WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
Madison WI 53703

To:	Medicaid Eligibility Handbook (MEH) Users
From:	Rebecca McAtee, Bureau Director Bureau of Enrollment Policy and Systems
Re:	**Medicaid Eligibility Handbook Release 18-01**
Release Date:	04/13/2018
Effective Date:	04/13/2018

EFFECTIVE DATE

The following policy additions or changes are **effective 04/13/2018** unless otherwise noted. **Grey highlighted text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

POLICY UPDATES

2.5.1.1 Signatures From Representatives

3. Durable power of attorney (Wis. Stat. ~~§ 243.07~~ ch. 244): 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.

2.5.3 Spousal Impoverishment Medicaid Signatures

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

~~For ongoing cases where eligibility was determined without using spousal impoverishment rules, apply the spousal impoverishment rules at the next renewal. This includes completing an asset assessment using the couples assets on the first day of the month of the review month and determining eligibility for the next certification period by comparing the current combined assets of the couple to the total of the community spouse asset share plus the $2,000 asset limit for the institutionalized spouse.~~

3.1.4 Signature at Renewal

The signature requirements for renewals are the same as those for applications (see Section 2.5 Valid Signature). The signature requirements do not apply to people whose renewal is completed through the administrative renewal process.

3.1.5.2.3 Exclusions From the Administrative Renewal Process

Cases can be excluded from the administrative renewal process for a number of reasons.

Exclusions During the Administrative Renewal Process

Cases are excluded from being administratively renewed if:

- Any person on the case has or is any of the following:
  - An unverified or missing SSN
  - An unresolved Prisoner, UIB, or SOLQ-I discrepancy
  - A new discrepancy found through a data exchange during the administrative renewal process
  - An expired immigration status

- An expired disability diary date
- MAPP benefits with a work requirement waiver or Health and Employment Counseling enrollment
- A presumptive disability
- Turning 19 or 65 years old

- The case has or is any of the following:
  - Income that cannot be verified or is not found reasonable compatible through a data exchange (such as self-employment or room and meals income)
  - A BadgerCare Plus assistance group with tax deductions on file
  - A BadgerCare Plus assistance group with a calendar year tax dependent(s)
  - A BadgerCare Plus Extension assistance group that is due for renewal (**Note:** BadgerCare Plus Extension assistance groups will not be administratively renewed, but other eligible health care categories on the same case may be selected for an administrative renewal as long as the extension is not due for renewal.)
  - A pending health care assistance group (i.e., health care eligibility has not been confirmed for all people in the case)
  - Related unprocessed ACCESS items, including applications, program adds, renewals, change reports, and SMRFs
  - Related unprocessed PPRF or SMRF documents
  - An unresolved EPP
  - A met deductible
  - A reason for exclusion from batch eligibility processes (for example, due to an eligibility override)
  - In review mode

(**Note:** Cases that are open only for Group A Community Waivers and/or QMB based on SSI eligibility will only be excluded from an administrative renewal if the case is in review mode. The other criteria do not apply to Group A cases.)

(This was effective April 22, 2017.)

5.3.6 Routine SSI Medicaid Extension

An SSI Medicaid member is eligible for a redetermination of Medicaid eligibility when SSI is terminated. The person is allowed an extra month of SSI Medicaid eligibility to allow the IM agency to redetermine eligibility. The IM agency must fill the gap ~~in~~ by ensuring continued Medicaid eligibility between the last date of SSI Medicaid and the date an eligibility determination for continuing Medicaid on another basis is completed. Determining Medicaid eligibility should usually occur within the month after the person loses SSI.

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until one of the following:

- The person notifies ~~states~~ the income maintenance agency that he or she no longer intends to reside in Wisconsin
- Another state determines the person is a resident in that state for Medicaid/Medical Assistance
- Other information is provided that indicates the person is no longer a resident

7.2.1 Documenting Citizenship and Identity Introduction

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 time frame (30 days from the filing date)~~, as long as the applicant has notified the worker that he or she is taking steps to obtain the necessary documentation or has asked for the worker's assistance to obtain it~~. Applicants are not eligible for backdated health care benefits while pending for citizenship and/or identity. Once verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested.

(This was effective March 3, 2018.)

7.2.1.1 Covered Programs

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

- BadgerCare Plus
- Medicaid
- Katie Beckett (**Note:** Since eligibility for Katie Beckett is determined by ~~Division of Long Term Care~~ staff in the Bureau of Children's Long Term Support Services, they will ensure citizenship and identity verification.)
- TB-related Medicaid
- WWWMA

7.2.6.1 Person Add

This section has been rewritten.

(This was effective April 1, 2018.)

8.3.2 Notice

The IM agency must provide a Good Cause Notice, ~~DWSP 2018~~ DCF-F-DWSP2018, 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.

8.3.3 Good Cause Claim

The Good Cause Claim form, ~~DWSP 2019~~ DCF-F-DWSP2019, 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.

10.1.1 Social Security Number Requirements Introduction

10.1.1 Overview of Social Security Number Requirements ~~Introduction~~

This section has been rewritten.

10.1.2 Emergency Services

10.1.2 ~~Emergency Services~~ Social Security Number Exceptions

This section has been rewritten.

10.1.3 SSN Mismatches

The second paragraph has been rewritten.

10.1.4 Failure to Provide SSN

This section has been deleted.

15.1.2 Special Financial Tests for Disabled Minors

Examples 1 and 2 have been updated.

(This was effective January 1, 2018.)

15.4.21 Reimbursement of Living Expenses

This section is new.

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 both the following conditions:

- For trusts established prior to December 13, 2016, the trust must be established for the sole benefit of the disabled person by his or her parent, grandparent, legal guardian, or a court. **Note:** For any special needs trusts established on or after December 13, 2016, the trust does not have to be established by a third party. The disabled person under age 65 may also set up the trust.
- Contain a provision that, upon the death of the beneficiary, Wisconsin Medicaid will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

The funds deposited in, contributions to, and distributions from the special needs trust are disregarded. The exception continues after the person turns 65, provided he or she 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.

16.7.30 Achieving a Better Life Experience Accounts

While Wisconsin does not offer residents a state-specific ABLE program, Wisconsin residents may open these accounts in any state where an ABLE program is offered. If an applicant or member has an ABLE account, ~~count~~ treat the money in the account as follows:

1. Do not count the balance on the account as an asset.
2. Do not count contributions to the account, any interest or dividends earned, or other appreciation in value as income.
3. Exempt all distributions from these accounts to the beneficiary, as long as they are for qualified disability expenses. "Qualified disability expenses" means any expenses related to the eligible person's blindness or disability ~~which are made~~ that are incurred for the benefit of an eligible person who is the designated beneficiary. This includes the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses consistent with the purposes of ~~this section~~ the ABLE program. Unless the applicant or member reports that a distribution was used for non-qualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.
4. Disregard ABLE account distributions used for qualified disability expenses from a person's total income when calculating cost of care for long-term care and home and community-based waivers.

ABLE account funds remaining after an applicant's or member's death are subject to estate recovery.

Note: If a third party contributes to someone else's ABLE account, and then later applies for long-term care Medicaid, the contributed funds may be considered divestment.

17.4 Exceptions

2. *Example 2*

~~Homestead property is an exception. After the institutionalized person has become eligible, he or she can transfer the homestead to the community spouse, and the community spouse can transfer it to anyone once five years have passed since the eligibility of the institutionalized spouse. The community spouse's divestment of homestead property five years after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.~~

The transfer of homestead property to the community spouse and then to another person is treated as a divestment depending on when the transfers occur. If the institutionalized person transfers the homestead to the community spouse, and then the community spouse transfers it to someone else within five years of the institutionalized person becoming eligible for long-term care Medicaid, this would be considered a divestment, and it would affect the institutionalized person's eligibility. However, if five years have passed since the institutionalized person became eligible for long-term care Medicaid, the community spouse can transfer the homestead property without affecting the institutionalized person's eligibility.

Example 3 has been updated.

17.8.1 Introduction

Divestment ~~is~~ may occur when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him or her and any of

the conditions below are not met. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

17.13.4 Exceptions

4. Special needs trust: A trust containing assets of a person under age 65 who is totally and permanently disabled (under SSI program rules). Disregard the trust if it meets the conditions in Section 16.6.5 Special Needs Trust. ~~both the following conditions:~~

- ~~The trust must be established for the sole benefit of the disabled person by his or her parent, grandparent, legal guardian, or a court.~~
- ~~Contain a provision that, upon the death of the beneficiary, Wisconsin Medicaid 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 he or she 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.~~

18.4.3 Calculate the Community Spouse Asset Share

The table has been updated.

(This was effective January 1, 2018.)

18.6.2 Community Spouse Income Allocation

a. $~~2,670.00~~2,706.66 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $~~3,022.50~~3,090.00.

"Excess shelter allowance" means shelter expenses above $~~801.00~~812.00. Subtract $~~801.00~~812.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $~~2,670.00~~2,706.66 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

(This was effective July 1, 2017.)

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $~~667.50~~676.66 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $~~667.50~~676.66 and the actual monthly income of the dependent family member.

(This was effective January 1, 2018.)

20.3.6 Medical Expenses

20.3.6 Medical or Remedial Expenses

This section has been rewritten.

20.3.7 Power of Attorney and Guardianship

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.

If verification is not provided, do not grant the claimed power of attorney or guardian access to case notices or follow any direction provided by that person unless he or she is an authorized representative. Do not deny or terminate eligibility for failure to provide the requested verification.

20.7.1.2 Eligibility Renewals

Example 1 has been updated.

20.8.3 Negative Actions

Deny or reduce benefits when all of the following are true:

- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- The requested verification is needed to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility.

Note: Do not deny or terminate eligibility for failure to verify expenses. The disallowance of unverified expenses is the only penalty to be imposed.

21.5 Copayment

The following members do not have to pay a copayment:

- Children ~~under age 18 whose income is at or below 100 percent of the FPL~~ eligible for BadgerCare Plus who are:
  - Under age 6 with income at or below 150 percent of the FPL.
  - Age 6 through 18 with income at or below 133 percent of the FPL.
- Children under age 18 who are eligible for SSI
- Children eligible for Katie Beckett
- Pregnant women
- ~~Children who are members of a federally recognized tribe~~ People who are eligible to receive services from Indian Health Services or an Urban Indian Health Center, members of a federally recognized tribe, or the child or grandchild of a tribal member
- Nursing home residents

21.6.1 HMO Enrollment Introduction

Most Medicaid members who are eligible for ~~Family Medicaid~~ Badger Care Plus or SSI-related Medicaid and reside in a Medicaid HMO service area must enroll in a HMO.

21.6.4 Disenrollment

Members are automatically disenrolled from the HMO program if:

- Their medical status code changes to a ~~non-Family~~ BadgerCare Plus or Medicaid subprogram that does not require enrollment in an HMO.

21.7.3 Lock-in Program

21.7.3 Pharmacy Services Lock-in Program

This section has been rewritten.

21.8 Waiver of Medicaid Benefit Limitations

This section has been rewritten.

22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid ~~home~~ health and LTC benefits by:

22.1.2.1 Qualified Medicare Beneficiary

22.1.2.1 ~~Qualified Medicare Beneficiary~~ Medicare Savings Programs

As of January 1, 2010, payments for premiums, copayments, and deductibles for QMB and Medicare Part B for ~~a QMB~~ any MSP member are not recoverable through ERP.

22.1.9 Estate Recovery Program Contacts

The ERP address is:

Estate Recovery Program Section
~~Division of Health Care Access and Accountability~~ Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

22.1.12 Other Programs

ERP also recovers for Community Options Program (COP), WCDP, ~~Medicaid~~ and non-Medicaid Family Care~~, and Partnership~~.

Note: Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from those who received benefits under this program prior to May 1, 2003.

22.2.1 Overpayments

- Concealing or not reporting income.
- Failure to report a change in income, expenses, or assets.
- Providing misinformation at the time of application that would affect eligibility.

Note: Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from those who received benefits under this program prior to May 1, 2003.

22.2.1.1 Recoverable Overpayments

- **Applicant or Member Error.** Applicant or member error exists when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates (financial or nonfinancial) facts, which results in the member receiving a benefit that he or she is not entitled to or more benefits than he or she is entitled to.

  Failure to report nonfinancial 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 nonfinancial change. For applications on or after July 27, 2005, overpayment claims can be established effective with the application date.~~

  Applicant or member error occurs when there is ~~one of the following~~ a:
  - Misstatement or omission of facts by an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf at a Medicaid application or renewal.
  - Failure on the part of the member or any person responsible for giving information on the member's behalf to report required changes in financial (income, assets, expenses) or nonfinancial information that affects eligibility, premium, patient liability, or cost share amount.

  A Medicaid member is responsible for notifying his or her IM ~~worker~~ agency 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).

- **Member Loss of an 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 or the amount of claims and HMO capitation payments the state paid for each month (whichever is less).

	Note: As of February 1, 2002, there should be no compromise of overpayment claims. If it is determined that a recoverable overpayment exists, recovery may not be waived.
22.2.2.1 Overpayment Period	This section has been rewritten.
22.2.2.2 Overpayment Amount	This section has been rewritten.
22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact	If a member is still eligible for long-term care benefits but a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability or cost share amount and the one the member originally paid is the overpayment amount.
22.2.2.2.1.2 Family Care	This section has been rewritten.
22.2.2.3 Deductible	~~**22.2.2.3**~~ **22.2.2.2.2 Deductible** This section has been rewritten.
22.2.2.4 Premiums	This section has been deleted.
22.2.2.4.1 BadgerCare	This section has been deleted.
22.2.2.4.2 Medicaid Purchase Plan	~~**22.2.2.4.2**~~ **22.2.2.2.3 Medicaid Purchase Plan** This section has been rewritten.
22.2.2.4.1 Overpayments for Individuals Eligible for Family Planning Only Services Benefits	This section has been deleted.
22.2.2.4.2 Overpayments for Qualified Medicare Beneficiary Cases	~~**22.2.2.4.2**~~ **22.2.2.2.4 Overpayments for Qualified Medicare Beneficiary Cases** This section has been rewritten.
22.2.2.5 Determining Liable Individual	~~**22.2.2.5 Determining**~~ **22.2.2.3 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 or her. Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments. For cases for which spousal impoverishment rules have been applied, the legally married spouses who signed the application or renewal are jointly liable even though one of the spouses may be institutionalized.

Example 8 has been updated.

Examples 9 and 10 are new.

22.4.3 Valid Request

Note: A long-term care facility could include a nursing home, CBRF, or IMD (see Section 27.1 Institutions)

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).~~ subtract the income deductions (see Section 15.7 Income Deductions), including any applicable Special Exempt Income, IRWE, the $65 and ½ earned income deduction, and the $20 disregard, from the applicant's gross income to get the monthly countable net income. Some of the income deductions allowed in other forms of Medicaid, such as the COLA for Special Status Medicaid or medical/remedial expenses for MAPP, are not deducted when calculating a deductible.

24.7 Meeting the Deductible

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 has not yet met the deductible within the deductible period, it may choose to start a new deductible period that begins ~~starting~~ with a later month in the current deductible period without a new application (see Section 24.3 Deductible Period).

25.5 1619 Cases

1619(a): They are working people with earnings at or above the SGA who continue to receive a small SSI check. They retain SSI Medicaid eligibility.

26.3.5.1 Health and Employment Counseling Processing

Employment Initiatives Section
HEC Manager
Room ~~418~~ 527
1 W. Wilson St.
Madison, WI 53708

27.7.1 Introduction

After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount the person will pay each month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution, including those enrolled in Family Care, Family Care Partnership, or PACE ~~and cost share when applied to a community waivers client, PACE, or Family Care Partnership, or Family Care member~~ who are in or likely to be in a medical institution for 30 or more days. Institutionalized people are expected to pay their patient liability to the institution that they are residing in, or to their MCO if they are enrolled in Family Care, Family Care Partnership, or PACE, as of the first day of the month.

27.7.3 Partial Months

If a member is residing in an institution (see Section 27.1 Institutions) and not Medicaid-eligible as of the first of the month, there is no patient liability for that month.

If a member was not institutionalized as of the first of the month or was discharged to the community prior to and including the last day of the month, there is no patient liability. However, if the ~~member is opening for home and community-based services, he or she may owe a cost share to the MCO~~ member is enrolled in Family Care,

Family Care Partnership, or PACE, he or she may owe a cost share to the MCO if a cost share is determined following the change in living arrangement.

27.10 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 or cost share have the following effective dates:

- **Before** adverse action: Effective the first of the following month.
- **After** adverse action: Effective the first of the month after the following month.

Do not complete F-10110 (formerly DES 3070) for retroactive patient liability or cost share increases since the member must receive timely notice. This includes scenarios in which a member is switching from a patient liability to a cost share or from a cost share to a patient liability.

Decreases in patient liability or cost share 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 fiscal agent's 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.

