Medicaid and BadgerCare

Linda Hall, Health Policy Consultant

Introduction
Medicaid and BadgerCare are comprehensive health care insurance programs available to certain low-income persons with limited assets. Medicaid is also available to individuals whose income is reduced to the low-income level when medical expenses are deducted from their gross income. These programs pay service providers for medical and rehabilitative services, drugs and equipment which they have provided to a Medicaid or BadgerCare enrollee. Both programs are administered by the state and funded by federal and state dollars.

Eligibility Options and Issues
The Medicaid program is also known as Medical Assistance, MA, Title XIX, T-19 and the Wisconsin Medical Assistance Program (WMAP).

There are two major categories of individuals who qualify for Medicaid:

Elderly and Disabled. The “Aged, Blind and Disabled” group is the primary category of low-income persons with limited assets who are eligible for Medicaid. These individuals are over age 65 or permanently blind or disabled as defined by the Supplemental Security Income (SSI) program. Elderly and disabled individuals who have medical expenses that reduce their income to the SSI income guidelines may qualify as “Aged, Blind and Disabled Medically Needy.”

Poverty-Related. Parents, pregnant women and children who meet various income and asset limits can qualify for Medicaid, including the following groups: Healthy Start, Healthy Start Medically Needy, and limits effective in 1996 for Aid to Families with Dependent Children (AFDC), and AFDC Medically Needy.

Some of the subpopulations of these major categories are so well known that their medical coverage is referred to as if it were a program separate from Medicaid. For example, the “Katie Beckett” program for children whose disabilities qualify them for institutional care, but they live at home with their parents. “Healthy Start,” the poverty-related group for women and young children, is also referred to as if it were a separate program when it is actually an eligibility group within the Medicaid population.

Other eligibility routes may help
There are at least 15 ways to qualify for Medicaid. Individuals who don’t meet the disabled definition, but are low-income and/or have significant medical expenses may want to explore whether they qualify...
under one of the poverty-related categories for Medicaid or payment of certain Medicare expenses. One such program is the Medicaid Purchase Plan. (See pg. 49.) Children who were adopted under federal adoption assistance programs are also eligible for Medicaid coverage. (See Child Welfare & Juvenile Justice Systems and Children with Complex and Enduring Needs chapter, pg. 175.) More information on the “Aged, Blind and Disabled” group follows.

**Need More Information?**

Understanding Medicaid and BadgerCare eligibility and services is never easy. However, there are many resources to help you figure out if you are eligible or the service you need is covered.

- SSI-Medicaid Hotline 800-888-7989
- Recipient (Covered) Services 800-362-3002
  (TTY and translation services available)

If you have access to the Internet, check the Department of Health and Family Service’s (DHFS) site:

- Medicaid - www.dhfs.state.wi.us/medicaid/index.htm
- BadgerCare - www.dhfs.state.wi.us/badgercare/index.htm

**Categorically needy and medically needy**

People who are eligible for SSI and most people in nursing homes and Medicaid-covered institutions are called **Categorically Needy**. People outside of institutions who use medical expenses to offset income are called **Medically Needy**. Currently, the services covered for both groups are identical although Wisconsin could choose to provide fewer services to Medically Needy individuals in the future.

**Federal role in Medicaid**

Authorized under Title XIX of the federal Social Security Act, Medicaid is funded jointly by the state and federal governments. The federal government’s share, which is recalculated each year, is based on the state’s per capita income compared to the national figure. In 2000, the federal government will pay Wisconsin 59% of its costs under the program. In exchange for the federal funds, the state must operate its program within federal guidelines and under the State Plan for Medicaid as approved by the federal government. If there is a conflict between state and federal law, federal law usually controls. The state must pay for all covered services, even if it means that the state Medicaid program will exceed its budget.

**BadgerCare eligibility and federal role**

**BadgerCare** offers the same health care coverage as Medicaid to low-income families without access to health insurance whose income exceeds the Medicaid guidelines, but is below 185% of the federal poverty level. There is no asset test. Once in the program, the family’s income may increase to not more than 200% of the poverty guidelines before eligibility is terminated. The parents are actually enrolled in **Medicaid & BadgerCare** - 39
Medicaid. Families with incomes above 150% of the federal poverty level must pay a monthly premium equal to 3% of their income.

The state has authority to reduce the income eligibility for BadgerCare to control program enrollment and expenditures. If implemented, this “rollback” of income limits would apply to new applicants. Persons on the program would retain their eligibility as long as they meet the original income limits.

Medicaid and BadgerCare provide extensive coverage of health-related services and cover many services that are not paid for under Medicare or commercial health insurance policies. These programs pay providers, not enrollees, for covered services, drugs and equipment which they have provided to an eligible person. Generally, the person only pays for small copayments on some items. (See pg. 59.)

**Eligibility for People Who Are Elderly or Disabled (SSI Qualified)**

A person must be a Wisconsin resident to qualify for Wisconsin Medicaid benefits. U.S. citizenship is generally also required; however, certain types of legal residents of the United States may also be eligible.

Persons who move to Wisconsin are considered legal residents if they live here and intend to stay in the state. The exception to this rule would be an adult who is placed by another state into a Wisconsin institution, nursing home or group home. Otherwise, even if the person moves directly into a nursing home, residency may be established.

Individuals who move here with the intention of carrying out some temporary purpose (e.g., a visit to relatives or a medical operation) are not eligible. However, migrant workers and other people who come to Wisconsin for employment, even if the job is temporary and even if they are not currently working, are eligible for Medicaid.

Competency, that is, the ability to make one’s own decisions about where to live, is not required to indicate intent to live in Wisconsin. Individuals who became unable to indicate intent before age 21 may move from another state directly into a Wisconsin institution, nursing home, or group home. Such an adult, no matter his/her age at the time of the move, becomes a Wisconsin resident if a parent or guardian, who is a Wisconsin resident, applies for Medicaid for the individual or if the parents abandon the individual and there is no guardian. The exception to this rule is for people who became unable to indicate intent before age 21 and who moved directly from another state into a Wisconsin institution, nursing home, or group home. Such an adult, no matter what their age when s/he moved, becomes a Wisconsin resident only if a parent or guardian who is a Wisconsin resident applies for Medicaid for the individual, or if the parents abandon the individual and there is no guardian.
Generally, a person under age 21 who is eligible for Medicaid based on blindness or disability and who is not living in an institution, is considered a resident. However, such a person if placed into an institution, nursing home, or group home in Wisconsin is considered a resident of the state where his/her parent(s) or legal guardian lived at the time of the placement. This individual can become a Wisconsin resident only if:

1. One or both parents or a legal guardian becomes a Wisconsin resident and makes the application for Medicaid;
2. The youth is abandoned by his or her parents and has no legal guardian; or
3. The youth is married or is no longer dependent on, or controlled by, his or her parents, and is able to make decisions about where to live.

A person who becomes a Wisconsin resident remains a resident until moving somewhere else and establishing residency there. For example, a person who temporarily visits another state is still a Wisconsin resident and eligible for Wisconsin Medicaid services. However, coverage of services for people who are outside the state is very limited. (See pg. 57.)

The fact that a person does not have a fixed place of residence (e.g., the person is homeless) may not be used to deny Medicaid, as long as the individual meets other residency tests.

A Wisconsin resident who receives SSI payments through the Social Security Administration (SSA) is automatically eligible for Medicaid without making a separate application. (See Social Security Disability Insurance and Supplemental Security Income chapter, pg. 10.) SSA should inform the state’s SSI Medicaid Unit in the Division of Health Care Financing, which should issue a Medicaid card automatically. If a person is receiving SSI from the State of Wisconsin and not through SSA, the Medicaid card is issued by the DHFS Division of Supportive Living. A person eligible for SSI who chooses not to apply for SSI may apply for Medicaid through the county Department of Human Services (HSD), also called Department of Community Programs or Unified Services Board.

**Persons Not Qualified for SSI**

Some individuals with disabilities do not meet SSI’s financial tests, but may meet other Wisconsin Medicaid income and asset guidelines. For example, people who meet the SSI disability definition but have financial resources that exceed the SSI guidelines, but are within the state SSI supplemental guidelines (see SSI & SSDI chapter, pg. 29.) are still eligible for Wisconsin Medicaid. In addition, there are some instances in which Medicaid counts resources differently than the...
federal SSI program. Also, the Medicaid medically needy program allows the offsetting of income with medical expenses. In other cases, a person who loses SSI due to Social Security cost-of-living increases or earnings increases from work may remain eligible. Finally, certain SSI-eligible individuals who received benefits in 1973, including “essential persons” (persons who care for a disabled individual) remain Medicaid eligible. People in these groups should apply for Medicaid at the county HSD.

Status as disabled or blind

The Medicaid definitions of disability and blindness are the same as under SSI. (See SSI & SSDI chapter, pgs. 12 & 22.) The fact that a person is receiving Social Security or Medicare benefits based on disability is considered proof of disability for Medicaid. Otherwise, disability must be determined by the state’s Bureau of Social Security Disability Income. Sometimes, this office will find a person to be disabled, and eligible for Medicaid, even though the SSI program did not.

Emergency eligibility determinations

Persons in certain emergency situations may access Medicaid more quickly through the preliminary disability determination process. Under this process, the Wisconsin Department of Health and Family Services must make a determination within 7 days of receiving a completed disability determination form. Qualified emergencies include situations in which a person needs Medicaid eligibility:

1. Because s/he is a patient in a hospital.
2. Because s/he is seriously impaired and the attending physician says the applicant cannot work or return to normal functioning for at least one year.
3. To access nursing home care.
4. To access in-home services and equipment needed to return home from a nursing home.

Resource Tests

To qualify for Medicaid, an individual may have no more than $2,000 in countable resources (assets). A couple is limited to $3,000. Federal law requires the state to exclude from countable resources all resources that would be excluded under the SSI program. (See SSI & SSDI chapter, pg. 24.)

Excluded resources

In addition, Wisconsin’s Medicaid program excludes some resources that might be counted for SSI, including:

HFS 103.06, Wis. Admin. Code

1. Noncash resources that are unavailable; such resources include:

   • items that the person is trying to sell or cash in, but it will take more than 31 days to do so;
- real estate (buildings or land) that the person has listed for sale but has not yet sold; or

- property that is owned jointly with another person who refuses to sell it.

2. One motor vehicle, regardless of its value. (A second vehicle may also be excluded if the person or family needs two vehicles for employment or for transportation to medical care.)

3. Proceeds from the sale of a home if set aside in a special account intended for the purchase of another home.

4. The home of a person who is in an institution, if:

   - the person’s wife, minor child, or developmentally disabled adult child is living in the home; or
   
   - it is likely that the person will be able to return to the home (If the likely absence is more than one year, a doctor must certify that it is realistic to expect the person to return home and that needed home health services will be available.).

5. Trusts that meet special Medicaid requirements

There is no “spend-down” (see pg. 45) for resources as there is for income. If a person is even one dollar over the limit for resources at any time, the person is not covered by Medicaid, no matter how high his/her medical expenses may be. Therefore, if a person is facing major medical expenses, such as surgery or a hospital stay, and wants to be eligible for Medicaid, s/he should reduce his/her countable resources below the resource limit. This can be done by using countable resources to:

1. Buy resources that will not be counted.

2. Pay for expected medical costs ahead of time, or as soon as services are received.

If a person is in a nursing home or Medicaid institution, the Medicaid program only considers his/her own resources and not those of a parent. However, if the person has a joint bank account with someone else, the whole account is counted as available to the individual in the nursing home or institution. One way to reduce this resource is to divide all joint accounts equally at the time the person enters the institution. Then only his/her half will need to be spent before s/he becomes eligible.
Giving away property that would be countable as a resource, or "divestment," is usually not a good way to reduce resources. Medicaid counts as a resource any property given away, or sold for less than its market value, within three years before application for Medicaid or participation in Medicaid services, unless the person can prove that the transfer was not made for the purpose of becoming eligible for Medicaid. This rule against divestment also applies if the person is in an institution or nursing home and has given away his/her home or sold it for less than its real market value. Even though the home is normally an exempt resource, the divestment rule applies unless any of the following:

1. The person is likely to return to the home.
2. The transfer was to the person’s spouse, minor child, or developmentally disabled adult child.
3. The person thought s/he was getting fair value for the home.
4. Denial of eligibility would cause the person “undue hardship.”

A person who violates the divestment rule is not eligible for long-term care services (institutional or community-based), but is still covered for physician visits and other short-term care services. Generally, the person is not eligible until the amount of the “illegal” divestment equals the approximate amount spent by the person for long-term care services. The Medicaid program calculates the amount using a formula that considers the statewide average monthly cost of nursing facility care for a private-pay resident.

The Medicaid program can attempt to recover some or all of the costs it incurred for the care of a long-term care Medicaid enrollee by making a claim on their estate. The program may use claims, liens or transfer of assets to secure payment. Claims or liens on the enrollee’s home can be made only if the enrollee is no longer survived by a spouse or child who is disabled or under age 21.

**Medically Needy Income Tests and the Medicaid Deductible (“Spend-down”)**

A person who is over age 65, blind or disabled, and who meets the Medicaid resource test, will be eligible for Medicaid if his/her available monthly income, after subtracting out his/her medical expenses, is below the medically needy income limit. The medically needy income limit as of January, 2001 is $592 per month for either an individual or a couple. Federal law requires that Medicaid first deduct any income that would be deducted under the SSI program in determining countable income. (See SSI & SSDI chapter, pg. 26.)
Some HSD workers may not be familiar with SSI. Be sure the county HSD worker excludes all income that would be deducted under the SSI program.

The Medicaid deductible (or “spend-down”) procedure allows the person to deduct medical expenses from income to establish eligibility. The amount of expenses the person must have is calculated over a six-month “spend-down period.” The person may become eligible for payment of part of a service.

Calculating the Medicaid Deductible or “Spend-down”

Example: Elizabeth has $30 per month in countable income above the Medically Needy income test. She needs to have $180 in deductible expenses during the 6 month spend-down period to become eligible. When she has $180 in expenses, she will be eligible as a Medically Needy person for the rest of the spend-down period. If she has an operation that costs $1500, she is responsible only for $180 and Medicaid will pay the rest. Many individuals use new or old unpaid bills to “spend-down” their income so they can meet the Medicaid income guidelines and enroll in the program.

The person may choose any six-month period, beginning up to three months before the month s/he applies, provided s/he was eligible for Medicaid (except for excess income) throughout the period. For example, a person applying in June could begin the spend-down period as early as March 1. A person who waits more than three months after an expense occurs will lose the ability to deduct it, so the date of application is important. A person may apply before s/he has enough medical expenses in order to establish the spend-down period s/he wants. S/he can then come back with additional expenses to establish eligibility.

The county HSD must deduct the following expenses, in the following order:

1. Medicare and health insurance premiums, deductibles and coinsurance amounts.
2. Charges for necessary medical and remedial services that are not covered services under Medicaid.
3. Charges for medical expenses that would have been covered by Medicaid if the person had been eligible.
Almost all medical expenses should count, as long as they are services that are recognized under state law and provided by a person who is legally authorized to do so. For example, costs of physician services, drugs, dental services, or a home health agency should be deductible, whether or not the item would have been paid for by Medicaid. However, a payment to a friend for help with personal care might not be deductible because s/he is not a recognized health care provider.

It is very important that people who might become eligible for Medicaid keep good records of their medical expenses, even those that may not be covered by Medicaid. They may count toward the Medicaid deductible.

Old medical bills

Two kinds of expenses can be deducted:

1. If the person receives a service during the spend-down period, s/he can deduct the cost of the service, whether or not s/he has actually paid for it yet.

2. If the person has old medical bills and is consistently paying them off, s/he can deduct any payments made during the spend-down period.

To be deductible, an expense must be something the person is required to pay him/herself. For example, if the person has Medicare, s/he can only deduct the part of an expense that Medicare does not pay. If the incomes of some other person, such as a spouse or parent, is considered in figuring the person’s eligibility, then that person’s medical expenses should also be deductible.

Effect of resources

To deduct an expense, the person must have been eligible for Medicaid (except for income) at the time s/he received the service or made the payment. Thus, it is very important that the person have assets below the Medicaid resource limits at the time s/he receives a service or makes a payment that s/he wants to deduct.

Eligibility for People in Institutions, or Community-Based Programs

A special eligibility process is used for a person who is in an institution for an entire calendar month and receiving care that is covered by Medicaid. Medicaid institutions include most hospitals, nursing homes, centers for people with developmental disabilities, and mental health institutes for people age 21 or younger or age 65 or older. This process also applies for people who are in community-based long-term care as an alternative to institutional care. (See Family Care chapter, pg. 203, Community Options Program chapter, pg. 194 and Medicaid Home and Community Based Services Waiver Programs chapter, pg. 197.)
Under this process, only the income and resources of the person are counted. Income and resources of a parent should not be considered in determining eligibility, although they may be required to make support payments under other laws.

The person may be eligible in one of two ways:

1. If the person’s income is below a special higher income limit ($1,590/month in 2001), s/he will be considered eligible as a Categorically Needy person.

2. If the person’s total medical expenses allow him/her to spend-down to the Medicaid income limits, s/he will be considered eligible for that month as a Medically Needy person. (See pg. 45.)

Regardless of whether the person is Categorically Needy or Medically Needy, s/he will be required to contribute his/her income to the cost of care at the institution, after the subtraction of certain protected amounts. The amounts that the person is allowed to keep or use for other purposes include:

1. An allowance for the person to use for his/her personal needs. The Medicaid program does not guarantee that the person will receive the personal needs amount, only that s/he can keep that much from income s/he already receives. The personal needs allowance varies:
   - persons in institutions are generally allowed to retain $40 per month (scheduled to increase to $45 in July, 2001), however, if the person qualified as Categorically Needy under the higher income limit, s/he may be allowed to retain an additional amount per month;
   - community-based care participants are allowed $710 to $1,080 in 2001; and
   - people with no other income should be eligible for $30 per month from SSI.

2. An allocation may be made from the person’s income to support a spouse and/or minor child. The allocation is only enough to bring the spouse or family up to the SSI payment level, unless there is a court order or other legal obligation to make a higher payment. (See pg. 48.)

3. Expenses the person has for Medicare or health insurance costs or for other necessary medical expenses that are not covered by Medicaid.
4. An allocation may be made to pay rent or maintain the person’s home if there is a realistic expectation that s/he will be able to return home. This allocation is limited to the SSI payment standard for a single person.

5. If the person is working, s/he should be allowed to keep the first $65 per month s/he earns, plus half of anything s/he earns over $65 per month.

If the person has income above the personal needs allowance, it should be applied to his/her medical expenses before it is applied to costs of care. Unfortunately, if the person has no other income s/he may be forced to use the personal needs allowance for medical expenses not covered by Medicaid.

Eligibility for People in Long-Term Care who have Community Spouses

Spousal impoverishment protections apply to married couples in which one spouse receives certain long-term care services (institutionalized spouse) while the other spouse does not (community spouse). Under these protections, a portion of the couple’s income and assets may be retained for the community spouse. The spousal impoverishment protections apply whether the institutionalized spouse is in a nursing home, other Medicaid-funded institution or receiving long-term care services in the community under Family Care or another qualifying community-based care program.

At the time a married person enters a nursing home or community-based care program, the county Department of Social Services (DSS) Economic Assistance Division, upon request, conducts an assessment of the couple’s combined total assets. The “snapshot” assessment includes all countable assets owned by either or both spouses. Countable assets do not include the couple’s home, one vehicle, assets related to burial (including insurance, trusts, funds or plots), household furnishings and clothing or personal items.

If the total countable assets of the couple are less than $100,000, the community spouse asset share is $50,000. The maximum community spouse asset share is $87,000 in 2001 (adjusted annually based on changes in the consumer price index). The institutionalized spouse may keep $2,000 in assets, in addition to the community spouse’s assets. The community spouse’s assets are assessed only once. The institutionalized spouse’s assets may be examined again when it is time for the person’s Medicaid eligibility to be re-examined.

Once the asset test is met, the income of the long-term care spouse is tested. The spousal income limit, which is adjusted annually, is $2,175 in 2001. Only income in the long-term care spouse’s name is counted and some income may be transferred to the community spouse.
The asset and income rules related to long-term care and community spouses are complex and most of the guidelines fluctuate annually with the consumer price index. Those who think that they might be eligible under this provision should contact their county HSD for more information on the asset and income tests.

**Children with Disabilities Living at Home**

Some children with long-term disabilities who live at home cannot qualify for Medicaid, because their parent(s) income exceeds the eligibility guidelines. Under the Katie Beckett Program, these children are considered based on their care need rather than on their family’s income and assets. To be eligible, a child must meet all of the following criteria:

1. Be under 19 years of age and living at home.
2. Qualify as disabled by standards in the Social Security Act.
3. Require a level of care at home that is typically provided in a hospital or nursing facility.
4. Require care that can be provided safely and appropriately in the family home.
5. Have income and assets within Medicaid program guidelines.
6. Trust funds, if any, must meet necessary legal criteria.
7. Have home care costs that do not exceed what Wisconsin Medicaid would pay if the child were in an institution.

For children accessing Medicaid through this program, applications and annual recertifications require a home visit by a local Katie Beckett Consultant. To apply, obtain the locations of these consultants by contacting DHFS-Bureau of Developmental Disabilities Services at 608-266-3236.

**Medicaid Purchase Plan**

The Medicaid Purchase Plan (MAPP) began on March 15, 2000 for people with a disability who are working or interested in working. Under the plan people with a disability can purchase Medicaid coverage by paying a premium, based on their monthly income. This option is sometimes called Wisconsin’s Medicaid buy-in program.

A Wisconsin resident who meets the following criteria may be eligible:

- age 18 or older;
determined to have a disability by the DHFS Disability Determination Bureau;

- employed or enrolled in a certified Health and Employment Counseling program;

More than one member of a family may be eligible. Those who are eligible can:

- receive the same package of health benefits available through Wisconsin Medicaid;

- earn more income and not lose health or long term care coverage, including home health care services;

- maintain higher asset levels; and

- save for retirement, a new home, or other goods and services that increase personal and financial independence by placing up to 50% of earnings in an “Independence Account”. Funds in these accounts are not counted against the $15,000 asset limit.

Premiums

Premiums are based on monthly income. Some expenses (such as medical expenses and impairment-related work expenses) reduce countable income and, therefore, the premium amount. People with income below 150% of the federal poverty level, pay no premium. Other family members' income is not included in figuring the premium payment.

Application process

To apply, call the county HSD to make an appointment. Proof of employment or enrollment in a Health and Employment Counseling Program is required as well as verification of a disability determination.

Persons with Chronic Medical Conditions

Wisconsin Medicaid administers special programs for people who have chronic renal disease, cystic fibrosis or hemophilia. Special eligibility rules apply. Under this program, Medicaid pays for covered services not paid for by Medicare, private insurance or Medicaid. Individuals must pay a portion of the costs. People receiving treatment for kidney disease must make payments similar to those that apply under the Medicare program. People who receive treatment for hemophilia must pay according to a sliding fee scale based on income and net worth.

Federal poverty level information

www.ssc.wisc.edu/irp/faq1.htm

Sec. 49.472(3)(b), Wis. Stats.

Sec. 49.68-.685 & .687, Wis. Stats.
AZT and Pentamidine
Sec. 49.686, Wis. Stats.

For Human Immunodeficiency Virus (HIV) positive individuals a companion program helps pay for the medications azidothymidine (AZT) or pentamidine. (Call the Medicaid hotline or try the DHFS website on pg. 39 for more information about these special programs.)

Application and Retroactive Coverage

SSI-eligible persons should apply for both SSI and Medicaid at the nearest federal Social Security Office. Most applications can be completed over the telephone.

All other people, except those seeking Katie Beckett program eligibility, must apply to the county human services department. The county HSD should make its decision within 30 days, or within 60 days if medical reports are needed to determine disability. If there is an “emergency,” the faster, preliminary disability determination process should be used. (See pg. 42.)

Medicaid generally pays for covered services received up to three months prior to the month in which the person applies. For example, if a person applies on July 30, s/he could be covered for a service received as early as April 1, if s/he met all other eligibility requirements on April 1.

Sometimes it is important to make an application quickly to assure retroactive coverage. The county HSD may not refuse an application because it is incomplete or because it cannot schedule an immediate interview. The HSD should accept the application and get complete information afterwards.

Forward card

Once approved, individuals will be issued a “Forward” card. This plastic identification card must be presented to providers. Like a credit card, this card will allow providers to verify coverage information and eligibility. A person who loses Medicaid coverage should keep this card, in case s/he regains eligibility. The same card can be used without having to wait for another to be issued.

Changes in income or resources
Secs. 49.46(2) and 49.47(6)(a), Wis. Stats. HFS 107, Wis. Admin. Code

Medicaid enrollees are required to notify the Medicaid program within 10 days of changes in income or resources that might affect their eligibility.

Covered Services

Medicaid pays for a comprehensive package of medical, rehabilitative and support services. The range of services is much broader than Medicare coverage. However, there are limitations on some services and for some services, enrollees will have difficulty finding a provider who is willing to take a Medicaid patient. Both the coverage limits and the inability to find willing providers can create significant difficulties for Medicaid enrollees, since they have limited resources to pay for services.
A Medicaid enrollee should always make sure that the provider knows that s/he is a Medicaid enrollee before receiving a service. If the enrollee has any doubts, s/he should ask the provider if a particular service is covered and whether prior authorization is needed. (See pg. 59.)

Some of the more commonly-used services are discussed below. An enrollee should check with his or her provider or the Medicaid program concerning coverage of other services.

**Physician Services**

The services of a physician, including a psychiatrist, are covered wherever they are provided. Some physician services require prior authorization and some elective surgical procedures require a second opinion. Some services, such as acupuncture, are not covered at all. Other services are not covered because they are considered experimental, that is, not generally recognized by the professional medical community as an effective or proven treatment for the identified condition. There are copayments on office visits and other physician services, with a maximum of $30 per year per physician.

**Hospital Services**

Medically necessary hospital services are covered for all recipients. Generally, if the person is hospitalized for a surgical or dental procedure that is not covered by Medicaid, the hospital stay also will not be covered. A copayment of $3 per day for inpatient hospital care, up to a limit of $75 per hospital stay, is required. Outpatient hospital visits require a $3 copayment.

Medicaid usually does not pay for services for people ages 22-64 in a hospital that specializes in services for mental illness. It does pay for mental health services provided in a general hospital.

**Nursing Homes and Institutions**

Inpatient care in a skilled nursing facility or intermediate care facility is covered if a physician recommends admission to the facility. The physician must complete a plan of care for the individual and prescribe either skilled or intermediate care. Placement of people with mental illness or mental retardation in nursing facilities must be reviewed by the State Bureau of Developmental Disabilities to ensure that the facilities can provide the specialized services these individuals require.

A plan of care must be reviewed regularly (every 60 days for skilled care; every 90 days for intermediate care) to determine that the individual still needs the level of care prescribed. The individual has a right to request a hearing before payment to the facility is terminated.
Home Health Services

Home health services are provided by a home health or social service agency and may include the following services: nursing, home health aide, personal care, medical supplies and equipment, and therapies. Services must be prescribed by a physician and provided to a person living outside of a hospital or nursing home under a plan of care.

Services can include help with dressing, bathing, doing laundry, food shopping and meal preparation. Unlike Medicare, there is no requirement that the person need skilled nursing care to be covered. However, the person must have a disability or illness that restricts his/her ability to leave the home. Services should be covered if the person needs crutches, a cane, a walker or a wheelchair to leave home, or if leaving home creates a health risk or requires a “taxing effort.”

If a person has more than 30 home health visits (including nursing, home health aide and physical and other therapies) in a calendar year, prior authorization will be necessary. Most individuals who qualify for home health services will quickly need prior authorization for continued services and should keep that in mind from the outset. No copayment is charged for home health services.

Skilled and Private-Duty Nursing

Skilled nursing services are available to persons who require less than eight hours of direct, skilled nursing services per day. People who require more than eight hours of skilled nursing may be approved for private-duty nursing services and hire a nurse who works independently, rather than for a home health agency. All private-duty nursing services require prior authorization.

Respiratory Care

Services, medical supplies and equipment for ventilator-assisted individuals are covered for persons who have been hospitalized for at least 30 consecutive days for the respiratory condition and who need a ventilator for at least six hours per day. These services must be prior authorized and provided under a plan of care.

Physical, Occupational and Speech Therapies and Audiology Services

Physician prescribed physical, occupational and speech therapies and audiology services are covered by Medicaid. To receive physical, occupational and speech therapy services for more than 35 days per “spell of illness,” the service must be prior authorized. Prior authorization for extended services is not required if the service is provided to a hospital inpatient. A person may be considered to be in a new “spell of illness” if s/he has a new disease or injury or if a former condition worsens. Generally, ongoing maintenance therapy is covered only if it requires the skills of a trained therapist.
Most audiology services beyond the initial evaluation require prior authorization. Covered services can include services to help the person function better or to maintain current functioning, but maintenance therapy is covered only if it requires the skills of a trained therapist.

Copayments are required for the first 30 hours or $1,500 of services each calendar year. Audiology testing, equipment and repairs also have copays. If these therapy services are provided as home health services, no copayments are charged.

**Outpatient Treatment for Mental Illness and Substance Abuse**

Services to address mental illness and substance abuse or AODA (alcohol and other drug abuse) services include outpatient psychotherapy, in-home intensive psychotherapy and day treatment.

Outpatient psychotherapy and substance abuse services must be prescribed in writing by a physician after a diagnostic evaluation. These services may be provided in a provider’s office, hospital, hospital outpatient clinic, nursing home or school. Prior authorization is required for services in excess of 15 hours (or $500 in costs for Medicaid) in a calendar year and there are copayments on the first 15 hours of service.

In-home psychotherapy services are available for some adults and children with certain mental health needs who cannot get to, or keep appointments, at an outpatient office. These services are available in counties that have elected to cover them, and require prior authorization.

There are three types of day treatment programs which include mental health and substance abuse services. They are adult medical day treatment, AODA day treatment and child and adolescent day treatment. Day treatment programs are for individuals who require supervision and/or services more intense than may be offered in an outpatient office setting. Medicaid will reimburse up to 5 hours of day treatment per day. Up to 90 hours of adult medical day treatment may be provided without prior approval. AODA and Child and Adolescent Day treatment services require prior authorization for all services.

Behavioral health managed care demonstration projects for mental health and substance abuse services are planned for mental health and substance abuse services are planned for up to six counties. In participating counties, all mental health services for certain individuals will be provided by contracted public or private agencies. The Children Come First program in Dane County and the Milwaukee Wraparound Program in Milwaukee County, for children with severe mental health needs.
emotional disturbance, are examples of existing managed behavioral health care programs. (See Integrated Services for Youth with Mental Health Needs chapter, pg. 146.)

**Drugs**

Medicaid covers drugs, but its drug payment policies restrict covered drugs to those that are on the Medicaid drug list or “formulary”. To be covered, a drug must be prescribed by a physician, even if it can be bought at a drugstore over the counter without a prescription. Even with a prescription, the only over-the-counter drugs that are covered are insulin, antacids, cough preparations, and analgesics (aspirin, Tylenol, etc.). Other over-the-counter drugs, such as laxatives are not covered. There are copayments for all drugs (50 cents for over-the-counter drugs and $1 for prescription drugs), with a maximum of $5 per month at each pharmacy. The state has begun to require prior authorization for certain experimental and expensive drugs.

**Medical Supplies and Equipment**

Medical supplies and equipment are covered if they are on Medicaid’s list of covered items and if they are prescribed by a physician and supplied by specified providers. Examples of covered items are equipment to help the person be more independent such as corrective shoes, braces, oxygen equipment, artificial limbs, hearing aids, and wheelchairs (including electric wheelchairs).

Prior authorization is required for many items. Individual wheelchairs for people in nursing homes are covered only if the person needs a special adaptive or electric wheelchair, if the wheelchair will help the person achieve greater independence, or if the person is about to move to a more independent setting.

If the Medicaid program determines that a piece of medical equipment will only be needed on a short-term basis, it may only pay for rental, rather than purchase of the equipment. Most medical equipment and supplies require copayments.

**Dental Services**

Basic dental services are covered including check-ups, fillings, crowns, root canals, complete dentures, removal of diseased gum tissue and removal of teeth. Procedures to correct conditions that “seriously interfere with...personal or social adjustment or employ-ability” should also be covered. Partial dentures and bridges usually are not covered. Most dental procedures require prior authorization. Copayments from 50 cents up to $3.00 are required for all services.

Many dentists do not accept Medicaid because the reimbursement rates are below their actual costs. Contact disability groups in your area to find the names of dentists who accept Medicaid, and have a good reputation among consumers and families.
Vision Care Services

Evaluation, diagnostic and vision care services provided by optometrists and ophthalmologists are covered. Eyeglass frames, lenses and replacement parts must be provided by opticians, optometrists and ophthalmologists who participate in the Medicaid program’s volume purchase plan. Purchase outside this program requires prior authorization. Prior authorization is also required for contact lenses and more than one replacement pair of glasses in a year. Some purchases are not covered, including spare eyeglasses and tinted lenses. Office visits, therapies and equipment all have copayments.

Transportation

Transportation is a covered service for all recipients when it is necessary for the person to get to a Medicaid-covered service.

Three types of transportation are covered:

1. If the person can travel by ordinary car, bus or taxi, payment to the provider should be made by the county HSD. Except in an emergency, the person must get prior authorization from HSD. No copayment is required.

2. If the person uses a wheelchair or otherwise has a condition which requires a specialized motor vehicle, transportation is covered when it is prescribed by a physician. There is a $2 per trip copayment.

3. Ambulance services are covered in an emergency or if they are medically necessary and prescribed by a physician. Non-emergency use of an air or water ambulance must be prior authorized. For nonemergency ambulance services, there is a copayment of $1 per trip.

HealthCheck and “HealthCheck Other Services” for Children

Children under age 21 are entitled to comprehensive health screenings. Each screening should include a physical exam, vision test, dental assessment, appropriate immunizations and a comprehensive health and developmental history.

If a child is determined through a HealthCheck screen to require a medically necessary service not provided by Wisconsin Medicaid, but allowed for under the federal Medicaid program, the service must be provided if prescribed by a physician. Many services that are not normally provided to children under the Wisconsin Medicaid program can be accessed as a result of a HealthCheck screen, (e.g., specialized medical equipment and child and adolescent day treatment). However, the Medicaid program does limit these services to...
those that it considers to be “in accordance with reasonable standards of medical and dental practice.”

When a service is not covered, the State Division of Health Care Financing or the family’s regular provider should attempt to refer the family to a provider willing to perform the service at little or no expense.

Case Management
A person who needs help accessing or coordinating medical, social, educational, vocational and other services may be eligible for case management services. Most Medicaid enrollees are eligible for these services which may be provided by a social worker or other individual trained in helping people coordinate services.

School-based Services
Many children under age 21 receive Medicaid services at school or in a Birth to Three program. These programs may provide, or arrange for, many services, including speech therapy, occupational therapy, nursing, psychological counseling, social work, developmental testing, assessments, transportation and medical supplies. The services must be included in the student’s individualized education program (IEP) or individualized family service program (IFSP). (See Special Education chapter, pg. 109 and Birth to Three Program chapter, pg. 103.)

Other Services
Additional services covered by the Medicaid program include: laboratory and x-ray, chiropractic, independent nurse practitioner, family planning, and rural health clinic services. For more information on these and other services contact a provider or the Medicaid recipient services hotline. (See pg. 39.)

Coverage of Out-of-State Services
A Wisconsin resident can receive Medicaid coverage for a service received outside the state only under one of the following conditions:

1. The service is provided in a community that borders on Wisconsin by a provider who is certified under the Wisconsin Medicaid program.

2. The service is needed due to an emergency.

3. The person’s health would be endangered if s/he had to travel back to Wisconsin to receive services.

4. Wisconsin’s Medicaid program has prior authorized the out-of-state service. Generally, approval is limited to situations in which equally effective services are not readily available in Wisconsin.
Payment for Services

Medicaid makes payments to providers of services who are certified to participate in the Medicaid program and agree to follow the program’s rules. Medicaid does not pay Medicaid enrollees for services, even if the enrollee has already paid for the service.

When a Medicaid enrollee receives a covered service from a Medicaid-certified provider, the provider must bill Medicaid for the cost of the service. The individual should tell the provider that s/he is (or may be) covered by Medicaid and give the provider all the information necessary to bill Medicaid.

Freedom from charges

If a provider knows a person is covered by Medicaid, the provider must not charge the person for any part of the service cost, unless the Medicaid program requires the person to make a copayment. Unlike Medicare, the providers may not charge the person for the difference between his/her usual charges and the amount Medicaid pays. The only exception to this rule is when an individual has already paid for a service and later becomes Medicaid covered for the period of time when the service was received. The provider then is required to bill Medicaid and to return the person’s money, up to the amount the provider receives from Medicaid. However, if the person has paid a higher fee than Medicaid pays, state rules allow the provider to keep the difference.

Medicaid pays for services if:

- You are eligible for Medicaid at the time that you receive the service.
- The service is covered by the Medicaid program. (If prior authorization is required, it must be obtained before you get the service).
- You get the service from a provider who is certified to participate in Wisconsin’s Medicaid program.
- You apply for Medicaid within 3 months after the month in which you get the service.

A provider may charge an individual for services that are not covered by Medicaid. However, if the provider knows that the person is eligible for Medicaid, then the provider must tell the person beforehand that the service will not be covered, and how much the person will have to pay.

Medicare or private insurance

If an individual has Medicare or other insurance, the provider must bill those sources before billing Medicaid. Medicaid will then pay the
Medicaid requires enrollees to pay part of the cost of some services. The provider may charge the individual for this amount, called a copayment. Medicaid deducts the copayment amount from its payment to the provider. No person should be denied a service if s/he is unable to make the copayment.

No copayment is required under the following circumstances:

1. The person receiving the service is under age 18 or pregnant.
2. The person is enrolled in an HMO and receiving the service through the HMO. (See pg. 60.)
3. The person receiving the service is a resident of a nursing home (including a State Center for the Developmentally Disabled).
4. The person needs emergency services due to sudden symptoms that indicate a need for immediate medical attention.

Copayment amounts for some services are listed in the discussion of covered services. A complete list of copayment amounts is available on the DHFS web site.

Prior Authorization, Second Opinions, and Primary Provider Programs

For many services, the provider must ask the Division of Health Care Financing (DHCF) to authorize payment for the services before it is provided. This process is called prior authorization. Except in an emergency, Medicaid will not pay for this type of service if the person receives it before DHCF makes its decision, even if DHCF later approves the request. It is important that the request contain complete
information justifying the service. Among the items the Medicaid program considers in deciding whether to authorize a service are:

1. Whether it is medically necessary and appropriate.
2. How much it will cost.
3. Whether it is likely to be effective, of high quality, and at the right time.
4. Whether there is a less expensive or more appropriate alternative.
5. Whether the provider or recipient has overused or misused services.

