts

A member who has a pension or retirement account can designate that account as an Independence Account. The initial balance is a countable asset (16.7.21 Retirement Benefits). Any dividends, interest, and deposits to the account are exempt from the date the Independence Account is approved. Continue to count the initial balance as an asset.

26.4.2 Income

The *spouse* and member's net income must not exceed 250% of the FPL (See 39.5 FPL) for appropriate fiscal test group size. To determine this, do the following:

1. Determine family earned income. Count the member and his/her spouse's income if residing together.

2. Deduct the $65 and ½ of the earned income *disregard* from the spouse and member's earnings (15.7.5 $65 and ½ Earned Income Deduction).

3. Deduct the member's IRWEs (15.7.4 Impairment Related Work Expenses (IRWE)). The result is the adjusted earned income.

4. Determine unearned income. Count the member and his/her spouse's income if residing together.

5. Add the adjusted earned and unearned income together.

6. Deduct $20 from the combined income.

7. Deduct special exempt income (15.7.2 Special Exempt Income).

8. If a MAPP member receives Social Security payments, subtract the current *COLA* disregard between January 1st and the date the FPL is effective in CARES for that year.

Example 3: Ed's Social Security payment amounts were $875 a month for the previous year and $900 for the current year. Calculate the current COLA disregard by subtracting the Ed's previous Social Security payment amounts from the current payments. Allow $25 as the current COLA disregard.

9. Subtract the historical COLA *Disregard* Amount (39.6 COLA) for MAPP members who are also determined to be a 503 (25.1 503 Eligibility) or Disabled *Adult* Child (DAC) (25.2 DAC). Do not allow the historical COLA disregard amount (39.6 COLA) in the premium calculation for MAPP members who are also determined to be a 503 or a DAC.

10. Compare the result to 250% of the FPL (39.5 FPL Table). Include the member's *minor* dependent children (natural or adoptive) when determining fiscal test group size. Do not include the member's stepchildren in the fiscal test group size.

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26.5 MAPP PREMIUMS

26.5.1 Calculation
26.5.1.1 Penalty
26.5.2 Initial Premium
26.5.3 Payment Information
26.5.3.1 Payment Methods
26.5.3.2 Advance Payments
26.5.3.3 Refunds
26.5.4 Ongoing Cases
26.5.5 Late Payments
26.5.5.1 Between Due Date and Adverse Action of the Benefit Month
26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month
26.5.5.3 Anytime in Month After the Benefit Month
26.5.5.4 Two Months After the Benefit Month
26.5.6 Non-Payment
26.5.6.1 Insufficient Funds
26.5.7 Opting Out

26.5.1 Calculation

Calculate premiums using only the *member*'s income. Calculate a premium if the member's gross monthly amount exceeds 150% of FPL (39.5 FPL Table) for the appropriate fiscal test group size.

Steps to calculate monthly premium amount:

1. From gross monthly unearned income, subtract the following:
    a. Special Exempt Income (15.7.2 Special Exempt Income).

b. Standard Living Allowance (39.4.2 EBD Deductions and Allowances).
c. Impairment Related Work Expenses (IRWE). For *MAPP*, use only anticipated incurred expenses, past medical expenses are not allowed. (15.7.4 Impairment Related Work Expenses (IRWE)).
d. Medical Remedial Expenses (MRE). For MAPP, use only anticipated incurred expenses, past medical expenses are not allowed. (15.7.3 Medical/Remedial Expenses (MRE))
e. Current *COLA Disregard* from January 1st through the date the FPL is effective in CARES for that year. 503, DAC, widow/widower disregards allowed in eligibility determinations can not be allowed in premium calculations.

The balance is the Adjusted Countable Unearned Income. This number may be a negative number.

2. From gross monthly earned income, subtract any remaining deductions from #1. If the result from #1 is a negative amount, change it to a positive number. The balance is the Adjusted Earned Income.

3. Multiply the adjusted earned income by three percent (.03).

4. Add the results of #3 and #1 together.

5. Compare the result from #4 to the Premium Schedule (39.10 MAPP Premiums) to determine monthly premium amount.

26.5.1.1 Penalty

If the member puts (earned or unearned) in an amount that exceeds 50% of the actual earnings into an Independence Account, the member would be penalized using the following formula. At review, look back 12 months and take the:

Total verified Annual Deposits minus 50% of verified annual gross earned income divided by 12 = monthly assessment.

Add this monthly assessment to the premium for the next 12 months of eligibility. Only impose Independence Account penalties if the member is otherwise required to pay a premium.

Example 1: Brenda deposited $1,200 more than 50% of her actual annual gross earned income in her Independence Account. If Brenda's income exceeds 150% of the FPL (39.5) and she is responsible for a monthly premium, add the monthly assessment of $100 to her monthly premium for the next 12 months. If Brenda's income does not exceed 150% of the FPL (39.5), do not impose a penalty.

26.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the member must pay applicable premiums for the initial benefit month and for any backdate months for which the member elects coverage. If determining eligibility in the month after application, the premium for the second month also must be paid before confirming eligibility.

Example 2: Eric applies for MAPP on January 29th, but his application is not processed until February 11th. The IM agency determines that he owes a $50 premium per month. Before eligibility is approved (confirmed), Eric must pay a $50 premium for January and a $50 premium for February.

Example 3: If Eric applies for MAPP on January 29th. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

Complete the premium coupon and the Medicaid Purchase Plan (MAPP) Recipient/Premium Information (F-10122) for benefit months prior to January 2002. For benefit months beginning January 2002, CARES will send premium information to MMIS, but the IM continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the member elects coverage. Complete the premium coupon and record receipt of the premium payment in CARES.

Send MAPP premium payments separate from BadgerCare premium payments and other agency funds. Send premium payments to the following address:

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738

26.5.3 Payment Information

26.5.3.1 Payment Methods

When requested, EDS will provide members with instructions for choosing the payment method they want. Clients can contact Member Services at 1-800-362-3002.

The payment methods are:

1. Direct payment by check or money order.
2. Electronic Funds Transfer (EFT).

3. Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in premium wage withholding. If the employer decides not to participate, the participant will have to choose direct pay or EFT.)

Provide members with the MAPP Premium Recipient/Employer Electronic Funds Transfer (F-13023) and MAPP Premium Employer Wage Withholding (F-13024) forms to allow the member to choose a payment method other than direct payment. Since it takes some time to set up EFT and wage withholding, the member pays directly until EDS informs them otherwise.

26.5.3.2 Advance Payments

Clients can make advance payments, but the payment cannot exceed the certification period. If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial month payments). If the income amount changes, recalculate the premium. The member will be notified through CARES that their premium amount has changed. If the premium amount has decreased, EDS will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the member will receive a coupon with the new premium amount. If the premium coupons have already been sent, the member will need to pay the additional amount owed. The member will not receive a coupon for the difference that is owed.

26.5.3.3 Refunds

EDS issues refunds if the member:

1. Lost MAPP eligibility and already paid the premium. Refunds will only be given if *adverse action* notice requirements were met.
2. Overpaid. The member overpaid and the excess cannot be applied to the next month's premium.
3. Retroactive Adjustment. The premium was recalculated and reduced for prior month(s).
4. Requested to close MAPP and already paid the premium.

The member's estate can receive a refund if s/he dies between adverse action and the beginning of the benefit month.

26.5.4 Ongoing Cases

Ongoing premium payments are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the tenth of the benefit month, no matter which payment method is chosen. For members who have chosen 'direct pay' as their payment method, EDS sends out the premium coupon on the 20th of the month before the benefit month. The

payment must be received at EDS by the tenth of the benefit month. EFT occurs on the third business day of the benefit month.

26.5.5 Late Payments

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Clients must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 4: If the member owed a premium for September, and does not pay it until October, then s/he will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

26.5.5.1 Between Due Date and Adverse Action of the Benefit Month

The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by adverse action in the benefit month.

26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month

If the member pays between adverse action of the benefit month and the last day of the benefit month, s/he can reopen. Run SFED with dates and confirm.

Example 5: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He does pay on September 26th. The case closed effective September 30th. Run with dates to open for October. Then run without dates for November eligibility.

26.5.5.3 Anytime in Month After the Benefit Month

If the member pays any time in the month after the benefit month, s/he can reopen. S/he must pay the premium that closed them. If they owe a premium for that following month, s/he must pay that premium before CARES will open MAPP. The member must pay the IM agency directly (not EDS). The IM Worker can check with EDS to see if a premium has already been collected for that month.

When the payment(s) is received, record the payment in CARES and run eligibility for the benefit month and confirm. Then run eligibility for the following month, and confirm.

Example 6: Adverse action is September 16th. Jim has not paid his September premium by September 16th. He pays on October 26th. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen it, run eligibility for October and confirm. Finally, run eligibility for November and confirm. (The November premium is not due until November 10th and does not have to be paid in advance.)

26.5.5.4 Two Months After the Benefit Month

If the member pays in the second month after the benefit month, it is a non-payment (See 26.5.6 Non-Payment below).

26.5.6 Non-Payment

If a MAPP member does not pay the monthly premium by adverse action in the benefit month, apply a restrictive re-enrollment period (RRP) (26.6 MAPP Restrictive Re-enrollment Period (RRP), unless there is good cause (26.6.2 Good Cause). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, lift the RRP.

26.5.6.1 Insufficient Funds

You will be notified with an 056 “Run SFED/SFEX” alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply a restrictive re-enrollment period (RRP), unless there is good cause (anything which is beyond the member’s control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists and process the overpayment.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, anytime prior to the beginning of the next benefit month, close the case in CARES for the next possible month. If the case cannot be closed in CARES at the end of the current benefit month, do not impose a RRP. Close the case in CARES. Submit a F-10110 (formerly DES 3070) by mail, email or fax.

1. **Mail**:
   EDS
   P.O. Box 7636
   Madison, WI 53707

2. **E-mail:** veds3070@wisconsin.gov

3. **Fax**: (608) 221-8815

Enter “MAPP OPT OUT” in red in the comment section of the 3070.

Example 7: Sally calls her worker on July 25th to de-request MAPP for August. Since Sally opted out prior to the benefit month Sally should not owe a premium for August. The worker will need to change the request for MAPP on ANMR and “zero” out the premium due for August.

To zero out the premium the worker has to alter the income for the process month. The altered income should be low enough that MAPP still passes with no premium, and high enough that the *applicant* does not qualify for another MA subprogram. At this point the worker would have to run the eligibility with appropriate dates and confirm the results. A RRP should not be imposed because Sally de-requested August MAPP coverage prior to the beginning of the benefit month.

Her worker must override the RRP on AGRR by entering an override RRP end date using the reason code “SY”, system problem. Change the request for MAPP on ANMR to “N”, and suppress the CARES notice stating that the member’s MAPP eligibility will end August 31st. Send a manual negative notice indicating that the member’s MAPP eligibility ends July 31st.

A MAPP applicant’s decision to “opt out” does not affect other family members eligibility for MA or MA related Programs.

26.6 MAPP RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

26.6.1 MAPP RRP Introduction
26.6.2 Good Cause

26.6.1 MAPP RRP Introduction

When a *member* is placed in a restrictive re-enrollment period (RRP), s/he is ineligible for the next six consecutive months following the closure of *MAPP*, unless there is good cause (26.6.2 Good Cause). After the six consecutive months, the member may regain eligibility if s/he pays all arrears and current premiums. After 12 calendar months, s/he may regain eligibility without paying the past due premiums.

RRPs are tied to non-payment of premiums only. RRPs do not apply to recipients who have not met HEC requirements.

26.6.2 Good Cause

The following are good cause reasons for not paying a MAPP premium:

1. Problems with electronic funds transfer.
2. Problems with an employer's wage withholding.
3. Administrative error in processing the premium.
4. Fair hearing decision.
5. Those you determine are beyond the member’s control.

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26.7 MAPP CHANGES

26.7.1 MAPP Changes Introduction
26.7.2 Reduced Premiums or No Premiums

26.7.1 MAPP Changes Introduction

The *member* must report within ten days all changes to income, household composition, allowable deductions and other non-financial changes, including loss of employment, which affect eligibility. The IM worker should re-determine eligibility as a result of the changes. If it is determined that s/he remains eligible for *MAPP* and owes a premium, recalculate the premium amount.

26.7.2 Reduced Premiums or No Premiums

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. If the change results in no premium, the IM agency may have to run eligibility with dates in CARES for the month the change occurred or was reported (which ever is later) and any subsequent months as well as for recurring.

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26.8 MAPP PREPAID DEDUCTIBLES

If the client prepaid a deductible and then becomes eligible for *MAPP* without a premium, s/he can only get a refund of the prepayment if the deductible period has not started. Use the Community Aids Reporting System (CARS) to report the accounting.

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26.9 MAPP NOTICES

For manual *MAPP* eligibility determinations:

1. Use the F-16015, Medicaid / BadgerCare Manual Positive Notice, when MAPP is approved or the premium decreases.
2. Use the F-16001, Medicaid / BadgerCare Manual Negative Notice, when eligibility is denied or terminated or the premium increases.

Note: The client must be given *adverse action* notice of any negative action (e.g. premium increase).

Use the following notice text that is applicable to the denial reason. Use §49.472 WIS STATS as the citation for each of the reasons.

You are not eligible for the MAPP because:

1. Your assets exceed the $15,000 asset limit.
2. Your income exceeds 250% of the FPL (39.5 FPL Table) for your family size.
3. You have not paid your MAPP premium.
4. You have been determined 'not' disabled under MAPP rules by the *Disability* Determination Bureau.
5. You are not working.
6. You no longer meet the work or HEC participation requirement of MAPP.

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26.10 MAPP / HEALTH AND EMPLOYMENT COUNSELING PROGRAM (HEC) SPECIALISTS

See http://www.eri-wi.org/Benefits/HEC/HECMAPPSpecialists.htm for an updated list of *MAPP* / HEC specialists, by region.

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27 INSTITUTIONAL LONG TERM CARE (ILTC)

27.1 INSTITUTIONS

27.1.1 Institutions Introduction
27.1.2 Institutions for Mental Disease
- 27.1.2.1 Eligible Age
- 27.1.2.2 Temporary Leave
- 27.1.2.3 Minors in IMD

27.1.3 Hospitals

27.1.1 Institutions Introduction

For Medicaid purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (*SNF*), intermediate care facilities (*ICF*), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,
2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,
3. Is authorized under State law to provide medical care, and,
4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

27.1.2 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs (27.11 Institutions for Mental Disease (IMDs)).

27.1.2.1 Eligible Age

IMD residents under age 21 and over age 64 may be Medicaid eligible. Persons aged 21 through 64 are not eligible unless they were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge (a 21 year old can be transferred from one IMD into another and remain eligible for Medicaid) or until turning age 22, whichever comes first.

27.1.2.2 Temporary Leave

A person aged 21 through 64 can go on conditional release from an IMD or convalescent leave and become eligible for Medicaid while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.

    a. The trial period must last no less than four days. It must be no longer than 30 days.
    b. The trial period begins after the initial three days of community residence following discharge.
    c. A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until s/he is unconditionally released from the IMD, or turns 22, whichever comes first.

For purposes of Medicaid, conditional release is permitted only once every calendar year.

2. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD. A person under age 22 who leaves the IMD on Convalescent Leave remains eligible as an IMD resident until s/he is unconditionally released from the IMD, or turns 22, whichever comes first.

27.1.2.3 Minors in IMD

When a *minor* applies for Medicaid after being discharged from the IMD, certify the individual as a recipient, if eligible, for the inpatient IMD days only. Certify for the remainder of the month if s/he would be eligible after being tested for Family Medicaid with his/her parents and siblings.

27.1.3 Hospitals

Hospitals are medical institutions that:
1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,
3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (27.4.1 Institutionalized Person) if s/he:
1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

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27.2 ILTC LICENSING AND CERTIFICATION

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Division of Public Health, Bureau of Quality Assurance, is the licensing agency.

In order to receive Medicaid payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency which certifies their compliance is the Division of Health Care Access and Accountability.

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27.3 FACILITIES NOT MEDICAID CERTIFIED

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. Medicaid will not pay cost of care for these persons, but they may still be eligible for Medicaid card services (17.15 Medicaid Card Services).

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27.4 ILTC DEFINITIONS

27.4.1 Institutionalized Person
27.4.2 Community Spouse
27.4.3 SSI Recipient and Institutional Medicaid application

27.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Participates in Community Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until s/he is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

27.4.2 Community Spouse

See 18.2.1 Community Spouse.

27.4.3 SSI Recipient and Institutional Medicaid application

An *SSI* recipient who has resided or is likely to reside in a medical institution for 30 days or more may apply and be non-financially eligible for institutional Medicaid if the *SSA* will discontinue the person's SSI because of the financial effect of his/her residence in the medical institution.

An SSI recipient who has not resided or is not likely to reside in a medical institution for 30 days or more is non-financially ineligible for institutional Medicaid. The person remains Medicaid eligible through SSI.

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27.5 ILTC FINANCIAL

27.5.1 ILTC Assets
27.5.2 ILTC Income
27.5.3 Divestment
27.5.4 Instructions for Manual Eligibility Determinations

27.5.1 ILTC Assets

Refer to 16.1 Assets Introduction to determine when an asset is countable. If countable assets exceed the appropriate limit, the Medicaid *applicant*/recipient is ineligible.

Note: Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his/her support and maintenance (16.2 Assets Availability).

1. Unmarried *member*- See 39.4 EBD Assets and Income Tables or the EBT asset limits for an unmarried member

2. Married member (*Spousal Impoverishment*) -The assets of both the institutionalized person and his/her *community spouse* are counted in the initial asset test. For information about how to determine a married member's asset limit and the community *spouse* asset share refer to 18.4 Spousal Impoverishment Assets.

27.5.2 ILTC Income

Follow the policies listed in 15.1 Income Introduction to determine an applicant's income. The income limit is the same for non-spousal impoverishment institutionalized persons as for spousal impoverishment cases. But, for spousal impoverishment cases, after the institutionalized person becomes eligible, s/he is allowed to allocate some of his/her income back to his/her community spouse. (See 18.6 Spousal Impoverishment Income Allocation)

If income is greater than Institutions Categorically Needy Income Limit (39.4 EBD Assets and Income Tables) the person is ineligible for categorically needy Medicaid.

If the income is greater than need (See 27.6 ILTC Monthly Need) the person is ineligible for medical needy Medicaid.

Sometimes, when both spouses are institutionalized, the income of one is greater than his/her monthly need and the income of the other is less than his/her monthly need. When this occurs, calculate the couple's combined monthly need and compare it with their combined income. If the total need is greater than the total income, and if the spouse with greater income is willing to combine it with his/her spouse's lesser income, both spouses could be eligible.

27.5.3 Divestment

See 17.1 Divestment Introduction for Divestment policies.

27.5.4 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution (27.1 Institutions) residents with no community spouse (18.2.1 Community Spouse).

   Use the Medicaid Institution Worksheet (Worksheet #4).

2. Medical institution residents who have a community spouse and who became institutionalized before 09-30-89:

   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the Medicaid Institution Worksheet (Worksheet #4).

3. Medical institution residents who have a community spouse and who became institutionalized on or after 09-30-89:

Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form and the Spousal Impoverishment Income Allocation Worksheet (Worksheet #7).

4. Community waiver applicants with no community spouse:
Use the Medicaid Waiver Eligibility and Cost Sharing Worksheet

5. Community waiver applicants with a community spouse:

Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form the Medicaid Waiver Eligibility and Cost Sharing Worksheet , and the Spousal Impoverishment Income Allocation Worksheet (Worksheet #7).

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27.6 ILTC MONTHLY NEED

27.6.1 ILTC Monthly Need Introduction
27.6.2 Hospitalized Persons
27.6.3 Both Spouses Institutionalized
27.6.4 Health Insurance
27.6.4.1 Nursing Home and Hospital Insurance
27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments
27.6.5 Support Payments
27.6.6 Fees to Guardians or Attorneys

27.6.1 ILTC Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his/her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (39.4 EBD Assets and Income Tables).
2. Cost of institutional care (use private care rate).
3. Cost of health insurance (27.6.4 Health Insurance).
4. Support payments (15.7.2.1 Support Payments).
5. Out-of-pocket medical costs.
6. Work related expenses (15.7.4 Impairment Related Work Expenses (IRWE)).
7. Self-support plan (15.7.2.2 Self-Support Plan).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.
10. Other deductible expenses.

27.6.2 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See 39.7 Hospital Daily Rates. If his/her hospital is not on the list, enter $2,318.08 on Long Term Care Gatepost/ Institutions screen.

27.6.3 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his/her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

27.6.4 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

Example 1: Mr. W. pays a health insurance premium of $600 every quarter. The monthly amount, prorated over three months, is $200. Deduct $200 from Mr. W's monthly income. Each quarter, exempt $600 of Mr. W's assets until that quarter's premium due date.

27.6.4.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance polices are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that s/he resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments

All members must cooperate in providing Third Party Liability (*TPL*) coverage and access information (9.2 Nursing Home and Hospital Insurance). All members must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (9.2.2 Assignment). Terminate eligibility for any individual that will not cooperate in:

1. Providing TPL coverage and access information.
2. Turning over payments from indemnity insurance policies.

27.6.5 Support Payments

Support payments are payments which an institutionalized Medicaid *member* makes to another person for the purpose of supporting and maintaining that person. See 15.7.2.1 Support Payments.

27.6.6 Fees to Guardians or Attorneys

See 15.7.2.3 Fees to Guardians or Attorneys

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27.7 ILTC COST OF CARE CALCULATION

27.7.1 ILTC Cost of Care Calculation Introduction
27.7.2 Hospitalized Persons
27.7.3 Managed Care Programs
27.7.4 Partial Months
    27.7.4.1 Death

27.7.4.2 Community and Nursing Home
27.7.5 Transfers Between Institutions
27.7.6 Retroactive Cost of Care
27.7.7 Personal Needs Allowance
27.7.8 Payment for Non-Covered Services

27.7.1 ILTC Cost of Care Calculation Introduction

After an institutionalized person has been determined eligible for Medicaid, his/her cost of care must be calculated. Cost of care is the amount s/he will pay each month to partially offset the cost of his/her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution and cost share when applied to a community waivers client, Pace/ Partnership, or Family Care client. The institutionalized *member* will be expected to pay their patient liability to the institution that they are residing in as of the first day of the month.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a *community spouse*, subtract the following from the person's monthly income:

    a. $65 and ½ earned income *disregard* (15.7.5 $65 and ½ Earned Income Deduction).
    b. Monthly cost for health insurance (27.6.4 Health Insurance).
    c. Support payments (15.7.2.1 Support Payments).
    d. Personal needs allowance (39.4 EBD Assets and Income Tables).
    e. Home maintenance costs, if applicable (15.7.1 Maintaining Home or Apartment).
    f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (27.6.6 Fees to Guardians or Attorneys).
    g. Medical Remedial Expenses. See 27.7.8 Payment for Non-Covered Services.

2. For a Medicaid member in a medical institution who has a community *spouse*, follow the directions in 18.6 Spousal Impoverishment Income Allocation.

3. For a community waivers member with or without a community spouse, follow the directions in 28.5 HCBWLTC Cost Sharing.

4. There is no cost of care for *SSI* recipients.

5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

If the cost of care amount is equal to or more than the medical institution 's Medicaid rate, the individual is responsible for the entire cost of his/her institutional care. S/he would be entitled to keep any overage without restriction. S/he would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

27.7.2 Hospitalized Persons

Effective December 1st, 2008, hospitalized individuals will be responsible for paying a patient liability. See 27.7.5 Transfers Between Institutions for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

27.7.3 Managed Care Programs

Payment procedures are different for institutionalized Family Care or Pace/Partnership members. These members pay their cost share to the *Managed Care* Program instead of to the nursing home. The program then pays the nursing home.

27.7.4 Partial Months

If a member is not Medicaid eligible and residing in an institution (27.1 Institutions) as of the first of the month, there is no patient liability for that month.

Exception: There is a patient liability if the reason why the person didn't reside in the institution for the entire month was due to death or being on Therapeutic leave.

27.7.4.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month send a completed F-10101 (formerly DES 3070) form to:

1. **Mail**:
   EDS
   P.O. Box 7636
   Madison, WI 53707

2. **E-mail**: veds@wisconsin.gov

3. **Fax:** (608) 221-8815

Indicate the patient liability amount as equal to the nursing home charges for the month. This is done for potential retroactive nursing home rate adjustments. The nursing home will notify the Estate Recovery Program (*ERP*) of who received the excess income. ERP will attempt recovery even if the money goes to the heir directly. ERP uses the same process to recover this excess income as it does for recovering patient fund accounts (22.1.5.7 Patient Fund Account).

27.7.4.2 Community and Nursing Home

There is no patient liability in a month a member moves from:
1. The community into a nursing home after the first of the month, or
2. From a nursing home to the community before the end of the month.

27.7.5 Transfers Between Institutions

Effective 12/01/08:
When an institutionalized individual transfers between institutions (nursing homes, hospitals, hospices) in the same month, you will no longer pro rate the patient liability between the various institutions that they resided in during that month. The client/member will pay their patient liability to the institution that they were residing in on the first day of the month. ForwardHealth will automatically deduct the appropriate patient liability amount from the **first** nursing home, hospice, or long term inpatient hospital claim received for the member. If the amount of the patient liability exceeds the reimbursement amount of the first claim, the remaining liability amount will be deducted from the next claim(s) received for services provided in the month that patient liability is owed. Patient liability amounts deducted from claims will appear in the provider's remittance information. Nursing home, hospice, and inpatient hospital providers may have to occasionally transfer a patient liability amount that they collected from a client/member, on the first day of a month, to the appropriate provider who ultimately had their claim adjusted to reflect the required patient liability amount.

27.7.6 Retroactive Cost of Care

Occasionally a nursing home or community waivers *applicant* becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively certify him/her and compute retroactive cost of care. The directions are the same as for current cost of care (27.7.1 ILTC Cost of Care Calculation Introduction).

27.7.7 Personal Needs Allowance

Deduct the personal needs allowance (39.4.2 EBD Deductions and Allowances) for all institutionalized members in both the eligibility test and the patient liability calculation.

27.7.8 Medical/Remedial Expenses and Payments for Non-Services

27.7.8.1 Introduction

Medicaid members in nursing homes are allowed to pay for some medically necessary non-covered services out of their patient liability. They are not required to use their personal needs allowance for these services.

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, are used as a need item when determining their eligibility for MA. These actual payments are also allowed as an income deduction to reduce the cost share amount. This includes payments for medical/remedial expenses that the person is currently incurring as well as payments for certain previously incurred medical/remedial expenses.

In order to use the medical/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/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 27.7.8.2 Disallowed Expenses

Example 1: In February 2008, Al had a root canal performed by a dentist who is not an MA provider. He is responsible for paying $600 for the procedure. Al began making payments of $100 per month on this medical bill in March 2008. On April 1st, Al became institutionalized and eligible for MA. The $100 payment that Al is making on a previously incurred medical expense should be used as a need item when determining Al's institutional MA eligibility. The expense should also be used as in income deduction when calculating Al's cost share obligation. The $100 payment can be used as an income deduction in the cost share calculation until it is fully paid in August. Since Al will no longer be making payments in September, the expense should be decreased to zero prior to *adverse action* in August.

Example 2: In April 2008, Edna applied for Institutional MA and requested a one-month backdate. Her request for eligibility in March was denied because her assets exceeded program limits, but was approved effective April 1st. Edna used her excess assets to make a partial payment to the nursing home

for March costs, but still has an outstanding balance of $1,800. Edna agrees to make payments to the nursing home of $500 per month until the expense is paid in full. The $500 payment to the nursing home should be used as an income deduction when calculating her cost share for the months of April through June. In July she will only owe $300 to the nursing home so the deduction for July should be decreased to $300 prior to adverse action in June. Edna will no longer be making payments in August so the expense should be decreased to zero prior to adverse action in July.

Example 3: Jack has been an institutionalized MA recipient since January 2008. In March, he had a tooth extracted. The procedure was performed by a dentist who is not an MA provider, so it was a non-covered service. Jack contacts the agency in April to request a deduction from his cost share so that he can pay the expense. The cost of the extraction was $209. Since this was a one-time expense and his patient liability exceeds this amount, the agency enters the expense in CWW to reduce the May cost share by $209.

27.7.8.2 Disallowed Expenses

Do not allow payments that an institutionalized person is making, or requests to make, as a need item, or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

1. Remains unpaid, but was previously used to meet a Medicaid deductible.
2. Were incurred as the result of imposition of a divestment penalty period.
3. A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.
4. Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month.

Example 4: On September 17, 2007, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a $2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay $100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of $1,800 and was determined MA eligible from September 2007 through February 2008.

In May 2008, Alice was determined to be functionally eligible for Home and Community Based Waivers and was determined eligible for MA under Group B waiver rules. Without a medical/remedial expense, Alice's cost share would be $100. Alice's Care Manager verified that Alice still owes $1,200, but only $200 of the expense is allowable because $1,800 was already used to satisfy a deductible. Her Care Manager will include the $100 payment in the medical/remedial expense amount submitted to the IM worker for determining

her cost share, but will reevaluate Alice's medical/remedial expense amount in two months.

Example 5: On August 1, 2008, Alice moved to a nursing home. Her eligibility for Home and Community Based Waiver ended and she was determined eligible for Nursing Home MA beginning August 1st. She is still making the $100 payments to the hospital, and has an outstanding balance of $900. However, Alice used $1,800 to meet a deductible and already received a deduction of $200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.

Example 6: In January 2008, Lyle was institutionalized and applied for MA. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December 2007. During this three month period, MA will not cover the cost of Lyle's institutional care, but will only cover his card services. In March 2008, the divestment penalty period expired, and Lyle is eligible for MA payment of his institutional cost share. He would like to use $2,000 of his monthly income to pay for the nursing home bills that he incurred in January and February 2008 and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior MA divestment penalty period.

CARES Process

Until changes in CARES can be made to accommodate this policy and process change for institutional cases, enter the allowable medical and remedial expenses as a court ordered support payment on the Support Obligations/Payments page in CWW. Be sure to document detailed information about the expense and cost share calculations in case comments. Remember, Medical/remedial expenses for group B waiver cases are still entered on AFME. There are no CARES processing changes/overrides required for community waiver/FC cases.

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27.8 ILTC NURSING HOME CONTRACTS

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (Medicaid).

In essence, this requires the prospective resident waive the right to apply for Medicaid for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for Medicaid before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the Medicaid program. The standards must be enforced as a condition of federal funding. They apply to all residents in an Medicaid certified nursing home, both Medicaid and private pay, as a condition of participation in the Medicaid program.

A resident can be involuntarily discharged or transferred essentially only for:

1. medical reasons,
2. his/her welfare or that of other patients, **or**
3. nonpayment.

Changing status from private pay to Medicaid and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for Medicaid by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHFS has notified all Wisconsin nursing home providers that:

1. violations of private pay duration of stay contract provisions aren't grounds for discharge, **and**
2. they must notify all present and prospective residents of this.

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27.9 ILTC NURSING HOME REFUNDS

When an institutionalized person becomes eligible for Medicaid, s/he is certified with a begin date of the first of the month in which s/he became eligible. If s/he prepaid his/her patient liability for that month, the recipient may ask the nursing home to send the bill to Wisconsin Medicaid and ask that s/he be reimbursed for the month.

Treat the refund as a reimbursement in the month it is received. (15.3.19 Reimbursements) Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount s/he keeps as an available asset. S/he can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for *fair market value* for an exempt asset.
2. Transfer it to his/her *spouse*.
3. Refund it to the Medicaid program in an amount equal to what Medicaid has already paid for his/her care up to the date of the reimbursement.

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27.10 ILTC LIABILITY EFFECTIVE DATES

Nursing homes, State centers, and State mental hospitals receive a CARES weekly paper report, #CCN150RA, that lists the patient liability amounts for their Medicaid residents. The report includes case number, primary person name, patient liability status (approval, closure, increase, decrease, unchanged), the date the action was confirmed on AGEC, prior patient liability amount, current patient liability amount, effective begin date, and effective end date.

Income changes which are reported timely and result in an increased patient liability have the following effective dates:

1. Before *cutoff* , effective the first of the following month.
2. After cutoff, effective the first of the month after the following month.

Do not complete F-10110's (formerly DES 3070) for retroactive patient liability increases since the *member* must receive timely notice.

Decreases in patient liability are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later. If the date of change that you enter into CARES will cause an incorrect effective date on the EDS file, run with dates in CARES. Do not complete a F-10110 (formerly DES 3070) unless you are unable to confirm the decrease after running with dates in CARES.

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27.11 INSTITUTIONS FOR MENTAL DISEASE (IMDS)

Brown
Bellin Psychiatric Center, Green Bay
Brown County Mental Health Center, Green Bay
Libertas Center, Green Bay (aka St. Joseph's)

Dane
Mendota Mental Health Institute, Madison

Fond du Lac
Fond du Lac County Health Care Center

Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Rogers Memorial Hospital, Milwaukee
Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Trempealeau
Trempealeau County Health Care Center IMD, Whitehall - license # 2961
Trempealeau County IMD, Whitehall - license # 5001

Waukesha
Rogers Memorial Hospital,Oconomowoc
Waukesha County Mental Health Center, Waukesha

Winnebago
Winnebago Mental Health Institute, Winnebago

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid *applicant*/recipient resides.

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28 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC)

28.1 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) INTRODUCTION

Community waivers enable *elderly*, blind, and disabled (EBD) persons to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for community services, which normally are not covered by Medicaid .

Community waivers include the following programs:

1. Community Integration Program I (CIP 1A and CIP 1B).
2. Community Integration Program II (CIP II).
3. Community Options Program Waiver (COP-W) .
4. Brain Injury Waiver.
5. Program of All-Inclusive Care for the *Elderly* (PACE).
6. Wisconsin Partnership Program (WPP).
7. Children's Long Term Support waiver programs (CLTS). These programs serve children with physical disabilities, developmental disabilities and mental health needs.

To be eligible for these waivers, a person must:

1. Meet Medicaid level of care requirements for admission to nursing homes, and
2. Meet non-financial requirements for Medicaid, and
3. Meet financial requirements for Medicaid, and
4. Reside in a setting allowed by community waivers policies, and
5. Have a need for long term care services.
6. Have a *disability* determination if they are under age 65. (*Disability* is a non-financial eligibility requirement for Community Waiver programs for anyone under age 65.)

Note: A person who is *MAPP* disabled may be eligible as a Group A participant even if a regular disability has not been determined by *DDB*.

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28.2 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) APPLICATION

28.2.1 Case Manager
28.2.2 Spousal Impoverishment
28.2.3 Minors
28.2.4 Tentative Approval

All waiver clients being discharged from a nursing home, and persons in non-institutional living arrangements must complete an application form unless they are already receiving full-benefit Medicaid (21.2 Full Benefit Medicaid).

28.2.1 Case Manager

All waiver clients receive assessment and case planning services from a case manager. The case manager is responsible for determining a level of care and completing a service plan for each client. In some counties this function is performed at the Resource Center. IM Agency staff should assist case mangers/resource centers in determining eligibility for a potential Group A waiver recipient by checking MMIS.

The service plan packet contains documentation verifying the person's eligibility for waivers. For Group A clients, case managers submit CARES eligibility and budget screens. (Budgets> Community Waivers Budget), or the Medicaid Waiver Eligibility and Cost Sharing Worksheet (DDE-919). For Group B and C clients, the CARES eligibility and budget screens are submitted. DDE-919 serves as a backup to CARES.

28.2.2 Spousal Impoverishment

Spousal impoverishment policy applies to waiver participants with a *community spouse*, with the exception of Medicaid Purchase Plan (*MAPP*) waiver participants (18.2.3 Institutionalized and 26.3.7 Spousal Impoverishment).

28.2.3 Minors

Minors are not eligible for waiver services unless they have been determined disabled (5.2 Determination of Disability). Consider only the disabled child's income unless the parents make an actual cash contribution to the child. If they

do, include that amount as part of the child's unearned income (28.6 HCBWLTC Uniform Fee System).

28.2.4 Tentative Approval

Persons who apply for waivers other than PACE and WPP may receive tentative waiver approval from the Division of *Disability* and Elder Services (DDES) while their Medicaid eligibility is being determined.

The tentative approval process begins when the case manager refers the waiver *applicant* to the IM Agency with accompanying information about the type of waiver, waiver begin date, medical/remedial expenses, and Medicaid card coverable expenses. Enter the case into CARES and send the case manager the CARES screen prints showing the eligibility determination, cost share amount, family *member* allowance, and spenddown amount.

If it is a spousal impoverishment case, also send along the CARES screen prints or manual worksheets which show the spousal and family member income allocations. Complete a manual *Spousal Impoverishment* Income Allocation Worksheet (40.1 WKST 07) for any spousal impoverishment case that is Group C eligible. Send a copy of this worksheet or a modified copy of ECSC to the case manager. Send a manual notice to the client with the corrected cost share amount, if the cost share calculated on WKST 07 differs from the amount calculated in CARES.

The case manager then submits the screen prints and the service plan packet to DDES for tentative approval. Until the case manager informs you the case has been tentatively approved, keep it in pending status in CARES. After tentative approval is received, confirm the case on CARES. This will certify the person for Medicaid.

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28.3 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) FISCAL TEST GROUP

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.
2. Married couple, when one *spouse* is applying for community waivers, and the other is a *community spouse*. This is a *spousal impoverishment* situation. Combine the assets (18.4.3 Calculate the CSA and apply the spousal impoverishment asset test (18.4.4 Asset Test). The income limit is the same as for institutionalized persons who do not have a community spouse.
3. Married couple, both applying, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example 1: Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.

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28.4 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) DIVESTMENT

When requested, assist the case manager in assessing divestment. See 17.1 Divestment Introduction.

Note: Effective 10/01/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a Medicaid case for a child.

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28.5 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) COST SHARING

28.5.1 HCBWLTC Cost Sharing Introduction
28.5.2 Spenddown

28.5.1 HCBWLTC Cost Sharing Introduction

Cost sharing is the monthly amount a waivers participant may have to contribute toward the cost of his/her waiver services. Count only the income of the *member* when you calculate the cost share.

Payment of the cost share is a condition of eligibility. See 28.8.3.1 Personal Maintenance Allowance for instructions about how to calculate a cost share.

28.5.2 Spenddown

The spenddown obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or Medicaid card services to lower countable income to the Medically Needy Income limit (See 39.4 EBD Assets and Income Tables) The care manager monitors and documents that this occurs monthly.

A single Group C waivers participant must:

1. Incur, **and**
2. Be held financially responsible for the spenddown amount on a monthly basis.

A married Group C waivers participant must:

1. Incur the spenddown amount, **and**
2. Pay the cost share monthly, if applicable.

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28.6 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) UNIFORM FEE SYSTEM

Following the procedures of the Uniform Fee System (Chap. HSS 1, Wisconsin Administrative Code), the case manager determines if the parent(s) must contribute toward the care of a child who is in CIP IA, IB, II, or COP-W. When the parents are already contributing according to the Uniform Fee System, no additional contribution is required.

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28.7 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) EFFECTIVE DATE

The begin date of waiver eligibility is the date given in the approval letter sent by the Division of *Disability* and Elder Services (DDES) waiver staff to the county case manager/social worker.

Persons in Groups B and C will receive tentative approval of eligibility for waiver services when the case manager submits a waiver service plan packet to DDES and receives a tentative approval in return.

The start date stated in this tentative approval becomes the date of waiver eligibility if the person is determined eligible for Medicaid as of that date.

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28.8 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) INSTRUCTIONS

28.8.1 HCBWLTC Instructions Introduction
28.8.2 Group A
28.8.3 Group B
- 28.8.3.1 Personal Maintenance Allowance
- 28.8.3.2 Family Maintenance Allowance
- 28.8.3.3 Special Exempt Income
- 28.8.3.4 Health Insurance
- 28.8.3.5 Medical/Remedial Expenses
- 28.8.3.6 Cost Share Amount

28.8.4 Group C

28.8.1 HCBWLTC Instructions Introduction

Eligibility for Group A, B, and C Community Waivers cases are determined in CARES. Group A Katie Beckett cases are processed manually outside of CARES.

Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett program. In addition, care managers will determine if divestment of the child's assets has taken place.

If so, a referral will be made to IM workers to determine manually if a penalty period exists. If a penalty period exists, the IM worker will notify the care manager, and the care manager will notify the *applicant*.

Katie Beckett waiver cases will now be considered "Group A". The Katie Beckett medical status code will be retained. Because of the small number of these cases, the certification process will not be automated in CARES. Certification will be processed manually by care managers and Katie Beckett staff.

Complete the Waiver Eligibility and Cost Sharing Worksheet (DDE-919) when an institutionalized *member* is going to be discharged, and enter the Community Waivers program.

When CARES screens are unavailable, use simulation or complete the DDE-919 as follows:

1. Fill out the identifying information at the top. The Medicaid eligibility date is the date of most recent Medicaid eligibility.
2. Fill out the financial information in Section I, Lines 1-4. When you have determined that the person is financially eligible, set the effective begin date of eligibility (See 28.7 HCBLTC Effective Date).

Read the descriptions of Groups A, B, and C below. After deciding which group the person is in, check the appropriate box in Section I. A person cannot be in more than one group at the same time.

28.8.2 Group A

Group A members are waiver functionally eligible and Medicaid eligible via *SSI* (including SSI-E and *1619A* and B) or a full-benefit Medicaid subprogram (See 21.2 Full Benefit Medicaid). This does not include someone solely eligible for any of the limited benefit Medicaid subprograms (See 21.3 Limited Benefit Medicaid).

Note: Group A members do not have an asset limit if s/he is Group A eligible via Family Medicaid. Family Medicaid and it subprograms do not have an asset test.

Clients who have met a deductible are eligible for Community Waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for Community Waivers as a Group B with a potential cost share, or Group C with a potential spenddown/cost share.

Group A members are financially eligible with no cost share. Put a check before Group A in Section I. Then complete Sections II and V on the worksheet.

28.8.3 Group B

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit. (See 39.4 EBD Assets and Income Tables) Calculate a cost share based on the member's income and allowable deductions.

Put a check before Group B in Section I. Then complete Sections III and V on the worksheet. Count only the income of each individual when you calculate that individual's cost share.

28.8.3.1 Personal Maintenance Allowance

The Personal Maintenance Allowance is an income deduction used primarily when calculating a cost share for a Group B waiver member. However, it is also used in the cost share calculation of a Group C waiver member when completing Section C of the *Spousal Impoverishment* Income Allocation Worksheet (18.6.4).

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is for room, board, and personal expenses. It is the total of:

1. Community Waivers Basic Needs Allowance (See 39.4.2 EBD Deductions and Allowances)
2. $65 and ½ earned income deduction (See 15.7.5 $65 and ½ Earned Income Deduction).
3. Special housing amount. This is an amount of the person's income set aside to help pay housing costs. If the waiver applicant's housing costs are over $350, add together the following costs:
    a. Rent.
    b. Home or renters insurance.
    c. Mortgage.
    d. Property tax (including special assessments).
    e. Utilities (heat, water, sewer, electricity).
    f. "Room" amount for members in a Community Based Residential Facility (*CBRF*), Residential Care Apartment Complex (RCAC) or an *Adult* Family/Foster Allowance.) Home (AFH). The case manager determines and provides this amount.

The total, minus $350, equals the special housing amount. The person can set this amount aside from his/her income.

If both spouses are applying and both have income, divide the special housing amount equally between them.

Example 1: Two spouses applying with income:
$600 rent
\- 350
= 250/2 spouses = $125 that each can set aside

If only one *spouse* has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

When one spouse has income and both are applying:

1. And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.
3. And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income

gets a deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.

Example 2 : Emma and Herbert are living in the same residence. Herbert has income of $1000 per month. Emma does not have any income. The total housing costs are $650 for both of them. Allocate the full special housing amount to Herbert. ($650-$350 = $300 special housing amount)

Example 3 : Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1000 per month. Ingrid does not have any income. The total rent amount is $650 for both of them. Allocate the full special housing amount to Bert. ($650-$350 = $300 special housing amount)

Example 4: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1000 per month. Maria does not have any income. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate Ned's special housing amount ($550-$350 = $200 special housing amount). Do not consider Maria's room and board amount when calculating Ned's special housing amount.

When both spouses have income and both are applying:

1. And they reside together in the same residence, divide the special housing amount equally between them.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between them.
3. And they reside in separate living arrangements (e.g. they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his/her own individual room and board contract) then calculate a separate special housing amount for each, based on their individual "rent" costs that are obtained from the care manager.

Example 5: Emma and Herbert are living in the same residence. Herbert has income of $1000 per month and Emma has income of $500 per month. The total housing cost for both of them is $650. Divide the special housing amount equally between them. ($650-$350 = $300 special housing amount, so the special housing amount for Emma and Herbert is $150 each)

Example 6: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1000 per month and Ingrid has income of $500 per month. The total "rent" from the room and board amount for both of them is $650. Divide the special housing amount equally between them. ($650-$350 = $300 special housing

amount, so the special housing amount for Bert and Ingrid is $150 each)

Example 7: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1000 per month and Maria has income of $500 per month. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate the special housing amounts separately.
Ned's is calculated as follows: $550-$350 = $200 special housing amount.
Maria's is calculated as follows: $400- $350= $50 special housing amount.

Do not give the special housing amount to waiver participants under age 18.

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (39.4.2 EBD Deductions and Allowances).

28.8.3.2 Family Maintenance Allowance

The family maintenance allowance is for the support of family members when *spousal impoverishment* policies do not apply. If the member is a disabled child, omit the family maintenance allowance.

Family Related - When the waiver participant is the custodial parent of a *minor* child living in the home, and there's no spouse in the home, do the following:

1. Minor children's gross earned income.

2. -$65 and ½ of gross earned income (15.7.5 $65 and ½ Earned Income Deduction).

3. =_____.

4. + Minor Children's total unearned income.

5. = _____Add (3) and (4).

6. AFDC Related med needy income limit _____ (39.3 AFDC Related Income Table). (Do not include the waiver applicant in the group size.)

If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

EBD Related - If there are no minor children in the home, and spousal impoverishment policies do not apply, do the following:

1. Spouse's gross earned income.

2. -$65 and ½ of total gross earned income (15.7.5 $65 and ½ Earned Income Deduction).

3. =_____.

4. +Spouse's total unearned income.

5. =_____ (3)+(4).

6. -$20 *disregard*.

7. =_____(6)-(5).

8. _____Enter the SSI Payment Level Plus the E Supplement for one person (See 39.4 EBD Assets and Income Tables)

If (7) is greater than (8) there is no family maintenance allowance. If (7) is less than (8) the family maintenance allowance is the difference between (7) and (8).

28.8.3.3 Special Exempt Income

Deduct special exempt income (15.7.2 Special Exempt Income).

28.8.3.4 Health Insurance

Include all health and dental insurance premiums covering the waiver person and for which s/he is responsible and pays a premium. This includes any Medicare Premium obligation including Medicare Part D. See 9.6.2 Policies Not To Report for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group, but not responsible for the premium, find his/her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example 2: Sally pays a $600 premium quarterly for her Medicare supplement policy. $600 divided by three equals $200. Enter $200 as her monthly health insurance premium payment on AFMC.

28.8.3.5 Medical/Remedial Expenses

Obtain the dollar amount for medical and remedial expenses (Line 10) from the case manager. See 15.7.3 Medical/Remedial Expenses (MRE).

Note: Case Managers should refer to the limitations associated with allowable medical/remedial expenses that are described in 27.7.8 Medical/Remedial Expenses and Payments for Non-Covered Services.

28.8.3.6 Cost Share Amount

The waiver cost share amount (Line 12) is the monthly amount s/he must pay toward the cost of his/her waiver services.

Institutionalized Pace/Partnership or Family Care enrollees pay their cost share to the *Managed Care* Program instead of the institution.

28.8.4 Group C

Persons in Group C meet the medically needy income test for waiver members.

Put a check before Group C in Section I. Complete Sections IV and V.

Most Group C members have a monthly spenddown. They must meet the spenddown each month to remain eligible. The case manager monitors the monthly spenddown.

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28.9 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) MEDICAL CODES

See the Process Help Chapter 81.5 for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy Medicaid client could be eligible as a categorically needy waiver client (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

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28.10 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) REVIEW

Review financial eligibility annually. The case manager reviews level of care eligibility annually. Do not discontinue eligibility if the case manager has not yet made the level of care review.

The case manager informs the IM Agency if the person is no longer level of care eligible. Notify the case manager if the person is no longer Medicaid eligible.

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28.11 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) COMMUNITY SPOUSE'S MEDICAID APPLICATION

When a community waivers person and his/her *community spouse* are both applying for Medicaid, they are one case, but separate AGs. Enter them in

CARES on the same application. Only one of the spouse's signature is needed on the application.

Both spouses are in the non-waiver spouse's fiscal test group (*FTG*). Since the waiver *spouse* is in the FTG, *disregard* any income that may have been allocated by the waiver spouse to the community spouse.

The waivers spouse is a FTG of one. CARES creates the separate FTG's and AG's.

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28.12 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) NOTICES

CARES generates a Notice of Decision each time the IM worker confirms a case.

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28.13 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) TRANSFERS

When a Community Waivers case transfers to a new county or tribe, and there is no slot available in the new agency, do the following:

Transfer the case to the new county through CARES. The transfer-in county takes care of the MA certification. The transfer-out county keeps the client in the waiver slot until a slot becomes available in the new county.

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28.14 HOME AND COMMUNITY BASED WAIVERS LONG TERM CARE (HCBWLTC) CHILDREN'S LONG TERM CARE (CLTC)

28.14.1 CLTC Introduction
28.14.2 CLTC CARES Processing
28.14.2.1 Processing A CLTS Application When No Funding Is Available

28.14.1 CLTC Introduction

The Children's Long Term Support (CLTS) Waivers include three programs, differentiated by the population they serve:

- Developmental Disabilities
- Physical Disabilities, and
- Mental Health Disabilities

The CLTS is entered in CWW as a CIP IB Waiver type. All the Medicaid eligibility criteria for the CLTS are identical to the CIP IB Waiver except not all children will need a *disability* determination in order to qualify. See 'County Funded Slot' below. The care manager will inform the IM worker which type of slot the child will be placed in.

County Funded Slot
Children placed in a county funded CLTS Waiver slot must meet the functional Level of Care but are not required to have a disability determined to become eligible.

State Funded Slot
Children placed in a state funded CLTS Waiver slot must be determined disabled in addition to meeting the functional Level of Care requirements.

28.14.2 CLTC CARES Processing

The child should first be tested with his or family to see if there is eligibility for Badgercare Plus Standard plan and Group A Waiver eligibility.

If the child is eligible for a type of non-CARES Medicaid such as *Foster Care* Medicaid, Adoption Assistance Medicaid, *SSI* Medicaid or Katie Beckett Medicaid (see 28.8.1 for waiver processing instructions for Katie Beckett MA individuals), the child will be eligible as a Group A Waiver.

If the child is not eligible for other categories of Medicaid or BadgerCare Plus Standard Plan, CARES will test the child for a Group B or Group C Waiver, based on the child's income.

If the child is placed in a county funded slot and has not been determined disabled, the question "Has the individual been established disabled by the *DDB*?" on the Disability Page in CWW must be answered 'Yes' with a verification code 'OW". Document in Case Comments that there is no DDB determination.

28.14.2.1 Processing A CLTS Application When No Funding Is Available
In order to be put on the waiting list for a CLTS Waiver slot, the child must be determined otherwise eligible.

IM workers who receive MA applications for one of the CLTS waiver programs should process those applications even if there is no funding available (no waiver slot). Follow the normal process:

1. Determine MA eligibility using community waiver methodology,
2. Assist in the completion of the Medical Assistance Disability Application (MADA) and
3. Forward the MADA to the Disability Determination Bureau (DDB).

If DDB determines that the child is disabled and meets *LOC* criteria, the child will be put on a waiting list for a CLTS slot.

The IM worker should determine if the child is eligible with his/her family for BadgerCare Plus or EBD Medicaid. If the child and/or family do not meet any other MA or BCP eligibility requirements, then the application should be denied and confirmed in CARES accordingly.

Note: Do not keep the CLTS waivers case in pending status in CARES until funding becomes available.

If a CLTS waiver slot becomes available more than 30 days after the denial of the original application, a new application must be submitted and processed.

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29 FAMILY CARE LONG TERM CARE (FCLTC)

29.1 FAMILY CARE LONG TERM CARE (FCLTC) INTRODUCTION

The Family Care Long Term Care (FCLTC) program is a long-term care benefit and a new way of delivering long-term care services. This program was originally piloted in Fond du Lac, La Crosse, Portage, Milwaukee, and Richland counties and is now being expanded statewide. The statewide expansion of Family Care will take several years.

Family Care target groups are *elderly* people, people with physical disabilities and those with developmental disabilities.

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29.2 FCLTC ADMINISTRATION

Three groups work together to administer the Family Care program:

1. An Aging and *Disability* Resource Center (*ADRC*) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. ADRC staff also assess potential clients' functional level of care, which is an eligibility criteria.
2. Income Maintenance Agencies determine and certify Medicaid and Family Care non-financial and financial eligibility, and process Family Care enrollment.
3. *Managed Care* Organizations (MCOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term care services for Family Care enrollees. Participants in the Family Care program choose to be enrolled in a *MCO* .

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29.3 FCLTC MEDICAID AND NON-MEDICAID

29.3.1 Family Care Medicaid
29.3.2 Family Care Non-Medicaid (MA)

29.3.1 Family Care Medicaid

Family Care Medicaid members are eligible for Medicaid services and receive a ForwardHealth Card. They have their long-term care needs met via a Family Care *MCO*. They may have a cost share or a spenddown. In CARES, their Medicaid eligibility is represented by an open Medicaid assistance group (which may include a community waivers AG) for example NS, MCWW, BCPA, etc. Enrollment in the Family Care MCO is represented by an open "FC" assistance group in CARES. Family Care Medicaid participants have both an open Medicaid and an open FC AG.

Family Care is a managed long-term care program for adults. A person not yet 18 years of age may be enrolled in Family Care effective the first day of the month in which (s)he turns 18, to the extent that the person meets all other Family Care financial and non-financial eligibility requirements (including Family Care *disability* requirements).

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 Family Care disability requirements until 1) an *adult* disability determination can be done, or 2) the child disability determination is no longer in effect (whichever occurs first). Family Care eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

There are 3 types of eligibility in Family Care Medicaid:
Group A eligibility

1. People 18 and over who meet full benefit EBD Medicaid financial and non-financial requirements and who are also functionally eligible for FC at either the nursing home or non-nursing home level of care.

2. People 18 and over who meet BC+ Standard Plan, Well Woman Medicaid, Medicaid through Adoption Assistance or *Foster Care* financial and non-financial requirements and who are functionally eligible for FC at either the nursing home or non-nursing home level of care.

Group B eligibility

People 18 and over who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for FC at the nursing home level of care, and whose income is at or below the special income limit (See the Community Waivers Special Income Limit in 39.4.1)

Group C eligibility

People 18 and over who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for FC at the nursing home level of care, and whose income is above the special income limit (see the Community Waivers Special Income Limit in 39.4.1), but whose allowable monthly expenses are sufficient to reduce their income to the medically needy limit (See EBD Medically Needy Limits in 39.4.1.)

29.3.2 Family Care Non-Medicaid (MA)

Effective July 1, 2008 the Family Care non-MA program is no longer available.

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29.4 FCLTC FUNCTIONAL ELIGIBILITY

Resource Center staff use the Long Term Care Functional Screen to assess a Family Care applicant's long term care needs and to determine level of care. The functional level of care information is provided to the IM Worker so that s/he can determine eligibility for Family Care.

Effective January 1, 2008 the levels of care are:

1. Nursing Home (formerly Comprehensive NH)
2. Non-Nursing Home (formerly Intermediate and Comprehensive non-NH)

Individuals who are found functionally eligible for Nursing Home *LOC* are subject to Waiver logic in determining their financial eligibility for Family Care (if they are 65 or older, or have been determined disabled).

Individuals who are found functionally eligible for Non-Nursing Home LOC are not subject to Waiver logic in determining their financial eligibility for Family Care.

Note: There are specific *Managed Care* Organization (*MCO*) capitation rates associated with these new levels of care, so it is important that level of care and level of care effective date information are entered accurately in CARES.

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29.5 FCLTC ENROLLMENT/DISENROLLMENT AND INTERCOUNTY MOVES

29.5.1 Enrollments
- 29.5.1.1 Urgent Services
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29.5.1 Enrollments

The enrollment date is always the date that the *member* is enrolled in the *MCO*. The Resource Center worker provides the IM worker with this information.

29.5.1.1 Urgent Services

Determine Family Care eligibility for a person who received urgent services as of the date the MCO began providing services. The MCO is paid the capitated rate as of that date, if the person is found eligible and chooses to enroll.

If the person is found ineligible for Family Care, the MCO bills the member for the care and urgent services it provided.

29.5.1.2 SSI Recipients

A full Medicaid application or review is not necessary for an *SSI* recipient who asks to enroll in Family Care, and is not applying for FoodShare. The RC worker will supply the IM worker with the following information:

1. Name.
2. Residence Address.
3. Mailing Address.
4. SSN (and MAID number if different).
5. Sex.
6. Primary Language (English or Spanish).
7. Guardian/Power of Attorney Name and Address.
8. Date of Birth.
9. Race (Optional)
10. Citizenship Status (Alien registration number, if not a citizen).
11. *Disability Status (if not age 65 or older).*
12. All information necessary to complete screens ANCW, AFME, ANMC and ANFR.

They may use the ”r;Model Agency Referral Form” to provide this information. Workers can contact members as needed for additional information.

29.5.2 Disenrollment

Disenrollment from the MCO may occur for a variety of reasons. Some of the more common
reasons for disenrollment include the loss of Medicaid eligibility, a change in functional eligibility, a move out of the MCO's service area, or simply that the member expresses a desire to disenroll.

29.5.2.1 ADRC Approved Disenrollments

Certain disenrollments, listed below, can only be approved by the Aging and Disability Resource Center or by the Department of Health Services (DHS) Office of Family Care Expansion (OFCE).

1. Member Requested Disenrollments. When a member requests to be disenrolled from the MCO for any reason, the Aging and Disability Resource Center (*ADRC*) will send the completed disenrollment form to both the IM Agency, as well as the MCO. The IM Agency should accept and process member requested disenrollments only when the associated disenrollment form is submitted by the ADRC. Disenrollment forms indicating the member requested to be disenrolled that have been submitted by the MCO should be returned unprocessed to the MCO, along with the completed 'r;Unprocessed Disenrollment Request Form [F-00009 (12/08)].'

2. MCO Requested Disenrollments. MCOs are required to contact the Department's Office of Family Care Expansion (OFCE) to obtain prior approval for any of the following types of disenrollment and to determine the actual disenrollment date. If the disenrollment request is approved, an OFCE representative will email the completed disenrollment form to both the MCO as well as the CARES Coordinator in the Income Maintenance agency to which the member's case has been assigned. The text of the email will explain the disenrollment reason as well as a contact name and telephone number. The CARES Coordinator should then assure that the disenrollment is processed by the IM worker.

   Disenrollment requests for any of the following reasons received from the MCO (i.e., not emailed to the CARES Coordinator by an OFCE representative) should be returned unprocessed to the MCO along with the completed 'r;Unprocessed Disenrollment Request Form[F-00009 (12/08)].'

   - Loss of Contact Disenrollments. When a member is no longer accepting services and the MCO has been unable to contact the member for 30 days or more, the member may be disenrolled due to loss of contact, but only with prior approval from the Department.

   - The MCO Cannot Assure the Member's Health/Safety. If the member accepts services under an approved plan of care, but refuses to allow

care manager contacts, the member may be disenrolled, but only with prior approval from the Department.

- The Member Has Jeopardized the Health/Safety of Others. If the member has committed or threatened acts that jeopardize the health or safety of MCO staff, contractors, or others, the member may be disenrolled, but only with prior approval from the Department.

29.5.2.2 Adverse Action Disenrollment

CARES populates the date when there is ineligibility for Family Care. It is not worker enterable. The date will be an end of month date according to *adverse action* logic, except when the member dies. In this case, the disenrollment date is the date of death.

If the disenrollment date on the disenrollment form is earlier than the adverse action closure date, the ES worker should fax the form to the DHCF Enrollment Specialist at 608-261-7793.

It is important to have the correct disenrollment date on file at ForwardHealth interChange. Providers verify eligibility each time a MA recipient has an appointment. The recipient's services may be delayed if the provider verifies through ForwardHealth interChange that the person is enrolled in Family Care when in actuality the disenrollment date on file at ForwardHealth interChange does not match the date on the disenrollment form.

If disenrollment is to occur prior to the date set according to adverse action logic, fax the paper disenrollment form to the DHCF Enrollment Specialist at (608) 261-7793. The request will then be forwarded to EDS for entry in ForwardHealth interChange.

29.5.2.3 Death Of A Family Care Participant & Disenrollment

If a Family Care member dies, ES workers need to enter the date of death on the Permanent Demographics page in CWW, run eligibility, and confirm. The date of death as well as the Family Care disenrollment will then be transmitted to ForwardHealth interChange. The Family Care disenrollment date on ForwardHealth interChange will be the member's date of death. It is not necessary to send a disenrollment form to DCHF when the member dies midmonth or prior to the disenrollment date populated in CARES. Keep the disenrollment form for ES records.

29.5.2.4 Non-Payment Of Cost Share & Disenrollment

When ES is informed in writing by the MCO that an enrollee has not met the cost share obligation for past months' services, the member will be disenrolled. ES should enter "r;N" to the question "r;Are you meeting your cost share/spend down obligation?" on the *Managed Care* section of the Family Care page in CWW, run eligibility and confirm. This will end the Family Care enrollment according to adverse action logic. A CARES notice will be sent to the recipient informing them of the termination of eligibility. ES should file the written notice of non-payment.

29.5.3 Re-enrollment in Family Care

Family Care enrollees who lose Medicaid eligibility, reapply and again are found eligible for Medicaid may be re- enrolled in Family Care for up to three calendar months prior to the Medicaid application month, only if all of the following conditions are met:

1. The person (or his/her representative) requests backdated Medicaid.
2. The person is determined to have met Medicaid financial and non-financial requirements in the month(s) being considered for re-enrollment in Family Care.
3. The person is determined to have been functionally eligible for Family Care in the month(s) being considered for re-enrollment in Family Care.
4. The person is determined to have received services, in addition to care management, under the Family Care (MCO) plan of care during the month(s) being considered for re-enrollment in Family Care.

The local income maintenance (IM) agency is not authorized to re-enroll anyone in Family Care earlier than the first of the month, three months prior to the application month.

Example 1: Richard was enrolled in Family Care until he lost his Medicaid eligibility on January 31, 2007. On May 11, 2007, he filed a new application for Medicaid with the county income maintenance agency, requesting backdated eligibility. Richard's IM worker determines that:

- He met Medicaid financial and non-financial requirements in February, March and April; and
- He was functionally eligible for Family Care in each of those three months; and
- In each of those three months, he received services under a plan of care developed by the Family Care MCO.

Richard may be re-enrolled in Family Care back to February 1, 2007 covering the entire three month period.

Example 2: Elizabeth was enrolled in Family Care until she lost her Medicaid

eligibility on January 31, 2007. On May 11, 2007, she filed a new application for Medicaid with the county income maintenance agency requesting backdated eligibility. Elizabeth's IM worker determines that:

- She met non-waiver EBD Medicaid financial and non-financial requirements in February, March and April.
- She was functionally eligible for Family Care in April, but not in February or March.
- In each of those three months, she received services under the MCO's plan of care.

Elizabeth may be re-enrolled in Family Care only back to April 1, 2007. Her non-waiver EBD Medicaid eligibility may, however, be backdated to February 1, 2007.

Example 3: Andrew was enrolled in Family Care until he lost his Medicaid eligibility on December 31, 2006. On May 11, 2007, he filed a new application for Medicaid with the county income maintenance agency requesting backdated eligibility to January. Andrew's IM worker determines that:

- The month of January 2007 may not be considered for Family Care re-enrollment or a Medicaid backdate because it is more than three calendar months prior to the application month; and
- Andrew met Medicaid financial and non-financial requirements in February, March and April; and
- He was functionally eligible for Family Care in February, March and April; and
- In each of those three months, he received services under a plan of care developed by the Family Care MCO.

Andrew may be re-enrolled in Family Care to February 1, 2007, covering the period from February through April.

29.5.4 Inter-county Moves

When a FC enrollee moves permanently to a non-MCO county, s/he can remain enrolled in the MCO only if the Resource Center worker informs IM that the following three conditions are met:

1. S/he is eligible for COP or waiver services.
2. After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, *CBRF*, or AFH).
3. The enrollee's placement in the long-term care facility is done under and pursuant to a plan of care approved by the MCO.

A single MCO may serve multiple counties. A FC member may:

1. move from one FC county to another served by the same MCO **and**
2. wish to remain enrolled in FC in the new county **and**
3. wish to continue to be served by the same MCO

Disenrollment from the MCO would not be necessary under these circumstances. Disenrollment from the MCO would be necessary only if the member changed MCOs, changed programs (e.g., from FC to Partnership) or ended services.

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29.6 FCLTC CLOSURES

If a FC case closes for any reason and a re-determination is allowed (see 2.9.1 Termination) without a new application, contact the *MCO* to determine if the *member* has been served continuously by the MCO beyond the effective date of ineligibility or disenrollment. Note in case comments any information from the MCO that verifies continuous service.

If the member has been served continuously by the MCO, a new enrollment form is not needed. If a disenrollment date exists on ANFR, begin another segment with a start date for the day following the disenrollment date.

If the member has not been served continuously by the MCO, or a period of ineligibility greater than 30 days has occurred, a new enrollment form signed by

the member and new enrollment date are required. The IM worker should obtain the form and date from the Resource Center.

Example 1: Sam's Family Care eligibility ended on December 31st, due to lack of review. The MCO continues to provide services in January while Sam completes his review. A new enrollment form is not required. Sam's review is completed, he meets all eligibility requirements, and eligibility is determined prior to January 31st. A new enrollment date of January 1st must be entered in ANFR.

Example 2: Tillie lost her Family Care eligibility on November 30th, due to having assets over the program limits. The MCO stopped serving her on December 1st. On January 15th, Tillie contacts the Resource Center and tells them that she reduced her assets. Since she became ineligible more than 30 days ago, Tillie must complete a new application and a new enrollment date must be set.

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29.7 FCLTC ENROLLMENT AND COST SHARE REPORTS

29.7.1 Enrollment Reports
- 29.7.1.1 Initial Enrollment Report
- 29.7.1.2 Final Enrollment Report
- 29.7.1.3 When the IM agency should contact the MCO

29.7.2 Cost Share Report
- 29.7.2.1 When agencies should contact the MCO

29.7.1 Enrollment Reports

Two enrollment reports are created from MMIS and sent to the MCOs. The initial enrollment report is created after *adverse action* and the final enrollment report is created on the last business day of the month.

MCOs use enrollment report information to identify the individuals that they are obligated to serve according to their contract requirements.

29.7.1.1 Initial Enrollment Report

The initial enrollment report is created after adverse action. This report includes information on:

1. New enrollees
2. Continuing enrollees
3. Pending enrollees (those with no eligibility on file for the next month.)
4. Disenrolled enrollees (i.e. those that have disenrolled from Family Care) based on information present in MMIS.

For those Family Care members that do not complete a review, the disenrollment date in MMIS will be the same as the effective end date for eligibility.

29.7.1.2 Final Enrollment Report

The final enrollment report is created on the last business day of the month. This report includes enrollment information for members that has changed since the initial enrollment report was created.

The final enrollment report identifies:

1. New enrollees,
2. Continuing enrollees **and**
3. Disenrolled enrollees

Example 1: Joe was pending on the initial enrollment report. Joe's Family Care eligibility was reopened after adverse action but before the last day of the month. Joe would display on the final enrollment report as an add/reinstate.

29.7.1.3 When the IM Agency Should Contact the MCO/ Enrollment Reports

The IM agency should notify the *MCO* of any changes that occur after adverse action that reopen Family Care in CARES for the next month. (i.e. confirmation of eligibility from a review or other determination)

MCOs review all PENDs and may contact IM workers if they do not know why the person is losing eligibility and therefore being disenrolled.

For members who have moved, died or voluntarily disenrolled, the MCOs should expect a PEND or disenroll status. However, if the MCO is not expecting the

PEND or disenroll status (review overdue, assets, etc), the MCO will likely need to get more information from the IM agency to determine whether or not they should continue serving the *member*.

29.7.2 Cost Share Report

The cost share report is a CARES generated report created after adverse action and sent to EDS staff. The report is zipped and password protected in an Excel file by EDS and then emailed to the MCO.

The cost share report identifies

1. Members being served by a MCO and
2. Any cost share or patient liability for the following three months:

    a. The month prior to the month in which the report is produced,
    b. The month in which the report is produced and
    c. The month following the month in which the report is produced.

For example, if a cost share report is created after adverse action in June it will include member cost share information for May, June and July.

Example 2: Buddy disenrolls/is ineligible for FC effective 02/28/05. Buddy would still be on the March 2005 cost share report (sent 03/18/05) with a $0 cost share. The first month that Buddy would not appear on the cost share report would be April 2005.

29.7.2.1 When Agencies Should Contact the MCO/Cost Share Report

IM agencies should notify the MCO of changes not captured on the current months cost share report. These changes include:

1. New enrollments with:
    a. A cost share or patient liability confirmed after adverse action, **and**
    b. An enrollment date in the current or following month.

    This enrollment information may

    a. Allow the MCO to begin collecting the cost share on the first of the following month. (Depending on the MCO billing cycle.) **and**
    b. Prevent the FC member from having to pay a two or possibly three month cost share at one time.

2. Retroactive reductions in the cost share:

a. For a period not covered in the current or next months cost share report,
or
b. That can not be confirmed in CARES.

3. Cases which can not be correctly determined in CARES. (such as Group C *spousal impoverishment* case)

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30 PARTNERSHIP LONG TERM CARE

30.1 PARTNERSHIP LONG TERM CARE

The Wisconsin Partnership program is a comprehensive waiver program integrating health and long term support services for people who are *elderly* or disabled. Services are delivered in the participant's home or a setting of his or her choice. Through team based care management, the participant, his or her physician, nurses and social workers together develop a care plan and coordinate all service delivery.

To participate in the Partnership program, people must be eligible for MA and meet the MA nursing home level of care requirement. The program also serves people who are eligible for both MA and Medicare. Participation in the program is voluntary.

Divestment is prohibited just like it is for any other Institutional/Community Waiver case. Individuals are ineligible for Partnership during the calculated divestment penalty period.

Partnership members are subject to estate recovery as described in MEH 22.1 Estate Recovery. Members who are enrolled in PACE Programs are not subject to estate recovery.

Partnership *Managed Care* Organizations enter into a MA managed care contract with the Wisconsin Department of Health and Services (DHS) and a Medicare managed care contract with the federal Centers for Medicare and Medicaid Services (*CMS*). Contractors receive monthly capitation payments from DHS and CMS for each participant. Participant's long term care and acute health care costs, including physician services, are paid out of the capitation payment.

The implementation of Partnership began in 2000 and was piloted in Dane, Milwaukee, Eau Claire, Dunn and Chippewa counties and is now being expanded statewide. The statewide expansion of Partnership will take several years.

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30.2 PARTNERSHIP ADMINISTRATION

Three groups work together to administer the Partnership program:

1. An Aging and *Disability* Resource Center (*ADRC*) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. ADRC staff also assess potential clients' functional level of care, which is an eligibility criteria.
2. Income Maintenance Agencies determine and certify Medicaid and Partnership non-financial and financial eligibility, and process Partnership enrollment.
3. *Managed Care* Organizations (MCOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term care services for Partnership enrollees. Participants in the Partnership program choose to be enrolled in a *MCO*.

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30.3 PARTNERSHIP MEDICAID ELIGIBILITY

30.3.1 Partnership Medicaid Eligibility Introduction
30.3.2 Non-Institutional Cases
30.3.3 Institutional Cases

30.3.1 Partnership Medicaid Eligibility Introduction

Partnership members are eligible for Medicaid services and receive a ForwardHealth Card. They have their long-term care needs met via a Partnership *MCO*. They may have a cost share or a spenddown.

Partnership participants have their MA eligibility determined in CARES, using either the Institutional or Community Waiver procedures based on their living arrangement.

30.3.2 Non-Institutional Cases

Partnership enrollees living in their own homes or other non-institutional settings including a Community Based Residential Facility (*CBRF*), an *Adult* Family Home (AFH) or a Residential Care Apartment Complex (RCAC) should be processed in CARES as if they were a Home and Community Based Waivers Program type case. The CARES category code will be MCWR. Their eligibility and cost share will be based on Group A, Group B, or Group C eligibility criteria.

30.3.3 Institutional Cases

The definition of institutionalization for Partnership participants will be the same one that is found in appendix 27.4.1 Institutionalized Person. Participants residing in an institution would have their MA eligibility determined in CARES, in the same manner as any other institutionalized person. The MA eligibility for these individuals will be based on MA institutions (categorically and medically needy) eligibility policies. A nursing home patient liability amount will be calculated; although the liability amount, also known as the cost share, is paid to the Partnership MCO by individuals residing in an institution. The MI-R (Partnership) AG will be built for these cases.

Partnership is a managed long-term care program for adults. A person not yet 18 years of age may be enrolled in Partnership effective the first day of the month in which (s)he turns 18, to the extent that the person meets all other Partnership financial and non-financial eligibility requirements (including Partnership *disability* requirements).

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 Partnership disability requirements until:

1. an adult disability determination can be done, **or**
2. the child disability determination is no longer in effect (whichever occurs first). Partnership eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

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30.4 PARTNERSHIP FUNCTIONAL ELIGIBILITY

Resource Center staff use the Long Term Care Functional Screen to assess a Partnership applicant's long term care needs and to determine functional eligibility at the nursing home level of care. *MCO* staff use the Long Term Care Functional Screen to redetermine functional eligibility at least annually or more frequently if an individual's condition changes. The functional level of care information is provided to the IM Worker so that s/he can determine eligibility for Partnership.

An individual must be found functionally eligible at the Nursing Home *LOC* to be eligible for Partnership. Waiver logic should be used in determining their financial eligibility for Partnership (if they are 65 or older, or have been determined disabled).

Individuals who are found functionally eligible at the Non-Nursing Home LOC are not eligible for Partnership.

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30.5 PARTNERSHIP ENROLLMENT/DISENROLLMENT AND INTERCOUNTY MOVES

30.5.1 Enrollments
30.5.1.1 SSI Recipients
30.5.2 Disenrollment
30.5.2.1 Adverse Action Disenrollment
30.5.2.2 Voluntary Disenrollment
30.5.2.3 Death Of A Partnership Participant & Disenrollment
30.5.2.4 Non-Payment Of Cost Share & Disenrollment
30.5.3 Re-enrollment In Partnership
30.5.3.1 Request For Retroactive Enrollment
30.5.4 InterCounty Moves

30.5.1 Enrollments

The enrollment date is always the date that the *member* is enrolled in the *MCO*. The Resource Center worker provides the IM worker with this information.

Because the Partnership Program is voluntary, the enrollment date is a mutually agreed upon date chosen by the participant and the *ADRC*, provided that the participant meets all other eligibility requirements on that date. The ADRC will provide this enrollment date to the Economic Support (ES) worker. It is possible that the client may be eligible for regular MA using the non-Partnership (waiver) eligibility criteria for the 3-month period prior to their month of application as well as the portion of the month prior to enrollment date. This potential backdated eligibility should be examined as it is for any other MA *applicant*. Unlike other Home Based Community Waiver cases, The Management Group (TMG) has no oversight or approval responsibilities for Partnership.

30.5.1.1 SSI Recipients

A full Medicaid application or review is not necessary for an *SSI* recipient who asks to enroll in Partnership, and is not applying for FoodShare. The ADRC will supply the IM worker with the following information:

1. Name.
2. Residence Address.
3. Mailing Address.
4. SSN (and MAID number if different).
5. Sex.

6. Primary Language (English or Spanish).
7. Guardian/Power of Attorney Name and Address.
8. Date of Birth.
9. Race (Optional)
10. Citizenship Status (Alien registration number, if not a citizen).
11. *Disability* Status (if not age 65 or older).
12. All information necessary to complete the Community Waiver, Medical Expense, and the Medical Coverage pages
13. Has this individual transferred any assets in the last 36 months or created a trust in the last 60 months? (If so, the eligibility worker needs to contact the applicant and ascertain if divestment has occurred).

They may use the ”r;Model Agency Referral Form” to provide this information. Workers can contact members as needed for additional information.

30.5.2 Disenrollment

Disenrollment from the MCO may occur for a variety of reasons. Some of the more common
reasons for disenrollment include the loss of Medicaid eligibility, a change in functional eligibility,
a move out of the MCO’s service area, or simply that the member expresses a desire to
disenroll.

30.5.2.1 ADRC Approved Disenrollments

Certain disenrollments, listed below, can only be approved by the Aging and Disability Resource Center or by the Department of Health Services (DHS) Office of Family Care Expansion (OFCE).

1. Member Requested Disenrollments. When a member requests to be disenrolled from the MCO for any reason, the Aging and Disability Resource Center (ADRC) will send the completed disenrollment form to both the IM Agency, as well as the MCO. The IM Agency should accept and process member requested disenrollments only when the associated disenrollment form is submitted by the ADRC. Disenrollment forms indicating the member requested to be disenrolled that have been submitted by the MCO should be returned unprocessed to the MCO, along with the completed ’r;Unprocessed Disenrollment Request Form [F-00009 (12/08)].’

Note: There is one exception to the above. Because Dane County does not yet have an ADRC, Dane is the only county where member requested disenrollments may, until further notice, be accepted directly from the MCO (i.e., Care Wisconsin) &endash; with a signed disenrollment form.

2. MCO Requested Disenrollments. MCOs are required to contact the Department's Office of Family Care Expansion (OFCE) to obtain prior approval for any of the following types of disenrollment and to determine the actual disenrollment date. If the disenrollment request is approved, an OFCE representative will email the completed disenrollment form to both the MCO as well as the CARES Coordinator in the Income Maintenance agency to which the member's case has been assigned. The text of the email will explain the disenrollment reason as well as a contact name and telephone number. The CARES Coordinator should then assure that the disenrollment is processed by the IM worker.

Disenrollment requests for any of the following reasons received from the MCO (i.e., not
emailed to the CARES Coordinator by an OFCE representative) should be returned
unprocessed to the MCO along with the completed 'r;Unprocessed Disenrollment Request
Form[F-00009 (12/08)].'

- Loss of Contact Disenrollments. When a member is no longer accepting services and the MCO has been unable to contact the member for 30 days or more, the member may be disenrolled due to loss of contact, but only with prior approval from the Department.
- The MCO Cannot Assure the Member's Health/Safety. If the member accepts services under an approved plan of care, but refuses to allow care manager contacts, the member may be disenrolled, but only with prior approval from the Department.
- The Member Has Jeopardized the Health/Safety of Others. If the member has committed or threatened acts that jeopardize the health or safety of MCO staff, contractors, or others, the member may be disenrolled, but only with prior approval from the Department.

30.5.2.2 Adverse Action Disenrollment

CARES populates the date when there is ineligibility for PACE/Partnership. It is not worker enterable. The date will be an end of month date according to *adverse action* logic, except when the member dies. In this case, the disenrollment date is the date of death.

When ES removes the Partnership program type from the Community Waivers Page, the Partnership AG will close with an effective date related to adverse action. If the disenrollment date on the disenrollment form is earlier than the adverse action closure date, the ES worker should fax the form to the DHCF Enrollment Specialist at 608-261-7793.

It is important to have the correct disenrollment date on file at ForwardHealth interChange. Providers verify eligibility each time a MA recipient has an appointment. The recipient's services may be delayed if the provider verifies through ForwardHealth interChange that the person is enrolled in PACE or Partnership when in actuality the disenrollment date on file at ForwardHealth interChange does not match the date on the disenrollment form. Do not use a manual F-10110form to send a mid-month disenrollment date. Medicaid will continue under Partnership waiver medical status code according to adverse action logic.

If disenrollment is to occur prior to the date set according to adverse action logic, fax the paper disenrollment form to the DHCF Enrollment Specialist at (608) 261-7793. The request will then be forwarded to EDS for entry in ForwardHealth interChange.

30.5.2.3 Death Of A Partnership Participant & Disenrollment

If a PACE or Partnership member dies, ES workers need to enter the date of death on the Permanent Demographics page in CWW, run eligibility, and confirm. The date of death as well as the PACE or Partnership disenrollment will then be transmitted to ForwardHealth interChange. The PACE or Partnership disenrollment date on ForwardHealth interChange will be the member's date of death. It is not necessary to send a disenrollment form to DCHF when the member dies midmonth or prior to the disenrollment date populated in CARES. Keep the disenrollment form for ES records.

30.5.2.4 Non-Payment Of Cost Share & Disenrollment

When ES is informed in writing by the MCO that an enrollee has not met the cost share obligation for past months' services, the member will be disenrolled. ES should enter "r;N" to the question "r;Are you meeting your cost share/spend down obligation?" on the *Managed Care* section of hte Community Waiver page in CWW, run eligibility and confirm. This will end the PACE or Partnership enrollment according to adverse action logic. A CARES notice will be sent to the recipient informing them of the termination of eligibility. ES should file the written notice of non-payment.

30.5.3 Re-enrollment In Partnership

Partnership enrollees who lose Medicaid eligibility, reapply and again are found eligible for Medicaid may be re- enrolled in Partnership for up to three calendar months prior to the Medicaid application month, only if all of the following conditions are met:

1. The person (or his/her representative) requests backdated Medicaid.

2. The person is determined to have met Medicaid financial and non-financial requirements in the month(s) being considered for re-enrollment in Partnership.
3. The person is determined to have been functionally eligible for Partnership in the month(s) being considered for re-enrollment in Partnership.
4. The person is determined to have received services, in addition to care management, under the Partnership (MCO) plan of care during the month(s) being considered for re-enrollment in Partnership.

The local income maintenance (IM) agency is not authorized to re-enroll anyone in Partnership earlier than the first of the month, three months prior to the application month.

Example 1: Richard was enrolled in Partnership until he lost his Medicaid eligibility on January 31, 2007. On May 11, 2007, he filed a new application for Medicaid with the county income maintenance agency, requesting backdated eligibility. Richard's IM worker determines that:

- He met Medicaid financial and non-financial requirements in February, March and April; and
- He was functionally eligible for Partnership in each of those three months; and
- In each of those three months, he received services under a plan of care developed by the Partnership MCO.

Richard may be re-enrolled in Partnership back to February 1, 2007 covering the entire three month period.

Example 2: Elizabeth was enrolled in Partnership until she lost her Medicaid eligibility on January 31, 2007. On May 11, 2007, she filed a new application for Medicaid with the county income maintenance agency requesting backdated eligibility. Elizabeth's IM worker determines that:

- She met non-waiver EBD Medicaid financial and non-financial requirements in February, March and April.
- She was functionally eligible for Partnership in April, but not in February or March.
- In each of those three months, she received services under the MCO's plan of care.

Elizabeth may be re-enrolled in Partnership only back to April 1, 2007. Her non-waiver EBD Medicaid eligibility may, however, be backdated to February 1, 2007.

Example 3: Andrew was enrolled in Partnership until he lost his Medicaid eligibility on December 31, 2006. On May 11, 2007, he filed a new application

for Medicaid with the county income maintenance agency requesting backdated eligibility to January. Andrew's IM worker determines that:

- The month of January 2007 may not be considered for Partnership re-enrollment or a Medicaid backdate because it is more than three calendar months prior to the application month; and
- Andrew met Medicaid financial and non-financial requirements in February, March and April; and
- He was functionally eligible for Partnership in February, March and April; and
- In each of those three months, he received services under a plan of care developed by the Partnership MCO.

Andrew may be re-enrolled in Partnership to February 1, 2007, covering the period from February through April.

30.5.3.1 Request For Retroactive Enrollment

PACE or Partnership members that lose MA eligibility and regain it within three calendar months may be retroactively enrolled into the respective program following the Medicaid backdating policies.

Example 4: Kelly was enrolled in the Partnership program until she lost Medicaid eligibility on January 31, 2001. On May 11, 2001, she re-applied at the county. The ES should contact the Partnership agency to ask if she received services from the agency since February 1, 2001. If the program states she had, ES will re-enroll her in Partnership if she is found to be eligible for Medicaid.

30.5.4 InterCounty Moves

When a FC enrollee moves permanently to a non-MCO county, s/he can remain enrolled in the MCO only if the Resource Center worker informs IM that the following three conditions are met:

1. S/he is eligible for COP or waiver services.
2. After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, *CBRF* , or AFH).
3. The enrollee's placement in the long-term care facility is done under and pursuant to a plan of care approved by the MCO.

A single MCO may serve multiple counties. A FC member may:

1. move from one FC county to another served by the same MCO and
2. wish to remain enrolled in FC in the new county and
3. wish to continue to be served by the same MCO

Disenrollment from the MCO would not be necessary under these circumstances. Disenrollment from the MCO would be necessary only if the member changed MCOs, changed programs (e.g., from FC to Partnership) or ended services.

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30.6 PARTNERSHIP CLOSURES

If a FC case closes for any reason and a re-determination is allowed (see 2.9.1 Termination) without a new application, contact the *MCO* to determine if the *member* has been served continuously by the MCO beyond the effective date of ineligibility or disenrollment. Note in case comments any information from the MCO that verifies continuous service.

If the member has been served continuously by the MCO, a new enrollment form is not needed. If a disenrollment date exists on ANFR, begin another segment with a start date for the day following the disenrollment date.

If the member has not been served continuously by the MCO, or a period of ineligibility greater than 30 days has occurred, a new enrollment form signed by the member and new enrollment date are required. The IM worker should obtain the form and date from the Resource Center.

Example 1: Sam's Partnership eligibility ended on December 31st, due to lack of review. The MCO continues to provide services in January while Sam completes his review. A new enrollment form is not required. Sam's review is completed, he meets all eligibility requirements, and eligibility is determined prior to January 31st. A new enrollment date of January 1st must be entered in ANFR.

Example 2: Tillie lost her Partnership eligibility on November 30th, due to

having assets over the program limits. The MCO stopped serving her on December 1st. On January 15th, Tillie contacts the Resource Center and tells them that she reduced her assets. Since she became ineligible more than 30 days ago, Tillie must complete a new application and a new enrollment date must be set.

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30.7 PARTNERSHIP ENROLLMENT AND COST SHARE REPORTS

30.7.1 Enrollment Reports
- 30.7.1.1 Initial Enrollment Report
- 30.7.1.2 Final Enrollment Report
- 30.7.1.3 When the IM Agency Should Contact the MCO/ Enrollment Reports

30.7.2 Cost Share Report
- 30.7.2.1 When Agencies Should Contact the MCO/Cost Share Report

30.7.1 Enrollment Reports

Two enrollment reports are created from MMIS and sent to the MCOs. The initial enrollment report is created after *adverse action* and the final enrollment report is created on the last business day of the month.

MCOs use enrollment report information to identify the individuals that they are obligated to serve according to their contract requirements.

30.7.1.1 Initial Enrollment Report

The initial enrollment report is created after adverse action. This report includes information on:

1. New enrollees
2. Continuing enrollees
3. Pending enrollees (those with no eligibility on file for the next month.)

4. Disenrolled enrollees (i.e. those that have disenrolled from Partnership) based on information present in MMIS.

For those Partnership members that do not complete a review, the disenrollment date in MMIS will be the same as the effective end date for eligibility.

30.7.1.2 Final Enrollment Report

The final enrollment report is created on the last business day of the month. This report includes enrollment information for members that has changed since the initial enrollment report was created.

The final enrollment report identifies:
1. New enrollees,
2. Continuing enrollees and
3. Disenrolled enrollees

Example 1: Joe was pending on the initial enrollment report. Joe's Partnership eligibility was reopened after adverse action but before the last day of the month. Joe would display on the final enrollment report as an add/reinstate.

30.7.1.3 When the IM Agency Should Contact the MCO/ Enrollment Reports

The IM agency should notify the *MCO* of any changes that occur after adverse action that reopen Partnership in CARES for the next month. (i.e. confirmation of eligibility from a review or other determination)

MCOs review all PENDs and may contact IM workers if they do not know why the person is losing eligibility and therefore being disenrolled.

For members who have moved, died or voluntarily disenrolled, the MCOs should expect a PEND or disenroll status. However, if the MCO is not expecting the PEND or disenroll status (review overdue, assets, etc), the MCO will likely need to get more information from the IM agency to determine whether or not they should continue serving the *member*.

30.7.2 Cost Share Report

The cost share report is a CARES generated report created after adverse action and sent to EDS staff. The report is zipped and password protected in an Excel file by EDS and then emailed to the MCO.

The cost share report identifies

1. Members being served by a MCO and
2. Any cost share or patient liability for the following three months:

a. The month prior to the month in which the report is produced,
b. The month in which the report is produced and
c. The month following the month in which the report is produced.

For example, if a cost share report is created after adverse action in June it will include member cost share information for May, June and July.

Example 2: Buddy disenrolls/is ineligible for FC effective 02/28/05. Buddy would still be on the March 2005 cost share report (sent 03/18/05) with a $0 cost share. The first month that Buddy would not appear on the cost share report would be April 2005.

30.7.2.1 When Agencies Should Contact the MCO/Cost Share Report

IM agencies should notify the MCO of changes not captured on the current month's cost share report. These changes include:

1. New enrollments with:
    a. A cost share or patient liability confirmed after adverse action, and
    b. An enrollment date in the current or following month.

This enrollment information may
    a. Allow the MCO to begin collecting the cost share on the first of the following month. (Depending on the MCO billing cycle.) and
    b. Prevent the FC member from having to pay a two or possibly three month cost share at one time.

2. Retroactive reductions in the cost share:
    a. For a period not covered in the current or next months cost share report, or
    b. That can not be confirmed in CARES.

3. Cases which can not be correctly determined in CARES. (such as Group C *spousal impoverishment* case)

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31 PACE (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY)

31 PACE (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY)

This chapter is under development. In the meantime, please see the following Operations Memos for information on this program.

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32 MEDICARE SAVINGS PROGRAMS (MSP)

32.1 MEDICARE SAVINGS PROGRAMS (MSP)

32.1.1 Medicare Savings Programs (MSP) Introduction
32.1.2 MSP Fiscal Test Group
32.1.3 MSP Benefits
32.1.4 LIS Requests

32.1.1 Medicare Savings Programs (MSP) Introduction

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (*CMS*) for people over 65 and for certain younger disabled people. People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into three types of health coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges. Drug Insurance (Part D) pays for prescription drug charges.

Medicare, being an insurance program, charges coinsurance, deductibles and monthly premiums. These out-of-pocket charges to Medicare beneficiaries are generally referred to as ”Medicare cost-sharing." For certain Medicare beneficiaries participating in the programs described below, Wisconsin Medicaid pays some or all of their Medicare cost-sharing. These programs are called ”*Medicare Savings Programs*." (They are also referred to as ”*Medicare Premium Assistance*," or ”Medicare Buy-In" programs.)

Use the same rules for determining financial eligibility as you do for Medicaid.

The following are types of Medicare beneficiaries that receive the Medicaid benefits described in 32.1.3:

1. Qualified Medicare Beneficiary (*QMB*). See 32.2 QMB.
2. Specified Low-Income Medicare Beneficiary (*SLMB*). See 32.3 SLMB.
3. Specified Low-Income Medicare Beneficiary Plus (SLMB+), also known as Qualifying Individuals &endash; 1 (QI-1). See 32.4 SLMB+.
4. Qualified Disabled and Working Individuals (*QDWI*). See 32.5 QDWI.

If a *member* is also eligible for Medicaid, they will receive a ForwardHealth card. The ForwardHealth card will indicate that they are Medicare Beneficiaries.

Members eligible for QMB will receive a forward card even if s/he is not eligible for any other subprograms of Medicaid.

32.1.2 MSP Fiscal Test Group

The fiscal test group (*FTG*) size is two when a couple is living together at home. If they are both living in the same nursing home, each person is an individual FTG.

32.1.3 MSP Benefits

1. QMB Medicaid pays Medicare Part A & B premiums and Medicare deductibles and coinsurance.
2. SLMB Medicaid pays Medicare Part B premiums.
3. SLMB +. Medicaid pays Medicare Part B premiums.
4. QDWI Medicaid pays Medicare Part A premiums.

32.1.4 LIS Requests

See 2.6.5 Low Income Subsidy (LIS) Program of Medicare Savings Programs (MSPs) for information on *LIS* Requests for *MSP*.

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32.2 QMB (QUALIFIED MEDICARE BENEFICIARY)

32.2.1 QMB Introduction
32.2.2 Entitled to Medicare
32.2.3 QMB Income Limit

32.2.1 QMB Introduction

The following persons are Medicaid recipients who are automatically eligible for *QMB* benefits.

1. Persons who are receiving or are eligible to receive *SSI*.
2. 503 AGs.
3. Disabled *adult* children.
4. Widows and Widowers.

Widow/widowers (See 25.3 Widows and Widowers), DAC's (See 25.2 DAC) and 503's (See25.1 503 Eligibility) have the option of not taking the QMB benefit.

If the person does not belong to one of the above named groups, s/he must:
1. Be non-financially eligible for Medicaid.
2. Be entitled to Medicare Part A.

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A if s/he meets one of the following conditions:

1. S/he does not have to pay Medicare Part A, and s/he is receiving Medicare Part A services as of the QMB determination.

Example 1: Mrs. Smith applies for QMB benefits August 15, 1989. She has a Medicare card with a Part A begin date of June 1, 1989. Since Medicare will pay for Part A services as of June 1, 1989, she is "entitled" to Part A at the time of the QMB determination.

2. S/he must pay a monthly premium to receive Medicare Part A, and s/he fits one of the following descriptions:

   a. S/he is a Medicaid recipient and has been enrolled in Medicare sometime in the past. In this case the State will attempt to enroll him/her in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 2: Mr. Helmuth's Part A lapsed because he did not work enough quarters for free enrollment and he could no longer afford the premiums. When he becomes eligible for Medicaid, the State will begin paying his Medicare premiums.

   b. S/he is a Medicaid recipient or QMB or *SLMB* or *QDWI applicant* and has never been enrolled in the federal Medicare system. In this case s/he must apply at the local *SSA* office for Part A Medicare eligibility. S/he will receive a receipt which entitles him/her to enrollment in Part A on the condition that s/he is found

eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB OR SLMB or QDWI eligibility cannot begin prior to the Part A begin date.

Example 3: Mrs. Brown was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She goes to the SSA office during the January-March enrollment period and is conditionally determined eligible for Part A effective July 1st. She applies for QMB at the IM Agency on May 1st. She becomes QMB eligible as of July 1st.

32.2.3 QMB Income Limit

The QMB income limit is 100% of the federal poverty level (FPL). See 39.5 FPL Table.

The method of counting income is based on the SSI method, not on the *spousal impoverishment* method. (See 28.1 HCBWLTC Introduction). Calculate QMB net income as follows:

$ Earned income (See 15.5 Earned Income)
- $65 and ½ earned income deduction (15.7.5 $65 and ½ Earned Income Deduction)
+ Unearned income (social security income, etc.) (15.4 Unearned Income)
- Special exempt income (15.7.2 Special Exempt Income)
- $20 standard deduction
= Net income used to determine QMB eligibility

When counting social security income, use gross social security income. Gross social security income:

1. Of a self-payer = the social security check amount + Medicare premiums s/he has paid.
2. Of someone for whom the State is paying the premiums = the social security check amount.

Disregard the *COLA* increase for the current year until the month after the new federal poverty limits become effective.

Example 4: Big Al is a QMB recipient. He has income of $895.83. The QMB income limit in December is $902.50. In January, a COLA increase of $11.17 increases Big Al's income to $907.00. 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.

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32.3 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB)

32.3.1 SLMB Introduction
32.3.2 SLMB Income Limit

32.3.1 SLMB Introduction

To be eligible for *SLMB* the person must:
1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A.

32.3.2 SLMB Income Limit

The SLMB income limit is at least 100% of the FPL, but less than 120%. See 39.5 FPL Table.

Calculate SLMB net income in the same way as *QMB* net income including the temporary *disregard* of the annual *COLA* increase. (See 32.2.2 QMB Income Limit).

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32.4 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PLUS (SLMB+)

32.4.1 SLMB+ Introduction
32.4.2 SLMB+ Income Limit

32.4.1 SLMB+ Introduction

To be eligible for *SLMB*+ the person must:

1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A.
3. Have been determined ineligible for MA (including Community Waivers, BadgerCare Plus, *QMB*, SLMB, and *QDWI*). Consider a person with an unmet deductible ineligible for MA until s/he meets the deductible.

32.4.2 SLMB+ Income Limit

SLMB+ income must be at least 120% of the FPL, but less than 135%. See 39.5 FPL Table.

Calculate SLMB+ net income in the same way as QMB net income including the temporary *disregard* of the annual *COLA* increase.(See 32.2.2 QMB Income Limit).

Since enrollment for the SLMB+ program is not automated in CARES, it must be determined and managed manually by local agencies. See Process Help 61.6 SLMB+ Processing.

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32.5 QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI)

32.5.1 QDWI Introduction
32.5.2 QDWI Income Limit

32.5.1 QDWI Introduction

A Qualified Disabled and Working Individual (*QDWI*) is a person who:

1. Is entitled to enroll in Medicare Part A. (See 32.2.2 Entitled to Medicare) **and**
2. Is not otherwise eligible for MA (including Community Waivers and BadgerCare). Consider a person with an unmet deductible ineligible for MA until s/he meets the deductible.

32.5.2 QDWI Income Limit

The QDWI income limit is 200% of the FPL. See 39.5 FPL Table.

Calculate QDWI net income in the same way as *QMB* net income including the temporary *disregard* of the annual *COLA* increase.(See 32.2.2 QMB Income Limit).

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32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS

QDWI

Group Size	Asset Limit

1	$4,000
2	$6,000

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

Group Size	Asset Limit
1	$6,600
2	$9,910

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility.

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32.7 MEDICARE SAVINGS PROGRAMS BEGIN DATES

32.7.1 QMB Begin Dates
32.7.1.1 QMB Applications
32.7.1.2 QMB Recertifications
32.7.2 SLMB, SLMB+,QDWI Begin Dates

32.7.1 QMB Begin Dates

32.7.1.1 QMB Applications

For initial applications, *QMB* benefits begin on the first of the month after the month in which the individual is determined to be eligible/confirmed in CARES.

Example 1: Mr. Smith has been in the same nursing home since 2004 and applied for MA on January 23, 2008. He also requested QMB. His application was processed for both on January 23, 2008 and he was determined eligible for both. His MA begin date is January 1, 2008. His QMB begin date is February 1, 2008.

32.7.1.2 QMB Recertifications

For recertifications, QMB benefits begin on the first of the month following the review due month, regardless if the review was confirmed in the review due month or the month following the review due month.

Example 2: Mrs. Jones has been receiving MA and QMB since 2004. Mrs. Jones Medicaid/QMB was due for review February 2006. Her Medicaid/QMB review began on February 20, 2006. The worker received verification for the review on 2/28/06. The IM worker entered verification to complete the QMB review certification March 1, 2006. Mrs. Jones' QMB review was confirmed eligible on March 1, 2006. Mrs. Jones QMB eligibility begins March 1, 2006 and not April 1, 2006. There is no gap in Mrs. Jones' QMB benefit.

32.7.2 SLMB, SLMB+,QDWI Begin Dates

SLMB, SLMB+, and *QDWI* benefits begin on the first of the month in which all eligibility requirements are met. They cannot begin earlier than three months prior to the month of application.

32.8 MEDICARE SAVINGS PROGRAMS BACKDATING

32.8.1 QMB Backdating
32.8.2 SLMB, SLMB+,QDWI Backdating

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for *QMB* did not begin on the first of the following month as they were supposed to. This can occur if:

1. The eligibility process was not completed within 30 days.
2. Certification of eligibility was not completed.
3. A fair hearing decision has ordered backdated QMB benefits.

To backdate QMB benefit, complete an F-10110 (formerly DES 3070) certification form and return to:

1. Mail:
   EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: veds@wisconsin.gov

3. Fax: (608) 221-8815

32.8.2 SLMB, SLMB+,QDWI Backdating

Benefits can be backdated for up to three months prior to the month of application. Use the backdating guidelines given in 2.8.2 Backdated Eligibility .

A person who would have been eligible as a QMB in the backdate period cannot receive backdated *SLMB*, SLMB+, or *QDWI* benefits.

Example: Henry Schoolcraft applied for QMB on June 15, 1996. He also requested backdated SLMB. His income for June 1996 was under the QMB limit (100% of the federal poverty level). He was determined eligible for QMB. But his request for backdated SLMB was denied because his income, in the backdate months of March, April, and May, 1996, was under the QMB limit (100% of the FPL).

If he had applied for QMB in those months, he would have been QMB eligible. Therefore, since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB benefits.

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32.9 MEDICARE SAVINGS PROGRAMS NO DEDUCTIBLE

There is no deductible (See 24.2 Medicaid Deductible Introduction) in the *Medicare Savings programs*. If a person's income is above the appropriate income limit, s/he cannot qualify for an *MSP* by meeting a deductible.

Example 1: Mr. George's net monthly income is too high for him to be eligible for any of the MSPs. He cannot become eligible through the Medicaid

deductible process. If he is also applying for Medicaid medically needy eligibility, calculate his Medicaid deductible (24.5 Calculating the Deductible). When he meets his Medicaid deductible, he becomes eligible for Medicaid, but not for any of the Medicare Beneficiary programs.

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32.10 MEDICARE SAVINGS PROGRAMS REVIEWS

Review *MSP*-only AGs every 12 months. If there are other persons in the AG who are not MSP members, review whenever the case normally comes up for review.

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32.11 POTENTIAL ADVERSE EFFECT OF MSP PARTICIPATION

When the State pays a person's Part B premium, his/her Social Security (SS) check will increase by the same amount as the premium. This increase in the SS

check may result in the person either losing Medicaid eligibility, or being reduced from categorically needy to medically needy.

When a person would be adversely affected in this way, s/he is allowed to choose between either losing his/her Medicaid current benefits and keeping free Medicare enrollment, or giving up the free Medicare enrollment and keeping his/her MA benefits. All but 503, DAC's and widow/widowers can opt out of the *QMB* buy-in through CARES.

When a 503, DAC, or widow/widower requests to not have the state pay the Part B premium, contact the Buy-In Analyst at 221-4746, extension 3107. S/he will update MMIS with the appropriate information to prevent the automatic buy-in.

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33 SENIORCARE (SC)

33.1 SENIORCARE (SC) INTRODUCTION

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

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

There is neither an asset test nor estate recovery for SC. Participation levels are determined by comparing the anticipated annual income of the fiscal test group (*FTG*) to a percentage of the Federal Poverty Level (FPL) corresponding to the FTG size.

SC is administered by the Department of Health and Family Services (DHFS), through the Central Application Processing Operation (*CAPO*). County and tribal agencies are not responsible for determining eligibility, but may need to coordinate with workers in the CAPO for mixed cases. Mixed cases include those persons eligible for SC and:

1. Food stamps, **or**

2. *Medicare premium assistance*, **or**
3. An unmet Medicaid (MA) deductible, **or**
4. Child care assistance, **or**
5. Are participating in a Department of Workforce Development (DWD) employment program such as Wisconsin Works (W-2).

Although SC is a subprogram of Medicaid, only the portions of the handbook that are referenced in chapter 33 SeniorCare apply to SC policy.

See 21.7 Forward Health Cards for a picture of the SeniorCare card.

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33.2 SC APPLICATION

33.2.1 SC Application Introduction
33.2.2 Application Processing
33.2.3 Signing the Application
33.2.3.1 Witnessing the Signature
33.2.4 Authorized Representative
33.2.5 Guardian and Power of Attorney

33.2.1 SC Application Introduction

An individual interested in participating in *SC* must complete a SeniorCare Application Form (F-10076). An application may be obtained from a local Office on Aging, Senior Center, or Aging Resource Center. Applications may also be printed from the Department of Health and Family Services web site at: http://www.dhfs.wisconsin.gov/seniorcare/index.htm. If the *applicant* is unsure where to obtain an application or wants to have one mailed to him/her, s/he should call 1-800- 657-2038 (TTY and translation services are available).

A $30 enrollment fee is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See 33.5.2 ID Cards).

SC applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: For benefit renewal requirements, see 33.5 SC Benefit Period.

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application Form (HCF 10076) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (See 33.2.3 Signing the Application) in Section V. Applications that are not signed in Section V of HCF 10076 will be returned to the applicant. (Section VI of the 07/02 version of F-10076)

However, non-financial (33.3 SC NonFinancial Requirements) and income (33.6 SC Financial Requirements) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but can not be used as a residence address.

The presence of a signature on a SC application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his/her intent.

The date a valid application is received by the SC program is the application filing date. Eligibility for SC will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his/her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, s/he should check the "New Application" box on the application form. "Reapplication" refers to current participants who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.3 Signing the Application

The applicant must sign the application form in Section V of HCF 10076 (Section VI of the 07/02 version of F-10076) with his/her signature, a mark or an "X", unless one of the following signs for him/her:

1. A guardian.
2. An *authorized representative*.
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

33.2.3.1 Witnessing the Signature

If a SC applicant signs the application form in Section V of F-10076 with a mark or an "X", the signature must be witnessed by two individuals. (Section VI of the 07/02 version of F-10076).

33.2.4 Authorized Representative

An authorized representative may act on behalf of the SC participant at application and/or reviews, and is authorized to provide information and any documentation that is necessary to establish SC eligibility.

A SC applicant may authorize someone to represent him/her by completing the authorized representative form HCF 10080. (**Note**: The early version of SC application included Section V for authorizing a representative. If the 07/02 version of HCF 10076 is submitted with Section V completed, SC will accept the authorization of the representative.)

33.2.5 Guardian and Power of Attorney

An applicant is not required to complete the *Authorized Representative* form HCF 10080 if a legal guardian or power of attorney (POA) is applying on the SC applicant's behalf.

Copies of guardianship or POA documentation will be requested after the SC application has been submitted. Documentation must be submitted to the SC Program before information about the applicant or participant will be released to the guardian or POA. A POA may also be authorized for representation by completing the authorization of representation form (F-10080) SeniorCare Authorization of Information in lieu of submitting the POA papers.

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33.3 SC NONFINANCIAL REQUIREMENTS

33.3.1 SC Nonfinancial Requirements Introduction
33.3.2 Enrollment Fee
- 33.3.2.1 Refunds
- 33.3.2.2 Refunds to Deceased Participants

33.3.2.3 Opt In
33.3.3 Age Limitation
33.3.4 Other Insurance

33.3.1 SC Nonfinancial Requirements Introduction

To be non-financially eligible for *SC*, an *applicant* must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident.

A Wisconsin resident is an individual who meets at least one of the following criteria:

1. Has a permanent residence in Wisconsin.
2. Is considered a Wisconsin resident for tax purposes.
3. Is a registered voter in Wisconsin.

   A SC participant may temporarily live outside the State of Wisconsin, as long as s/he maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement.

4. Be a U.S. citizen or a qualifying legal alien (7.1 US Citizens and Nationals).

   An applicant who is a resident alien will need to provide a copy of both sides of his/her alien card and identify his/her country of origin. If there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant. When legal documentation is not available and *SSA* benefits have been verified, this requirement has been met.

   Verification of alien status can be made through the U.S. Bureau of Citizenship and Immigration Services' Systematic Alien Verification for Entitlement (SAVE) program.

5. Provide a Social Security Number (SSN) or be willing to apply for one (20.3.2 Social Security Number).

   Applications without the SSN will not be returned. Applicants will be contacted and given an opportunity to provide a SSN. Eligibility will not be confirmed until the SSN or proof of application for SSN has been supplied. If the SSN or the proof of application is not received within 30 days of application for SC, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they have their SSN. The Eligibility begin date will be based on the new application receipt date.

If a person requires assistance in obtaining a SSN, the SC Program will assist him/her in applying for one.

6. Not be a full-benefit Medicaid recipient (21.2 Full Benefit Medicaid). This includes participants who are covered by Family Care Medicaid. (See the BadgerCare+ Handbook)

   Individuals are not considered Medicaid recipients for SC if they have an unmet Medicaid deductible (24.2 Medicaid Deductible Introduction) or receive one of the following:
   a. Medicare premium assistance (32.1 Medicare Beneficiaries Introduction).
   b. Family Care non-Medicaid (See the BadgerCare+ Handbook)
   c. *TB*-related Medicaid (25.7 Tuberculosis)
   d. Emergency Services.

7. Not be an inmate of a *public institution* (6.9.3 Inmates of State Correctional Institutions).

8. Cooperate with providing information and/or verification necessary to determine eligibility (20.2 General Rules) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SC program will assist him/her.

   If a person is not able to produce the required verification, and the SC program is not able to produce the required verification, the SC program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a participant reapplies for a new benefit period, a new enrollment fee is required.

When a SC enrollment fee check is returned for non-sufficient funds, the applicant is mailed a form letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a form letter giving another 10 days to replace the fee is sent to the participant. If the check is still not replaced, then the eligibility is terminated. A notice of decision is mailed to

the participant. The termination date is 10 days after the notice of the decision (mail) date.

33.3.2.1 Refunds

No Application Received
If *CAPO* receives a fee without an application a manual notice and application will be sent, if possible, to the individual from whom the fee was received. If an Application is not received by CAPO within 45 days of the receipt of the fee, a refund will be processed at the request of the person who submitted the fee.

Application Denied
Anytime an application for SC is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt out
Refunds are based on individual participation. A SC participant may receive an enrollment fee refund if s/he received an initial eligibility notification, but has not received any SC prescription drug benefits or services and requests to withdraw from the program (33.12.2 Withdrawal).

SC prescription drug benefits include use of the SC card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SC card at Level 3 where a spenddown has not been met constitutes receipt of SC prescription drug services. A refund may be issued if such claims are reversed by the pharmacy.

Example 1: Henry was a SC participant at Level 1 whose benefit period began 12/01/04. Henry passed away on 12/04/04. His daughter reported Henry's death to the SC program on 12/10/04 and requested a refund of his $30 enrollment fee. Henry's SC card had been used on 12/01/04 to purchase a prescription, however the pharmacy had reversed those charges on 12/05/04 since Henry's prescription had not been picked up. The $30 enrollment fee should be refunded in this case since Henry did not receive any SC prescription drug benefits or services.

Example 2: Julie is a SC participant at Level 2b. Julie's SC application filing date was 10/26/04 and her benefit period began 11/01/04. On 11/15/04 Julie calls SeniorCare Customer Service Hotline to withdraw from the SC program and request a refund of her $30 enrollment fee. Julie used her SC card on 11/10/04 when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using

her SC card.

Example 3: Mike is a Level 3 SC participant . Mike's SC application filing date was 10/28/04 and his benefit period began 11/01/04. On 11/20/04, Mike requests to withdraw from the SC program and that his $30 enrollment fee be refunded to him. Mike used his SC card on 11/18/04 when he purchased a prescription, however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SC prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

In all opt-out cases, a refund will be issued only if the request to withdraw from the SC program is received by the later of:

1. Ten days following issuance of the eligibility notice, **or**
2. 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

33.3.2.2 Refunds to Deceased Participants

A refund may also be requested by the family *member* of a deceased participant when all the following criteria are met:

1. S/he received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SC benefit period, and
3. The request is made within 45 days of the date of death; and
4. S/he had not received any SC prescription drug benefits or services.

Note: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

33.3.2.3 Opt In

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

A participant who decides after the 30-day period that s/he wants to rejoin the program will need to complete a new application and submit the enrollment fee.

33.3.3 Age Limitation

A single applicant should apply for SC no sooner than the calendar month before his/her 65th birthday.

When a couple applies where one *spouse* is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SC unless s/he is turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-month enrollment period, s/he will receive a notice pending his/her eligibility for the enrollment fee approximately one month prior to his/her 65th birthday.

33.3.4 Other Insurance

Applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts A and B, may enroll in SC. SC is the payor of last resort except state funded only programs such as Wisconsin Chronic Disease Program (WCDP) and HIRSP.

SC will coordinate benefit coverage with all other health insurance coverage. SC may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
PO Box 7873
Madison, WI 53707-7873
1-800-236-8517

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33.4 SC FISCAL TEST GROUP (FTG)

The *FTG* consists solely of an *applicant*, unless the applicant is married and resides with his/her *spouse*.

If the applicant is married and resides with his/her spouse, the FTG consists of both the applicant and his/her spouse. An applicant is considered to be residing with his/her spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
2. The applicant's spouse is a *SSI* recipient, **or**
3. The applicants are married but are living separately, **or**
4. Both spouses are living in a nursing home.

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33.5 SC BENEFIT PERIOD

33.5.1 SC Benefit Period Introduction
33.5.2 ID Cards
33.5.3 Eligibility Begin Date

33.5.1 SC Benefit Period Introduction

The benefit period for *SC* is 12 consecutive months. The benefit period and eligibility remain intact unless the participant :

1. Moves out of state,
2. Reapplies (33.11 SC Re-Application),
3. Requests to withdraw from the program (33.12 SC Early Termination), **or**
4. Dies.

33.5.2 ID Cards

When an *applicant* is found eligible for SC, s/he is mailed a plastic SeniorCare ID card and information about how to use it. SC participants who renew their eligibility will continue to use their original card.

33.5.3 Eligibility Begin Date

SC begins on the first day of the month following the month in which all eligibility requirements have been met.

Exception: SC eligibility begins the day after MA eligibility ends if a SC application is submitted prior to the MA termination date and all eligibility requirements are met.

Example 1: Carol applies for SC on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2: William applied for SC on September 19th but did not submit the enrollment fee with his application. His eligibility "pends" and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3: Mary is notified that MA eligibility will end on November 30th because her assets exceed the limit. She applied for SC on November 29th and will meet all SC eligibility requirements on December 1st (when she is no longer an MA recipient). Mary's benefit period is from December 1st through November 30th.

Note: If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example 4: Harold's PPRA was mailed to him on December 13th to be completed for his new benefit period, that begins February 1st. The PPRA was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the local agency worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SC program. Due to the incorrect address Harold did not receive the PPRA form to complete until late in January. The completed PPRA was received by the SC program on February 10th along with a letter explaining why it was late. Harold's new SC benefit period is February 1st through January 31st since the one month gap in

coverage was due to an agency error.

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33.6 SC FINANCIAL REQUIREMENTS

33.6.1 Assets
33.6.2 Income
33.6.3 Gross Social Security
33.6.4 Gross Earnings
33.6.5 Interest and Dividends
    33.6.5.1 Capital Gains
    33.6.5.2 Trusts
    33.6.5.3 Joint Savings
33.6.6 Self-Employment Earnings
    33.6.6.1 Rental Income
33.6.7 Gross Pension
    33.6.7.1 Retirement Benefits

33.6.8 Other Income
33.6.8.1 Allocated Income from a Medicaid Recipient's Spouse
33.6.8.2 Farm Subsidy
33.6.8.3 Rental Income
33.6.8.4 Veterans' Disability
33.6.9 Disregarded Income

Income information for *SC* is based on the applicant's good faith estimate of income for the next 12 months beginning with the month of application. Last year's information from tax returns or other sources may be used as a guide when determining the estimate.

All income should be rounded to the nearest whole dollar when entering the amount on the application or renewal application.

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). 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.

Example 1: Eric has a savings account with $5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income.

Eric anticipates withdrawing $1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset, and are not counted as income.

33.6.2 Income

The income of a *spouse* who is in the SC *FTG* is included in the estimate of the annual budgetable income, even if s/he does not apply or is non-financially ineligible.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SC (15.3 Disregarded Income), including Earned Income Tax Credit (EITC) and income tax refunds (15.5.8 Income and EITC Tax Refunds).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income. (33.6.6 Self-Employment Earnings).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application Form (F-10076). All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, add any deductions for Medicare Part B or D and court ordered guardianship fees, alimony and/or child support to the net payment amount.

Exception: If a SC *applicant* is receiving *Medicare premium assistance* (32.1 Medicare Beneficiaries Introduction), his/her monthly payment already includes the Medicare Part B premium.

The applicant should contact the Social Security Administration at 1-800-772-1213 if s/he does not know his/her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his/her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

33.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (33.6.6 Self-Employment Earnings). Gross earnings include the following:

1. AmeriCorp (15.5.10 AmeriCorps),
2. Contractual Income (15.5.2 Contractual Income),
3. Governor's Central City Initiative (15.5.7 Governor's Central City Initiative),
4. Income In Kind (15.5.1 Income In Kind),
5. Income Received By Members of a Religious Order (15.4.16 Income Received by Members of a Religious Order, 15.5.13 Income Received by Members of a Religious Order),
6. Jury Duty Payments (15.5.4 Jury Duty Payments),
7. Salary,
8. Severance Pay (15.5.12 Severance Pay),
9. Wage Advances (15.5.5 Wage Advances),
10. Wages,

11. Wages and salaries received from a program funded under Title V – Older Americans Act of 1965 (15.5.14 Title V – Older Americans Act of 1965),
12. Worker's Compensation (15.5.6 Worker's Compensation),
13. Respite Care Payment for Services

33.6.5 Interest and Dividends

The SC applicant must report the estimated gross amount of all interest and dividends that s/he expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to the following:

1. Bonds,
2. Certificates of Deposit (CD),
3. Checking Accounts,
4. Money Market Accounts,
5. Savings Accounts
6. Stocks,
7. Capital Gains (33.6.5.1 Capital Gains)
8. Trusts (33.6.5.2 Trusts)
9. Individual Retirement Accounts (15.4.4 Retirement Benefits)
10. Annuities
11. Land Contracts (15.4.7 Land Contract)
12. Loans (15.4.8 Loans)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, income that is received irregularly infrequently, and under $20 per month should be reported as budgetable income for SC applicants.

33.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported if it is greater than zero. Negative amounts should not be reported and shall not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when s/he sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

33.6.5.2 Trusts

All anticipated payments (including interest, dividends and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, withdrawals from principle are counted for SC as income in the month received.

33.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant/applicant's spouse should report only his/her share of the interest.

If the applicant and his/her spouse are not living together and hold a joint savings account, the applicant should only report his/her share of the interest

33.6.6 Self-Employment Earnings

SC will budget net self-employment income, which is calculated by deducting estimated business expenses, losses, and depreciation from gross self-employment income.

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported and shall not be used to offset other income. (15.6.5.2 Worksheets)

33.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income.

Refer to 33.6.8.3 Rental Income if rental income is not reported as self-employment income.

Note: See section 15.5.3 Rental Income, items #1 and 2, for more information about calculating net rental income for SC participants.

33.6.7 Gross Pension

Examples of income that should be included in the gross pension amount include:

1. Railroad Retirement Benefits,
2. Retirement Benefits (33.6.7.1 Retirement Benefits),
3. Veterans Benefits. (15.3.26 VA Allowances)

33.6.7.1 Retirement Benefits

Retirement benefits are work-related plans for providing income when employment ends (e.g., pension, *disability*, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans.

Retirement accounts, including individual retirement accounts (IRA), Keogh, etc., are assets, and are therefore not counted for SC.

Periodic payments received from a retirement account or annuity are counted as income. A periodic payment is any partial payment from a retirement account. Withdrawal of the full amount from any retirement account that has never had a withdrawal made from it is not considered a periodic payment and is not countable income.

Note: Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SC.

Example 2: Mike owns a $2000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one time withdrawal of $1,000 of the $2,000 from his IRA in the next 12 months, the $1,000 would be considered income on his SeniorCare application.

If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income on his SeniorCare application.

33.6.8 Other Income

Examples of other income are:

1. Allocated income from a Medicaid recipient spouse (33.6.8.1 Allocated Income from a Medicaid Recipient's *Spouse*),
2. Child Support (15.4.14 Child Support),
3. Federal Farm Subsidy (33.6.8.2 Farm Subsidy),
4. Gifts (15.4.6 Gifts),
5. Profit sharing (15.4.15 Profit Sharing),
6. Sick/*Disability* benefits (15.4.2 Sick Benefits),
7. Rental income (33.6.8.3 Rental Income),
8. Unemployment Compensation (15.4.3 Unemployment Compensation (UC)),
9. Veterans Disability Payments (33.6.8.4 Veterans Disability)

33.6.8.1 Allocated Income from a Medicaid Recipient's Spouse

SC applicants with an Medicaid recipient spouse living outside of the home (e.g. in a nursing home) must report the spousal income allocation amount (18.6 Spousal Impoverishment Income Allocation) as income.

Example 3: Betty is an Medicaid recipient and in the nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that $45 is set aside as her personal needs allowance. $605 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,260 as "Other Income" on his SeniorCare Application.

A SC applicant with an Medicaid recipient spouse living in the home (e.g. a community waivers participant) should not report income that is allocated to him/her. The allocated amount must be included in the income estimate for the Medicaid recipient spouse, because s/he is living in the home.

33.6.8.2 Farm Subsidy

The SC applicant must report anticipated farm subsidy payments. The SC applicant must also report payments from the Conservation Reserve Enhancement Program (CREP), a program where the landowner is paid to install conservation practices for a period of 10 to 15 years.

33.6.8.3 Rental Income

All expected rental income will be budgeted for SC. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses such as insurance, utilities, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering and replacing broken windows.

Refer to 33.6.6.1 Rental Income if rental income is reported to the IRS as self-employment income.

33.6.8.4 Veterans Disability

Veterans disability payments should be reported as income.

Do not count as income the portion of a veterans disability payment that is for: unusual medical expenses, aid and attendance, or a housebound allowance.

The applicant should check with the Veterans Administration at 1-800-827-1000 to determine if any portion of the payment is considered an allowance for unusual medical expenses, aid and attendance or housebound allowance.

Reimbursement from the Veterans Administration for medical costs does not count as income.

