

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

To: Medicaid Eligibility Handbook Users

From: Angela Dombrowicki, Director
Bureau of Enrollment Management

Re: **Medicaid Eligibility Handbook Release 08-04**

Release Date: 10/17/08
Effective Date: 10/17/08

EFFECTIVE DATE

The following policy additions or changes are effective 10/17/08, unless otherwise noted. **Bold text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

CHANGES

All References to the Forward card were changed to "ForwardHealth."

Glossary The following terms were added to the glossary:

Minor

A minor is a person less than age 18.

NLRR Child

A non-legally responsible relative (NLRR) child has no relatives in the household who are legally responsible for him/her. S/he meets these two conditions:

- 1. S/he does not have a parent in the household.**
- 2. The primary person, the primary person's spouse, or a nonmarital parent is his/her caretaker.**

Minor Parent

A minor parent is a minor who:

- 1. Is not the primary person, and**
- 2. Is living in a household where the primary person is his/her LRR caretaker, and**
- 3. Has his/her own child under his/her care.**

ADRC

Aging and Disability Resource Center .

LTMCP

Long Term Managed Care Program

Nonfinancial (Chs. 4 - 14) > 7 U.S. Citizen or Qualifying Immigrant > 7.2 A link to the Process Help was added to this paragraph.

Documenting Citizenship and Identity > 7.2.1

Documenting Citizenship and Identity Introduction

New Text:

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.

**Nonfinancial (Chs. 4 - 14) >
7 U.S. Citizen or Qualifying
Immigrant > 7.3
Immigrants> 7.3.5 Iraqis &
Afghans With Special
Immigrant Status> 7.3.5.3
Refugee Medicaid**

The title of this section was renamed from "Refugee Medicaid" to "Refugee Medical Assistance"

**Financial (Chs. 15 - 19) >
15 Income > 15.4 Unearned
Income> 15.4.1 Income
from Trusts**

This paragraph was deleted from this section on Income From Trusts

~~Do not count withdrawals from the trust principal as income when the withdrawals are in addition to or are an exception to payments under the terms of the trust agreement. These withdrawals are a conversion of an asset from one form to another.~~

**Financial (Chs. 15 - 19) >
15 Income > 15.6 Self
Employment Income>
15.6.4 Self Employed
Income**

The math in these instructions was corrected and an example was added.

New Text:

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.
4. Rental units means the total number of units minus the unit the owner lives in.
5. This equals total expenses.
6. Subtract total annual expenses from the total annual rental income to get net annual rental income.
7. 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.

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

The phone extension for the EDS phone number changed.

New Text

The divestment report, CRM1403A, doesn't register divestment penalty changes. If it is necessary to remove a divestment penalty, update AAAT, run eligibility, and confirm. Then contact EDS (608-221-4746, ext. **80215**). Provide EDS with the date

that the divestment penalty was removed. 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.

Program Admin. (Chs. 20 - 23) > 20 Verification > 20.3 Mandatory Verification Items > 20.3.1 Mandatory Verification Items Introduction

New Text

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).**

Subprograms (Chs. 24- 38) > 27 Institutional Long Term Care (ILTC) > 27.7 ILTC Cost of Care Calculation > 27.7.8 Payment for Non-Covered Services

Information from Ops Memo *08-02 Medical/Remedial Expenses Used for LTC Medicaid Eligibility and Cost Sharing* was added to this section.

New text effective 01/04/08

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, AI had a root canal performed by a dentist who is not an MA provider. He is responsible for paying \$600 for the procedure. AI began making payments of \$100 per month on this medical bill in March 2008. On April 1st, AI became institutionalized and eligible for MA. The \$100 payment that AI is making on a previously incurred medical expense should be used as a need item when determining AI's institutional MA eligibility. The expense should also be used as in income deduction when calculating AI'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 AI 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.

Subprograms (Chs. 24- 38)
> 28 Home and Community
Based Waivers Long Term
Care (HCBWLTC) > 28.8
HCBWLTC Instructions>
28.8.3.5 Medical/Remedial
Expenses

New Text:

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.

Subprograms (Chs. 24- 38)
> 29 Family Care Long
Term Care (FCLTC) > 29.3
FCLTC Medicaid and Non-
Medicaid

New Text:

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.

Subprograms (Chs. 24- 38)
> 29 Family Care Long
Term Care (FCLTC) > 29.5
FCLTC Enrollment/
Disenrollment and
Intercounty Moves> 29.5.4

New Text:

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 four conditions are met:

1. S/he is eligible for COP or waiver services.

Intercounty Moves

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.
4. The enrollee resided in the MCO county for at least six months prior to the date on which s/he moved to the non-MCO county.

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.

Subprograms (Chs. 24- 38) > 33 SeniorCare (SC) > 33.14 SC Appeals

The TTY number for Hearings and Appeals is no longer used.

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 (voice) or 1-608-264-9853 (TTY).)