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## FINANCIAL ELIGIBILITY

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### COMMUNITY WAIVERS ELIGIBILITY GROUPS

There are broader income limits for people who are waiver participants than for Medicaid fee-for-service beneficiaries because the waiver programs are patterned after nursing home eligibility rules rather than Medicaid fee-for-service rules. In a number of instances, this will allow people who would not normally be income eligible for Medicaid to become Medicaid eligible under the Community Waivers Program.

There are three different financial eligibility groups: Group A, Group B and Group C

- Group A includes individuals who are already eligible for Medicaid.
- Group B includes individuals who are not Group A and whose countable income is at or below \$2022/month (year 2010 figure).
- Group C includes individuals whose countable income exceeds \$2022/month (year 2010 figure), but whose income deductions, including medical/remedial expenses and Medicaid card costs reduces their countable income at or below the Medically Needy Medicaid income limit (\$591.67 – year 2010 figure).



## COMMUNITY WAIVERS FINANCIAL ELIGIBILITY

In addition to non-financial eligibility criteria, all community waiver applicants must meet certain financial eligibility criteria to participate in community waivers. The financial eligibility requirements are listed below under each community waiver group; however, please keep in mind two important non-financial eligibility criteria as we list each group of waiver applicants:

- For all applicants/participants – it is necessary to meet an appropriate nursing home level of care for the COP-W/CIP II waiver program according to the automated Long Term Care Functional Screen (LTC FS) and,
- For all individuals under age 65, it is necessary to have a determination of blindness or disability. The disability determination is processed in the course of the SSI or the Medicaid eligibility application by the Disability Determination Bureau. For **all** waiver applicants/participants under age 65, a disability determination is required in **addition** to the nursing home level of care requirements.

Note there is a certain category of Medicaid that does not require a disability determination for purposes of Medicaid eligibility. That is: BadgerCare Plus. For purposes of community waivers participation, when BadgerCare Plus eligible individuals apply for Medicaid waivers, they must have a disability determination via the Disability Determination Bureau, in addition to meeting the appropriate nursing home level of care and target group under the LTC FS.

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## GROUP A

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### DESCRIPTION OF GROUP A WAIVER PARTICIPANTS

Note that for all Group A listed below, if the waiver applicant is under age 65, a disability determination by the Disability Determination Bureau is needed in addition to a determination of appropriate nursing home level of care under the functional screen. See “Community Waiver Financial Eligibility” text on previous page.

Individuals who are receiving Medicaid through SSI, SSI-E, 1619 (a) or (b), children enrolled in the Katie Beckett Program, or any subprogram of Medicaid, including the Standard benefit plan of Badger Care Plus and the Medicaid Purchase Plan (MAPP), are eligible for community waivers as Group A, provided they are functionally eligible, meet the other waiver requirements, have a disability determination, and there is funding available to serve them in their county of residence.

**Individuals who are financially Group A eligible do not have a cost share.**

Please note: the following Medicaid subprograms are **not** considered Group A eligible:

- Emergency services for non-qualifying aliens,
- Presumptive eligible pregnant women,
- Tuberculosis related Medicaid,
- Qualified Medicare Beneficiary (QMB) only,
- Specified Low-Income Medicare Beneficiary (SLMB) only,
- Specified Low-Income Medicare Beneficiary Plus (SLMB+),
- Qualified Disabled and Working Individuals (QDWI).
- Badger Care Plus – Benchmark benefit plan

The more common Group A categories are highlighted below:

- **SSI recipients** – Eligibility for this program is administered solely by the Social Security Administration. Individuals who are found eligible for SSI are automatically eligible for Medicaid. Continued eligibility for SSI (and Medicaid) is handled by Social Security. Income Maintenance (IM) worker involvement in these cases may be limited to determining Food Stamp applications. In waiver cases, SSI recipients are handled by Care Managers, unless divestment is involved. Divestment cases are referred to IM workers for potential divestment penalty determination.
- **SSI-E recipients** – These are SSI recipients who have been determined by a care manager or other individuals to be in need of at least 40 hours per month of assistance with activities of daily living. These SSI recipients are referred to the County’s Long Term Support Unit for “E” (=Exceptional) Supplement screening. If eligible, an

individual will receive additional income to help him or her defray the costs of services. It is up to the individual to choose how to spend this additional income. Recipients may live in either their own home or in certain congregate living arrangements.

- **Katie Beckett** – Eligibility determination for this program is administered by the Bureau of Long Term Support (BLTS). The Katie Beckett Program is a special eligibility process that allows certain children with long-term disabilities or complex medical needs, living at home with their family, to be eligible for a Medicaid card. Children who are not eligible for other Medicaid programs because the income or assets of their parents are too high may be eligible for Medicaid through the Katie Beckett program if they meet all the following criteria: 1) the child is under the age of 19 and determined disabled by standards in the Social Security Act 2) has a level of care at home that is typically provided in a hospital or nursing home; 3) can be provided safe and appropriate care in the family home; 4) as an individual, does not have income or assets in his/her own name in excess of the current standards for a child living in an institution; and 5) does not incur a cost of care at home to Medicaid that exceeds the cost Medicaid would pay if the child were in an institution.
- **1619A** – 1619a is an SSI work incentive program managed by the Social Security Administration. It allows a person to receive SSI cash payments even when their earned income (gross wages and/or net earning from self-employment) is at the SGA (substantial gainful activity) level. This eliminates the need for a trial work period or extended period of eligibility under SSI. For more information regarding this work incentive program please see the “Red Book on Work Incentives.” The “Red Book on Work Incentives” is a summary guide regarding various work incentive programs and is available at your local social security office.
- **1619B** – 1619b is an SSI work incentive program managed by the Social Security Administration. It allows a person to retain Medicaid status if s/he earns more than the SSI income limit and loses the SSI cash payment. See the “Red Book on Work Incentives” for more information.

NOTE: Effective May 1, 1991, a person age 65 or over who is blind or disabled may qualify for continued Medicaid coverage under section 1619(b).

- **To qualify for the 1619B incentive, a person must:**
  - ✓ have been eligible for an SSI cash payment for at least one month;
  - ✓ still meet the disability requirement;
  - ✓ still meet all other non-disability requirements;
  - ✓ need Medicaid in order to work; and
  - ✓ have gross earned income, which is insufficient to replace SSI, Medicaid, and any

publicly funded attendant care.

The Social Security Administration uses an income threshold to measure whether a person's earnings are high enough to replace his/her SSI and Medicaid benefits.

- **What is the threshold?**

The threshold amount is based on:

- ✓ the amount of earnings which would cause SSI cash payments to stop in the person's state  
**AND**
- ✓ the annual per capita Medicaid expenditure for the state.

If the person's gross earnings are higher than the threshold amount for his/her state, the Social Security Administration can figure an individual threshold if the person has:

- ✓ impairment-related work expenses;
- ✓ blind work expenses;
- ✓ a plan to achieve self-support;
- ✓ publicly funded attendant or personal care; or
- ✓ medical expenses above the state per capita amount.

The individual is responsible for reporting employment status and income to the Social Security Administration (SSA). SSA makes adjustments to SSI payments and status based on what the person reports.

Other groups considered Group A include:

- **503** – A 503 person is someone who received SSI and Old Age, Survivor, Disability Income (OASDI) concurrently but subsequently became ineligible for SSI for any reason. 503 persons are entitled to a disregard of all COLA's received since they last received SSI, when determining their eligibility for Medicaid. Their eligibility is determined by the county IM/tribal ES agency.
- **Widows/Widowers** – Widows and widowers who meet the specific eligibility criteria and who lose SSI as a result of receiving OASDI widow/widower benefits are entitled to a disregard of the entire widow/widower OASDI benefit when determining their Medicaid eligibility. Their eligibility is determined by the county IM/tribal ES agency.
- **Disabled Adult Child – (DAC)** – A Disabled Adult Child (DAC) is someone who meets other specific eligibility criteria and loses SSI as a result of receiving initial OASDI – DAC benefits or an increase in his/her OASDI – DAC benefit. These individuals are entitled to a disregard of the DAC benefit/increase that caused them to lose SSI and a disregard of all COLA's received since the last receipt of SSI when determining their eligibility. Please

note: the disability must have been determined before age 22. Their eligibility is determined by the county IM/tribal ES agency.

- **Medicaid Medically Needy Who Have Met a Deductible** – This is another group of individuals who is considered Group A if they have been certified for Medicaid during the deductible period. At the next review, they can choose to satisfy the deductible immediately, thus remain a Group A, or they can become eligible for the waivers as a Group B with a cost share or Group C with a spenddown, depending on their income limit. To remain waiver eligible, these individuals must maintain **continuous** Medicaid eligibility, either as a “met” deductible or as a Group B or Group C participant, whichever applies.
- **Badger Care Plus** – Badger Care Plus (BC+) is a state/federal program that provides health coverage for Wisconsin families. BC+ replaces the former Family Medicaid programs (AFDC-Medicaid, AFDC-Related Medicaid and Healthy Start) and BadgerCare.

BC+ has two major healthcare benefit plans: Standard and Benchmark. The Standard Plan is for families with income at or below 200% of the Federal Poverty Level (FPL). These FPL levels change yearly and are available at:

<http://emhandbooks.wi.gov/bcplus/> (click on Tables, then on 50.1 FPL Tables).

In the year 2010, income at or below \$1805/month is at or below 200% of the FPL, and income over \$1,805/month is above 200% of the FPL.

All BadgerCare Plus eligible individuals who apply for the Medicaid Community Waiver program must have a disability determination from the Disability Determination Bureau. They must also meet all applicable criteria for waiver eligibility (e.g., level of care, target group, resides in a waiver allowable setting, need for waiver services, etc.).

Individuals who are eligible for BadgerCare Plus – Standard Plan, which means the person is at or below 200% of the Federal Poverty Level (FPL), and who pass the Medicaid Community Waiver financial and non-financial eligibility test, will be considered Group A and will have no cost-share to the waiver program. However, they may have a BadgerCare Plus premium that he/she may have to pay.

The Benchmark Plan, which provides more limited services than the Standard Plan, is for families with income above 200% of the FPL, and, for self-employed parents and caretakers who qualify through the unique depreciation methodology.

Individuals who are currently eligible for BadgerCare Plus – Benchmark Plan, and who apply for and pass the Medicaid Community Waiver financial and non-financial eligibility tests must choose to either remain on BadgerCare Plus – Benchmark Plan and not be served on the Community Waivers program, OR, be taken off of BadgerCare Plus – Benchmark Plan - and be Medicaid Community Waiver eligible. If the person chooses to be in the Medicaid Community Waiver program, their medical status code must reflect a Medicaid

Community Waiver program. As Medicaid Waiver Community eligible individuals, the person will be either a Group B or Group C, depending on their income levels, and Medicaid Community Waivers rules apply as far as assets, cost-share or spenddown amounts are concerned.

- **EBD Medicaid** - An individual who meets all other non financial and financial criteria is eligible for EBD Medicaid if at least one of the following applies:
  - ✓ Age 65 or older or
  - ✓ Blind: must be determined by the Disability Determination Bureau (DDB), Department of Health and Family Services to be legally blind or
  - ✓ Disabled: must be determined by the Disability Determination Bureau (DDB), Department of Health and Family Services to be permanently and totally disabled or
  - ✓ Presumptively disabled
- **Wisconsin Medicaid Purchase Plan (MAPP)** – MAPP is a Medicaid Subprogram for individuals with disabilities whose family income is below 250% of the Federal Poverty Level. The applicant must have countable (non-exempt) assets less than \$15,000 and must be employed or enrolled in the Health and Employment Counseling Program.

The participant must be at least 18 years old; must be determined disabled by the Disability Determination Bureau (DDB); must be employed or enrolled in the Health and Employment Counseling Program; and must meet all the SSI-related non-financial eligibility requirements. Important note: for individuals who are denied disability status due to earnings, DDB can conduct a separate MAPP Disability Determination. This determination uses all of the same disability criteria with the exception of “substantial gainful employment” limitations applied to a standard disability determination.

Individuals potentially eligible for MAPP include:

- ✓ SSDI Beneficiaries
- ✓ Individuals who have lost SSI due to excess income
- ✓ Nursing Home residents (private pay and meet all other eligibility criteria)
- ✓ Individuals currently enrolled in the Health Insurance Risk Sharing Program
- ✓ Individuals currently Medicaid ineligible pending satisfaction of a deductible
- ✓ 100% COP recipients qualifying for a Home and Community Based Waiver not receiving Medicaid due to excess income or assets (unless ineligible for MAPP or unless they meet one of the hardship criteria, if they are between ages 18 and 65, all 100% COP recipients must apply for MAPP).
- ✓ 100% COP recipients **not** qualifying for a Home and Community Based waiver who may become eligible for Medicaid Card services
- ✓ 1619b individuals
- ✓ Individuals currently participating in a Medicaid Home and Community Waivers program
- ✓ Individuals who may have too many assets to qualify for straight SSI-Related Medicaid

MAPP eligible individuals who are eligible for the waiver are categorized as Group A and as such do not have a cost share, but it is possible that, depending on income, they may have to pay a premium to participate in MAPP. These individuals have the option of accessing Medicaid via MAPP. If the participant is not interested in participating in MAPP, the IM worker will test for the appropriate category A, B, or C provided they meet all eligibility tests.

## **ASSET LIMIT**

The asset limit determination for SSI, SSI-E, and 1619 (a) and 1619(b) cases is done by the Social Security Administration. The asset limit for children enrolled in the Katie Beckett Program is determined by BDDS. All other Medicaid categories have their asset determination completed by IM workers.

The asset limit for an individual waiver participant is \$2,000. However, there are a few exceptions. For example, for a MAPP eligible individual there is an initial asset limit of \$15,000, and for a BadgerCare Plus – Standard Plan eligible individual there is no asset test. All Medicaid waiver program applicants are treated as individuals, even when married. Spousal impoverishment rules apply when a community spouse is involved. In these cases, the community spouse's asset share can be up to \$109,560 (year 2010 figure) of countable assets, plus up to \$2,000 for the waiver individual.

 **COST SHARE**

There is no cost share obligation for any Group A individuals.

However, MAPP and Badger Care Plus Standard plan participants may have to pay a premium based on the applicant's income.

## COMPLETING THE F-20919 WORKSHEET

The care manager completes the [F-20919](#) to verify financial eligibility of all SSI, SSI-E, 1619(a) and 1619(b) recipients, and children enrolled in Katie Beckett applying for the waiver programs. See the following page for an example of how this form is completed.

For other Medicaid subgroups, the IM worker uses the Client Assistance for Re-Employment & Economic Support (CARES) system to determine financial eligibility. The Income Maintenance worker gives the care manager a copy of a Community Waivers Budget (CWB) page. Please see the following page for an example of the CWB page. NOTE: for **documentation purposes** it is also acceptable for the IM worker to complete the [F-20919](#) for the individual fitting into a Group-A eligible Medicaid category subgroup if a CWB page is not available. **As a reminder: A person who is Group A eligible has no cost share obligation** to the Waiver program. See the following pages for examples of a F-20919 completed by a care manager for a participant who is on SSI, and another F-20919 completed by an IM worker for a “MAPP” case if the IM worker was unable to print a CWB page.

When completing the [F-20919](#), the care manager or IM worker must fill out the following parts of the worksheet:

1. The top box (which includes **the date** the form was completed and the names of the participant, his or her spouse, the care manager, and the IM worker, if applicable).
2. Section I - Financial Resources  
Enter the income amount in the appropriate lines 1-4. Place a check mark next to the appropriate Medicaid category (SSI, SSI-E, 1619 a or b or Katie Beckett) or have the IM worker indicate the Medicaid Type, as well as, the CARES Category code on the F-20919.
3. Section II - Special Declaration Regarding Divestment for Group A Waiver Applicants  
Note: Section II documents the care manager asked the individual if s/he or his/her spouse transferred resources in the past 36 months, or if the individual or his/her spouse set up a trust in the past 60 months (except for exempt funeral trusts). The care manager must ask the questions printed on the form and check the box reflecting the person's response.
4. Section V - Statement of Eligibility.  
Sections III and IV are not completed for Group A individuals.