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

- Have a disability determination if he or she is younger than 65 years old. Exceptions to this include the following:
  - A finding of disability made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirement until either an adult disability determination can be done or the child's disability determination is no longer in effect, whichever occurs first).
  - Children determined by functional screening to meet an institutional level of care and who meet all other eligibility requirements are eligible for the Children's Long-Term Support Waiver Program without a disability determination (see Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support).
  - ~~People~~ Adults younger than 65 years old who meet both of the following criteria may be enrolled in Family Care, Family Care Partnership, PACE, or IRIS without first obtaining a disability determination from DDB:
    - Functionally eligible for Family Care, Family Care Partnership, PACE, or IRIS at a nursing home level of care
    - Eligible for one of the following Medicaid or BadgerCare Plus categories: BadgerCare Plus Standard Plan, Wisconsin Well Woman Medicaid, Medicaid through Adoption Assistance, or Foster Care Medicaid

Note: To enroll in PACE, a person must be age 55 or older.

The Eligibility Results page of the long-term care functional screen indicates Family Care, Family Care Partnership, PACE, or IRIS eligibility for people who meet this criteria. Because CARES requires that they have a disability determination, these eligible Family Care Partnership or PACE members should be coded as presumptively disabled as long as they qualify for one of the Medicaid or BadgerCare Plus categories listed above.

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.

28.2 Home and Community-Based Waivers Long-Term Care Application

~~All waiver applicants must complete a Medicaid application unless they are already receiving full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid). Adult waiver applicants receive level of care assessment and case planning services from the ADRC. The ADRC will submit the waiver program start date to the IM agency along with the waiver functional eligibility determination.~~

To be eligible for LTC waiver services, applicants must be both Medicaid-eligible and functionally eligible. All waiver applicants must complete a Medicaid application unless they are already open for another program of assistance.

Adult waiver applicants receive level of care assessment, long-term care options, and enrollment counseling services from the ADRC. Once the level of care assessment is complete and the applicant is determined functionally eligible, the ADRC will submit the waiver program start (enrollment) date to the IM agency along with the waiver functional eligibility determination.

If an applicant is not functionally eligible, the ADRC will send the appropriate correspondence to the applicant regarding their functional eligibility results, which may include the Notice of Denial of Functional Eligibility, Notice of Non-Nursing Home Level of Care, and Appeal Rights.

28.6 Home and Community-Based Waivers Long-Term Care Uniform Fee System

Following the procedures of the Uniform Fee System (Wis. Admin. Code ch. DHS 1), 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~~ the Children's Long-Term Support Waiver Program (see Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support). When the parents are already contributing according to the Uniform Fee System, no additional contribution is required.

28.8.3.1 Personal Maintenance Allowance

3. Special housing amount equal to monthly housing costs over $350. ~~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 and subtract $350 to get the special housing amount:

- Rent.
- Home or renters insurance.
- Mortgage.
- Property tax (including special assessments).
- Utilities (heat, water, sewer, electricity).
- "Room" amount for members in a CBRF, Residential Care Apartment Complex, or an Adult Family~~/Foster Allowance~~ Home. The case manager determines and provides this amount.

~~The total, minus $350, equals the special housing amount. The person can set the special housing amount aside from his or her income.~~

28.8.3.6 Cost Share Amount

The waiver cost share amount is the monthly amount he or she must pay toward the cost of his or her waiver services.

~~Institutionalized PACE/Partnership or Family Care members pay their cost share to the managed care program instead of the institution.~~ Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than a cost share under this section. They pay the patient liability to the MCO instead of the institution.

29.1 Katie Beckett

To qualify under the Katie Beckett Program, a blind or disabled minor:

- Must require a level of care provided in a hospital, SNF, or ICF.
- Can appropriately receive this care in his or her home.
- Would be nonfinancially eligible for Medicaid if he or she were in a hospital, SNF, or ICF.

- Must have income below the Institutions Categorically Needy Income Limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.

~~If a minor meets these requirements and if the parent wants him or her to remain in the home,~~ Families may contact the Katie Beckett Program by ~~doing one of the following~~:

- Calling 608-266-3236.
- Faxing information to 608-226-5420.
- Writing to the following address:

30.2 Financial Tests

The asset limit for one person is $2,000. Count assets the same as for other EBD assistance groups.

The income limit for one person is ~~$1,555~~1,585. This is gross income. There is no net income test.

(This was effective January 1, 2018.)

32.1.1 Medicare Savings Programs Introduction

Medicare is the health insurance program administered by CMS for people 65 years old and older, ~~and for~~ people ~~who have been~~ determined disabled for two years or more, or people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant). People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into four types of health coverage:

- Hospitalization insurance (Part A), which pays hospital bills and certain skilled nursing facility, home health care, and hospice expenses.
- Medical insurance (Part B), which pays doctor bills and certain other charges.
- Medicare Advantage (Part C), which allows private health insurance companies to provide Medicare benefits.
- Drug insurance (Part D), which pays for prescription drug charges.

32.2.2 Entitled to Medicare

b. He or she is a Medicaid member or QMB or SLMB ~~or QDWI~~ applicant and has never been enrolled in Medicare Part A. In this case he or she must apply at the local SSA office for Part A Medicare eligibility. He or she will receive a receipt which entitles him or her to enrollment in Part A on the condition that he or she 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.

32.5.1 Introduction

This section has been rewritten.

32.6 Medicare Savings Programs Asset Limits

The asset limits for QMB, SLMB, and SLMB+ have been updated.

(This was effective January 1, 2018.)

33.3.1 SeniorCare Nonfinancial Requirements Introduction

The list has been renumbered.

5. Not be a full-benefit Medicaid member (21.2 Full Benefit Medicaid). This includes participants who are covered by ~~Family Care Medicaid~~ BadgerCare Plus (see the BadgerCare Plus Handbook).

Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (24.2 Medicaid Deductible Introduction) or receive one of the following:

- Medicare Savings Program (32.1 Medicare Beneficiaries Introduction).
- ~~Family Care non-Medicaid (See the BadgerCare+ Handbook)~~

- TB-related Medicaid (see Chapter 30 Tuberculosis)
- Emergency Services.

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 SeniorCare. SeniorCare is the payer of last resort except state funded only programs, such as WCDP ~~and HIRSP~~.

33.8.2 Carryover

Example 2 has been updated.

33.9.2.2.1 Unmet Spenddown

Example 3 has been updated.

(This was effective February 1, 2018.)

33.9.2.2.2 Met Spenddown

Example 4 has been updated.

(This was effective February 1, 2018.)

33.9.3.1 FTG Changes at Level 2a and 2b

Example 6 has been updated.

(This was effective February 1, 2018.)

33.9.3.2 FTG Changes At Level 3

Example 7 has been updated.

(This was effective February 1, 2018.)

33.10.2.2 Applicant or Member Error

Example 3 has been updated.

36.3.2 Disqualifying Insurance Coverage

A woman is ineligible for WWWMA if she is currently covered by any one of the following:

- Group health plans that cover treatment for her breast or cervical cancer
- Full benefit health insurance that covers treatment for her breast or cervical cancer
- Medicare Part A
- Medicare Part B
- BadgerCare Plus 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.)
- Veteran's benefits/TRICARE that cover treatment for her breast or cervical cancer
- ~~HIRSP~~

38.1 Introduction

The Medicaid Eligibility and Managed Long-Term Care or IRIS Enrollment sections have been rewritten.

Disability

To be eligible for EBD or LTC Medicaid, the person must be elderly, blind, or disabled with the following exception: a person eligible for BadgerCare Plus, WWWMA, Foster Care, or Adoption Assistance is not required to be determined disabled to enroll in Family Care, Family Care Partnership, or PACE as long as the member meets the functional LOC. If the member later loses eligibility for that program and must be tested for EBD or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care.

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

- An adult disability determination can be ~~done~~ completed
- The child disability determination is no longer in effect

	Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.
38.5 IRIS	This section has been rewritten.
39.4.1 Elderly, Blind, or Disabled Assets and Income Table	The values in the following table were effective January 1, 201~~7~~8. The table has been updated. *(This was effective January 1, 2018.)*
39.4.2 Elderly, Blind, or Disabled Deductions and Allowances	The cost-of-living adjustments in the following table were effective January 1, 201~~7~~8. The first table has been updated. *(This was effective January 1, 2018.)*
39.5 Federal Poverty Level Table	The table has been updated. *(This was effective February 1, 2018.)*
39.6 Cost-of-Living Adjustment	The table has been updated. *(This was effective January 1, 2018.)*
39.11.1 SeniorCare Income Limits Introduction	The table has been updated. * These income amounts are based on the 201~~7~~8 federal poverty guidelines, which typically increase by a small amount each year. *(This was effective February 1, 2018.)*
39.11.5.1 Level 3: Fiscal Test Group of One	Example 1 has been updated. *(This was effective February 1, 2018.)*
39.11.5.2 Level 3: Fiscal Test Group of Two	Examples 2 and 3 have been updated. *(This was effective February 1, 2018.)*