33.6.9 Disregarded Income

The applicant should not report income anticipated from any of the following:

1. Active Corp. of Executives (ACE) (15.3.22 Special Programs)
2. Adoption assistance payments (15.3.1 Adoption Assistance)
3. Agent Orange Settlement Fund payments (15.3.2 Agent Orange Settlement Fund)
4. Disaster and emergency assistance payments made by federal, state, county and local agencies or other disaster assistance agencies (15.3.5 Disaster and Emergency Assistance)
5. Earned Income Tax Credit (16.7.8 Earned Income Tax Credit (EITC))
6. Earnings of a census enumerator (15.3.22 Special Programs)
7. Emergency Fuel Assistance payments (15.3.22 Special Programs)
8. *Foster Care* payments (15.3.7 Foster Care)
9. Foster Grandparents Program (15.3.22 Special Programs)
10. Governmental rent or housing subsidies (15.3.22 Special Programs)
11. *Homestead* Tax Credit (15.3.22 Special Programs)
12. Income Tax Refunds (both state and federal) (16.7.7 Income Tax Refunds)
13. Individual Development Account payments (15.3.9 IDA Payments)
14. Kinship Care payments (15.3.11 Kinship Care)
15. Low-Income Energy Assistance Program (15.3.22 Special Programs)
16. Older American Community Service Program (except for wages or salaries which are counted) (15.3.22 Special Programs)
17. Payments made to individuals because of their status as victims of Nazi persecution (15.3.15 Payments to Nazi Victims)
18. Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted

the HIV virus from contaminated blood products (15.3.24 Susan Walker Payments)

19. Penalty payments made when the state does not correctly process child support refunds.
20. Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining (15.3.16 Radiation Exposure Compensation Act).
21. Reimbursement from private insurance company for medical, long-term care, or dependent care expenses (15.3.19 Reimbursements).
22. Restitution payments to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during WWII (15.3.27 Wartime Relocation of Citizens).
23. Retired Senior Volunteer Program (RSVP) (15.3.22 Special Programs)
24. Reverse mortgage payments (16.7.2.1 Reverse Mortgage)
25. Service Corp. of Retired Executives (SCORE) (15.3.22 Special Programs)
26. University Year for Action Program (15.3.22 Special Programs)
27. Volunteers in Service to America (VISTA) (15.3.22 Special Programs)
28. W-2 payments for transitional jobs and community service jobs (15.3.28 W2 Payments)
29. Wisconsin's Family Support Program (15.3.22 Special Programs)
30. Do not count payments from Indian Health Services. **Note**: Payments to Native Americans listed in 15.3.14 Payments to Native Americans must be counted.

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33.7 SC PARTICIPATION LEVELS

See 39.11 SeniorCare Income Limits

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33.8 SC COUNTABLE COSTS

33.8.1 SC Countable Costs Introduction
33.8.2 Carryover
33.8.3 Date of Purchase

33.8.1 SC Countable Costs Introduction

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible *SC* participant,
2. Purchased during the benefit period, and
3. Covered by the SC program (33.6 SC Financial Requirements).

All covered prescription drug costs the participant incurs will be tracked, and the SC Program will coordinate coverage with insurance companies. If the prescription is covered by insurance, only the portion not paid by insurance is applied toward the spenddown or deductible.

When a participant's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.8.2 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, within a benefit period, when carryover covered prescription amounts are applied.

1. When the covered prescription cost exceeds the remaining deductible amount, SC pays the difference.

Example 1: Jeff earns between 160% and 200% of the FPL for a *FTG* size of one (39.11 SeniorCare Income Limits and Participation Levels). He is eligible for SC and has a $500 deductible. In three months, Jeff has a remaining deductible amount of $30.

During the fourth month of his benefit period, with a $30 remaining deductible, Jeff purchases a covered prescription drug that costs $100. The pharmacist informs him that he owes $30 of the $100 prescription drug cost. He has met his deductible. The remaining $70 will be paid by SC.

For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

2. When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

Example 2: Rachel earns $27,793 which is $1,800 more than 240% of the FPL for a FTG of one (39.11 SeniorCare Income Limits and Participation Levels). Her spenddown amount for the 12-month benefit period is $1,800. In four months Rachel has incurred all but $50 of her spenddown amount by purchasing covered prescription drugs at retail price.

During the fifth month of her benefit period, when she has $50 of her spenddown left, Rachel purchases a covered prescription drug that costs $100. Rachel pays the full $100. Of the $100, $50 is applied to her spenddown, and $50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is $800.

33.8.3 Date of Purchase

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

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33.9 SC ADDITION OF A SPOUSE

33.9.1 SC Addition of a Spouse Introduction
33.9.2 Adding a Spouse No Change in FTG
33.9.2.1 Adding a Spouse, No FTG Change, At Levels 2a and 2b
33.9.2.2 Adding a Spouse, No FTG Change, At level 3
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33.9.2.2.2 Met Spenddown
33.9.3 FTG Changes
33.9.3.1 FTG Changes at Level 2a and 2b
33.9.3.2 FTG Changes At Level 3
33.9.4 Addition of a Spouse Summary Table

33.9.1 SC Addition of a Spouse Introduction

The following exceptions apply when one *spouse* (hereafter referred to as *Spouse* 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless s/he chooses to reapply (33.11 SC Re-Application).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (33.9.2 Adding a Spouse No Change in FTG).

    a. If spouse 1's eligibility was determined at level 2a or 2b, then refer to 33.9.2 Adding a Spouse No Change in FTG.
    b. If spouse 1's eligibility was determined at level 3 then refer to (33.9.2.2 Adding a Spouse, No FTG Change, At level 3)

        - Met spenddown (33.9.2.2.1 Unmet Spenddown)

        - Unmet spend (33.9.2.2.2 Met Spenddown)

Or

2. Spouse 2 was not included in the *FTG* (e.g. single or not living with Spouse 1) at the time of Spouse 1's application. (33.9.3 FTG Changes), but the are now residing together.

a. If spouse 1's eligibility was determined at level at level 2a or 2b, refer to 33.9.3.1 FTG Changes at Level 2a and 2b)

b. If spouse 1's eligibility was determined at level 3, refer to 33.9.3.2 FTG Changes At Level 3

See 33.9.4 Addition of a Spouse Summary Table

33.9.2 Adding a Spouse No Change in FTG

If Spouse 2' s participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual *income* information provided on Spouse 1's application.

Example 1: Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for *SC*. Anne takes no prescription drugs and does not request SC when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st.

In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SC on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income.

Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SC eligibility is reviewed in March.

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the FPL, and Spouse 2 becomes SC eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500/$850) by the number of months in Spouse 2's benefit period and divide by 12.

Example 2: Mary and Jim apply for SC in January. They have an annual income of $28,800, which is between 160% and 200% of the FPL for a FTG of

two (39.11). Their income places them in Level 2a ($500 deductible).

Jim is determined eligible for SC, but Mary's eligibility for SC is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible.

In June, Mary will turn 65. At *adverse action* in the month of May, *CARES* will process this case through batch. At that time, the application status is updated if the *applicant* who is turning 65 is:

1. In an open SC case, **and**
2. The individual has requested SC.

A letter is sent to Mary notifying her that if she still wishes to participate in SC, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st.

Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12.

$500 x 6=$3,000/12=$250

Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

33.9.2.2 Adding A Spouse, No FTG Change, At level 3

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

33.9.2.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is $850. The deductible for Spouse 2 is prorated (33.9.3.1 FTG Changes at Level 2a and 2b).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 3: Reginald and Elizabeth's joint income is $35,856, which is $3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SC effective January 1st. Only Elizabeth's covered prescription drug costs are applied toward the spenddown.

In March, Reginald turns 65 and is determined eligible for SC beginning April 1st. His benefit period ends December 31st, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1st.

In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a $850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, $850 is multiplied by nine and the total is divided by 12.

$850 x 9 = $7,650/12 = $638

Reginald's deductible is $638. Once Reginald meets the $638 deductible, he purchases covered prescription drugs at the co-payment amounts through the remainder of his benefit period. Once Elizabeth meets her $850 deductible, she purchases covered prescription drugs at the co-payment amounts through the remainder of the benefit period.

33.9.2.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 4: Bob and Bernice's joint income is $33,856, which is $1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SC effective January 1st. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of $1,000.

Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her $850 deductible. In June, she has $100 left before she will meet her deductible.

In May, Bob turns 65 and is determined eligible for SC. His eligibility begin date is June 1st. His benefit period ends December 31st, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, $850 is multiplied by seven and the total is divided by 12.

$850 x 7 = $5,950/12 = $496

Bob's deductible is $496. After he meets the $496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at co-payment amounts for the remainder of his benefit period.

Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another $100 in covered prescription drugs, she purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

33.9.3 FTG Changes

When a married SC participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**

2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**

3. The eligibility and benefit period for Spouse 1 is not affected, unless s/he chooses to reapply.

Example 5: Jim is a SC participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one.

In January Jim marries Helen. Helen applies for SC in February. Jim's eligibility is not re-determined when Helen applies.

Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February.

Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.

33.9.3.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated (33.9.3.1 FTG Changes at Level 2a and 2b) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

Example 6: Will is married, but he and his wife Grace were separated at the time he applied for SC.

Will applies for SC in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Will is determined to be SC eligible at Level 1 beginning November 1st. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Grace returns home in January. She applies for SC in February and is determined eligible beginning March 1st. Grace's benefit level is determined based on a FTG of two. Their joint income is determined to be $27,656, which is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends.

Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of $850 is multiplied by eight and then divided by 12.

$850 x 8=$6,800/12=$567

Grace's deductible amount is $567. After she has met her deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

33.9.3.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**

1. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**

2. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.3.1 FTG Changes at Level 2a and 2b). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, s/he purchases covered remainder of the benefit period.

Example 7: Tim is married, but his wife Marsha was institutionalized at the time he applied for SC. Marsha was expected to be out of the home for five months.

Tim applies for SC in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Tim is determined to be SC eligible beginning June 1st. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Tim's wife Marsha returns home in November. She applies for SC in November and is determined eligible beginning December 1st. Marsha's participation level is determined based on a FTG of two. Their joint income is determined to be $35,969 which is $1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31st, when Tim's benefit period ends.

Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of $1,000 is multiplied by six and then divided by 12.

$1,000 x 6=$6,000/12=$500

Marsha's spenddown amount is $500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, $850 is multiplied by six and then divided by 12.

$850x 6=$5,100/12=$425

Marsha pays for covered prescription drugs until she has met the $425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of benefit period.

Tim's eligibility and benefit period are not affected

33.9.4 Addition of a Spouse Summary Table

The following table assumes that Spouse 1 and Spouse 2 do not apply for SC at the same time.

	SPOUSE 1's Eligibility	**SPOUSE 2's Eligibility**
Benefit Period: **Begin Date**	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: End Date	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: Married at time of Spouse 1's application	FTG of two. Participation Level determined based on annual self-reported income of both spouses.	FTG of two. Participation Level determined based on annual self-reported income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level:	Gross annual income test	Gross annual income test

Single or not living together at time of Spouse 1's application.	based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless s/he chooses to do so.	based on a FTG of two. Participation Level determined based on annual self-reported income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time s/he applies. Spouse 1's income remains the same.
Deductible:	Has a $500/$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: Unmet Original FTG of 2	Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of $850.	Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: Met Original FTG of 2	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse 2 has a prorated deductible.
Spenddown: Unmet Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: Met Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note: If Spouse 1 terminates prior to spouse 2's request. A new application is required for a new 12- month benefit period.

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33.10 SC CHANGES

33.10.1 SC Changes Introduction
33.10.2 Correction of Errors
33.10.2.1 Agency Error
33.10.2.2 Applicant/Participant Error
33.10.3 Fraud

33.10.1 SC Changes Introduction

The following changes must be reported to the *SC* Program within ten days:

1. Address.
2. Household Composition (examples include marriage, divorce, separation)
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service Hotline at 1-800-657-2038.

Changes may also be reported by writing to:
SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Participants are asked to include an SSN on any written correspondence.

If a participant reports any changes before the case has been confirmed in CARES, the new information will be used in his/her SC eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the participant's SC benefits as follows:

1. Address change:

a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SC benefit levels will not change for the current benefit period.
b. Address changes that result in termination of Wisconsin residency result in discontinuation of SC benefits. Provide the participant with at least 10 days notice before the effective date of an *adverse action*.

Note: Reporting an out-of-state address does not necessarily signify that an *applicant* is not a Wisconsin resident (33.3 SC NonFinancial Requirements).

2. Death

A participant's death ends SC eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the participant should be equal to the participant's date of death.

If a participant's *spouse* dies, the participant will remain eligible at the same benefit level through the current SC benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. 3. Change in household composition

If a participant experiences a change in household composition, the SC benefit level will not change through the remainder of the SC benefit period. The participant may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a *public institution* (6.9.3 Inmates of State Correctional Institutions).

An inmate of a public institution is ineligible for SC on the date incarceration begins. Provide the participant with adequate notice before the effective date of the adverse action. The "early termination date" is equal to the notice mailing date.

If a participant's spouse is an inmate of a public institution the participant benefit level will remain the same through the current benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

An applicant who wishes to change or correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES.

Depending on the nature of a client-reported error or agency discovered error, a participant's eligibility will be re-determined (See 33.10.2 Correction of Errors). Provide the participant with at least 10 days notice before the effective date of an adverse action. If the case has already been confirmed in CARES, the applicant may opt out and reapply if s/he so desires.

Example 1: Sally and Fred are husband and wife and applied for SC in July. Both Sally and Fred were found eligible with a deductible (Level 2a) for August. In September, Fred loses his job. He reports the change to the SC program. This change will not affect Sally or Fred's SC benefits, because Fred reported the change after his case had been confirmed in CARES. In order to have eligibility redetermined Fred and Sally will need to file a re-application (33.11 SC Re-Application) and submit enrollment fees for each. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (33.11 SC Re-Application) to change their benefit level.

33.10.2 Correction of Errors

All errors made on the SeniorCare Application (F -0076) must be reported by the participant or his/her *Authorized Representative*, POA, or Guardian to the SeniorCare Customer Services Hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (totaling income on the application).
2. Income amounts are off by a factor of 100. (lack of decimal)
3. Application processing errors.

An applicant who wishes to change/correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES.

If a participant has been found eligible for either an incorrect SC benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be Agency Error or *Applicant* /Participant error, as follows:

33.10.2.1 Agency Error

Agency errors for SC will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the current benefit period.

33.10.2.2 Applicant/Participant Error

If the error resulted in an overpayment, benefit recovery will be pursued and the correction is processed with an effective date based on adverse action notice. Provide the participant with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and s/he reported the error within 45 days of the mail date of the notice of decision, restore corrected benefits back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 2: In August, Charlie lost this job at the Burger Palace. In September Charlie applied for SC. In his application Charlie erroneously reported income of $1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown.

Depending on when Charlie reports this error his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported. (33.10.2 Correction of Errors).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 3: Eric applied for SC in July and was determined eligible at level 1 effective August 1st. Prior to applying for SC, Eric got a part-time job that had begun in June. When Eric applied for SC, he neglected to report his

anticipated part-time earnings on the SC application.

Eric receives his notice of decision, dated August 8th. The notice informs he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice. Eric realizes that he forgot to report his earnings from his part – time job and he calls the CS Hotline on August 21 to report his error.

Eric reports to the CS Correspondent that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income add up to an annual estimated income of $19,700. Or level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

Prior to reporting this mistake, Eric had purchased several prescriptions at the co-pay levels with his SC Card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 (the end of his 12- month benefit period), SC will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

33.10.3 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which s/he is not entitled. Penalties for fraud include a fine of up to $10,000, imprisonment up to one year, or both, and suspension from the SC program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SC application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SC;
3. Applying for SC on behalf of another person and use of any part of the benefit for oneself;
4. Allowing another person to use someone else's card to get prescription drugs.

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33.11 SC RE-APPLICATION

SC participants may request to establish a new SC benefit period at any time. However, it is not beneficial for a SC participant to reapply unless s/he will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SC eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

Such a change may result from divorce, marriage, institutionalization or death of a *spouse*, or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a $30 enrollment fee per person. Eligibility will be re-determined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and s/he is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

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33.12 SC EARLY TERMINATION

33.12.1 Early Termination
33.12.2 Withdrawal

33.12.1 SC Early Termination

SC eligibility is terminated prior to the end of the established benefit period if:

1. A participant no longer meets non-financial eligibility requirements, or
2. S/he requests to withdraw from the program, or
3. S/he requests to establish a new benefit period and eligibility for the new benefit period is confirmed (33.11 SC Re-Application).

When SC eligibility has been terminated prior to the end of the established benefit period and the SC Program is notified that all eligibility requirements are again satisfied, within one calendar month of SC eligibility termination, the benefit period is restored.

Exception: SC participants who lose SC eligibility solely due to receipt of MA benefits do not have their benefit period terminated; however, they are not eligible for SC benefits or services for the calendar months that they receive MA benefits.

If MA eligibility ends prior to the end of the SC benefit period, and the participant is still SC eligible, SC eligibility automatically resumes.

Example 1: Amy applies for SC on October 4th and is determined eligible effective November 1st. In December she applies for MA and is determined eligible, effective December 1st. Amy is not eligible for SC benefits or services while she is receiving MA.

In January, Amy inherits $5,000 and is notified that her MA eligibility ends January 31st, because her assets exceed the limit. Amy still meets SC eligibility requirements, so SC eligibility will resume from February 1st through October 31st.

See 33.15 SC Annual Eligibility Review for termination as it applies to the need for an annual review.

33.12.2 Withdrawal

Applicants or participants may withdraw from the SC Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SC participant is eligible for an enrollment fee refund only if s/he meets the requirements listed in 33.3.2.1 Refunds.

If an *applicant* chooses to withdraw his/her application prior to eligibility confirmation, s/he will get a refund. If s/he later wishes to “opt in”, s/he will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to “opt-out” and SC receives the request to withdraw within the timeframe for obtaining a refund, s/he will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, s/he would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his/her benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that s/he meets eligibility requirements. If within thirty calendar days of opting out s/he does not contact SC and SC does not receive the enrollment fee, s/he will have to submit a new application and another $30 enrollment fee if s/he wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, s/he will not get a refund. Customer Service should counsel the participant that s/he will not be getting a refund, and s/he can keep his/her case open in the event his/her circumstances change and s/he wants to use the SC benefit in the next 12 months.

If the participant still opts out, but contacts SC within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. S/he will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another $30 enrollment fee to be credited for CARES to process correctly.

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33.13 SC NOTICE OF DECISION

A written notice is sent to the *applicant* indicating *SC* certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining participant level. It will also provide the participant with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SC benefits will be continued if a hearing is requested.

SC participants will be notified of an *adverse action* at least 10 days prior to the effective date of adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A participant chooses to withdraw from the program.
3. A participant requests to establish a new benefit period and eligibility for the previous benefit period is terminated (33.11 SC Re-Application).
4. A person is an inmate of a *Public Institution*.
5. Death of a participant.

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33.14 SC APPEALS

33.14.1 SC Appeals Introduction
33.14.2 Requesting a Hearing
33.14.3 Hearing

33.14.1 SC Appeals Introduction

SC applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.
2. An application is not acted upon within thirty calendar days.
3. A participant believes that the benefits s/he received, or the initial eligibility date of program benefits were not properly determined.
4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

33.14.2 Requesting a Hearing

The SC *applicant* or participant, or his/her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the *adverse action*.

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

33.14.3 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
2. Reasonably accessible to the petitioner.
3. Held on department or agency premises, subject to the judgement of the administrative law judge.
4. Accessible to those in need of accommodations for a *disability* or translation. (For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096.

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33.15 SC ANNUAL ELIGIBILITY REVIEW

An annual eligibility review is required for each participant by the end of the current 12 month benefit period, to prevent a gap of in coverage. Eligibility for a

new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed CARES renewal application or new application form (F-10076) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the $30 annual enrollment fee.

Note: For the definition of "valid," see 33.2.2 Application Processing.

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33.16 SC BENEFITS

33.16.1 SC Benefits Introduction
33.16.2 Discount Pricing
33.16.3 Early Refills
33.16.4 Out-of-state Pharmacies

33.16.1 SC Benefits Introduction

For all of the participation levels, *SC* allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Reimbursement for most drugs is limited to a 33-day supply. Some maintenance drugs may be provided in a 100-day supply.

The co-payment amount is not affected by the # of days in the supply.

Note: The participant should contact his/her provider to verify that SC covers a specific drug.

SC does not cover the following:

1. Prescription drugs administered in a physician's office.
2. Prescription drugs that are experimental or have a cosmetic, not a medical purpose.
3. Over-the-counter drugs (except for insulin) such as vitamins or aspirin, prilosec OTC, even with a prescription.
4. Prescription drugs for which prior authorization has been denied.
5. Colostomy supplies and other durable medical supplies (DMS) even though they may need a prescription.
6. Prescription drugs for participants in Levels 2b and 3 for which a rebate agreement has not been signed by the manufacturer.

33.16.2 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SC allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SC allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SC spenddown and/or deductible.

33.16.3 Early Refills

When the participant is temporarily leaving the state and the supply on his/her prescriptions is insufficient, s/he will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SC nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

33.16.4 Out-of-state Pharmacies

In an emergency, a participant can get a prescription filled out of state and have it count toward SC as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

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34 EMERGENCY SERVICES

34.1 EMERGENCY SERVICES

34.1.1 Emergency Services Eligibility Introduction
34.1.2 Determination of Emergency Services Eligibility
34.1.2.1 Medicaid Deductible
34.1.3 Certification of Emergency Services Eligibility
34.1.4 BC+ Emergency Services

34.1.1 Emergency Services Eligibility Introduction

Documented and undocumented non-citizens ineligible under regular Medicaid due to alien status can be eligible for Emergency Services, if s/he meets all other eligibility requirements except having or applying for an SSN. Non-citizens may have an SSN and may still qualify for Emergency Services. If a non-citizen would otherwise be eligible for any type of EBD Medicaid, s/he would qualify for Emergency Services.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate Medicaid could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying aliens.

The IM agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to EDS. EDS determines if a condition is an emergency medical condition covered by Emergency Services.

A citizen is not eligible for Medicaid Emergency Services even when s/he cannot produce citizenship and/or identity verification.

Example 1: Jill applies for Medicaid, declares U.S. citizenship and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services Medicaid does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However the IM worker cannot process Emergency Services Medicaid eligibility for persons declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency. Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying alien meets all other eligibility requirements during the dates of service and to certify if s/he is eligible for Emergency Services.

If a non-qualifying alien provides a “Certification of Emergency for Non-U.S. Citizens” (F-01162) at the time of application, determine his/her eligibility for Emergency Services for the dates of the emergency indicated on the form. If a non-qualifying alien does not have the form at the time of application, ask him/her

for the dates that s/he received emergency services. The HCF 01162 is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. S/he must meet the eligibility requirements for his/her type of Medicaid, such as being *elderly* blind or disabled*, and provide required verifications. S/he is also entitled to all notice rights and must receive a manual positive or negative notice regarding his/her eligibility. Positive Notices must provide the dates of eligibility for Emergency Services. Negative Notices must provide the reasons for the denial or termination.

*If a non-qualifying alien would only qualify for Medicaid if s/he was disabled, follow *disability* determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

34.1.2.1 Medicaid Deductible

Aliens who apply for emergency services may become eligible by way of the Medicaid deductible. If, on the date s/he applies, s/he is eligible in all respects except income, apply the same deductible policies (24.2 Medicaid Deductible Introduction) to him/her as any other client.

34.1.3 Certification of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. When an alien is determined eligible for Emergency Services, complete and submit a F-10110 (Formerly DES 3070). Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to an organ transplant procedure are not covered by Emergency Services. EDS needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

The F-10110 may be submitted to EDS in the following ways:

1. Mail:
   EDS
   P.O. Box 7636
   Madison, WI 53707

2. E-mail:
   veds@wisconsin.gov

3. Fax:

(608) 221-8815

An individual eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility ends when the emergency ends.

34.1.4 BC+ Emergency Services

For Emergency Services for children, parents, caretakers, and pregnant women, see the BC+ Handbook Chapters 39.1 Emergency Services and 41.1 BC+ Prenatal.

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35 LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP)

View History

35.1 LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP)

35.1.1 LTCIP Introduction
35.1.2 LTCIP Asset Disregard
35.1.3 Verification
35.1.3.1 Verification of the Qualified LTCIP Policy
35.1.3.2 Verification of Residency
35.1.3.3 Verification of Benefits Paid
35.1.4 Examples
35.1.5 Process Help

35.1.1 LTCIP Introduction

The Wisconsin Long-Term Care Insurance Partnership (LTCIP) is a joint effort between the federal Medicaid Program, long-term care insurers, and the Wisconsin Department of Health Services (DHS) and Office of the Commissioner of Insurance (OCI). The program's main purpose is to provide an incentive for people to plan for meeting their future long-term care needs, whether in a community-based setting such as their own home, or in a nursing home.

35.1.2 LTCIP Asset Disregard

The LTCIP allows a person with a qualified long-term care insurance policy to have assets disregarded in the Medicaid eligibility determination, while at the same time protecting those assets from Medicaid estate recovery. Under the LTCIP, assets are disregarded when determining eligibility for EBD Medicaid programs, or any of the programs for Medicare beneficiaries (i.e., *QMB*, *SLMB*, SLMB+, *QDWI*), up to the total amount of long-term care services paid by the qualified WI LTCIP policy on or after January 1, 2009. The amount paid out by the qualified LTCIP policy on or after January 1, 2009 is not counted toward the WI Medicaid asset limit, nor is it recoverable under the estate recovery program.

Maximum *Disregard*
The maximum amount that can be disregarded for the purpose of Medicaid eligibility, or protected from estate recovery, is the verified amount of benefits paid out by the qualified WI LTCIP policy on or after January 1, 2009.

The disregarded asset amount is still counted in the Asset Assessment when determining the Community *Spouse* Asset Share (CSAS) in a *Spousal Impoverishment* case. However, the disregarded asset amount is not counted in the individual's eligibility determination.

The disregarded amount is exempt from divestment policies, i.e., transferring assets for less than fair market value up to the LTCIP payout amount will not result in a divestment penalty. However, a divestment may result in a reduction

or elimination of the Medicaid eligibility and estate recovery protections under the LTCIP.

35.1.3 Verification

Verify the following items as described.

35.1.3.1 Verification of the Qualified LTCIP Policy

A "qualified LTCIP policy" must meet all relevant requirements of federal and state law. Qualified LTCIP policies are certified by the Wisconsin Office of the Commissioner of Insurance (OCI). OCI certification of the policy must be verified by assuring that the policy is listed on the OCI website, accessible via the following link:

http://oci.wi.gov/oci_home.htm

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.

35.1.3.3 Verification of Benefits Paid

In addition, the amount paid out by a qualified LTCIP policy must be verified before it can be disregarded for Medicaid eligibility or estate recovery purposes. The qualified LTCIP policy carrier must document the amount paid for benefits on or after January 1, 2009 using the appropriate OCI approved form (OCI 26-114) and provide verification of the pay out amount upon request. Only benefits paid on or after January 1, 2009 may be disregarded when determining eligibility for Medicaid programs. The OCI approved form is accessible via the following link:

http://oci.wi.gov/ociforms/26-114.pdf

35.1.4 Examples

Example 1: Ruth is a resident of a medical care facility. She has no *spouse*. Her qualified $90,000 LTCIP policy has been paying for her care. When Ruth applies for WI Medicaid payment of long-term care services, she verifies that her qualified LTCIP policy has paid out $80,000 in policy benefits since January 1, 2009. Ruth owns the following non-exempt assets:

- $5,000 savings account
- $6,000 checking account
- $70,000 equity value in non-*homestead* property

The worker determines that Ruth's total non-exempt assets equal $81,000 ($5,000 + $6,000 + $70,000). Her WI Medicaid asset limit is $2,000; however, because $80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional $80,000 in non-exempt assets is disregarded. Ruth passes the asset test for WI Medicaid because we disregard $80,000 of her assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away at this point, $80,000 of her assets would be protected from estate recovery.

Example 2: A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full $90,000 since January 1, 2009. Ruth owns the following non-exempt assets:

- $4,000 savings account
- $7,000 checking account
- $80,000 equity value in non-homestead property

The worker determines that Ruth's total non-exempt assets equal $91,000 ($4,000 + $7,000
+ $80,000). Her WI Medicaid asset limit is $2,000; however, because $90,000 has been paid
out by Ruth's qualified LTCIP policy, an additional $90,000 in non-exempt assets is
disregarded. Ruth continues to qualify for WI Medicaid because we disregard $90,000 of her
assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away,
$90,000 of her assets would be protected from estate recovery.

Example 3: Edith is applying for Family Care. She and her spouse reside in their home and have $100,000 in non-exempt assets. Her qualified $80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Edith applies for FC, she verifies that her LTCIP policy has paid out $80,000 in benefits since January 1, 2009. Because this is a Spousal Impoverishment case, an Asset Assessment (AA) must be done to establish the Community Spouse Asset Share. The total $100,000 is used in the AA and the CSAS is set at $50,000. Edith's asset limit of $2,000 is added to the CSAS when determining her eligibility. Since $80,000 of her assets can be disregarded, the remaining non-exempt assets are $20,000 which is less than the $52,000 limit. Prior to her first review (12 months) Edith must transfer, to her spouse, any of her assets that exceed $82,000 (the LTCIP policy pay out amount plus the regular WI Medicaid asset limit of $2,000) to remain eligible.

Example 4: Emma had been residing in a nursing home and had been eligible for
Institutional Medicaid for the past 2 years. Her qualified $90,000 LTCIP policy had been
paying for a portion of her care. As of her last WI Medicaid review, the policy had paid out
$70,000 since January 1, 2009, an amount disregarded in determining her continued
Medicaid eligibility. Ten months after her last review, Emma died. Emma's representatives
verify that, during those ten months, her qualified LTCIP policy paid out an additional
$10,000 toward her long-term care. Emma's estate can protect a total of $80,000 (i.e., the
total amount paid out by the qualified policy) from estate recovery.

Example 5: Joe has a $100,000 home and $100,000 in non-exempt liquid assets. He needs home care and his qualified LTCIP policy begins paying out. By the time Joe applies for Medicaid, his LTCIP policy has paid out $100,000. Joe's can have up to $102,000 in assets ($2,000 limit plus $100,000 disregarded) and still be eligible for Medicaid. His home is an exempt asset and his non exempt assets are less than $102,000 so he qualifies for Family Care.

Over the next few months, Joe decides to give $100,000 to his son. At his annual review, he
reports that he has done so, but because he has given away no more than the LTCIP protected asset amount (i.e., the LTCIP payout amount of $100,000), there is no divestment penalty. However, because he has divested the entire payout amount, he can no longer take advantage of the LTCIP protections with regard to his Medicaid eligibility. That means, when he's tested for Family Care, he must have assets below $2,000 to remain eligible (instead of $102,000). Also, because he already gave away the entire LTCIP protected amount during his lifetime, that amount will not be protected from estate recovery.

35.1.5 Process Help

Until CARES can be updated to accommodate this policy change, the amount of assets that are
disregarded under this policy should be designated as 'unavailable' in CARES. When processing an Asset Assessment (AA) the whole asset amount should be counted as available. Once the AA is completed, update the availability question to indicate the amount paid out by the LTCIP is unavailable. Be sure to document in Case Comments why the asset is being treated as unavailable. The

documentation provided for verification of the LTCIP policy and pay out should be scanned into the ECF under the Asset Information subfolder.

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36 WELL WOMAN MEDICAID (WWMA)

View History

36.1 WISCONSIN WELL WOMAN MEDICAID (WWMA) INTRODUCTION

Wisconsin Well Woman Medicaid (*WWMA*) is administered by the Department of Health Services (DHS) Division of Health Care Access and Accountability (DHCAA) and provides eligible women with access to full benefit Medicaid through non-HMO providers.

Well Woman Medicaid Eligibility

WWMA 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 WWMA:

1. Wisconsin Well Woman Program (*WWWP*),
2. Family Planning Waiver (FPW),
3. BC+ Benchmark Plan, **or**
4. CORE Plan

As long as the woman is enrolled in WWMA, she does not have to reapply for any of the above programs. She will have full benefit *fee-for-service* Medicaid health care coverage through WWMA.

Effective October, 2009, all WWMA enrollments and renewals are administered by EM *CAPO*. The local certifying agencies have no role in recertifications or new WWWMA enrollments, See 36.2.

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View History

36.2 WISCONSIN WELL WOMAN MEDICAID (WWMA) ENROLLMENT

36.2.1 EM CAPO Administrating Enrollment for WWMA
36.2.2 Enrollment Through The Wisconsin Well Woman Program (WWWP)
36.2.2.1Temporary Enrollment / Presumptive Eligibility (TE) Available Only To Women Enrolling Through WWWP
36.2.3 WWWP Clients Enrolling For Continuous WWMA
36.2.3.1 Applications For WWMA Through Well Woman Program (WWWP)
36.2.4 Enrollment For Family Planning Waiver (FPW), BadgerCare Plus CORE and Benchmark Members
36.2.4.1 Applications For Wisconsin Well Woman Medicaid Through the Family Planning Waiver (FPW),BadgerCare Plus CORE or Benchmark Plans

36.2.1 EM CAPO Administrating Enrollment for WWMA

All initial enrollments and renewals for continuous WWWMA are now processed by EM *CAPO*. Temporary Enrollment/Presumptive Eligibility enrollment is still processed by EDS/HP.

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*.

CONTACTS:
EM CAPO: DHSEMCAPO@dhs.wisconsin.gov
Fax: (608) 267-3381
Phone: 1-877-246-2276
Customer line: (608) 266-1720

36.2.2 Enrollment Through The Wisconsin Well Woman Program (WWWP)

The *WWWP* is administered by the DHS Division of Public Health (DPH). WWWP provides eligible women with various health screenings (including breast and cervical cancer screening), referrals, education and outreach.

The WWWP performs the financial and initial non-financial screening for *WWMA* for WWWP enrollees. A WWWP enrollee must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer to be considered for WWMA.

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. They also coordinate the WWWP client's referral to a health care provider for breast and cervical cancer screening.

1. The WWWP LCA will complete the F-4818 (formerly DPH-4818) with the assistance of the applicant prior to the applicant's health care screening. The F-4818 enrolls the woman in WWWP. Her WWWP eligibility will be recorded in interChange as "Med Stat CS".
2. The WWWP client will receive a breast and cervical cancer screening from a WWWP provider. If the WWWP client 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 & date the F-10075. The WWWP client 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 WWMA on the F-10075
4. The provider will forward a copy of the F-10075 to the WWWP LCA.

5. The LCA will provide the client with a copy of the signed F-10075 and F-4818 forms.
6. The LCA will check to be sure correct temporary eligibility dates (if appropriate) are entered on the F-10075 and explain that the client's temporary enrollment for WWMA 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

Temporary Enrollment (TE) for WWMA is available for women to assure immediate access to cancer treatment. The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the F-10075. The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.

The 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 a ForwardHealth card with the temporary enrollment dates activated on the card. (If the client 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:

1. WWWP Enrollment Form F-4818
2. WWMA Determination Form (F-10075).

To continue receiving WWMA, the member or the Local Coordinating agency must submit an F-10075 to the CAPO. If the member does not apply, her WWMA 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 CAPO is not able to process her application, within the 30-day processing time frame, the CAPO will extend the members's 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 WWMA

36.2.3.1 Applications For WWMA Through Well Woman Program (WWWP)

To apply for WWMA through the WWWP, the applicant or the Local Coordinating agency must send or fax the completed F-4818 and F-10075 forms to the CAPO. The applicant may apply for WWMA 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-4818 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 WWMA:

1. Review the F-4818 . There should be a ”No” answer to the following questions:

    a. Does the applicant have any health insurance? (Item #32 on F-4818)
    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 WWMA.

    b. Does the applicant have Medicare Part B? (Item #33 on F-4818)

    c. 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 WWMA. The CAPO will refer her back to the Well Woman Program and send a manual negative notice.

2. Review the F-4818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, and 27-45.

If the form is incomplete, the 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-4818 (# 6a); the CAPO will ask the applicant to provide her SSN. Providing an SSN for the Well Woman Program is voluntary, but providing an SSN, or applying for one, is required for WWMA

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 WWMA 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 Well Woman Program, 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 Well Woman Program Local Coordinating Agency.

6. The 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:

      EDS Attn: Eligibility Lead Worker WWWMA
      6406 Bridge Rd.
      Madison, WI 53716

   b. E-mail: veds3070@wisconsin.gov
      When submitting an e-F-10110 (formerly DES 3070), enter *Attn: Eligibility Lead Worker WWWMA* in the Comments" section.

   c. FAX: (608) 221-8815

   d. 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 Well Woman Medicaid prior to her date of diagnosis.

Example 1: Gina applies for Well Woman Medicaid (WWMA) at the Local Coordinating Agency (LCA) on September 20th 2009. The LCA submits the F-4818 and F 10075 to CAPO. The F-10075 indicates that Gina is enrolled in Well Woman Program (WWWP). The LCA provides a copy of the F-4818 documenting Gina's enrollment in the WWWP. Gina's date of diagnosis on the F-10075 is August 6th 2009. Gina meets the following non-financial requirements: citizenship/ID documentation, provides a valid SSN and has no public or private insurance that will cover her cancer treatment and she is under 65 years of age.

CAPO will certify Gina in interChange (iC) effective August 6th, 2009 through July 31 2010 with a CB medical status code. CAPO will send Gina a notice indicating her eligibility dates. About one month from the end of Gina's eligibility period, CAPO will send Gina a recertification notice indicating she needs to recertify for WWMA.

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

To contact the Local Coordinating Agencies refer to #27 of F-4818.

36.2.4 Enrollment For Family Planning Waiver (FPW), BadgerCare Plus CORE and Benchmark Members

Women enrolled in the Family Planning Waiver program (FPW), CORE, or Benchmark programs who meet the following criteria (regardless of age), will be eligible for WWMA. These are women who:

1. Are screened for, and diagnosed with, cervical cancer or a precancerous condition of the cervix, **or**

2. Receive a clinical breast exam through a Family Planning Waiver provider and through follow up medical testing (independent of the FPW,) ,or are screened for and are diagnosed with breast cancer while enrolled in the BadgerCare Plus CORE or Benchmark plans, and

a. Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition **and**
b. do not have other insurance that would cover their cancer treatment.

36.2.4.1 Applications For Wisconsin Well Woman Medicaid Through the Family Planning Waiver (FPW), BadgerCare Plus CORE or Benchmark Plans

A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a FPW member or her representative is a request to enroll in Well Woman Medicaid and disenroll from FPW. Women 15 through 44 years of age, enrolled in FPW in CARES who meet the criteria 36.2.3 Enrollment For Family Planning Waiver Members above, will be eligible for Well Woman Medicaid.

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

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36.3 WISCONSIN WELL WOMAN MEDICAID (WWMA) NONFINANCIAL REQUIREMENT

36.3.1 WWMA Introduction
36.3.2 Disqualifying Insurance Coverage
36.3.3 Non-Disqualifying Insurance Coverage

36.3.1 WWMA Introduction

The following are Wisconsin Well Woman Medicaid specific non-financial requirements:

1. Live in Wisconsin,
2. Meet general EBD citizenship and ID requirements.
3. Be under age 65.
4. Have been screened for breast or cervical cancer by the Well Woman Program, or enrolled in the Family Planning Waiver, CORE or Benchmark programs.
5. Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the clinical screener.
6. Require treatment for the breast or cervical cancer, or pre-cancerous conditions of the cervix, as identified by the clinical screener.
7. Not be eligible for BC+ without a premium or EBD MA.
8. Meet the insurance coverage requirements listed below in 36.3.2 Disqualifying Insurance Coverage

36.3.2 Disqualifying Insurance Coverage

A woman is ineligible for Wisconsin Well Woman Medicaid if she is currently covered by *any* one of the following:

1. Group health plans that cover treatment for her breast or cervical cancer,
2. Full benefit health insurance that covers treatment for her breast or cervical cancer,
3. Medicare Part A,
4. Medicare Part B,
5. BC+ without a premium or any other category of full benefit Medicaid that covers her treatment for breast or cervical cancer (Note: An unmet deductible is not full benefit Medicaid),

6. Veteran's benefits/TRICARE that cover treatment for her breast or cervical cancer,
7. HIRSP,
8. Federal employee health plans,
9. Peace Corps health plans, **or**
10. Other full benefit private or public health care plans that provide cancer treatment as determined by her health care team.

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits *do not* disqualify an *applicant* from Wisconsin Well Woman Medicaid:

    a. Coverage only for accident or *disability* income insurance, or any combination thereof,
    b. Liability insurance including general liability insurance and automobile liability insurance,
    c. Workers' compensation or similar insurance, credit-only insurance,
    d. Coverage for on-site medical clinics,
    e. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits,
    f. Indian Health Services,
    g. Non-coverage of cancer treatment due to waiting period, **or**
    h. Non-coverage of breast or cervical cancer treatment due to exclusion (max out) of cancer treatment in the policy.

2. Separate health insurance benefits that are not considered health insurance if offered separately are:

    a. Limited scope dental or vision benefits, **or**
    b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.

3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (for example,, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance).

4. Separate insurance policies are not considered health insurance if offered as a separate insurance (Wrap Around) policy:

    a. Coverage supplemental to military insurance (ex., TRICARE wrap around), **or**
    b. Similar "wrap around" supplemental coverage under a group health plan.

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: Medicare Parts A or B will disqualify an applicant from Wisconsin Well Woman Medicaid eligibility.

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36.4 WISCONSIN WELL WOMAN MEDICAID (WWMA) FINANCIAL REQUIREMENT

Because enrollment in *WWMA* is dependent on financial eligibility for a gatepost program, there are no financial requirements for WWMA.

Do not test for assets or income. Financial requirements are addressed through the *WWWP*, FPW, or BadgerCare Plus CORE or Benchmark enrollment process. See the BC+ Handbook Chs.16-20 for BadgerCare Plus and Ch. 40 for FPW.

Once a woman is enrolled in WWMA, she may not be financially tested as a condition of her continuing eligibility in WWMA.

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36.5 WISCONSIN WELL WOMAN MEDICAID (WWMA) CHANGES AND TRANSFERS

36.5.1 Member Loses Eligibility
36.5.2 WWMA InterAgency Case Transfers

36.5.1 Member Loses Eligibility

WWMA recipients are required to report changes that would affect eligibility. Reported changes that result in the WWMA case closing are:

1. Reaching the age of 65 years,
2. Moving out of state,
3. Reporting that she no longer needs treatment for breast or cervical cancer,
4. Obtaining health insurance that covers her treatment for breast or cervical cancer, **or**
5. Obtaining Medicare Part A, Part B, or both.

If a case closes, the *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 WWMA. 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 WWMA InterAgency Case Transfers

All WWMA cases are now processed through the CAPO. There should be no interagency transfers.

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36.6 WISCONSIN WELL WOMAN MEDICAID (WWMA) REVIEWS /RECERTIFICATIONS

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

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

1. **Email**: DHSEMCAPO@dhs.wisconsin.gov,
2. **Fax**: (608) 267-3381, **or**
3. **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 WWMA 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 CAPO sends a manual positive notice if all requirements are met.

The 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 WWMA Changes.

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37 IRIS

View History

37.1 IRIS (INCLUDE, RESPECT, I SELF-DIRECT)

37.1.1 Introduction
37.1.2 Role of the Aging and Disability Resource Center
37.1.3 IRIS Eligibility
37.1.4 IRIS In CARES

37.1.1 Introduction

The Include, Respect I Self-Direct (IRIS) program is a fee for service alternative to Family Care, PACE or Partnership for individuals requesting a long-term care support program in Family Care counties.

Under IRIS, the participant will be able to access services comparable to those provided under the Home- and Community-Based Waivers (HCBW) while managing an individual budget to meet their service needs.

37.1.2 Role of the Aging and Disability Resource Center

Since self-directed supports are also available under the Family Care program, participants must be fully aware of the available choices and understand the implications of choosing one option over the other in order to make a meaningful

decision. Aging and Disability Resource Centers (ADRCs) will be responsible for informing participants of all available options through an objective enrollment counseling process.

ADRCs will inform IM agencies of persons choosing to enroll in IRIS and provide the IM worker with certain information necessary to determine IRIS eligibility, such as functional eligibility information, medical/remedial expenses, and program start date.

37.1.3 IRIS Eligibility

The IRIS option is available to people living in Family Care counties when they come to the ADRC and are found in need of publicly-funded long term care services. It is also available to Family Care members (and Partnership members, if Partnership is also operated in the county) if the member requests to change to IRIS. (Such individuals would need to be disenrolled from their managed care long-term support program in order to participate in IRIS).

Individuals who wish to participate in IRIS must meet the following criteria in order to qualify:

- Reside in a county operating Family Care,
- Have a nursing home level of care as determined by the LTC Functional Screen, **and**
- All Medicaid Home- and Community-Based waiver financial and non-financial eligibility criteria

37.1.4 IRIS In CARES

IRIS Waivers should be entered in CARES using the OP Program Type code. IRIS cost share information will not be available on the cost share reports produced for Family Care and Partnership members, IM workers may have to provide this information to the ADRC if the ADRC is not able to query the budget pages in CWW.

38 RESERVED

CH. 35-38 RESERVED

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APPENDIX (CHS. 39-40)

39 TABLES

39.1 LIFE ESTATE AND REMAINDER INTEREST

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	42	.90457	.09543
1	.98988	.01012	43	.89855	.10145
2	.99017	.00983	44	.89221	.10779
3	.99008	.00992	45	.88558	.11442
4	.98981	.01019	46	.87863	.12137
5	.98938	.01062	47	.87137	.12863
6	.98884	.01116	48	.86374	.13626
7	.98822	.01178	49	.85578	.14422
8	.98748	.01252	50	.84743	.15257
9	.98663	.01337	51	.83674	.16126
10	.98565	.01435	52	.82969	.17031
11	.98453	.01547	53	.82028	.17972
12	.98329	.01671	54	.81054	.18946
13	.98198	.01802	55	.80046	.19954
14	.98066	.01934	56	.79006	.20994
15	.97937	.02063	57	.77931	.22068
16	.97815	.02185	58	.76822	.23178
17	.97700	.02300	59	.75675	.24325
18	.97590	.02410	60	.74491	.25509
19	.97480	.02520	61	.73267	.26733
20	.97365	.02635	62	.72002	.27998
21	.97245	.02755	63	.70696	.29304
22	.97120	.02880	64	.69352	.30648
23	.96986	.03014	65	.67970	.32030
24	.96841	.03159	66	.66551	.33449
25	.96678	.03322	67	.65098	.34902
26	.96495	.03505	68	.63610	.36390
27	.96290	.03710	69	.62086	.37914
28	.96062	.03938	70	.60522	.39478
29	.95813	.04187	71	.58914	.41086
30	.95543	.04457	72	.57261	.42739
31	.95254	.04746	73	.55571	.44429

32	.94942	.05058	74	.53862	.46138
33 34 35	.94608 .94250 .93868	.05392 .05750 .06132	75 76 77	.52149 .50441 .48742	.47851 .49559 .51258
36 37 38	.93460 .93026 .92567	.06540 .06974 .07433	78 79 80	.47049 .45357 .43659	.52951 .54643 .56341
39 40 41	.92083 .91571 .91030	.07917 .08429 .08970	81 82 83	.41967 .40295 .38642	.58033 .59705 .61358

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
84 85 86	.36998 .35359 .33764	.63002 .64641 .66236	99 100 101	.20486 .19975 .19532	.79514 .80025 .80468
87 88 89	.32262 .30859 .29526	.67738 .69141 .70474	102 103 104	.19054 .18437 .17856	.80946 .81563 .82144
90 91 92	.28221 .26955 .25771	.71779 .73045 .74229	105 106 107	.16962 .15488 .13409	.83038 .84512 .86591
93 94 95	.24692 .23728 .22887	.75308 .76272 .77113	108 109	.10068 .04545	.89932 .95455
96 97 98	.22181 .21550 .21000	.77819 .78450 .79000			

The source of the Life Estate & Remainder Interest Table is 26 CFR 20.2031 (49 Federal Register, Vol. 49, No. 93, May 11, 1984). The version of the table published here is from the Social Security Administration's Policy & Operations Manual Series (POMS), Section 01140.120.

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39.2 COUNTY & TRIBE AREA

39.2.1 Area 1

39.2.2 Area 2

Use this list to determine which column to use in the AFDC-related categorically needy income test. If a municipality is in 2 counties, use the area for the county in which the Medicaid fiscal group resides. If a pregnant woman is in a maternity home, use the area in which the home is located, even though the county of residence making the payment is in the other area. For example, if her county of residence is Vilas (Area 2) and she is in a maternity home in Milwaukee (Area 1), Vilas county pays at the Area 1 rate.

39.2.1 Area 1

Brown	Kenosha	Outagamie	Sheboygan
Dane	La Crosse	Ozaukee	Washington
Dodge	Marathon	Racine	Waukesha
Dunn	Manitowoc	Rock	Winnebago
Eau Claire	Milwaukee	St. Croix	Winnebago Tribe*
Fond du Lac			

39.2.2 Area 2

Adams
Ashland
Bad River
Barron
Bayfield
Buffalo
Calumet
Chippewa
Clark
Columbia
Crawford
Door
Douglas
Florence
Forest
Green
Green Lake
Grant
Iowa
Iron
Jackson
Jefferson
Juneau

Kewaunee
Lafayette
Langlade
Lincoln
Marinette
Marquette
Menominee
Monroe
Oconto
Oneida
Pepin
Pierce
Polk
Portage
Price
Richland
Rusk
Sauk
Sawyer
Shawano
Taylor
Trempeleau
Vernon
Vilas
Walworth
Washburn
Waupaca
Waushara

Lac Courte Oreilles
Lac du Flambeau
Menominee Tribe
Mole Lake
Potawatomi
Red Cliff
St.Croix Tribe
Stockbridge -Munsee
Winnebago Tribe

*Only if residing on tax-free land in La Crosse or Marathon County. All other locations are Area 2.

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39.3 AFDC-RELATED INCOME TABLE

Group Size	Categorically Needy		Medically Needy
	Area I	**Area II**	
1	$ 311	$ 301	$ 591.67
2	$ 550	$ 533	$ 591.67
3	$ 647	$ 626	$ 689.33
4	$ 772	$ 749	$ 822.67
5	$ 886	$ 861	$ 944.00
6	$ 958	$ 929	$1,021.33
7	$ 1,037	$ 1,007	$1,105.33
8	$ 1,099	$ 1,068	$1,172.00
9	$ 1,151	$ 1,117	$1,226.67
10	$ 1,179	$ 1,143	$1,257.33
11	$ 1,204	$1,168	$1,284.00
12	$1,229	$1,193	$1,310.67
13	$1,254	$1,218	$1,337.33
14	$1,279	$1,243	$1,364.00
15	$1,304	$1,268	$1,390.67
16	$1,329	$1,293	$1,417.33
17	$1,354	$1,318	$1,444.00
18	$1,379	$1,343	$1,470.67

+	+25 each person above 18	+25 each person above 18	+26.67 each person above 18

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39.4 ELDERLY, BLIND, AND DISABLED (EBD) ASSETS & INCOME TABLES

39.4.1 EBD Assets and Income Table
39.4.2 EBD Deductions and Allowances

39.4.1 EBD Assets and Income Table

Group Size				
Category		**1**		**2**
EBD Categorically Needy Limits	**Assets**	$2,000	**Assets**	$3,000
	Income	$533.11 (+ actual shelter up to $224.67)	**Income**	$806.05 (+ actual shelter up to $337.00)
EBD Medically Needy Limits	**Assets**	$2,000	**Assets**	$3,000
	Income	$591.67	**Income**	$591.67
SSI Payment Level				
Federal SSI Payment Level	**Income**	$674.00	**Income**	$1,011.00

State Supplementary Payment (SSP)	**Income**	$ 83.78	**Income**	$132.05
Total	**Income**	$757.78	**Income**	$1,143.05
SSI Payment Level + E Supplement	**Income**	$853.77		
SSI E Supplement	**Income**	$95.99		
Community Waivers Special Income Limit	**Income**	$2,022.00	**Income**	
Institutions Categorically Needy Income Limit	**Income**	$2,022.00		
Substantial Gainful Activity limit (non-blind individuals)	**Income**	$980		
Substantial Gainful Activity limit (blind individuals)	**Income**	$1640		

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		$2,022.00
3	EBD Deeming Amount to an Ineligible *Minor*		$337.00
4	Community Waivers Basic Needs Allowance		$854.00
5	Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$674.00 $1,011.00
6	*MAPP Standard Living Allowance (SLA)* SLA = SSI + State Supplement + $20		$777.00
7	*Community Spouse* Lower Income Allocation Limit		$2428.33
8	Community *Spouse* Excess Shelter Cost Limit		$728.50
9	Family *Member* Income Allowance		$607.08

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39.5 FEDERAL POVERTY LEVEL (FPL) TABLE

					2009 Federal Poverty Level Based Income Limits							
		QMB Income Limit	SLMB	QI-1	BC+ Adult & MAPP premium limit	SeniorCare Tier One Limit	BC+ EE for Kids Ages 1-5	QDWI & Lower Spousal Impov.	SeniorCare Tier Three Limit	MAPP Income Limit	BC+ Pregnant Women Income	Excess Shelter Allowance
		BC+ Extns. Trigger		(SLMB+) Income Limit				BC+ kids premiums				
								BC+ Adults Eligibility Limit				
	Annual				←		**Monthly**			→		
group size	Annual FPL	100% FPL	120% FPL	135% FPL	150% FPL	160% FPL	185% FPL	200% FPL	240% FPL	250% FPL	300% FPL	30% of 200% FPL
1	$10,830	$902.50	$1,083.00	$1,218.38	$1,353.75	$1,444.00	$1,669.63	$1,805.00	$2,166.00	$2,256.25	$2,707.50	-
2	14,570	$1,214.17	$1,457.00	$1,639.13	$1,821.25	$1,942.67	$2,246.21	$2,428.33	$2,914.00	$3,035.42	$3,642.50	$728.50
3	18,310	$1,525.83	$1,831.00	$2,059.88	$2,288.75	$2,441.33	$2,822.79	$3,051.67	$3,662.00	$3,814.58	$4,577.50	-
4	22,050	$1,837.50	$2,205.00	$2,480.63	$2,756.25	$2,940.00	$3,399.38	$3,675.00	$4,410.00	$4,593.75	$5,512.50	-
5	25,790	$2,149.17	$2,579.00	$2,901.38	$3,223.75	$3,438.67	$3,975.96	$4,298.33	$5,158.00	$5,372.92	$6,447.50	-
6	29,530	$2,460.83	$2,953.00	$3,322.13	$3,691.25	$3,937.33	$4,552.54	$4,921.67	$5,906.00	$6,152.08	$7,382.50	-
7	33,270	$2,772.50	$3,327.00	$3,742.88	$4,158.75	$4,436.00	$5,129.13	$5,545.00	$6,654.00	$6,931.25	$8,317.50	-
8	37,010	$3,084.17	$3,701.00	$4,163.63	$4,626.25	$4,934.67	$5,705.71	$6,168.33	$7,402.00	$7,710.42	$9,252.50	-
9	40,750	$3,395.83	$4,075.00	$4,584.38	$5,093.75	$5,433.33	$6,282.29	$6,791.67	$8,150.00	$8,489.58	$10,187.50	-
10	44,490	$3,707.50	$4,449.00	$5,005.13	$5,561.25	$5,932.00	$6,858.88	$7,415.00	$8,898.00	$9,268.75	$11,122.50	-
11	48,230	$4,019.17	$4,823.00	$5,425.88	$6,028.75	$6,430.67	$7,435.46	$8,038.33	$9,646.00	$10,047.92	$12,057.50	-
12	51,970	$4,330.83	$5,197.00	$5,846.63	$6,496.25	$6,929.33	$8,012.04	$8,661.67	$10,394.00	$10,827.08	$12,992.50	-
13	55,710	$4,642.50	$5,571.00	$6,267.38	$6,963.75	$7,428.00	$8,588.63	$9,285.00	$11,142.00	$11,606.25	$13,927.50	-
14	59,450	$4,954.17	$5,945.00	$6,688.13	$7,431.25	$7,926.67	$9,165.21	$9,908.33	$11,890.00	$12,385.42	$14,862.50	-
15	63,190	$5,265.83	$6,319.00	$7,108.88	$7,898.75	$8,425.33	$9,741.79	$10,531.67	$12,638.00	$13,164.58	$15,797.50	-
16	66,930	$5,577.50	$6,693.00	$7,529.63	$8,366.25	$8,924.00	$10,318.38	$11,155.00	$13,386.00	$13,943.75	$16,732.50	-
17	70,670	$5,889.17	$7,067.00	$7,950.38	$8,833.75	$9,422.67	$10,894.96	$11,778.33	$14,134.00	$14,722.92	$17,667.50	-
18	74,410	$6,200.83	$7,441.00	$8,371.13	$9,301.25	$9,921.33	$11,471.54	$12,401.67	$14,882.00	$15,502.08	$18,602.50	-
19	78,150	$6,512.50	$7,815.00	$8,791.88	$9,768.75	$10,420.00	$12,048.13	$13,025.00	$15,630.00	$16,281.25	$19,537.50	-
20	81,890	$6,824.17	$8,189.00	$9,212.63	$10,236.25	$10,918.67	$12,624.71	$13,648.33	$16,378.00	$17,060.42	$20,472.50	-
21	85,630	$7,135.83	$8,563.00	$9,633.38	$10,703.75	$11,417.33	$13,201.29	$14,271.67	$17,126.00	$17,839.58	$21,407.50	-
22	89,370	$7,447.50	$8,937.00	$10,054.13	$11,171.25	$11,916.00	$13,777.88	$14,895.00	$17,874.00	$18,618.75	$22,342.50	-
23	93,110	$7,759.17	$9,311.00	$10,474.88	$11,638.75	$12,414.67	$14,354.46	$15,518.33	$18,622.00	$19,397.92	$23,277.50	-
24	96,850	$8,070.83	$9,685.00	$10,895.63	$12,106.25	$12,913.33	$14,931.04	$16,141.67	$19,370.00	$20,177.08	$24,212.50	-
each additional person	$3,740	$311.67	$374.00	$420.75	$467.50	$498.67	$576.58	$623.33	$748.00	$779.17	$935.00	-
					Annual figures:	$17,328.00		$21,660.00	$25,992.00			
						$23,312.04		$29,139.96	$34,968.00			

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39.6 COST OF LIVING ADJUSTMENT (COLA)

To calculate the Cost-of-Living Adjustment (*COLA*) *disregard* amount, do the following:

1. Find the AG's current gross Old Age Survivors *Disability* Insurance (*OASDI*) Benefits income. The gross OASDI income is the amount of the OASDI check **plus** any amount that has been withheld for a Medicare premium **plus** any amount with-held to repay an earlier overpayment. Do not include in the *gross income* any Medicare Plan B premiums which the State has purchased for the AG.

2. On the COLA *Disregard* Amount Table below find the last month in which the person was eligible for and received a check for both OASDI and Supplemental Security Income (*SSI*).

3. Find the decimal figure that applies to this month.

4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount Table	
January - December 2009	0.054820416
January - December 2008	0.076070788
January - December 2007	0.105586435
January -December 2006	0.140813098
January -December 2005	0.163401264

January -December 2004	0.180608486
January - December 2003	0.191921584
January - December 2002	0.212399205
January - December 2001	0.239033048
January - December 2000	0.256868211
January - December 1999	0.266404946
January - December 1998	0.281493581
January - December 1997	0.301743033
January - December 1996	0.319437654
January -December 1995	0.337974372
January -December 1994	0.35475085
January -December 1993	0.373544514
January -December 1992	0.395896349
January -December 1991	0.426846631
January -December 1990	0.452575579
January -December 1989	0.473630365
January -December 1988	0.494846799

January -December 1987	0.501329515
January -December 1986	0.516323487
January -December 1985	0.532679698
January -December 1984	0.5484828
July 1983- December 1983	0.579592923
July 1982-June 1983	0.621936082
July 1981-June 1982	0.669235418
July 1980-June 1981	0.699031317
July 1979-June 1980	0.717400298
July 1978-June 1979	0.733144757

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39.7 HOSPITAL DAILY RATES

City	Hospital Name	Average IP Daily Charge Based on Gross Inpatient Revenue*
Amery	Amery Regional Medical Center	2,089.80
Antigo	Langlade Memorial Hospital	2,138.75
Appleton	Appleton Medical Center	2,619.86
Appleton	St. Elizabeth Hospital	2,116.37

Arcadia	Franciscan Skemp Healthcare-Arcadia	3,092.15
Ashland	Memorial Medical Center, Inc.	1,482.73
Baldwin	Baldwin Area Medical Center, Inc.	2,533.16
Baraboo	St. Clare Hospital and Health Services	2,179.26
Barron	Barron Medical Center, Mayo Health System	1,954.05
Beaver Dam	Beaver Dam Community Hospitals, Inc.	2,668.64
Beloit	Beloit Memorial Hospital, Inc.	2,372.91
Berlin	Berlin Memorial Hospital	2,281.50
Black River Falls	Black River Memorial Hospital	2,008.27
Bloomer	Bloomer Medical Center, Mayo Health System, Inc.	2,650.71
Boscobel	Boscobel Area Health Care	2,223.16
Brookfield	Elmbrook Memorial Hospital	2,939.91
Burlington	Memorial Hospital Corporation of Burlington	3,388.85
Chilton	Calumet Medical Center, Inc.	2,275.09
Chippewa Falls	St. Joseph's Hospital	1,328.26
Columbus	Columbus Community Hospital, Inc.	2,189.11
Cumberland	Cumberland Memorial Hospital and ECU	1,401.31
Darlington	Memorial Hospital of Lafayette County	2,176.27
Dodgeville	Upland Hills Health	2,319.07
Durand	Chippewa Valley Hospital	4,079.93
Eagle River	Eagle River Memorial Hospital, Inc.	2,089.94
Eau Claire	Luther Hospital	2,856.90
Eau Claire	Sacred Heart Hospital	2,048.11
Edgerton	Memorial Community Hospital	4,277.41
Elkhorn	Lakeland Medical Center, Inc.	2,818.54
Fond du Lac	Agnesian HealthCare, Inc.	2,038.43
Fond Du Lac	Fond du Lac County Department of Com. Prog.	542.75
Fort Atkinson	Fort Atkinson Memorial Health Services	1,611.49

Friendship	Adams County Memorial Hospital	2,122.78
Grantsburg	Burnett Medical Center, Inc.	2,463.85
Green Bay	Bellin Memorial Hospital	3,203.79
Green Bay	Bellin Psychiatric Center	1,127.78
Green Bay	Brown County Mental Health Center	604.30
Green Bay	Libertas Treatment Center	599.69
Green Bay	St. Mary's Hospital Medical Center	2,150.08
Green Bay	St. Vincent Hospital	2,181.42
Greenfield	Kindred Hospital-Milwaukee	2,863.08
Hartford	Aurora Medical Center	1,951.60
Hayward	Hayward Area Memorial Hospital	2,499.17
Hillsboro	St. Joseph's Comm. Health Services, Inc.	3,214.87
Hudson	Hudson Hospital	3,123.36
Janesville	Mercy Health System Corporation	2,959.12
Janesville	Rock County Psychiatric Hospital	627.07
Kenosha	Aurora Medical Center - Kenosha	3,394.71
Kenosha	Children's Hospital of WI, Inc. - Kenosha	1,583.90
Kenosha	Kenosha Hospital and Medical Center	3,002.25
La Crosse	Franciscan Skemp Healthcare - La Crosse	2,472.35
La Crosse	Gundersen Lutheran Medical Center, Inc.	3,399.28
Ladysmith	Rusk Co. Memorial Hospital and Nursing Home	1,713.81
Lancaster	Grant Regional Health Center, Inc.	2,827.16
Madison	Mendota Mental Health Institute	577.84
Madison	Meriter Hospital, Inc.	2,740.11
Madison	St. Mary’s Hospital Medical Center	2,785.67
Madison	University of WI Hospital and Clinics Authority	3,171.65
Manitowoc	Holy Family Memorial Medical Center	2,349.37
Marinette	Bay Area Medical Center	1,985.82
Marshfield	Norwood Health Center	662.10
Marshfield	Saint Joseph's Hospital	2,693.24

Mauston	Hess Memorial Hospital	2,500.85
Medford	Memorial Health Center, Inc.	2,079.43
Menomonee Falls	Community Memorial Hospital	2,527.08
Menomonie	Myrtle Werth Hospital-Mayo Health System	2,020.15
Mequon	St. Mary's Hospital-Ozaukee	2,626.39
Merrill	Good Samaritan Health Center	1,862.32
Milwaukee	Aurora Sinai Medical Center	3,504.31
Milwaukee	Children's Hospital of Wisconsin	4,109.72
Milwaukee	Columbia Hospital, Inc.	3,142.63
Milwaukee	Froedtert Memorial Lutheran Hospital	3,763.75
Milwaukee	Milwaukee County Mental Health Complex	658.69
Milwaukee	Sacred Heart Rehabilitation Institute	1,590.18
Milwaukee	St. Joseph's Hospital	2,870.63
Milwaukee	St. Luke's Medical Center	4,194.60
Milwaukee	St. Mary's Hospital-Milwaukee	3,038.61
Milwaukee	St. Michael Hospital	3,041.39
Monroe	The Monroe Clinic	2,821.34
Neenah	Theda Clark Medical Center	2,123.14
Neillsville	Memorial Hospital, Inc	2,546.27
New London	New London Family Medical Center	2,048.86
New Richmond	Holy Family Hospital	2,331.20
Oconomowoc	Oconomowoc Memorial Hospital	2,756.58
Oconomowoc	Rogers Memorial Hospital	845.81
Oconto	Oconto Memorial Hospital, Inc.	2,419.99
Oconto Falls	Community Memorial Hospital	2,436.47
Osceola	Osceola Medical Center	2,533.79
Oshkosh	Mercy Medical Center of Oshkosh	2,204.91
Osseo	Osseo Area Hospital and Nursing Home, Inc.	8,485.86
Park Falls	Flambeau Hospital, Inc.	2,149.84
Platteville	Southwest Health Center, Inc.	2,053.36
Portage	Divine Savior Healthcare	2,096.57

Prairie Du Chien	Prairie du Chien Memorial Hospital	2,986.91
Prairie Du Sac	Sauk Prairie Memorial Hospital	2,575.36
Racine	All Saints-St. Luke's Hospital, Inc.	1,500.18
Racine	All Saints-St. Mary's Medical Center, Inc.	2,203.06
Reedsburg	Reedsburg Area Medical Center	2,252.02
Rhinelander	Saint Mary's Hospital, Inc.	2,601.07
Rice Lake	Lakeview Medical Center	1,649.24
Richland Center	The Richland Hospital, Inc.	2,376.05
Ripon	Ripon Medical Center	2,345.92
River Falls	River Falls Area Hospital	2,771.15
Shawano	Shawano Medical Center	1,945.56
Sheboygan	Sheboygan Memorial/Valley View Medical Center	2,414.85
Sheboygan	St. Nicholas Hospital	1,870.69
Shell Lake	Indianhead Medical Center Shell Lake, Inc.	1,889.70
Sparta	Franciscan Skemp Healthcare-Sparta	2,503.34
Spooner	Spooner Health System	2,063.49
St. Croix Falls	St. Croix Regional Medical Center, Inc.	2,738.80
Stanley	Victory Medical Center	2,768.09
Stevens Point	Saint Michael's Hospital	2,016.21
Stoughton	Stoughton Hospital Association	1,945.35
Sturgeon Bay	Door County Memorial Hospital	3,027.83
Superior	St. Mary's Hospital of Superior	1,959.67
Tomah	Tomah Memorial Hospital, Inc.	1,660.85
Tomahawk	Sacred Heart Hospital, Inc.	1,350.84
Two Rivers	Aurora Medical Center of Manitowoc City, Inc.	2,441.01
Viroqua	Vernon Memorial Hospital	2,196.89
Waterford	Lakeview NeuroRehab Center Midwest	1,655.79
Watertown	Watertown Memorial Hospital	2,476.15
Waukesha	Waukesha County Mental Health Center	694.85

Waukesha	Waukesha Memorial Hospital, Inc.	2,691.44
Waupaca	Riverside Medical Center	1,958.61
Waupun	Waupun Memorial Hospital	1,903.18
Wausau	North Central Health Care Facilities	694.88
Wausau	Wausau Hospital	2,602.82
Wauwatosa	Aurora Psychiatric Hospital	1,075.72
West Allis	Rogers Memorial Hospital - Milwaukee	1,674.72
West Allis	Select Specialty Hospital	2,372.35
West Allis	West Allis Memorial Hospital	3,282.94
West Bend	St. Joseph's Community Hospital	1,758.48
Whitehall	Tri-County Memorial Hospital, Inc.	2,472.95
Wild Rose	Wild Rose Community Memorial Hospital Inc.	2,077.47
Winnebago	Winnebago Mental Health Institute	457.54
Wisconsin Rapids	Riverview Hospital Association	1,934.27
Woodruff	Howard Young Medical Center, Inc.	2,509.65

Data Source: Gross Inpatient Revenue and Total Discharge Days, 2001 Wisconsin Hospital Fiscal Survey

* Average Daily Charge is the sum of Gross Inpatient Revenue and Gross Inpatient Ancillary Revenue divided by Total Discharge Days.

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39.8 LIFE EXPECTANCY TABLE

See the Life Expectancy Table at Social Security Administration site.

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39.9 BADGERCARE PREMIUMS

See the BadgerCare + handbook Section 48 for BC+ premiums

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39.10 MAPP PREMIUMS

MAPP Premiums - Income exceeds 150% of the FPL

MAPP PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
$0	$25.00	$0.00	500.01	525.00	500.00
25.01	50.00	25.00	525.01	550.00	525.00
50.01	75.00	50.00	550.01	575.00	550.00
75.01	100.00	75.00	575.01	600.00	575.00
100.01	125.00	100.00	600.01	625.00	600.00
125.01	150.00	125.00	625.01	650.00	625.00
150.01	175.00	150.00	650.01	675.00	650.00
175.01	200.00	175.00	675.01	700.00	675.00
200.01	225.00	200.00	700.01	725.00	700.00
225.01	250.00	225.00	725.01	750.00	725.00
250.01	275.00	250.00	750.01	775.00	750.00

275.01	300.00	275.00	775.01	800.00	775.00
300.01	325.00	300.00	800.01	825.00	800.00
325.01	350.00	325.00	825.01	850.00	825.00
350.01	375.00	350.00	850.01	875.00	850.00
375.01	400.00	375.00	875.01	900.00	875.00
400.01	425.00	400.00	900.01	925.00	900.00
425.01	450.00	425.00	925.01	950.00	925.00
450.01	475.00	450.00	950.01	975.00	950.00
475.01	500.00	475.00	975.01	1000.00	975.00
			1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than $1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

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39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS

39.11.1 SC Income Limits Introduction
39.11.2. Level 1 : Co-Payment
39.11.3 Level 2a: Deductible
39.11.4 Level 2b: Deductible
39.11.5. Level 3: Spenddown
    39.11.5.1 Level 3: FTG of One
    39.11.5.2 Level 3: FTG of Two

39.11.1 SC Income Limits Introduction

For applicants determined eligible, *SC* pays for a portion of covered prescription drugs (See 33.6 SC Financial Requirements), depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his/her annual *income* and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

1. **Level 1:** Co-Payment (Annual income is at or below 160% of the FPL.)
2. **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
3. **Level 2b**: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
4. **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL is set annually by the Department of Health Services see 39.5 FPL Table

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $17,328 per individual or $23,312 per couple annually.*	▪ No deductible or spenddown. ▪ $5 co-pay for each covered generic prescription drug. ▪ $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL** $17,329 to $21,660 per individual and $23,313 to $29,140 per couple annually.*	▪ $500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the $500 deductible is met. ▪ After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% - and at or**	▪ $850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the $850 deductible

below 240% of FPL $21,661 to $25,992 per individual and $29,141 to $34,968 per couple annually.	is met. ▪ After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $25,993 or higher per individual and $34,969 or higher per couple annually.*	▪ Pay retail price for drugs equal to the difference between your income and $25,993 per individual or $34,969 per couple. This is called "spenddown." ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an $850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2009 federal poverty guidelines, which increase by a small amount each year.

39.11.2 Level 1 : Co-Payment

SC will pay for covered prescription drugs purchased from participating pharmacies except for participant co-payments.

Level 1 participants are required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

If a participant has private insurance with a higher co-payment per prescription than SC, the SC co-payment rules will apply and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services Hotline at 1-800-947-9627.

Residents of nursing homes and community based residential facilities will have to pay the usual SC co-payment even when they are required to purchase drugs on less than a monthly basis.

39.11.3 Level 2a: Deductible

Participant has an annual deductible of $500. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

39.11.4 Level 2b: Deductible

Participant has an annual deductible of $850. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Note: If married persons in the same *FTG* with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the *spouse* who applies later. (See 33.9.3.1 FTG Changes at Level 2a and 2b)

39.11.5 Level 3: Spenddown

Level 3 participants must meet a spenddown. The amount of spenddown is the difference between the FTG annual income and 240% of the FPL corresponding the size of the FTG. The SC program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spenddown.

39.11.5.1 Level 3: FTG of One

A SC participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 1: Dorothy's annual income is $26,993. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period

39.11.5.2 Level 3: FTG of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his/her deductible, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 2: Bob and Alice's annual income is $36,969, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the co-payment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his/her costs count toward the spenddown. S/he pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 3: Tracy and Dave's annual income is $39,969, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SC. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

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40 WORKSHEETS

40.1 WORKSHEETS TABLE OF CONTENTS

Following is a list of Medicaid worksheets. All worksheets should be copied for your use.

WORKSHEETS	
NUMBER	**NAME**
Wkst 01	Medicaid Non-Financial
Wkst 02	Dependent Care
Wkst 03	Medicaid Deductible
Wkst 04	Medicaid Institution Determination
Wkst 05	Medicaid Extensions
Wkst 06	EBD – Related Determination Worksheet
Wkst 07	*Spousal Impoverishment* Income Allocation
Wkst 08	Medicaid Purchase Plan (*MAPP*) Eligibility
Wkst 09	Medicaid Purchase Plan (MAPP) Premium Calculation
Wkst 10	Medicaid Purchase Plan (MAPP) Work Expenses
Wkst 11	Medicaid Purchase Plan (MAPP) Medicaid/Remedial Expenses
Wkst 12	Family Care Eligibility – Non-MA Financial Determination
Wkst 13	FFU Income
Wkst 14	AFDC-Related Determination Worksheet

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