The [F-20919](#) form should **always be dated** to demonstrate that financial eligibility for SSI, SSI-E, 1619 a or b and children enrolled in Katie Beckett has been re-determined every 12 months.

## MEDICAID WAIVER ELIGIBILITY AND COST SHARING WORKSHEET

Completion of this form meets the requirements of the Federal Regulations 42 CFR 435.

Check One:  Application  Review/Recertification  Change

Name – Applicant Beatrice Jones	Medicaid ID Number 123-45-67890	Medicaid Eligibility Date 2-11-96
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Name - Care Manager Ivanna Help	Name – Income Maintenance Worker (IMW)	IMW No.	Date 10-10-08
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### SECTION I – FINANCIAL RESOURCES (Complete for all Applicants)

1. Nonexempt Assets	\$ 900.00
2. Gross Earned Income	\$ 0.00
3. Total Unearned Income	\$ 720.78
4. Total Income (2 + 3)	\$ 720.78

**Group A** (Applicant is currently eligible for Medicaid) **Care Manager checks eligible category and completes sections II and V for the following types:**  
 SSI Recipient  SSI-E  1619a  1619b  Katie Beckett  
**Other Medicaid Eligibility: Income Maintenance Worker writes in Type and Category Code:**

Other Medicaid Type (Specify) \_\_\_\_\_

CARES Category code (Specify) \_\_\_\_\_

NOTE: This form may be used by IMW for a Group B or Group C applicant only if the applicant is institutionalized at the time of application.

**Group B** Special Income Limit (IMW completes Sections III and V)

**Group C** Medically Needy (IMW completes Sections IV and V)

### SECTION II – SPECIAL DECLARATION REGARDING DIVESTMENT FOR GROUP A WAIVER APPLICANTS WHO RECEIVE SSI, SSI-E, 1619a, 1619b, OR KATIE BECKETT

Care Manager: Ask the applicant both of the following questions:

1. "Have you or your spouse sold, traded, transferred or given away property, land stocks, bonds, cash, vehicles, or anything of value in the past 36 months?"
2. "Have you or your spouse created a trust or added funds to a trust within the last five years?"

Yes. Complete DDE-919-D and Refer applicant to Income Maintenance Worker for investigation and determination. After Income Maintenance Worker makes determination, proceed to Section V.

x  No. Proceed to SECTION V.

### SECTION III – COST SHARING/GROUP B UNDER "SPECIAL INCOME LIMIT." When Spousal Impoverishment Protections Apply, Substitute "Income Allocation Worksheet" for Section III

1. Total Income	\$
2. Personal Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
3. Family Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
4. Special Exempt Income	\$
5. Health Insurance Premium	\$
6. Out of Pocket Medical/Remedial Expenses Obtain this figure from care manager.	\$
7. Total Deductions ( 2 + 3 + 4 + 5 + 6)	\$
8. Waiver Cost Share Amount (1 – 7) The amount on line 8 is monitored and documented by the care manager. Proceed to Section V.	\$

### SECTION IV – FOR GROUP C MEDICALLY NEEDED

1. Gross Earned Income (2)	\$
2. \$65 and ½ Disregard	\$
3. (1 – 2)	\$
4. Total Unearned Income (3)	\$
5. (3 + 4)	\$
6. \$20 Disregard	\$
7. Balance (5 – 6)	\$
8. Special Exempt Income	\$
9. Countable Income (7 – 8)	\$
10. Health Insurance Premium	\$
11. Balance (9 – 10)	\$
12. Excess Self Employment Expense	\$
13. Balance (11 – 12)	\$
14. Monthly Medical/Remedial Expenses Obtain this figure from care manager	\$
15. Balance (13 – 14)	\$
16. Medicaid Card Coverable Services	\$
17. Balance (15 – 16)	\$

If the Balance on line 17 is greater than the current medically needy income limit, the applicant is not eligible for Medicaid Waivers. Proceed to line 18 with all eligible Group C Applicants.

### SPENDDOWN DETERMINATION FOR ALL ELIGIBLE GROUP C APPLICANTS

18. Balance (from line 13)	\$
19. Current Medically Needy Income Limit	\$
20. Spenddown Amount (18 – 19)	\$

The amount on line 20 must be incurred by the applicant on a monthly basis to sustain eligibility. This is monitored and documented by the care manager. **Now complete an Income Allocation Worksheet for all spousal impoverishment cases.** Proceed to Section V.

**DATE NEXT MA REVIEW DUE** - Reviews must be completed every 12 months

**SECTION V – STATEMENT OF ELIGIBILITY. COMPLETE FOR ALL MA WAIVER APPLICANTS. (Check One)**

- Applicant is eligible as a Group A.
- Applicant is not eligible for waiver services as a Group A for \_\_\_\_\_ months due to Divestment.
- Applicant is eligible as a Group B with no cost share.
- Applicant is eligible as a Group B with a monthly cost share of \$\_\_\_\_\_.
- Applicant is eligible as a Group B married, spousal impoverishment rules apply, with a monthly cost share of \$\_\_\_\_\_ (from Spousal Income Allocation Worksheet).

- Applicant is eligible as a Group C with no spenddown.
- Applicant is eligible as a Group C with a monthly spenddown liability of \$\_\_\_\_\_ (Line 20).
- Applicant is eligible as a Group C married, spousal impoverishment rules apply, by incurring a monthly spenddown of \$\_\_\_\_\_ (Line 20) and monthly cost share of \$\_\_\_\_\_ (from Spousal Income Allocation Worksheet)
- Applicant is not eligible under Group C – not medically needy.

**ALLOWANCE DETERMINATIONS FOR SECTION III**

**PERSONAL MAINTENANCE ALLOWANCE CALCULATION**

Add the amounts in a, b, and c. Enter the total personal maintenance allowance on page 1, Section III, line 2. This total must not exceed \$\_\_\_\_\_ (figure adjusts annually).

- a. Basic Needs Allowance \$\_\_\_\_\_
    - Everyone is allowed the basic needs allowance
  - b. Earned Income Disregard \$\_\_\_\_\_
    - People who have earned income are allowed an additional \$65 & half of the remaining income.
  - c. Special Housing Amount \$\_\_\_\_\_
    - [Reference Medicaid Handbook 5.9.9.2.1(3)]
    - The special housing amount is an amount of the person's income set aside to help pay certain high housing costs. If the housing costs listed below are over \$350 per month, the waiver applicant may be eligible for the special housing amount.
- Special Housing costs include only the following:
- a. Rent \$\_\_\_\_\_
  - b. Insurance \$\_\_\_\_\_
  - c. Mortgage \$\_\_\_\_\_
  - d. Property Tax (includes special assessments) \$\_\_\_\_\_
  - e. Utilities (heat, water, sewer, electricity) \$\_\_\_\_\_
  - f. Rent in an Adult Family Home, CBRF, or RCAC. \$\_\_\_\_\_

Add together all housing costs. If the amount is more than \$350 per month, the special housing amount equals monthly housing costs minus \$350.

If both members of a couple are applying and both have income, and they reside together in the same residence, divide the housing amount equally between them. If only one spouse of a couple has income and both are applying, and they reside together in the same residence, allocate the full housing amount to the spouse with income.

Note: The special housing amount does not apply to waiver participants under the age of 18 years.

**FAMILY MAINTENANCE ALLOWANCE CALCULATION**

Calculate the family maintenance allowance and enter it on page 1, Section III, line 3, using formula a or b.

**a. For AFDC-related households in which the waiver participant is the custodial parent of minor child(ren) living in the household and there is no spouse in the household:**

- (1) Minor children's gross earned income \$\_\_\_\_\_
- (2) Enter \$65 & half of gross earned income (Reference Medicaid Handbook 4.1.3.6) \$\_\_\_\_\_
- (3) Subtract (2) from (1) \$\_\_\_\_\_
- (4) Minor children's total unearned income \$\_\_\_\_\_
- (5) Add (3) and (4) \$\_\_\_\_\_
- (6) Enter AFDC related medically needy income limit (Reference Medicaid Handbook 8.1.4) (Group size is the number of minor children in the household. Do not include the waiver applicant.) \$\_\_\_\_\_
- (7) If (5) is greater than (6), there is no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

**b. For households in which there are no minor children living in the household and there is a spouse in the household but spousal impoverishment policies do not apply.**

- (1) Spouse's gross earned income \$\_\_\_\_\_
- (2) Enter the first \$65 & 1/2 of total gross earned income \$\_\_\_\_\_
- (3) Subtract (2) from (1) \$\_\_\_\_\_
- (4) Spouse's total unearned income \$\_\_\_\_\_
- (5) Add (3) and (4) \$\_\_\_\_\_
- (6) Enter \$20 disregard \$\_\_\_\_\_
- (7) Subtract (6) from (5) \$\_\_\_\_\_
- (8) Enter the SSI-E payment level for 1 person (figure adjusts annually) \$\_\_\_\_\_

If (7) is greater than (8) there is no family maintenance allowance. If (7) is less than (8) the family maintenance allowance is the difference between (7) and (8).

## MEDICAID WAIVER ELIGIBILITY AND COST SHARING WORKSHEET

Completion of this form meets the requirements of the Federal Regulations 42 CFR 435.

Check One:  Application  Review/Recertification  Change

Name – Applicant Florence Major		Medicaid ID Number 367-57-09470	Medicaid Eligibility Date 05-23-97
Name - Care Manager Mary Green	Name – Income Maintenance Worker (IMW) Janet Brown	IMW No. 2304	Date 10-10-08

### SECTION I – FINANCIAL RESOURCES (Complete for all Applicants)

1. Nonexempt Assets	\$987.00
2. Gross Earned Income	\$50.00
3. Total Unearned Income	\$605.00
4. Total Income (2 + 3)	\$655.00

**Group A** (Applicant is currently eligible for Medicaid) **Care Manager checks eligible category and completes sections II and V for the following types:**  
 SSI Recipient  SSI-E  1619a  1619b  Katie Beckett  
**Other Medicaid Eligibility: Income Maintenance Worker writes in Type and Category Code:**

Other Medicaid Type (Specify) \_\_\_"MAPP"\_\_\_\_\_

CARES Category code (Specify) \_MAP\_\_\_\_\_

NOTE: This form may be used by IMW for a Group B or Group C applicant only if the applicant is institutionalized at the time of application.

**Group B** Special Income Limit (IMW completes Sections III and V)

**Group C** Medically Needy (IMW completes Sections IV and V)

### SECTION II – SPECIAL DECLARATION REGARDING DIVESTMENT FOR GROUP A WAIVER APPLICANTS WHO RECEIVE SSI, SSI-E, 1619a, 1619b, OR KATIE BECKETT

Care Manager: Ask the applicant both of the following questions:

1. "Have you or your spouse sold, traded, transferred or given away property, land stocks, bonds, cash, vehicles, or anything of value in the past 36 months?"
2. "Have you or your spouse created a trust or added funds to a trust within the last five years?"

Yes. Complete DDE-919-D and Refer applicant to Income Maintenance Worker for investigation and determination. After Income Maintenance Worker makes determination, proceed to Section V.

x  No. Proceed to SECTION V.

### SECTION III – COST SHARING/GROUP B UNDER "SPECIAL INCOME LIMIT." When Spousal Impoverishment Protections Apply, Substitute "Income Allocation Worksheet" for Section III

1. Total Income	\$
2. Personal Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
3. Family Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
4. Special Exempt Income	\$
5. Health Insurance Premium	\$
6. Out of Pocket Medical/Remedial Expenses Obtain this figure from care manager.	\$
7. Total Deductions (2 + 3 + 4 + 5 + 6)	\$
8. Waiver Cost Share Amount (1 – 7) The amount on line 8 is monitored and documented by the care manager. Proceed to Section V.	\$

### SECTION IV – FOR GROUP C MEDICALLY NEEDED

1. Gross Earned Income (2)	\$
2. \$65 and ½ Disregard	\$
3. (1 – 2)	\$
4. Total Unearned Income (3)	\$
5. (3 + 4)	\$
6. \$20 Disregard	\$
7. Balance (5 – 6)	\$
8. Special Exempt Income	\$
9. Countable Income (7 – 8)	\$
10. Health Insurance Premium	\$
11. Balance (9 – 10)	\$
12. Excess Self Employment Expense	\$
13. Balance (11 – 12)	\$
14. Monthly Medical/Remedial Expenses Obtain this figure from care manager	\$
15. Balance (13 – 14)	\$
16. Medicaid Card Coverable Services	\$
17. Balance (15 – 16)	\$

If the Balance on line 17 is greater than the current medically needy income limit, the applicant is not eligible for Medicaid Waivers. Proceed to line 18 with all eligible Group C Applicants.

### SPENDDOWN DETERMINATION FOR ALL ELIGIBLE GROUP C APPLICANTS

18. Balance (from line 13)	\$
19. Current Medically Needy Income Limit	\$
20. Spenddown Amount (18 – 19)	\$

The amount on line 20 must be incurred by the applicant on a monthly basis to sustain eligibility. This is monitored and documented by the care manager. **Now complete an Income Allocation Worksheet for all spousal impoverishment cases.** Proceed to Section V.

**DATE NEXT MA REVIEW DUE** - Reviews must be completed every 12 months

**SECTION V – STATEMENT OF ELIGIBILITY. COMPLETE FOR ALL MA WAIVER APPLICANTS. (Check One)**

- Applicant is eligible as a Group A.
- Applicant is not eligible for waiver services as a Group A for \_\_\_\_\_ months due to Divestment.
- Applicant is eligible as a Group B with no cost share.
- Applicant is eligible as a Group B with a monthly cost share of \$\_\_\_\_\_.
- Applicant is eligible as a Group B married, spousal impoverishment rules apply, with a monthly cost share of \$\_\_\_\_\_ (from Spousal Income Allocation Worksheet).

- Applicant is eligible as a Group C with no spenddown.
- Applicant is eligible as a Group C with a monthly spenddown liability of \$\_\_\_\_\_ (Line 20).
- Applicant is eligible as a Group C married, spousal impoverishment rules apply, by incurring a monthly spenddown of \$\_\_\_\_\_ (Line 20) and monthly cost share of \$\_\_\_\_\_ (from Spousal Income Allocation Worksheet)
- Applicant is not eligible under Group C – not medically needy.

**ALLOWANCE DETERMINATIONS FOR SECTION III**

**PERSONAL MAINTENANCE ALLOWANCE CALCULATION**

Add the amounts in a, b, and c. Enter the total personal maintenance allowance on page 1, Section III, line 2. This total must not exceed \$\_\_\_\_\_ (figure adjusts annually).

- a. Basic Needs Allowance \$\_\_\_\_\_
    - Everyone is allowed the basic needs allowance
  - b. Earned Income Disregard \$\_\_\_\_\_
    - People who have earned income are allowed an additional \$65 & half of the remaining income.
  - c. Special Housing Amount \$\_\_\_\_\_
    - [Reference Medicaid Handbook 5.9.9.2.1(3)]
    - The special housing amount is an amount of the person's income set aside to help pay certain high housing costs. If the housing costs listed below are over \$350 per month, the waiver applicant may be eligible for the special housing amount.
- Special Housing costs include only the following:
- a. Rent \$\_\_\_\_\_
  - b. Insurance \$\_\_\_\_\_
  - c. Mortgage \$\_\_\_\_\_
  - d. Property Tax (includes special assessments) \$\_\_\_\_\_
  - e. Utilities (heat, water, sewer, electricity) \$\_\_\_\_\_
  - f. Rent in an Adult Family Home, CBRF, or RCAC. \$\_\_\_\_\_

Add together all housing costs. If the amount is more than \$350 per month, the special housing amount equals monthly housing costs minus \$350.

If both members of a couple are applying and both have income, and they reside together in the same residence, divide the housing amount equally between them. If only one spouse of a couple has income and both are applying, and they reside together in the same residence, allocate the full housing amount to the spouse with income.

Note: The special housing amount does not apply to waiver participants under the age of 18 years.

**FAMILY MAINTENANCE ALLOWANCE CALCULATION**

Calculate the family maintenance allowance and enter it on page 1, Section III, line 3, using formula a or b.

- a. For AFDC-related households in which the waiver participant is the custodial parent of minor child(ren) living in the household and there is no spouse in the household:**
  - (1) Minor children's gross earned income \$\_\_\_\_\_
  - (2) Enter \$65 & half of gross earned income \$\_\_\_\_\_
    - (Reference Medicaid Handbook 4.1.3.6)
  - (3) Subtract (2) from (1) \$\_\_\_\_\_
  - (4) Minor children's total unearned income \$\_\_\_\_\_
  - (5) Add (3) and (4) \$\_\_\_\_\_
  - (6) Enter AFDC related medically needy income limit \$\_\_\_\_\_
    - (Reference Medicaid Handbook 8.1.4)
    - (Group size is the number of minor children in the household. Do not include the waiver applicant.)
  - (7) If (5) is greater than (6), there is no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).
- b. For households in which there are no minor children living in the household and there is a spouse in the household but spousal impoverishment policies do not apply.**
  - (1) Spouse's gross earned income \$\_\_\_\_\_
  - (2) Enter the first \$65 & ½ of total gross earned income \$\_\_\_\_\_
  - (3) Subtract (2) from (1) \$\_\_\_\_\_
  - (4) Spouse's total unearned income \$\_\_\_\_\_
  - (5) Add (3) and (4) \$\_\_\_\_\_
  - (6) Enter \$20 disregard \$\_\_\_\_\_
  - (7) Subtract (6) from (5) \$\_\_\_\_\_
  - (8) Enter the SSI-E payment level for 1 person \$\_\_\_\_\_
    - (figure adjusts annually)

If (7) is greater than (8) there is no family maintenance allowance. If (7) is less than (8) the family maintenance allowance is the difference between (7) and (8).

## **CARE MANAGER RESPONSIBILITIES**

The care manager (CM) should complete the [F-20919](#) for Group A individuals who receive SSI, SSI-E, 1619a or b participants, or, children enrolled in Katie Beckett and are applying for the waiver. The care manager is responsible for asking individuals if they have divested assets and, if so, completing a [F-20919D](#) form to submit to the IM worker (See information pertaining to Divestment in this manual).

## **INCOME MAINTENANCE WORKER RESPONSIBILITIES**

The IM worker completes Medicaid applications, reviews or requests for re-determination of eligibility for all other Group A categories in CARES. The Community Waivers page in CWW must be completed for all Group A applicants in CARES. A copy of the Community Waivers Budget page should show group type and Medicaid category. It will display a “PASS” or “PEND” to confirm eligibility or a “FAIL” to confirm non-eligibility (see next page for an example of a CWB page for a Group A applicant). When a Group A case is pending for any reason, the CM and IM worker should cooperate to obtain needed information.

A copy of a Community Waivers Budget page is sent to the Care Manager, who will include it in the packet for review.

Note that [F-20919](#) forms are acceptable when the Community Waivers Budget page is not available (for example, if a prospective waiver participant is currently in an institution). F-20919 should be completed following the directions described earlier in this guide.



## **SSI-E**

The Supplemental Security Income - Exceptional (SSI-E) rate is a supplement to SSI. The state provides SSI-E supplements to individuals who reside in natural (community) settings or substitute care living arrangements and have exceptional expenses.

In order to receive SSI-E, a person must be 1) elderly (over age 65), or disabled, 2) meet the income and asset limits for the federal SSI benefit, and 3) require at least 40 hours of services per month. Income limits vary depending on the applicant's marital status and, if married and both apply, the spouse's disability status. Contact your county SSI-E lead worker for more information on eligibility and procedures. See also the state's SSI-E handbook at <http://www.emhandbooks.wi.gov/ssi-e/>. **Applications for SSI-E (See Forms [F-20817](#) , [F-20817a](#) and [F-20818](#)) should be sent to the following address:**

**State of Wisconsin - EDS  
P.O. Box 6680  
Madison, WI 53716**

EDS will notify the participant and county waiver agency of the status of the application within 30 days.

## DIVESTMENT

Divestment occurs when a person disposes of certain resources (income and/or assets) for less than fair market value. For example, a person might divest by giving money or property to his/her children or grandchildren and receiving nothing of fair market value in return. Please note that not all transfers are actually divestments, and not all divestments result in a penalty to the program participant. If the person or his/her spouse has given away resources for less than fair market value within the last 36 months, or if the person or his/her spouse has set up a trust (except for exempt funeral trusts\*) within the past 60 months, the care manager must complete the [F-20919D](#) form (see the following page) and give it to the income maintenance worker.

When a waiver participant does not receive SSI, SSI-E, 1619 (a) or (b), or Katie Beckett, Medicaid eligibility is determined by the county IM unit using Medicaid Waiver Program rules. The IM worker determines if divestment occurs. If divestment occurs the IM worker will determine how long the person is ineligible for Medicaid. This would impact payment for a nursing home stay or participation in the waiver program. When divestment occurs, and a penalty period is associated with the divestment, **waiver** Medicaid eligibility terminates entirely. The individual has to be tested for some other type of Medicaid eligibility if s/he wants Medicaid to cover non-waiver medical services.

For more information, see DLTC Memo 09-05 and pages III 2 and 3 in the Medicaid Waivers Manual. Effective January 1, 2009 and thereafter, the divestment penalty period for Waivers begins on the date that the individual applies for the Waiver services and meets the functional and financial eligibility criteria for the Waiver. Once eligibility is determined, the divestment question needs to be asked so the penalty period can begin, even if the individual is placed on the waiting list.

Like current waiver participants, additional potential divestments must be addressed when they occur, even when an individual is on a waiting list for waiver services. This is because an additional penalty period may be assessed. Penalty periods will not be combined but run concurrently.

Refer to the chart in DLTC Memo 09-05. Starting in 2012, look back periods will increase by one month beyond the current 36 months until the new policy of a look back period of 60 months (5 years) is reached on January 1, 2014.

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**NOTES**

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*EXAMPLE OF BLANK FORM*

**DECLARATION REGARDING TRANSFER OF RESOURCES  
 LONG-TERM CARE MEDICAID WAIVER PROGRAMS**

Care Manager: Complete this form at application or at review and send it to your Economic Support Unit for evaluation of a possible divestment when a Group A (SSI, SSI-E, 1619, Katie Beckett) participant / applicant answers "Yes" to either one of the questions below.

Name - Applicant / Participant: \_\_\_\_\_

Participant Medicaid Number: \_\_\_\_\_

**Yes No**

1. Have you or your spouse sold, traded, transferred or given away property, land, stocks, bonds, cash, vehicles, or anything of value in the past 36 months?
2. Except for exempt burial trusts, have you or your spouse created a trust, or have you added funds to a trust within the last five years?

If you answered "Yes" to either question, complete the chart below.

	Items(s) Transferred	Type of Trust Established (If funds were added to trust, so indicate)	Approximate Value	Transfer Date, or Date Trust was Established, or Date Funds Were Added to Trust (mm/dd/yyyy)	Name of Person to Which Property Was Transferred and His / Her Relationship to the Applicant / Participant
1.			\$		
2.			\$		
3.			\$		
4.			\$		
5.			\$		
6.			\$		
7.			\$		
8.			\$		

\_\_\_\_\_

**SIGNATURE** - Participant

\_\_\_\_\_

Today's Date

**Note: Record any additional transfers or trust establishments on another form DDE-919D.**

## EXAMPLE OF COMPLETED FORM

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Disability and Elder Services  
DDE-919D (09/2004)

STATE OF WISCONSIN  
42 CFR 441

### DECLARATION REGARDING TRANSFER OF RESOURCES LONG-TERM CARE MEDICAID WAIVER PROGRAMS

Care Manager: Complete this form at application or at review and send it to your Economic Support Unit for evaluation of a possible divestment when a Group A (SSI, SSI-E, 1619, Katie Beckett) participant / applicant answers "Yes" to either one of the questions below.

Name - Applicant / Participant: Gerald Smith

Participant Medicaid Number: 399-99-99990

**Yes**   **No**

1. Have you or your spouse sold, traded, transferred or given away property, land, stocks, bonds, cash, vehicles, or anything of value in the past 36 months?
2. Except for exempt burial trusts, have you or your spouse created a trust, or have you added funds to a trust within the last five years?

If you answered "Yes" to either question, complete the chart below.

	Items(s) Transferred	Type of Trust Established (If funds were added to trust, so indicate)	Approximate Value	Transfer Date, or Date Trust was Established, or Date Funds Were Added to Trust (mm/dd/yyyy)	Name of Person to Which Property Was Transferred and His / Her Relationship to the Applicant / Participant
1.	House Transferred		\$54,000.00	01/04/2005	Margaret Smith, niece
2.			\$		
3.			\$		
4.			\$		
5.			\$		
6.			\$		
7.			\$		
8.			\$		

*4-25-08*

  
SIGNATURE - Participant

*4-7-2008*  
Today's Date

**Note: Record any additional transfers or trust establishments on another form DDE-919D.**

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## CLIENT ASSISTANCE FOR RE-EMPLOYMENT & ECONOMIC SUPPORT (CARES)

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### ☞ DESCRIPTION OF CARES

The CARES system is an automated computer system used to process public assistance programs such as Medicaid, FoodShare, W2, Caretaker Supplement and Child Care. CARES is an acronym for **C**lient **A**ssistance for **R**e-employment and **E**conomic **S**upport. CARES contains many computer screens relating to many different assistance programs. The IM worker uses a small number of CARES screens to electronically determine the eligibility for some Group A waiver cases, and all Group B and Group C waiver cases.

The CARES computer system was made up of two primary components:

- 1) The CARES MAINFRAME
- 2) The CARES WORKERWEB

Effective October 2008, the functions of the CARES Mainframe have been transitioned over to the CARES WorkerWeb and the CARES Mainframe is no longer being updated.

Therefore CARES Mainframe screens are no longer accepted for verification of waiver cases. Only the Community Waivers Budget page is acceptable.

Income Maintenance Workers are able to verify Medicaid Waiver eligibility via the Community Waivers Budget page. This one page document contains the eligibility determination, the cost-share budget, and when applicable, the spousal income allocation.

The IM worker will give the care manager copies of these budget screens for Group A, Group B & Group C waiver eligible persons. As a point of information, CARES also generates standardized notice letters that request verification information, as well as provide eligibility information to the individual.

In the case of a nursing home resident who will become a waiver participant, the IM worker will process the case manually and will give the care manager a completed [F-20919](#), or the IM worker may generate the CWB page that are a result of the IM worker processing the case in simulation. Once the person is actually discharged from the nursing home, the IM worker should re-run the CARES information to ensure that actual financial information is secured. In the event the IM worker completed the F-20919 for a person being discharged from a nursing home, it is suggested the IM worker generate the Community Waivers Budget page and give this to the care manager upon the person's discharge from the nursing home.

## CARE MANAGER RESPONSIBILITIES

Whenever the care manager refers a waiver applicant to Income Maintenance, the care manager must provide the IM worker with certain information. The CARES system requires this information up front. Without it, the IM worker will not be able to determine eligibility.

- The anticipated waiver start date.
- The name of the waiver (because CARES uses this to create the medical status code).
- The applicant's out-of-pocket medical/remedial expenses (for Group B participants and Group C married participants when spousal impoverishment rules apply.)
- The applicant's total medical/remedial expenses (for Group C participants this is a combination of out-of-pocket expenses, waiver services, and COP services – if any).
- For Group C applicants the cost of Medicaid card coverable services.
- Is this individual a transfer from a Family Care county? This will promote continuous Medicaid eligibility for the individual.

A model referral form has been developed to help make the referral process easier for care managers (see the following page). The web link to this form is:

<http://dhs.wisconsin.gov/forms1/f2/f21051.pdf>



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## NOTES

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## CARES SCREENS FOR INITIAL APPLICATION AND RECERTIFICATION

The following describes what CARES screens a care manager can typically expect to see for the different eligibility groups. Sample screens are illustrated in this manual.

### ▪ **Group A**

If the participant is one of the identified Medicaid subgroups, that status will be confirmed by the IM worker. Care managers will receive a copy of the Community Waivers Budget page indicating the participant has “passed” the Group A Community Waivers Eligibility Test.

However please note: for documentation purposes, an [F-20919](#) completed by the IM worker indicating Group A eligibility via a specific Medicaid sub code will be accepted as well.

If divestment is suspected, CARES activity will occur to either rule out divestment or find the applicant ineligible due to divestment. In either case, the care manager will not need to see the screens. The care manager should process the case when it has been determined that divestment has not occurred.

### ▪ **Group B**

Unmarried Applicant: A copy of the Community Waivers Budget page to confirm eligibility and view any cost share amount.

Married Applicant when spousal impoverishment rules apply: A copy of the Community Waivers Budget page to confirm eligibility and view any cost share amount, allowances, and amounts of allocations under spousal impoverishment. (Note: Spousal *asset* allocation occurs separately).

Married Applicant when spousal impoverishment rules do not apply: A copy of the Community Waivers Budget page to confirm eligibility and view any cost share amount. FYI: in cases such as this, the waiver applicant is viewed similar to a single person.

### ▪ **Group C**

Unmarried Applicants: A copy of the Community Waivers Budget page to confirm eligibility and view the spenddown amount

Married Applicant when spousal impoverishment rules apply: A copy of the Community Waivers Budget page to confirm eligibility and view any cost share amount, allowances, and amounts of allocations under spousal impoverishment. **Special note:** CARES does not automatically apply spousal impoverishment protections to any married Group C waiver applicant with a community spouse. The IM worker will have to manually complete the Spousal Impoverishment Income Allocation Worksheet to determine the applicant’s cost share obligation and then manually write this information on the Community Waivers Budget page. (Note: Spousal *asset* allocation occurs separately.)

Married Applicant when spousal impoverishment rules do not apply: A copy of the Community Waivers Budget page to confirm eligibility and view the spenddown amount.

- **Persons in Institutions**

**Group A: 2 options:**

- a) The IM worker can complete an [F-20919](#). The information on the F-20919 should be reflective of what the person's income and financial eligibility group (i.e., Group A) **will be** upon his/her discharge from the institution.
- b) The IM worker can generate CARES that have been "run in simulation". The financial information should be reflective of what the person's income and financial eligibility group (i.e., Group A) will be upon his/her discharge from the institution. The IM worker will give the CM a copy of the Community Waivers Budget page. **Important reminder:** once the person is formally discharged from the institution, the IM worker should take the case out of simulation and re-run CARES to secure financial information.

**Group B and C: 2 options**

- a) The IM worker can complete an [F-20919](#). The financial information should be reflective of what the person's income and financial eligibility group (i.e., Group B or C) **will be** upon his/her discharge from the institution. As such, it would be expected that Sections I, II, III or IV (depending upon the person's income) on the F-20919 be completed.
- b) The IM worker can generate CARES that have been "run in simulation". The financial information should be reflective of what the person's income and financial eligibility group (i.e., Group B or C) will be upon his/her discharge from the institution. The IM worker will give the CM a copy of the Community Waivers Budget page. **Important reminder:** once the person is formally discharged from the institution, the IM worker should take the case out of simulation and re-run CARES to secure financial information.

**User ID**  
**Primary Person:**

**User Name:**  
**Case:**

**Quick Select:** CASE/RFA  
**Status:** Open    **Mode:** Ongoing

<b>■ Navigation Menu</b>
Search
▪ CARES Home
▪ Search
▶ Inbox Search
RFA/Case
▶ Client Registration (0)
▪ Case Summary
▶ Application Entry (0)
√ Initiative Eligibility Determination
▼ Eligibility (5)
▶ Run Results
▶ Eligibility Results
▼ Budgets
▪ BadgerCare Plus
▪ BadgerCare Plus Premium Summary
▪ SSI-Related Medicaid
▪ Family Planning Waiver
▪ MAPP
→ Community Waiver
▪ Institution Medicaid
▪ Family Care
▪ Caretaker Supplement
* FoodShare
▪ Child Care
▪ W-2
▶ Post Eligibility
* Confirmation Access
▶ Query
▶ Benefit Issuance

## Community Waivers Budget

### Assistance Group Overview

Assistance Group: MCWW- COMMUNITY WAIVERS COP      Sequence:  
Benefit Begin Date:      Benefit End Date:  
Determination Date:

### Results

Assistance Group Status:      Eligibility Status:  
Group Indicator:B      Community Waivers Eligibility Test:

### Individuals

Community Waivers Name:      Community Spouse:  
Community Waivers Eligibility Determination –

Gross Earned Income: \$  
Gross Unearned Income: +  
Excess Self Employment Expenses: -  
Student Disregard: -  
Gross Income: \$  
Categorically Needy Income Limit: \$

### Community Waivers Cost Share Budget

Gross Income: \$  
COLA/DAC/MW Disregard: +  
Accumulated Gross Income: \$  
\$65 & ½ Disregard: -  
Special Exempt Income: -  
Basic Needs Allowance: -  
Special Housing Amount: -  
Family Maintenance Allowance: -  
Health Insurance Premium: -  
Medical/Remedial Expenses: -  
Cost Share: \$

Assistance Group	Sequence	Updated on or by
MCWW- COMMUNITY WAIVERS COP		

**Important note about formatting of the Community Waivers Budget page:**

When obtaining copies of the Community Waivers Budget (CWB) page from the Income Maintenance Worker, please be sure they are in **landscape** format. This will ensure that all information is visible.

Information was sent to all CARES and Policy Coordinators in the local agencies and asked that the following information be shared with staff. It reads:

“When submitting screen prints of waiver/potential waiver cases, please make sure to print it landscape, this will show all of the detail staff need to know about a case when it is sent in (i.e.; if the case is in ongoing/simulation, all of the budgets, etc.) For help on printing landscape, you can find this in CWW System Help by going to: CWW System Help/Home  
How to use CWW  
Icon / Button Overview

The instructions there state: Use this button to print the page. Note: Change to landscape layout for best readability. To change to landscape, click the print icon. A choice of Preferences appears. Choose “landscape.”

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## GROUP B

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### DESCRIPTION OF GROUP B PARTICIPANTS

Group B waiver participants are considered categorically needy because their monthly income falls at or below a special federal income limit. As of January 1, 2010, this limit is \$2,022/month for an individual. In all cases, the IM worker must establish Medicaid eligibility before a Group B person becomes eligible for the waiver program. A Group B individual may have a cost share if his or her total income is not sufficiently reduced by allowable deductions. A cost share is the dollar amount an individual has to pay towards his/her cost of waiver services each month. Allowable deductions include the personal maintenance allowable (PMA) – which is a combination of the basic needs allowance, the special housing amount and the earned income disregard. Additional deductions include the family maintenance allowance, health insurance premiums, and medical/remedial expenses.

Reminder: if a person who is currently on BadgerCare Plus – Benchmark Plan applies for the Community Waivers Program, the person will be taken off of BadgerCare Plus – Benchmark and must meet the financial eligibility rules for Community Waivers Group B applicants.

### INCOME AND ASSET LIMITS

Effective January 1, 2010:

- The monthly income range is \$0 to \$2022 for each applicant.
- The asset limit is \$2,000 per applicant or participant. If only one spouse of a married couple is applying, the asset limit is \$2,000 for the applicant and no greater than \$109,560 (year 2010 figure) for the community spouse. The exact amount that may remain in the name of the community spouse depends on the amount of total countable assets shared by the couple at the time the applicant applies for community waivers. (See table on the following page).

IF the total countable assets of the couple (TCAC) are:	THEN the community spouse asset share is:	AND the waiver participant spouse asset maximum is:
\$219,120 or more	\$109,560 (maximum effective 1/1/10)	\$2000
Less than \$219,920 but greater than \$100,000	½ the TCAC	\$2000
\$100,000 or less	\$50,000 (minimum effective 1/1/96)	\$2000

Note: "Community spouse" refers to the participant's spouse if that spouse is not living in a medical (hospital or nursing home) institution.

## THE ELIGIBILITY DETERMINATION PROCESS

The IM worker determines eligibility for Group B applicants. The care manager should have a basic understanding of this process and should be familiar with the personal maintenance allowance, the family maintenance allowance, the health insurance deduction, and the process for determining a cost share. The care manager is responsible for calculating, monitoring, and documenting the participant's medical/remedial expenses and reporting any changes in medical/remedial expenses when these changes would impact a cost share up or down. Care managers are also responsible for monitoring and documenting the participant's cost share liability.

The following is a line-by-line description of the cost sharing calculation:

### ▪ **Gross Income**

This is the sum of the person's gross earned and unearned income.

- When one spouse applies for the waiver program, only the applicant's income is considered. However, the community spouse's income will be considered when determining the community spouse income allocation and may have an impact on whether the waiver applicant has a cost share.
- When both spouses apply for the waiver program, their income should be treated separately. His or her individual incomes will determine to which waiver group each applicant belongs (Group A, Group B or Group C). With regard to assets, normal spousal impoverishment rules apply however, within one year each person may only have up to \$2,000 in assets.

### ▪ **Personal Maintenance Allowance**

The personal maintenance allowance is the amount of money the waiver program applicant can use from his or her monthly income for the purpose of meeting personal expenses. This figure is one of several that may reduce or eliminate a Group B participant's cost share. The care manager can ensure the waiver applicant receives the highest possible personal maintenance allowance by understanding its components and sharing as much information as possible with the Income Maintenance (IM) worker.

The personal maintenance allowance is the sum of three separate figures: the Earned Income Disregard; the Basic Needs Allowance (also called the minimum personal maintenance allowance), and the Special Housing Amount. These components are described below. A description of the personal maintenance allowance can be found in Section 28.8.3.1 of the Medicaid Handbook. It is also described on Page 2 of the [F-20919](#) worksheet.

The maximum Personal Maintenance Allowance (the sum of the three components outlined above) cannot exceed 300% of the current Federal SSI individual rate. In year 2010, this amount is \$2,022..

- **\$65 & ½ Disregard** - This is a work incentive that allows a certain amount of a participant's monthly-earned income to be disregarded from income. This disregard applies most frequently to younger individuals with physical disabilities who are employed, but is available to anyone who has income from employment. Each month a program participant is allowed to have \$65 plus half of his/her remaining earned income deducted from his/her gross earned income. For example, if an individual earned \$400 each month from his/her job, \$65 would be subtracted and the remainder would be divided in half. This amount, plus \$65, would be the person's earned income disregard, which in this case would equal \$232.50.
- **Basic Needs Allowance** - The basic needs allowance (also called the minimum personal allowance) is \$854 in year 2010.
- **Special Housing Amount** - This is the amount of money program participants are allowed as a deduction to offset high housing costs. Allowable costs include the following shelter expenses: rental payments, mortgage payments, insurance (renters or homeowners), property taxes (including special assessments), and utilities (including heat, wood/coal for heating purposes, water, sewer, and electricity). Please note: telephone or cable TV services are *not* included in the housing cost.

The special housing amount is the amount remaining after \$350 is deducted from the total shelter expenses of the waiver participant. For example, if the applicant pays \$400/month for rent and \$60/month for utilities and has no renters insurance, mortgage, or property taxes, the total monthly costs would equal \$460. This monthly total of \$460 minus \$350 equals a special housing amount of \$110.

FYI: If both spouses are applying for the waiver program and they both live in their own home/apartment or substitute care facility, and special housing appears to be an allowable deduction, the IM worker will divide the special housing amount equally between the two IF they both have income that puts them in either the Group B or C financial eligibility group. If, however, only one spouse of the married couple has income, and they are both applying for the waiver program, the IM worker will give the entire amount of the special housing deduction to the person with the income. (See back of [F-20919](#) for reference.) Another reference is the handbook that an IM worker utilizes - Medicaid Handbook section. 28.8.3.1

The exception to this is that if both spouses are applying for the waiver program and they both live in their own home/ apartment or substitute care facility, but one of the spouses is in the Group A financial group, then the IM Worker will not divide the special housing amount deduction equally between them. The entire amount of the special housing amount deduction goes to the person who is a Group B or Group C.

The minimum personal maintenance allowance is \$854 (which equals the amount of the basic needs allowance). This amount may be increased by the earned income disregard and the special housing amount up to a maximum personal maintenance allowance of \$2,022 (effective 1-1-10). Given the examples provided above, the personal maintenance allowance would be calculated as follows:

\$854.00	=	Basic Needs Allowance in year 2010
\$232.50	=	Earned Income Disregard
\$110.00	=	Special Housing Amount
<hr/>		
\$1196.50	=	TOTAL (must be capped at \$2,022 therefore...)
\$1196.50	=	Personal Maintenance Allowance

- **Special Exempt Income**

This is any special income exempted from the eligibility determination process: *court-ordered* payments like child support or alimony payments to persons who live outside the participant's home; or *court-ordered* guardianship, guardian ad-litem, or attorney fees that are the participant's responsibility. IM workers are referred to the Medicaid Handbook – section 28.8.3.3 for further explanation regarding this type of income.

- **Family Maintenance Allowance**

The family maintenance allowance is the amount of money waiver program applicants can claim if they have minor children living in the household and no spouse, or, there

are no minor children in the household but a spouse is present in the home, but spousal impoverishment rules do not apply. See the [F-20919](#), Section 3 on the back page to accurately calculate the family maintenance allowance.

For those applicants that fit into the second scenario, if spousal impoverishment rules do not apply, one spouse can claim a family maintenance allowance if the other spouse has an income below the SSI-E amount (\$853.77 – effective January 1, 2010 figure). This is an allowance not an allocation. As a result, the IM worker should not add the family maintenance allowance to the spouse with the lower income.

- **Health Insurance Premium**

This deduction is the monthly health insurance premium for insurance that covers the waiver person **and** for which he/she is responsible to pay. In the event the participant is fully responsible for paying the health insurance premium, the participant gets the full deduction. If the policy is a group or family policy and the waiver participant is **not** responsible for paying the premium, the IM worker will divide the monthly premium by the number of members. If there is a married couple and both people are on the waiver program but only one person is paying the premium, the premium is divided equally. Dental insurance premiums can be included in this category as well. Any annual premiums over 12 months are prorated. If the applicant/participant selected a Medicare Part D plan that requires him/her to pay a monthly premium, the IM worker will count that expense in this deduction.

Do not deduct the Medicare Part B premium on this line, because the Medicare Part B premium is not included as part of the income amount entered in CARES. Do not deduct life insurance premiums as an expense. Life insurance proceeds benefit survivors and not the waiver participant.

- **Medical and Remedial Expenses for Group B**

Medical and remedial expenses for Group B are items and services purchased by participants that are not covered by Medicaid, Medicare or some other health insurance, or by some other program. These expenses are used as an income deduction during the cost share determination process. For an explanation of medical and remedial expenses for Group C, see the Group C financial eligibility section.

For Group B, the care manager must provide the IM worker with an estimate of these average out of pocket monthly expenses. The care manager must review a Group B participant's medical and remedial expenses at least annually to ensure that the expenses (which are used to reduce the cost share) are both incurred *and* paid. It is best to do the annual review when financial eligibility is being re-determined by the IM worker. The care manager must document that the medical and remedial expenses were reviewed.

Once individuals are eligible for the waiver program, their out-of-pocket expenses are generally less than \$100/month. If new applications or recertifications show expenses over \$100, and the applicant/participant needs that full amount in order not to have a cost share, the COP-Waiver/CIP II Quality Assurance reviewer will generally call the care manager to find out what items are included in this total and to verify that they are allowable expenses. It is useful to include a list of medical & remedial expenses when a packet is sent in for approval.

- **Cost Share**

A cost share is the amount of money a participant has to contribute to the cost of his/her waiver services each month. The cost share is determined by subtracting allowable deductions from the applicant's/participant's total monthly income. Cost share payments must be made toward waiver-allowable services. The participant can either pay the service provider directly or write a check out to the county waiver agency for the amount of the cost share. If the participant sends the check to the county, the county waiver agency will enter the amount on HSRS under SPC 095.01. The cost share obligation amount is listed on the ECSC screen print or, the Community Waivers Cost Share Budget portion of the Community Waivers Budget page and needs to be listed on the ISP.

Note: If the cost share exceeds the cost of waiver services, **the participant is allowed to keep the difference.** As per Chapter III, of the Medicaid Waivers Manual reads: "The participant is not required to pay any amount of a cost share which is in excess of the cost of the Medicaid waiver services received in that month."

The care manager must monitor that the correct monthly cost share has been paid, and, document within the participant's case file that the cost share has been paid. It is not necessary to keep copies of receipts or checks for the file. The care manager must monitor, at least every three months, the cost share was paid on a monthly basis. There are several acceptable ways a care manager can document this activity. These are outlined in the Question and Answer section regarding cost shares located in this section of Waiver Basics.

## Group B - Single (Who is Employed)

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Benefit Begin Date:	10/17/2008	Benefit End Date:	
Determination Date:	10/17/2008		
<b>Results</b>			
Assistance Group Status:	P-PEND	Eligibility Status:	PEND
Group Indicator:	B	Community Waivers Eligibility Test:	PEND
<b>Individuals</b>			
Community Waivers Name:	ANTHONY JONES 11M PP	Community Spouse:	
Community Waivers Eligibility Determination – Group B			
<p>Gross Earned Income: \$ 400.00</p> <p>Gross Unearned Income: + 869.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: - _____</p> <p>Gross Income: \$1,269.00</p> <p>Categorically Needy Income Limit: \$2,022.00</p>			
<b>Community Waivers Cost Share Budget</b>			
<p>Gross Income: \$</p> <p>COLA/DAC/WW Disregard: + _____</p> <p>Accumulated Gross Income: \$1,269.00</p> <p>\$65 &amp; ½ Disregard: - 232.50</p> <p>Special Exempt Income: -</p> <p>Basic Needs Allowance: - 854.00</p> <p>Special Housing Amount: - 110.00</p> <p>Family Maintenance Allowance: -</p> <p>Health Insurance Premium: - 109.00</p> <p>Medical/Remedial Expenses: - <u>30.00</u></p> <p>Cost Share: \$ 0.00</p>			

Assistance Group	Sequence	Updated on or by
MCWW- COMMUNITY WAIVERS COP		

# Group B - Single (Who has a Cost Share)

Primary Person:TODD KING

Case:0000000000

Status: Open

Mode: Ongoing

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<b>Community Waivers Budget</b>	
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Benefit Begin Date: 10/17/2008	Benefit End Date:
Determination Date: 10/17/2008	
<b>Results</b>	
Assistance Group Status:P - PEND	Eligibility Status:PASS
Group Indicator: B	Community Waivers Eligibility Test: PEND
<b>Individuals</b>	
Community Waivers Name: TODD KING	Community Spouse:
Community Waivers Eligibility Determination – Group B	
<p>Gross Earned Income: \$</p> <p>Gross Unearned Income: + 869.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: - _____</p> <p>Gross Income: \$ 869.00</p> <p>Categorically Needy Income Limit: \$2,022.00</p>	
<b>Community Waivers Cost Share Budget</b>	
<p>Gross Income: \$</p> <p>COLA/DAC/WW Disregard: + _____</p> <p>Accumulated Gross Income: \$869.00</p> <p>\$65 &amp; ½ Disregard: -</p> <p>Special Exempt Income: -</p> <p>Basic Needs Allowance: -854.00</p> <p>Special Housing Amount: -</p> <p>Family Maintenance Allowance: -</p> <p>Health Insurance Premium: -</p> <p>Medical/Remedial Expenses: - 30.00</p> <p>Cost Share: \$ 0.00</p>	

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# Group B - Married (Only Participant Applying)

Primary Person: WILLIAM MAXWELL Case: 0000000000

Status: Open Mode: Ongoing

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<b>Community Waivers Budget</b>	
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Benefit Begin Date: 04/17/2008	Benefit End Date:
Determination Date: 04/17/2008	
<b>Results</b>	
Assistance Group Status: PEND	Eligibility Status: PENDED
Group Indicator: B	Community Waivers Eligibility Test: PEND
<b>Individuals</b>	
Community Waivers Name: WILLIAM MAXWELL 72MPP	Community Spouse: JOANNE MAXWELL 72Fwi
Community Waivers Eligibility Determination – Group B	
<p>Gross Earned Income: \$</p> <p>Gross Unearned Income: +1,023.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: - _____</p> <p>Gross Income: \$</p> <p>Categorically Needy Income Limit: \$2,022.00</p>	
<b>Community Waivers Cost Share Budget</b>	
<p>Gross Income: \$1,023.00</p> <p>COLA/DAC/WW Disregard: + _____</p> <p>Accumulated Gross Income: \$1,023.00</p> <p>\$65 &amp; ½ Disregard: -</p> <p>Community Spouse Income Allcation: 932.00</p> <p>Special Exempt Income: -</p> <p>Basic Needs Allowance: - 854.00</p> <p>Special Housing Amount: -</p> <p>Community Dep Income Allowance: -</p> <p>Health Insurance Premium: -</p> <p>Medical/Remedial Expenses: - <u>10.00</u></p> <p>Cost Share: \$</p>	

Assistance Group

Sequence

Updated on or by

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## Group B - Married Couple on Waiver and both spouses are Group B eligible (Mr. Mudd)

**User ID:**  
**Primary Person:** OLIVER MUDD

**User Name:**  
**Case:**0000000000

**Quick Select:** CASE/RFA  
**Status:** Open **Mode:** Ongoing

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<b>Results</b>	
Assistance Group Status:PEND	Eligibility Status:PEND
Group Indicator: B	Community Waivers Eligibility Test: PEND
<b>Individuals</b>	
Community Waivers Name:OLIVER MUDD	Community Spouse:SONIA MUDD
Community Waivers Eligibility Determination –	
<p>Gross Earned Income: \$1023.00  Gross Unearned Income: +  Excess Self Employment Expenses: -  Student Disregard: - _____  Gross Income: \$1023.00  Categorically Needy Income Limit: \$2022.00</p>	
<b>Community Waivers Cost Share Budget</b>	
<p>Gross Income: \$  COLA/DAC/WW Disregard: + _____  Accumulated Gross Income: \$1023.00  \$65 &amp; ½ Disregard: -  Community Spouse Income Allcation - _198.00_  Special Exempt Income: -  Basic Needs Allowance: - 854.00  Special Housing Amount: -  Community Dep Income Allowance: -  Health Insurance Premium: -  Medical/Remedial Expenses: - <u>40.00</u>  Cost Share: \$</p>	

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## Spousal Impoverishment Income Allocation Worksheet

Primary Person's Name & SSN

*Oliver Mudd*

*398 20 1907*

<b>Section A – Community Spouse Income Allocation</b>			
Spouse's Name <i>Sonia Mudd</i>			
1. ENTER Maximum Community Spouse Income Allocation	\$ 2333.33		
2. MINUS Gross Income of Community Spouse	- 599.00		
3. EQUALS Community Spouse Income Allocation	= 1734.33		
<b>Section B – Dependent Family Member Income Allocation</b>			
<i>NA</i>	Name	Name	Name
1. ENTER Dependent Family Member Income Allocation	\$	\$	\$
2. MINUS Dependent Family Member's Income	-	-	-
3. EQUALS Individual Allowance	=	=	=
4. ENTER Total Dependent Family Member Allocation	\$ 0		
<b>Section C – Cost of Care/Cost Sharing Collection</b>			
1. ENTER Institutionalized Spouse's Gross Income	\$ 1,023.00		
2. MINUS Personal Allowance	- 854.00		
3. EQUALS	= 206.00		
4. MINUS Community Spouse Income Allocation	- 198.00		
5. EQUALS	= 8.00		
6. MINUS Total Dependent Family Member Allocation	- 0.00		
7. EQUALS	= 8.00		
8. MINUS Any Court-Ordered Guardian or Attorney Fees	- 0.00		
9. EQUALS	8.00		
10. MINUS	Community Waivers Only: Medical/Remedial Costs and Cost of Community Waivers Person's Health Insurance Premiums		- 40.00
	Nursing Home Cases Only: Cost of Institutionalized Person's Health Insurance Premiums		
11. EQUALS	Nursing Home Liability Amount/ Community Waivers Cost Sharing Amount		= 0.00

(REV. 01/99)

Group B - Married Couple on Waiver and both spouses are Group B eligible (Mrs. Mudd)

User ID:  
Primary Person:

User Name:  
Case:

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Status: Open Mode: Ongoing

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<b>Results</b>	
Assistance Group Status:PEND	Eligibility Status:PEND
Group Indicator:B	Community Waivers Eligibility Test: PEND
<b>Individuals</b>	
Community Waivers Name: SONIA MUDD	Community Spouse: OLIVER MUDD
Community Waivers Eligibility Determination – B	
<p>Gross Earned Income: \$</p> <p>Gross Unearned Income: + 797.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: - _____</p> <p>Gross Income: \$ 797.00</p> <p>Categorically Needy Income Limit: \$2,022.00</p>	
<b>Community Waivers Cost Share Budget</b>	
<p>Gross Income: \$797.00</p> <p>COLA/DAC/WW Disregard: + _____</p> <p>Accumulated Gross Income: \$797.00</p> <p>\$65 &amp; ½ Disregard: -</p> <p>Community Spouse income Allcation: - _____</p> <p>Special Exempt Income: -</p> <p>Basic Needs Allowance: - 854.00</p> <p>Special Housing Amount: -</p> <p>Community Dep Income Allowance: -</p> <p>Health Insurance Premium: -</p> <p>Medical/Remedial Expenses: - <u>82.00</u></p> <p>Cost Share: \$</p>	

Assistance Group

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Please note: Mrs. Mudd's actual income is \$599.00/month. The \$797.00 is a combination of \$599.00 + \$198 (what her husband allocated to her) = \$797.00

Note to IMW: The allocated amount must be entered on Unearned Income Page in CWW as OTMA for the spouse who is receiving an income allocation.

**NOTES**

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User ID:ABC123

User Name:B FRY

Quick Select: CASE/RFA

Primary Person: JOHN BROWN

Case:0000000000

Status: Open Mode: Ongoing

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## Community Waivers Budget

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<b>Results</b>	
Assistance Group Status:P - PEND	Eligibility Status:PASS
Group Indicator: B	Community Waivers Eligibility Test: PEND

<b>Individuals</b>	
Community Waivers Name: JOHN BROWN	Community Spouse:
Community Waivers Eligibility Determination – Group B	

Gross Earned Income:	\$
Gross Unearned Income:	+ 914.00
Excess Self Employment Expenses:	-
Student Disregard:	- _____
Gross Income:	\$ 914.00
Categorically Needy Income Limit:	\$2,022.00

## Community Waivers Cost Share Budget

Gross Income:	\$
COLA/DAC/MW Disregard:	+ _____
Accumulated Gross Income:	\$914.00
\$65 & ½ Disregard:	-
Special Exempt Income:	-
Basic Needs Allowance:	-854.00
Special Housing Amount:	- 55.00
Family Maintenance Allowance:	-
Health Insurance Premium:	-
Medical/Remedial Expenses:	- 12.00
Cost Share:	\$ 0.00

Assistance Group	Sequence	Updated on or by
MCWW- COMMUNITY WAIVERS COP		

**DEPARTMENT OF HEALTH AND  
FAMILY SERVICES**

Division of Disability and Elder Services  
DDE-0920 (11/05)

**STATE OF WISCONSIN**

HFS 1

**FORMULA TO DETERMINE AMOUNT OF INCOME AVAILABLE  
TO PAY FOR ROOM AND BOARD IN SUBSTITUTE CARE**

Name – Applicant/Participant	Today's Date
1. Total income from all sources	\$914.00
2. Discretionary Income ( <b>not less than \$65</b> )	\$65.00
3. Enter the difference between line 1 and line 2 here	\$849.00
4. Health insurance premium that the person pays out of pocket	\$0
5. Enter the difference between line 3 and line 4 here	\$849.00
6. Out of pocket medical/remedial expenses	\$12.00
7. Enter the difference between line 5 and line 6 here	\$837.00
8. Special exempt income	\$0
9. Enter the difference between line 7 and 8 here	\$837.00
10. Family Maintenance Allowance	\$0
11. Enter the difference between line 9 and line 10 here	\$837.00
12. Spousal income allocation	\$0
13. Enter the difference between line 11 and line 12 here	\$837.00
14. Cost Share or Spenddown obligation	\$30.00
15. Enter the difference between line 13 and line 14 here	\$807.00
16. Actual cost of room and board	\$818.00
17. Enter the difference between line 15 and line 16 here	\$11.00

506.61	Room/ Board	1	Sunnyside CBRF 113 Maple Drive Allentown, WI 54960	10/24/08		807.00/mo 11.00/mo \$818 Total	7 days/wk	.36	SS COP
506.61	Care/ Supvisn	1,2	Sunnyside CBRF 113 Maple Drive Allentown, WI 54960	10/24/08		\$1500/mo	7 days/wk	\$49.32	COP-W
604	CM	5	Blue County DHS PO Box 732 Allentown, WI 54960	10/24/08		\$60/hr	2 hr/mo	\$3.95	COP-W
095.01	Cost share		John Brown pays cost share directly to county	10/24/08		\$30.00/m	Monthly		SS
	Pers. Allow		John Brown	10/24/08		\$65.00/m	Monthly		SS
	MD Meds		Dr. Casey Walgreens				2 x/year monthly		MA Medica re
	Social Supt		Mary Douglas Pastor Goodguy				weekly 1 visit/month		Vol Vol

## ☞ COMMON QUESTIONS AND ANSWERS ABOUT COST SHARES

- **What is a cost share?**  
A cost share obligation is the amount of money a participant must contribute toward his/her cost of waiver services each month. The cost share is determined by subtracting allowable deductions from total income. CARES shows this figure on the CWB page.
- **What should the cost share be used to pay for?**  
Cost share payments must be made towards waiver-allowable services. In most cases the participant will write a check out to the county waiver agency for the amount of the cost share and the county waiver agency will enter this information on HSRS under SPC 095.01. If the cost share obligation is greater than the total for waiver services received in a given month, the participant may keep the difference. FYI, this is different in Family Care counties. In Family Care counties the participant is liable for the entire amount of his or her monthly cost-share obligation, regardless of the total cost of monthly waiver services received.
- **A COP participant with a cost share is applying for the waiver program. The waiver cost share will be different than the COP cost share. What cost share should the person pay during the application period?**  
The applicant should pay the COP cost share during the application period. Once full waiver approval of the case is received, the county waiver agency should adjust the cost share to the amount required under the waiver program. The change should be made retroactive to the effective date of eligibility for the waiver program. An adjustment will need to be made to collect (or refund) any difference between the waiver cost share and the COP cost share as of the waiver start date. The COP cost share can then be dropped.
- **When a participant is initially determined to be eligible for the waiver program, and it has been determined he/she has a cost share, does the participant have to begin paying his/her cost share effective his/her start date?**  
Yes. If it has been determined that a participant has a cost share, his/her obligation to pay the cost share is effective the day of the waiver start date. However, persons only have to pay up to the cost of the waiver services they receive.

**EXAMPLE:** A participant is being assessed for participation in the waiver program on January 18, 2008. A nursing home level of care is established and a plan of care has been developed by the care manager on January 18, 2008. By the time the IM worker and the care manager complete the rest of his/her work respectively, the service plan packet is submitted to The Management Group (TMG) on March 10, 2008. The CARES screens indicate the participant has an \$83.00 cost share. A tentative approval letter is sent to the county waiver agency giving a January 18, 2008 start date. Upon receipt of the tentative approval letter, the IM worker enters this date, runs SFED and confirms eligibility. This process sends eligibility to MMIS. Some time lapses, and Medicaid eligibility via EDS is confirmed. A final approval letter is mailed back to the county waiver agency April 7,

2008 again indicating the eligibility start date is January 18, 2008. The participant has to begin paying his/her \$83.00 a month cost share effective January 18, 2008.

However, if in the months of January, February, and March the only service provided to the participant was case management, it may be necessary to adjust what the participant actually pays. For example, if case management were provided at a cost of \$130.00 in January, \$60.00 in February, and \$40.00 in March, the participant would have to pay his/her full cost share in the month of January, but only \$60.00 in February and only \$40.00 in March. The participant would be entitled to keep the rest of the money. If on the other hand, he/she received numerous waiver services that exceeded his/her cost share in a given month, he/she would have to pay the full amount of his/her cost share for each month going back to January 18, 2008.

- **What happens when a person has a cost share, uses no waiver services in a month, but uses the Medicaid card?**

No cost share payment is due to the county or to Medicaid since no waiver services were used. The person retains the money.

- **How is the cost share handled if the person enters a hospital or nursing home?**

*Note: the following answer is still in effect. However please be advised that the Department is reviewing this policy. County waiver agencies will be notified if a change occurs.*

It is the county's responsibility to use the cost share payment to offset the cost of any waiver program services provided in a month. After waiver services are paid for, the remaining cost share amount can be retained by the participant. If the cost share was already collected in full prior to the participant's institutionalization, the difference must be refunded to the participant. **EXAMPLE:** A participant has a \$100/month cost share and enters a hospital on March 6<sup>th</sup>. He/she is then transferred to a nursing home for additional convalescent care. He/she is not able to return home until May 20<sup>th</sup>. The care manager should review the cost of waiver services the participant received in March and in the month of May. If the participant only received \$80.00 worth of waiver services prior to March 6<sup>th</sup>, he/she only has to pay \$80.00 of the cost share. If upon his/her return home on May 20<sup>th</sup>, he/she receives \$500 worth of waiver services from May 20 through May 31<sup>st</sup>, he/she would have to pay the full \$100/month cost share.

As a reminder, if a participant is in an institution for a full month (i.e. in our example the entire month of April), he/she does not have to pay any cost share because he/she did not receive any waiver services.

This answer illustrated in another way:

*A waiver participant with a \$100.00/month cost share falls on the ice and breaks her hip. She enters the hospital on March 6<sup>th</sup> and then is transferred to a nursing home for additional convalescent care. She is discharged home on May 20<sup>th</sup>.*

*During the entire time period, Personal Emergency Response System (PERS) services are maintained because in this instance it is more cost-effective to continue the service than to stop it and then start it again. Also, due to limited availability of PERS in this county, terminating the service while the waiver participant is temporarily institutionalized could mean that upon returning home the participant may have to wait before PERS would become available to her.*

*The following chart illustrates how to determine the cost-share liability. FYI: the last question in this section explains how PERS costs should be entered on HSRs.*

<b>March</b>	<b>April</b>	<b>May</b>
March 1 – 5 at home March 6 – 11 in hospital March 11- 31 in NH	April 1 – 30 in NH	May 1 – 19 in NH May 20 – discharged home
<p>The care manager reviews the costs of all the waiver services the participant received from March 1 – 5<sup>th</sup>.</p> <p>Between care management (CM), supportive home care (SHC), personal emergency response system (PERS) and home delivered meals (HDM) services, the participant received \$80.00 worth of waiver services in those 5 days. The participant only needs to pay \$80.00 of her cost share – not the full \$100.00 for the month of March.</p>	<p>No cost share needs to be paid because the participant did not receive any waiver services.</p> <p>(Note: Although in this example, waiver funds are paying for PERS, the participant still does not have to pay the cost share in this month).</p>	<p>The care manager reviews the costs of all the waiver services the participant received from May 20 – 31.</p> <p>Between CM (including any discharge related care management provided within 30 days of discharge), SHC, PERS and HDM services, the participant received \$500.00 worth of waiver services. The participant must pay the full \$100.00 of her cost share for the month of May.</p> <ul style="list-style-type: none"> <li>• Upon the date of discharge, the IM worker will have to manually complete a 3070 form to ensure that the medical status code is changed to waiver status.</li> <li>• FYI: When an individual is institutionalized for less than a full month, the individual does not have a cost-of-care liability to the institution.</li> </ul>

- **If a participant enters a nursing home, when does his/her nursing home liability begin?**

When a person has a nursing home liability, typically all but \$45 of the person's income is paid to the nursing home. For a long term nursing home stay, the nursing home liability begins no sooner than the first day of the first full calendar month the individual resides in the nursing home. If an individual enters a nursing home on any day other than the first day of the month, the person's nursing home liability begins on the first day of the next full calendar month.

**Example:** A participant enters a nursing home on June 4<sup>th</sup>. The participant's nursing home liability begins July 1<sup>st</sup>, **if** the participant is in the nursing home during the entire month of July.

*Scenario:* Participant entered NH on June 4<sup>th</sup>. Participant was discharged from nursing home back to his/her apartment on August 11<sup>th</sup>. The participant would have a nursing home liability only for the month of July because the participant was in the nursing home for a full calendar month in July. If the participant has a cost share for the waiver program, the cost share would be applied to waiver services he/she received from June 1 – 3<sup>rd</sup>, and then again from August 11 – 31.

*Scenario:* Participant entered NH on June 4<sup>th</sup>. Participant was discharged from nursing home back to his/her apartment on September 27<sup>th</sup>. The participant would have a nursing home liability only for the months of July and August because the participant was in the nursing home for a full calendar month in the months of July and August. If the participant has a cost share for the waiver program, the cost share would be applied to waiver services he/she received from June 1 – 3<sup>rd</sup>, and then again from September 27 – 30.

*Scenario:* Participant entered NH on June 4<sup>th</sup>. Participant was discharged from nursing home back to his/her apartment on July 24<sup>th</sup>. The participant would not have a nursing home liability for either June or July because the participant was not in the nursing home for a full calendar month in either of those months. If the participant has a cost share for the waiver program, the cost share would be applied to waiver services he/she received from June 1 – 3<sup>rd</sup>, and then again from July 24 – 31.

It is important in these cases that the care manager reports this information to the IM worker for timely processing.

- **What are the care manager's responsibilities with regard to the cost share?**

The care manager's responsibilities are to monitor that the correct monthly cost share has been paid, and, document within the participant's case file that the cost share has been paid.

The care manager should ascertain the county's policy regarding cost share payments. For example, does the participant pay the cost share to the county waiver agency directly, or, does the participant pay the cost share directly to the vendor of a waiver allowable service? In most cases, when the cost share is paid directly to the county waiver agency, this dollar amount is entered on HSRS under SPC 095.01 – cost share.

When monitoring that the cost share payment has been made, the care manager has several options available to him/her. These include: reviewing receipts or canceled checks that the participant may have; conferring with the county's DSS/HSD fiscal department to determine if the cost share payment has been received; or contacting the service provider to whom the cost share has been paid.

The care manager must monitor, at least every three months that the cost share was paid on a monthly basis. There are several acceptable ways a care manager can document this activity:

- A case note within the participant's file that confirms the care manager has monitored the cost share payments. The case note would reflect a conversation or correspondence with either the participant, the county's fiscal staff, or, the vendor that confirms the cost share has been paid.
- The county waiver agency could develop a form that indicates the cost share has been received. This form should be kept in the participant's case file. There would be no need for the care manager to have a separate case note concerning monitoring the cost share payment every three months.
- The county's DSS/HSD fiscal department could give the care manager a printout of an accounting ledger that confirms the cost share payment. This ledger should be kept in the participant's case file.\* There would be no need for the care manager to have a separate case note concerning the monitoring of the cost share payment every three months.
- Copies of checks that the participant has paid to the county waiver agency confirming that the cost share has been paid. These check copies should be kept in the participant's case file. There would be no need for the care manager to have a separate case note concerning monitoring of the cost share payment every three months.
- Copies of the HSRS L-300 Report indicating that a cost share payment has been entered on HSRS under SPC 095.01. This should be kept in the participant's case file.\* There would be no need for the care manager to have a separate case note concerning monitoring the cost share payment every three months.

\*Note: if a county waiver agency chooses to have a system that involves giving the care manager an accounting ledger printout generated by the DSS/HSD, or HSRS L-300 Report, etc., there is an expectation that the care manager has verified that the cost share was paid. The care manager's initialing a copy of the printout or L-300 Report every three months is sufficient verification. Most importantly, in the event a cost share payment is missed, the care manager will follow up with the participant on this issue.

If the dollar amount of a cost share changes during the course of a year of eligibility due to changes in medical/remedial costs or other financial changes, it is the responsibility of the care manager to obtain an updated copy of the Community Waivers Budget (CWB) page from the IM worker that illustrates the new cost share amount and place these screen prints in the participant's case file. The Cost Share Budget section of the CWB page will confirm the higher or lower cost share (or in some case, no cost share) that needs to be paid by the participant.

- **What should the care manager do if a participant does not pay or misses his/her cost share?**

If a participant misses a cost share payment, the care manager should review and discuss the participant's budget with the participant, or with the person who is responsible for managing the participant's budget. Upon closer review, the care manager may be able to identify additional living expenses or medical/remedial expenses and could reduce **future** cost share amounts. It is important the care manager report any additional expenses to the IM worker as soon as possible. If necessary, old cost share payments can be made on a payment schedule.

Failure to make cost share payments might be a sign of financial abuse, poor money management skills, or mental incompetence. In some instances, the participant may have opted to pay for other "convenience" items instead of paying the cost share. If necessary, a third party (a guardian, or power-of-attorney, or representative payee, etc.) could be identified to manage the person's finances.

- **What should be done if the person refuses to pay the cost share?**

The county waiver agency can choose to garnishee the individual's income. Note: Social Security benefits cannot be garnisheed. Only income from a pension, earned income or annuity can be garnisheed. Garnisheeing can be pursued through the county's corporate counsel.

Refusal to pay the cost share may result in termination of waiver services. When a waiver participant refuses to pay the cost share, the care manager should follow the termination directives contained in DDES Action Memo 2005-18 (see copy of the

memo in Appendix 8 of this manual). Termination steps are outlined on the next page.

**STEPS:**

1. As soon as the care manager learns that the waiver participant refuses to pay the cost share<sup>1</sup>, the care manager should notify the IM worker via Form [F-22637](#) stating that Medicaid Waiver Services are going to be terminated for non-payment of cost-share.
2. The IM worker runs eligibility in CARES and the IM worker issues the “Notification Termination of Medicaid Waiver Eligibility for a Community Waiver Participant” (Form [F-10142](#)) and will deliver this form to the care manager. **IMPORTANT:** the care manager needs to have the Medicaid Waiver Termination Date listed on Form F-10142 in order to issue a Medicaid waiver services termination notice to the waiver participant. Therefore, if the care manager does not hear back from the IM worker after the care manager has delivered Form F-22637 to the IM worker, the care manager should check back with the IM worker to ascertain that termination of Medicaid Waiver services is being run in CARES.
3. Once the care manager has received Form F-10142 from the IM worker, the care manager will issue the “Notification of Waiver Program Termination” (Form [F-22638](#)) to the waiver participant. The effective date used on this form should coincide with the Medicaid Termination Date that the IM worker listed on Form F-10142<sup>2</sup>.
4. Note that form F-22638 contains language to the effect that if a hearing request is made by the waiver participant prior to the effective date of termination, and services continue to be provided per order of the Office of Hearing and Appeals, Medicaid waiver services received during the period pending the hearing decision may be recoupable by the county waiver agency if the hearing officer rules in favor of the county waiver agency.

**IMPORTANT:** If the cost share payment is not made, the cost of waiver program services that were to be funded by the cost share amount **cannot** be billed on HSRS. The dollar amount billed on HSRS needs to have the amount of the unpaid cost share factored out of the amount billed.

- **If the participant has a cost share obligation, but has been in an institution for a couple of months and waiver funds have been used to pay for their personal**

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<sup>1</sup> The earlier in the month the care manager communicates this information to the IM worker, and the sooner the IM worker runs eligibility in CARES, the earlier the effective termination date will be (i.e., information entered in CARES prior to the adverse action date – example March 10<sup>th</sup>, will create a termination date effective the first of the following month – or April 1<sup>st</sup>; information entered in CARES after adverse action date – example March 23<sup>rd</sup>, will create a termination date effective May 1<sup>st</sup>).

<sup>2</sup> Note that the IM worker will issue a separate Medicaid Waiver termination notice with the same effective termination date. The IM worker will also run the case through the CARES cascade to see if the person may be eligible for other types of Medicaid (other than Medicaid waivers).

**emergency response system (PERS) – more commonly known as “Lifeline”, does the participant need to pay their monthly cost share – at least up to the amount of the cost of the Lifeline – even if they have been in an institution and the waiver program has been funding that service?**

No. Waiver participants who are institutionalized for an entire calendar month **do not** have to pay their monthly cost share obligation even if the waiver program has been funding a PERS. There are three reasons for this: 1) depending upon when the participant went into the institution and their situation, the participant may be paying towards their nursing home liability, 2) the participant is not benefiting from the PERS service while they are in an institution, and 3) according to the Medicaid Waivers Manual, the correct way to enter PERS costs on HSRS is to aggregate the total cost that has been paid for this service while the participant has been in an institution, and enter this costs on HSRS in the month of the participant’s discharge.

County waiver agencies should not enter a monthly charge on HSRS for PERS if the participant is in an institution for an entire calendar month. As stated earlier, the correct way to enter PERS costs on HSRS is to aggregate the total cost that has been paid for this service while the participant has been in an institution, and enter this cost on HSRS in the month of the participant’s discharge.

Reminder: care managers should be entering SPC 503 hospital/institutional days for the period the person is institutionalized.

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## COST SHARE PAYMENT CHART

(Revised February 2004)

*Below is an "at-a-glance" description of what to do when a participant has a cost share*

### Where does the participant send his/her cost share?



#### **Participant sends check to DSS/HSD/USB**

1. County enters cost share amount on HSRS under SPC 095.01 and enters full dollar amount for waiver services onto HSRS.
2. Care manager must monitor that cost share has been paid by participant. At least every 3 months, the care manager must monitor that the cost share has been paid monthly.
3. Documentation must be in the participant's file that the cost share has been paid. This can be done in one of several ways: 1) the care manager can document in the case notes they have monitored the cost share payment, either by discussing this with the participant directly, or with fiscal personnel within the county, or 2) a form documenting cost share payments placed in the participant's file, or 3) copies of the participant's checks paid to the county waiver agency is placed in the file, or 4) an accounting ledger generated by the DSS/DHS documenting cost share payments\* (5) the care manager can place copies of the HSRS L-300 Report in the file.\* \*Note: if a county waiver agency uses either the L-300 Report or accounting ledger to document cost share payments, the care manager should initial copies of the report every three months.

#### **Participant sends check directly to vendor**

1. Vendor deducts cost share from invoice from a waiver allowable service. The vendor then sends invoice to county.
2. County enters remaining dollar amount onto HSRS.
3. Care manager must monitor that cost share has been paid by participant. At least every 3 months, the care manager must monitor that the cost share has been paid monthly.
4. Documentation must be in the participant's file that the cost share has been paid.

#### **Reminders:**

- A. The participant is not required to pay any cost share if there are no waiver services provided in a given month.**
- B. The participant is not required to pay an amount of his/her cost share which is in excess of the cost of his/her waiver services in a given month.**

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## NOTES

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## GROUP C

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### ☞ DESCRIPTION OF GROUP C PARTICIPANTS

To participate in the waiver programs, Group C waiver participants must be found to be medically needy. This means they must have enough long term care related services or expenses to "spend down" their disposable income to the year 2010 net income limit of \$591.67. If an individual's services or expenses reduce his/her net income to \$591.67 or less, the individual becomes eligible for Medicaid. When the IM worker can confirm Medicaid eligibility, the person becomes eligible for the waiver program. Note: Long term care services or expenses include medical/remedial expenses, COP (except if COP funds are assisting with room/board or housing expenses), waiver program services, and Medicaid card expenses.

Reminder: if a person who is currently on BadgerCare Plus – Benchmark Plan, applies for the Community Waivers Program, the person will be taken off of BadgerCare Plus – Benchmark and must meet the financial eligibility rules for Community Waivers Group C applicants.

### ☞ INCOME AND ASSET LIMITS

Effective January 1, 2010:

- The monthly income must be **greater** than \$2,022 for a single person.
- The asset limit is \$2,000 per applicant or participant. If one spouse is applying, the asset limit is \$2,000 for the applicant and no greater than \$109,560 (year 2010 figure) for the community spouse. The exact amount that may remain in the name of the community spouse depends on the amount of total countable assets shared by the couple at the time one requests waivers. The table below illustrates this point:

IF the total countable assets of the couple (TCAC) are:	THEN the community spouse asset share is:	AND the waiver participant spouse asset maximum is:
\$219,120 or more	\$109,560 (maximum effective 1/1/10)	\$2000
Less than \$219,120 but greater than \$100,000	½ the TCAC	\$2000
\$100,000 or less	\$50,000 (minimum effective 1/1/96)	\$2000

Note: "Community spouse" refers to the participant's spouse if that spouse is not living in a medical (hospital or nursing home) institution.

## ☞ THE ELIGIBILITY DETERMINATION PROCESS

The IM worker uses CARES to determine eligibility for Group C applicants. The care manager should have a basic understanding of the process used to determine the spenddown amount. The care manager is responsible for calculating, monitoring, and documenting the participant's medical and remedial expenses and COP and Waiver expenses and calculating the Medicaid card-coverable expenses. The care manager is also responsible for monitoring and documenting the participant's spenddown payments and cost share payments (if applicable).

The following is a line-by-line description of the eligibility and spenddown calculation found on the ECED screen print or CWB page.

- **Gross Earned Income**

This is the participant's gross earned income (see Section I, Line 2, or, Section IV, Line 1 of the [F-20919](#)).

- **\$65 & ½ Disregard**

Each month a program participant is allowed to deduct \$65 plus half of the remaining amount from the total gross earned income.

- **Gross Unearned Income**

This is the participant's total unearned income (see Section I, Line 3, or, Section IV, Line 4 of the F-20919).

- **\$20 Disregard**

Twenty dollars is subtracted from the income of all Group C participants.

- **Special Exempt Income**

This is any special income exempted from the eligibility determination process: *court-ordered* payments like child support or alimony payments to persons who live outside the participant's home; or *court-ordered* guardianship, guardian ad-litem, or attorney fees that are the participant's responsibility. IM workers are referred to the Medicaid Handbook Section 28.8.3.3 for further explanation regarding this type of income.

- **Health Insurance Cost**

This deduction is the monthly health insurance premium for insurance covering the waiver person **and** for which he/she is responsible. In the event the participant is fully responsible for paying the health insurance premium, the participant gets the full deduction. If the policy is a group or family policy and the waiver participant is not responsible for paying the premium, divide the monthly premium by the number of members. If there is a married couple and both people are on the program but only one person is paying the premium, divide the premium equally. If the applicant/participant selected a Medicare Part D plan that requires him/her to pay a monthly premium, the IM worker will count that expense in this deduction. Dental insurance premiums can be included in this category as well. Prorate any annual premiums over 12 months.

Do not count the Medicare Part B premium. This amount is automatically deducted in CARES. Do not count life insurance premiums as they are not medical costs.

- **Excess Self-Employment Expense**

This is a special disregard given to working waiver participants. IM workers are directed to their Medicaid Handbook section 15.6 for explanation regarding this expense.

- **Countable Net Income**

This is the total income remaining after initial disregards are taken.

- **Medical and Remedial Expenses for Group C**

Medical and remedial expenses are items and services received by the participant that are not covered by Medicaid, Medicare or other health insurance. This includes services or durable medical equipment that might normally be covered by Medicaid but prior authorization was denied. Medical and remedial expenses for Group C participants include those allowable for Group B **plus** any expenses for services that would be covered by the waiver program or COP\*, including care management. It is assumed the individual would need to pay for these expenses out-of-pocket if the waiver program did not cover them. *\*The only exception to this is any room/board or housing costs that are paid by COP or any other funds, or by the participant. Room/board or housing expenses cannot be counted as medical/remedial expenses.*

Medical and remedial expenses are used during the financial eligibility determination process and are treated differently for Group B and Group C participants. See the Group B financial eligibility section for medical and remedial expenses for Group B.

For Group C, the care manager must provide the IM worker with an estimate of average monthly expenses.

Medical and remedial expenses are considered part of the spenddown.

- **Medicaid Card-Coverable Expenses**

To establish financial eligibility, any expenses that will be covered by the Medicaid card once Medicaid eligibility is determined are included.\* Again, it is assumed these costs would be paid out-of-pocket if the Medicaid card was not issued. Note: A care manager can only use the Medicaid reimbursable dollar amount for these expenses.

In other words, the amount that EDS would pay to a provider for the service, not the full amount that was billed to EDS.

**\*Important note:** effective January 1, 2006, care managers cannot count the cost of prescription drugs as part of the Medicaid Card-coverable expenses for waiver applicant/participants who also have Medicare (dually eligible). Reason: Medicare Part D will be paying for prescription drugs. (However, if there are any prescriptions that the applicant/participant will be taking and whose costs are not going to be covered by Medicare Part D, *and the Group C applicant/participant is paying for these prescription drugs out of pocket*, then these expenses can be counted as a Medical/Remedial expense.)

In the event the Group C waiver participant is not dually entitled (in other words the person is not on Medicare), Medicaid will continue to cover all Medicaid coverable prescription drugs. For these cases, the simplest way to identify Medicaid reimbursement **for brand name drugs (non-generic)**, would be for a care manager to ask a pharmacy to look up the AWP (average wholesale price) for a particular drug and then deduct the current discount amount. Pharmacists receive the AWP listings on a regular basis.

FYI: The simplest way to identify Medicaid reimbursement **for generic** drugs is through the reimbursement rate found on the Legend Drug Maximum Allowed Costs (MAC) published as an attachment to the Medicaid pharmacy handbook. This list is updated regularly and can be found at:

[http://dhs.wisconsin.gov/medicaid4/pharmacy/data\\_tables/archives.htm](http://dhs.wisconsin.gov/medicaid4/pharmacy/data_tables/archives.htm)

Also note that Medicaid card coverable services such as Durable Medical Equipment (DME), Durable Medical Supplies (DMS), etc., can still be counted to meet the spenddown when these items are not covered by Medicare Part D.

- **Net Income**

Applicants with income equal to or less than the current medically needy income limit (\$591.67- 2010 figure) are eligible for the waiver program.

- **Countable Net Income**

This is the total income remaining after initial disregards are taken.

- **Medically Needy Income Limit**

The medically needy income limit is the highest amount of monthly income (following all allowable deductions) allowable for Medicaid eligibility. Effective January 1, 2010, the income limit equals \$591.67 for an individual.

- **Waiver Spenddown Amount**

The spenddown obligation is the amount of money a Group C eligible person must incur each month on medical/service-related expenses to lower his or her disposable income to the medically needy income limit of \$591.67. This is necessary on a monthly basis to maintain Medicaid eligibility. The spenddown obligation is the difference between the countable net income and the medically needy income limit. Note: The sum total of medical/remedial expenses and Medicaid card coverable expenses must be equal to or greater than the spenddown amount for the individual to be eligible.

The care manager must monitor and document on a monthly basis that the Group C participant has incurred, and in some cases, be held financially responsible for his/her spenddown amount each month. A *single person* must incur and be held financially responsible for the spenddown amount each month. A *married* individual with a community spouse must incur the spenddown amount each month, however depending upon what he/she is allocating to their community spouse, may have a cost share which he/she has to pay towards waiver services each month.

Please note: A married person who is not allocating money to his/her community spouse for whatever reason (either can't allocate because the community spouse's income is too high; or, the waiver applicant/participant chooses not to allocate any money to his/her community spouse; must incur the spenddown amount each month, and in the event he/she has a cost share, pay the cost share amount each month. **In the event a married person cannot allocate money to his/her spouse because the spouse is in a medical institution (for example a nursing home) and spousal impoverishment rules do not apply**, the married Group C applicant/participant must incur **and** be held financially responsible for the spenddown amount on a monthly basis (similar to the Group C single waiver applicant/participant).

Spenddown payments should first be applied towards the out-of-pocket medical and remedial expenses on the ECED or the CWB page. The payment should next be applied to COP services (except if COP is being used for room/board or housing expenses), and then towards waiver program services. By following this sequence it will maximize federal funding.

If a waiver participant pays his/her spenddown amount towards out-of pocket expenses, COP expenses (except room/board or housing expenses), and his/her waiver expenses, and still has a spenddown amount remaining, the participant must then pay towards his/her Medicaid card services. Effective January 2006, the correct manner to pay towards Medicaid card service was outlined in DDES Info Memo 2006-01. That memo indicates that how this depends upon the age of the waiver participant. If the participant is age 54 or under, the payment should be made to the county and the county reports the receipt on the Community Aids Reporting System (CARS) on line 909. If the participant is age 55 or older, the participant should write a check made payable to DHFS and the county's fiscal unit will disburse the payment to the Estate Recovery Program.

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## NOTES

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## MEDICAID WAIVER ELIGIBILITY AND COST SHARING WORKSHEET

Completion of this form meets the requirements of the Federal Regulations 42 CFR 435.

Check One:  Application  Review/Recertification  Change

Name - Applicant		Medicaid ID Number	Medicaid Eligibility Date
Name - Care Manager	Name - Income Maintenance Worker (IMW)	IMW No.	Date

### SECTION I – FINANCIAL RESOURCES (Complete for all Applicants)

1. Nonexempt Assets	\$
2. Gross Earned Income	\$
3. Total Unearned Income	\$
4. Total Income (2 + 3)	\$

**Group A** (Applicant is currently eligible for Medicaid) **Care Manager checks eligible category and completes sections II and V for the following types:**  
 SSI Recipient  SSI-E  1619a  1619b  Katie Beckett  
**Other Medicaid Eligibility: Income Maintenance Worker writes in Type and Category Code:**  
 Other Medicaid Type (Specify) \_\_\_\_\_  
 CARES Category code (Specify) \_\_\_\_\_

NOTE: This form may be used by IMW for a Group B or Group C applicant only if the applicant is institutionalized at the time of application.  
 **Group B** Special Income Limit (IMW completes Sections III and V)  
 **Group C** Medically Needy (IMW completes Sections IV and V)

### SECTION II – SPECIAL DECLARATION REGARDING DIVESTMENT FOR GROUP A WAIVER APPLICANTS WHO RECEIVE SSI, SSI-E, 1619a, 1619b, OR KATIE BECKETT

Care Manager: Ask the applicant both of the following questions:

- "Have you or your spouse sold, traded, transferred or given away property, land stocks, bonds, cash, vehicles, or anything of value in the past 36 months?"
- "Have you or your spouse created a trust or added funds to a trust within the last five years?"

Yes. Complete DDE-919-D and Refer applicant to Income Maintenance Worker for investigation and determination. After Income Maintenance Worker makes determination, proceed to Section V.

No. Proceed to SECTION V.

### SECTION III – COST SHARING/GROUP B UNDER "SPECIAL INCOME LIMIT." When Spousal Impoverishment Protections Apply, Substitute "Income Allocation Worksheet" for Section III

1. Total Income	\$
2. Personal Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
3. Family Maintenance Allowance (Compute on Page 2 and Enter Here)	\$
4. Special Exempt Income	\$
5. Health Insurance Premium	\$
6. Out of Pocket Medical/Remedial Expenses Obtain this figure from care manager.	\$
7. Total Deductions (2 + 3 + 4 + 5 + 6)	\$
8. Waiver Cost Share Amount (1 – 7) The amount on line 8 is monitored and documented by the care manager. Proceed to Section V.	\$

### SECTION IV – FOR GROUP C MEDICALLY NEEDY

1. Gross Earned Income (2)	\$ 0.00
2. \$65 and ½ Disregard	\$ 0.00
3. (1 – 2)	\$ 0.00
4. Total Unearned Income (3)	\$ 1920.00
5. (3 + 4)	\$ 1920.00
6. \$20 Disregard	\$ 20.00
7. Balance (5 – 6)	\$ 1900.00
8. Special Exempt Income	\$ 0.00
9. Countable Income (7 – 8)	\$ 1900.00
10. Health Insurance Premium	\$ 170.00
11. Balance (9 – 10)	\$ 1730.00
12. Excess Self Employment Expense	\$ 0.00
13. Balance (11 – 12)	\$ 1730.00
14. Monthly Medical/Remedial Expenses Obtain this figure from care manager	\$ 1000.00
15. Balance (13 – 14)	\$ 730.00
16. Medicaid Card Coverable Services	\$ 500.00
17. Balance (15 – 16)	\$ 230.00

If the Balance on line 17 is greater than the current medically needy income limit, the applicant is not eligible for Medicaid Waivers. Proceed to line 18 with all eligible Group C Applicants.

### SPENDDOWN DETERMINATION FOR ALL ELIGIBLE GROUP C APPLICANTS

18. Balance (from line 13)	\$ 1730.00
19. Current Medically Needy Income Limit	\$ 591.67
20. Spenddown Amount (18 – 19)	\$ 1138.33

The amount on line 20 must be incurred by the applicant on a monthly basis to sustain eligibility. This is monitored and documented by the care manager. **Now complete an Income Allocation Worksheet for all spousal impoverishment cases.** Proceed to Section V.

**DATE NEXT MA REVIEW DUE** - Reviews must be completed every 12 months

# Group C - Single (Applicant)

User ID: ABC 123  
 Primary Person: PERRY SMITH

User Name: J DOE  
 Case: 0000000000

Quick Select: CASE/RFA  
 Status: Open Mode: Ongoing

<b>Navigation Menu</b>
Search
▪ CARES Home
▪ Search
▶ Inbox Search
RFA/Case
▶ Client Registration (0)
▪ Case Summary
▶ Application Entry (0)
√ Initiative Eligibility Determination
▼ Eligibility (5)
▶ Run Results
▶ Eligibility Results
▼ Budgets
▪ BadgerCare Plus
▪ BadgerCare Plus Premium Summary
▪ SSI-Related Medicaid
▪ Family Planning Waiver
▪ MAPP
→ Community Waiver
▪ Institution Medicaid
▪ Family Care
▪ Caretaker Supplement
* FoodShare
▪ Child Care
▪ W-2
▶ Post Eligibility
* Confirmation Access
▶ Query
▶ Benefit Issuance

## Community Waivers Budget

<b>Assistance Group Overview</b>		
Assistance Group:	MCWW- COMMUNITY WAIVERS COP	Sequence:
Benefit Begin Date:	04/17/2008	Benefit End Date:
Determination Date:	04/17/2008	

<b>Results</b>			
Assistance Group Status:	P-PEND	Eligibility Status:	PENED
Group Indicator:	C	Community Waivers Eligibility Test:	

<b>Individuals</b>		
Community Waivers Name:	PERRY SMITH	Community Spouse:
Community Waivers Eligibility Determination – Group B		

Gross Earned Income:	\$
Gross Unearned Income:	+1,920.00
Excess Self Employment Expenses:	-
Student Disregard:	-
Gross Income:	\$1,920.00
Categorically Needy Income Limit:	\$1,911.00

## Community Waivers Eligibility Determination – Group C

Gross Earned Income:	\$
\$65 & ½ Disregard:	-
Gross Unearned Income:	\$1,920.00
\$20 Disregard:	- 20.00
Health Insurance Cost:	- 170.00
Excess Self Employment Expenses:	-
Special Exempt Amount:	-
Countable Net Income:	-1,730.00
Medical/Remedial Expenses:	-1,000.00
MA Card Coverable Expenses:	- 500.00
Net Income:	\$ 230.00
Countable Net Income:	\$1,730.00
Medically Needy Income Limit:	- 591.67
Spend down Amount:	\$1,138.33

Assistance Group	Sequence	Updated on or by
MCWW- COMMUNITY WAIVERS COP		

User ID: ABC 123  
 Primary Person: George Fuller

User Name: J DOE  
 Case: 0000000000

Quick Select: CASE/RFA  
 Status: Open Mode: Ongoing

■ <b>Navigation Menu</b>
Search
▪ CARES Home
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RFA/Case
▶ Client Registration (0)
▪ Case Summary
▶ Application Entry (0)
√ Initiative Eligibility Determination
▼ Eligibility (5)
▶ Run Results
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▼ Budgets
▪ BadgerCare Plus
▪ BadgerCare Plus Premium Summary
▪ SSI-Related Medicaid
▪ Family Planning Waiver
▪ MAPP
→ Community Waiver
▪ Institution Medicaid
▪ Family Care
▪ Caretaker Supplement
* FoodShare
▪ Child Care
▪ W-2
▶ Post Eligibility
* Confirmation Access
▶ Query
▶ Benefit Issuance

<b>Community Waivers Budget</b>	
<b>Assistance Group Overview</b>	
Assistance Group: MCWW- COMMUNITY WAIVERS COP	Sequence:
Benefit Begin Date: 10/17/2008	Benefit End Date:
Determination Date: 10/17/2008	
<b>Results</b>	
Assistance Group Status: P-PEND	Eligibility Status: PENDED
Group Indicator: C	Community Waivers Eligibility Test:
<b>Individuals</b>	
Community Waivers Name: GEORGE FULLER	Community Spouse: LOUISE FULLER
Community Waivers Eligibility Determination – Group B	
<p>Gross Earned Income: \$</p> <p>Gross Unearned Income: +1,930.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: -</p> <p>Gross Income: \$1,930.00</p> <p>Categorically Needy Income Limit: \$1,911.00</p>	
<b>Community Waivers Eligibility Determination – Group C</b>	
<p>Gross Earned Income: \$</p> <p>\$65 &amp; ½ Disregard: -</p> <p>Gross Unearned Income: \$1,930.00</p> <p>\$20 Disregard: - 20.00</p> <p>Health Insurance Cost: -</p> <p>Excess Self Employment Expenses: -</p> <p>Special Exempt Amount: -</p> <p>Countable Net Income: -1,910.00</p> <p>Medical/Remedial Expenses: -1,050.00</p> <p>MA Card Coverable Expenses: - 300.00</p> <p>Net Income: \$ 560.00</p> <p>Countable Net Income: \$1,910.00</p> <p>Medically Needy Income Limit: - 591.67</p> <p>Spend down Amount: \$1,318.33</p>	

Assistance Group

Sequence

Updated on or by

MCWW- COMMUNITY WAIVERS COP

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## Spousal Impoverishment Income Allocation Worksheet

Primary Person's Name & SSN

George Fuller

123 56 1299

<b>Section A – Community Spouse Income Allocation</b>			
<b>Spouse's Name</b>			
<b>Louise Fuller</b>			
1. ENTER Maximum Community Spouse Income Allocation		\$	2333.33
2. MINUS Gross Income of Community Spouse		-	1310.00
3. EQUALS Community Spouse Income Allocation		=	\$1023.33
<b>Section B – Dependent Family Member Income Allocation</b>			
0	Name	Name	Name
1. ENTER Dependent Family Member Income Allocation	\$	\$	\$
2. MINUS Dependent Family Member's Income	-	-	-
3. EQUALS Individual Allowance	=	=	=
4. ENTER Total Dependent Family Member Allocation	\$	0	
<b>Section C – Cost of Care/Cost Sharing Collection</b>			
1. ENTER Institutionalized Spouse's Gross Income		\$	1930.00
2. MINUS Personal Allowance		-	817.00
3. EQUALS		=	1113.00
4. MINUS Community Spouse Income Allocation		-	1023.33
5. EQUALS		=	89.67
6. MINUS Total Dependent Family Member Allocation		-	0.00
7. EQUALS		=	89.67
8. MINUS Any Court-Ordered Guardian or Attorney Fees		-	0.00
9. EQUALS		=	89.67
10. MINUS <u>Community Waivers Only: Medical/Remedial Costs and Cost of Community Waivers Person's Health Insurance Premiums</u>		-	92.00
	<u>Nursing Home Cases Only: Cost of Institutionalized Person's Health Insurance Premiums</u>		
11. EQUALS <u>Nursing Home Liability Amount/Community Waivers Cost Sharing Amount</u>		=	0.00

NOTE: The CWW budget screen combines all the separate old budget pages in the CARES Mainframe. Depending on group type (Group A, B or C), the appropriate M/R expenses dollar amount are displayed. It is only appropriate to put down those medical/remedial expenses that include over-the-counter items, co-pays, payments on past medical bills incurred by the participant.)

Important note:

On the CARES Worker Web (CWW), even though the budgets have moved to CWW, the logic has not. IM Workers should be doing what has been done in the past per MEH 28.2.4: Complete a manual Spousal Impoverishment Income Allocation Worksheet (40.1 WKST 07) for any spousal impoverishment case that is Group C eligible. Send a copy of this worksheet to the care manager.

## ☞ COMMON QUESTIONS AND ANSWERS ABOUT SPENDDOWNS

- **What is a Spenddown?**

A spenddown is the amount of money a Group C waiver person must incur **each** month on service-related expenses to lower his/her disposable income to the net income limit of \$591.67 (the medically needy income limit), in order to maintain Medicaid eligibility. The spenddown obligation amount is the difference between the countable net income and the medically needy income limit. For the individual to be eligible as a Group C waiver, the sum total of the medical/remedial expenses and Medicaid card coverable expenses must be equal or greater than the spenddown amount.

Eligibility for a Group C waiver participant must be monitored on a **monthly** basis. This is different than the “deductible” program under regular Medicaid, where once the individual meets his or her deductible during the six-month “deductible period,” Medicaid eligibility begins and lasts until the end of the six-month deductible period.

- **What are the care manager's responsibilities related to the spenddown?**

The care manager must monitor and document monthly that the Group C participant has incurred the spenddown each month. In addition, depending on the participant’s marital status and on whether or not spousal impoverishment rules apply, the care manager may also have to document that the participant has paid or has been held financially responsible for the spenddown amount or the cost share, as follows.

**a) Group C Waiver – Single person**

A single person must incur and be held financially responsible for the spenddown amount **each month**. To document financial eligibility, the care manager needs the CARES Community Waivers Budget (CWB) page. This screen print also shows the spenddown amount that must be incurred and spent each month. The care manager must monitor **monthly** that the Group C single waiver participant is eligible and that he or she has been held financially responsible for his/her spenddown amount on a monthly basis.

If during the year there are changes that impact eligibility and/or spenddown amount, a new CARES CWB page is needed in the participant's file.

**b) Group C Waiver – Married person, when spousal impoverishment rules do apply**

When there is a community spouse, spousal impoverishment rules apply. A community spouse is a spouse who resides in the community and not in a medical institution (for example a nursing home).

A community spouse may or may not be a COP-W/CIP II (or COP) participant. Therefore, it is possible for both members of a couple to be on COP-W/CIP II (or COP) and be considered each other's community spouse for purposes of the spousal impoverishment income allocation.

When spousal impoverishment rules apply, the waiver applicant/participant has the option of allocating income to his or her spouse. If both members of a couple are Group B or C waiver participants, either spouse could allocate income to the other. The goal in these cases is to reduce a potential cost-share liability for both spouses. Usually the spouse with higher income will allocate some or all of his or her income to the spouse with lower income. In those instances if money is allocated from one spouse to the other, the other person's income will be increased by the amount of money allocated. **Important Note:** in the event one of the members of the couple is a Group A, then the money that the Group C person allocates to the Group A spouse is not added to the Group A's income. There is no post-eligibility (i.e., cost-share) determination for a Group A individuals.

The Income Maintenance worker is able to "simulate" various scenarios in CARES to determine the best outcome.

However, there are instances when the Group C Waiver applicant/participant either cannot allocate, or, chooses not to allocate income to the community spouse. For example, the community spouse's income is too high and the waiver participant cannot allocate money to his/her spouse; or the waiver participant just chooses not to allocate money to his/her spouse.

Whether or not the waiver participant allocates income to the community spouse, when spousal impoverishment rules apply, the Group C waiver participant's eligibility is still determined via the CWB. A copy of the annual CWB page used to determine eligibility kept in the waiver participant's file documents financial eligibility.

To maintain eligibility, the Group C married waiver participant must incur the spenddown amount on a monthly basis. The care manager must monitor that financial eligibility is met on a monthly basis. If there are changes that would impact eligibility, a new financial eligibility determination must be made and a new CWB page in the waiver participant's file must document that financial eligibility has been met.

In addition to financial eligibility, the married Group C waiver participant with a community spouse may have a cost-share liability that must be paid towards waiver services (*instead of being held financially responsible for the spenddown*). It is possible for the married Group C waiver participant to have a zero cost share when income is being allocated to the community spouse.

If the Group C married waiver participant has a cost-share, he or she must pay the cost-share monthly. The cost-share liability appears on the Spousal Income Allocation Worksheet. When there is a cost-share liability, the care manager must ensure that the cost-share is paid monthly. As a reminder, cost-shares must be paid towards waiver allowable services.

If during the year there are financial changes that would impact the cost-share amount, a new CARES CWB page, or a new Spousal Income Allocation Worksheet is required for the participant's file.

To recap, in these types of cases, care managers must monitor financial eligibility on a monthly basis to ensure the participant has incurred the spenddown amount, and must ensure that the cost share liability – if there is one- is paid monthly.

c). **Group C Waiver – Married person, when spousal impoverishment rules do not apply**

Spousal impoverishment rules do not apply when the spouse of the waiver participant resides in a medical institution (for example a nursing home). In these cases, the married Group C participant must incur and be held financially responsible for the spenddown amount on a monthly basis (similar to the Group C single waiver participant). An annual CARES CWB page is needed to document financial eligibility and the spenddown amount. If there are changes that impact financial eligibility and/or the spenddown amount during the course of the year, a new CWB page is required.

The care manager must monitor **monthly** that the Group C married participant (whose spouse is in a medical institution) is eligible and that he or she had been held financially responsible for his/her spenddown amount on a monthly basis.

- **What should the spenddown be used to pay for?**

Spenddown payments should first be applied towards the out-of-pocket medical and remedial expenses. They must be applied to COP services (except room/board or housing costs if applicable) next, and then towards waiver services (this will maximize the federal dollar). If the person's spenddown obligation is greater than the cost of waiver, COP services and out-of-pocket expenses, then the participant must pay toward some of his/her Medicaid card services.

- **Does the waiver participant have the option of paying the spenddown amount directly to the county waiver agency, and then the county waiver agency disburses the spenddown as appropriate?**

Yes. Effective January 2006, the option of paying the entire monthly spenddown directly to the county waiver agency is available to the waiver applicant/participant. The county waiver agency will then disburse the spenddown as appropriate. See details in DDES Info Memo 2006-01 at [2006/InfoMemo200601.htm](#)

- **What should the care manager do if a participant does not incur his/her monthly spenddown?**

Because the care manager must monitor whether the participant incurred the spenddown amount on a monthly basis, this situation will be identified right away.

The first thing a care manager should do is determine *why* the participant did not incur the spenddown. Was it because a service has stopped or been permanently reduced, or, were there extenuating circumstances that prevented the participant from incurring the spenddown amount in full? Some examples of these circumstances include: the participant went to a relative's home. Or, perhaps the participant was ill and cancelled home delivered meals and supportive home care services for a few days. In other words, there was a reason why the person did not incur the spenddown but the care manager expects that in the current month the spenddown will be incurred.

If it is determined that there were extenuating circumstances that impacted whether or not the participant incurred the spenddown, the care manager should:

**For a single participant:** 1) Send a formal notice to the participant and 2) have the participant pay up to the amount of services (OTC's, COP (except for room/board expenses), Waiver and Medicaid) they did receive in that month. See the following example of a notice that could be sent:

“Please be advised that you did not incur your monthly spenddown amount (\$\_\_\_\_\_) in the month of \_\_\_\_\_, 2010 due to extenuating circumstances. Because of the extenuating circumstances, no termination of

waiver services will occur. However, please note you are still financially responsible for your spenddown up to the dollar amount of services (medical/remedial, COP, Waiver and Medicaid) you received. That dollar amount has been determined to be \$\_\_\_\_\_.”

“If this is a permanent change and you will no longer incur the spenddown amount necessary to maintain Medicaid eligibility, this information will be relayed to the IM worker. It may be determined that you are no longer eligible for participation in the waiver program and the funding of waiver services will end. The IM worker will notify you of your Medicaid status with a separate notice.”

**For a married participant with a community spouse and does not have a cost share:**

1) Send a formal notice to the participant stating the following:

“Please be advised that you did not incur your monthly spenddown amount (\$\_\_\_\_\_) in the month of \_\_\_\_\_, 2010 due to extenuating circumstances. Because of the extenuating circumstances, no termination of waiver services will occur.”

“If this is a permanent change and you will no longer incur the spenddown amount necessary to maintain Medicaid eligibility, this information will be relayed to the IM worker. It may be determined that you are no longer eligible for participation in the waiver program and the funding of waiver services will end. The IM worker will notify you of your Medicaid status with a separate notice.”

**For a married participant with a community spouse and does have a cost share:**

1) Send a formal notice to the participant and 2) collect the cost share up to the amount of waiver services the participant received. See below for an example of the notice:

“Please be advised that you did not incur your monthly spenddown amount (\$\_\_\_\_\_) in the month of \_\_\_\_\_, 2010 due to extenuating circumstances. Because of the extenuating circumstances, no termination of waiver services will occur. You are still obligated to pay for your cost share up to the amount of waiver services you received. The amount of cost share you owe for the month of \_\_\_\_\_, 2010 is \$ \_\_\_\_\_. You will continue to be responsible for your cost share each month.”

“If this is a permanent change and you will no longer incur the spenddown amount necessary to maintain Medicaid eligibility, this information will be relayed to the IM worker. It may be determined that you are no longer eligible for participation in the waiver program and the funding of waiver services will end. The IM worker will notify you of your Medicaid status with a separate notice.”

**For a married participant whose spouse resides in a medical institution and therefore spousal impoverishment rules do not apply:**

1) Send a formal notice to the participant and 2) have the participant pay up to the amount of services (OTC's, COP (except for room/board or housing expenses), Waiver and Medicaid) they did receive in that month. Below see an example of a notice that could be sent:

“Please be advised that you did not incur your monthly spenddown amount (\$\_\_\_\_\_) in the month of \_\_\_\_\_ 2010 due to extenuating circumstances. Because of the extenuating circumstances, no termination of waiver services will occur. However, please note you are still financially responsible for your spenddown up to the dollar amount of services (medical/remedial, COP, Waiver and Medicaid) you received. That dollar amount is \$\_\_\_\_\_.”

“If this is a permanent change and you will no longer incur the spenddown amount necessary to maintain Medicaid eligibility, this information will be relayed to the IM worker. It may be determined that you are no longer eligible for participation in the waiver program and the funding of waiver services will end. The IM worker will notify you of your Medicaid status with a separate notice.”

**Important note applicable to all Group C participants:**

If it is determined that there has been an end to a service(s), a reduction in authorized hours, etc., the care manager should revisit the service plan and determine the correct amount for medical/remedial expenses and Medicaid Card costs. This information should be relayed to the IM worker to determine if the participant is still eligible for the waiver program. In addition, if it is learned that the participant has dropped his/her health insurance, or ended a special exempt obligation, this information should be relayed to the IM worker. The IM worker will in turn determine if the participant is still eligible for the waiver program, or, perhaps while still financially eligible, the participant's spenddown amount may change.

- **What should the care manager do if a Group C single participant does not pay, or is not being financially responsible for their monthly spenddown?**

Because the care manager must monitor whether the single Group C participant has paid his/her spenddown amount on a monthly basis, this situation will be identified right away.

If a single Group C participant misses a spenddown payment, the care manager should review the participant's budget and assess his or her ability to make financial decisions. Reminder: It is allowable for the participant to “make up” his spenddown amount over time if need be. The key thing to remember is that neither COP nor Waiver funds can be used to pay for services for which the participant is responsible.

However, if it is determined that the participant will not pay the spenddown amount, failure to pay the spenddown may result in termination of waiver services. If the spenddown obligation is not met by the end of each month, the care manager will follow the instructions in DDES Action Memo 2005-18. To follow are the termination steps.

**STEPS:**

1. As soon as the care manager learns that the waiver participant refuses to be financially responsible for the spenddown<sup>3</sup>, the care manager should notify the IM worker via Form [F-22637](#) stating that Medicaid Waiver Services are going to be terminated for non-payment of the spenddown.
2. The IM worker runs eligibility in CARES and the IM worker issues the “Notification Termination of Medicaid Waiver Eligibility for a Community Waiver Participant” (Form [F-10142](#)) and will deliver this form to the care manager. **IMPORTANT:** the care manager needs to have the Medicaid Waiver Termination Date listed on Form F-10142 in order to issue a Medicaid waiver services termination notice to the waiver participant. Therefore, if the care manager does not hear back from the IM worker after the care manager has delivered Form F-22637 to the IM worker, the care manager should check back with the IM worker to ascertain that termination of Medicaid Waiver services is being run in CARES.
3. Once the care manager has received Form F-10142 from the IM worker, the care manager will issue the “Notification of Waiver Program Termination“ (Form [F-22638](#) ) to the waiver participant. The effective date used on this form should coincide with the Medicaid Termination Date that the IM worker listed on Form [F-10142](#)<sup>4</sup>.
4. Note that form F-22638 contains language to the effect that if a hearing request is made by the waiver participant prior to the effective date of termination, and services continue to be provided per order of the Office of Hearing and Appeals, Medicaid waiver services received during the period pending the hearing decision may be recoupable by the county waiver agency if the hearing officer rules in favor of the county waiver agency.

**NOTE:** if the spenddown payment is not made, the cost of the waiver program services that were to be funded by the spenddown amount **cannot** be billed on HSRS. The dollar amount billed on HSRS needs to have the amount of the unpaid spenddown amount factored out from the amount billed.

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<sup>3</sup> The earlier in the month the care manager communicates this information to the IM worker, and the sooner the IM worker runs eligibility in CARES, the earlier the effective termination date will be (i.e., information entered in CARES prior to adverse action date – example March 10<sup>th</sup>, will create a termination date effective the first of the following month – or April 1<sup>st</sup>; information entered in CARES after adverse action date – example March 23<sup>rd</sup>, will create a termination date effective May 1<sup>st</sup>).

<sup>4</sup> Note that the IM worker will issue a separate Medicaid Waiver termination notice with the same effective termination date. The IM worker will also run the case through the CARES cascade to see if the person may be eligible for other types of Medicaid (other than Medicaid waivers).

- **What if a single Group C waiver participant is in an institution (hospital or nursing home) for a *brief time* during an individual month – how should the spenddown amount, both incurring and paying, be handled during that time?**

In this scenario, a single Group C waiver participant is still required to meet Group C waiver eligibility. This means that a Group C single individual must both incur and be held financially responsible for the entire spenddown amount during that particular month.

EXAMPLE 1: Mr. Jerry Smith, a **single Group C** participant is hospitalized on March 5<sup>th</sup>. He is discharged back to his home on March 15<sup>th</sup>. Mr. Smith’s monthly spenddown amount is \$900.00. *How much of his spenddown does Mr. Smith have to incur **and** be held financially responsible for during March?*

Answer: In March, Mr. Jerry Smith **must incur the entire spenddown amount of \$900.00. If Mr. Smith does not meet his spenddown, his eligibility is at risk. In addition, Mr. Smith must be held financially responsible for the entire spenddown amount of \$900.00** for the month of March.

FYI: To determine if Mr. