

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 08-05**

Release Date: 11/17/08
Effective Date: 11/17/08

EFFECTIVE DATE

The following policy additions or changes are effective 11/17/08, 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."

12.1 This new section was added.

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).

16.6.4.2

New Text:

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: Same facts as above, 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 Dave would be income in the month of receipt. The other half of the income would be an unavailable asset

and tested for divestment.

20.7

New Text:

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: Veteran's 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 veteran's 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 veteran's 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 veteran's benefit income verification every January.

27.7.1

New Text:

Effective 12/01/08

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.**

27.7.2

New Text:

Effective 12/01/08

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).

27.7.5

New Text:

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.

29.3

New Text:

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). FamilyCare eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

39.4.2

This allowance is removed per Ops Memo 07-63.

~~Personal Needs Allowance for PACE/partnership participants who reside in a CBRF
-\$65~~