Information on prior authorization for some services is discussed under the Covered Services section of this chapter. *(See pg. 51.)*

DHCF should decide most prior authorization requests within two weeks. If a request is denied, the individual can appeal. *(See pg. 61.)* S/he should make sure that good information is provided on the need for the service and why alternatives are not as effective. If a prior authorization request is denied and the person receives the service after the denial but before the appeal is decided, Medicaid will pay for the service if the appeal is successful.

Medicaid requires a second doctor’s opinion for certain elective surgical procedures to determine whether they are really necessary. Except in an emergency, Medicaid will only pay the surgeon for one of these procedures if the person obtained a second opinion before the surgery. However, the patient should not have to pay the surgeon either, unless the surgeon told the patient, before the surgery, that s/he would have to pay.

If the Division of Health Care Financing decides that a person is misusing the Medicaid program, it can require the person to choose a primary provider. The person must then have some or all services approved by the primary provider, or Medicaid will refuse to pay.

**HMO, Managed Care and Prepaid Health Plans**

Most individuals with disabilities use individual providers under the Medicaid “fee-for-service” system which means that a Medicaid enrollee finds a Medicaid-certified provider who submits a bill for a specific Medicaid-covered service. However, an increasing number of Medicaid enrollees with disabilities receive all or a portion of their care through a managed care system. Medicaid uses several types of organizations to manage the care of Medicaid enrollees in exchange...
for a monthly fee (a capitation payment), regardless of the service costs for the enrolled individuals.

The most common managed care organization (MCO) used by Medicaid, is a health maintenance organization (HMO) which is usually a private, for-profit insurance company. Other nonprofit or county organizations, may provide care for a capitation or prepaid health care payment and may be referred to as care management organizations (CMOs). Family Care and the Behavioral Health Care Demonstration projects are examples of other managed care programs.

Persons in managed care programs generally receive services from providers in the MCO and must comply with enrollment and disenrollment rules. The organizations may have their own prior authorization procedures which may be more restrictive than regular Medicaid. The services an MCO should provide are described in their contract with the State Medicaid program. Generally, MCOs should provide the same range and amount of services, allowed under Medicaid.

If a person is denied service from an MCO, s/he should follow the appeal procedures within that organization. If an inadequate response is received, an appeal should be made to the Medicaid program.

**Notice and Appeal Rights**

Whenever a decision is made that affects a person’s eligibility or services, the person should receive a notice of the decision, the reasons for it, the laws or rules that apply, and the person’s hearing rights.

A Medicaid applicant or enrollee is entitled to a hearing if eligibility or services are denied, unreasonably delayed, suspended, reduced or stopped. A hearing may also be requested when a prior authorization for a service has been denied or modified.

To request a fair hearing the individual must file an appeal within 45 days of a denial notice. If a person already receiving Medicaid requests a hearing within 10 days of the action being appealed, Medicaid must continue benefits and may not reduce or stop benefits until the hearing examiner has made a decision after the hearing. If the notice from the agency was late in arriving, the individual should mention this in the appeal. It may also help to make a telephone request for a hearing and then follow up with a written request. The request for a hearing must be received by the 45th day at the DHFS Division of Hearings and Appeals in Madison.

HFS 104.05 & .035, Wis. Admin. Code
HFS 107.28, Wis. Admin. Code

**Notice**

42 CFR 431.206-.214
HFS 104.02(9)(b), Wis. Admin. Code

**Right to hearing**

42 CFR 431.220-.231
HFS 104.01(5), Wis. Admin. Code

**Continuing benefits**

42 CFR 430.231

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Hearings are conducted by the Division of Hearings and Appeals in the state Department of Administration. Requests for a hearing can be made on one of their forms or in a letter that states the person wants a hearing, the agency action with which the person disagrees, whether the person needs an interpreter at the hearing, or needs to have the hearing held in a hospital, home or other location. Usually hearings are held at the county HSD office.

Hearings are usually informal. The person can testify, bring witnesses, or present letters from other people as evidence. A county HSD representative may also be there. The person may be represented by an attorney, a friend, or another spokesperson. It is important to know which rules apply and which facts need to be proved. Being represented by an advocate who knows Medicaid well is very helpful. The Hearing Examiner is supposed to hold the hearing and make a written decision within 90 days after the request for a hearing.

Need More Information to Build Your Case?

If you think you have been wrongly denied Medicaid coverage or specific services, you should find out why the agency took its action and what rules apply, so that you can know what you need to prove at a hearing. State rules and policy should be made available to you to review at the county HSD office during business hours. The Medicaid Handbook is used in deciding eligibility, and often is a good source of information. You might also try the Medicaid hotline at 1-800-263-3002.

Some counties have ombudspersons who will help you sort through the rules and how they have been applied in your case. Also, the Legal Resources listed in the Additional Resources Appendix may be helpful.

The Division of Hearings & Appeals may be contacted by phone at 608-266-3096 (voice) and 608-264-9853 (TTY) or in writing at 5005 University Avenue, Suite 201, Madison, WI 53703-7875.

Appeal

Sec. 227.12-.21, Wis. Stats.

If the individual disagrees with the fair hearing decision, a request for a rehearing may be made within 20 days or an appeal of the decision in court may be made within 30 days after receiving the decision or denial of a request for a rehearing. The judge usually reviews only the record from the hearing and no new evidence, so it is important that all evidence and arguments in support of the case be made at the hearing.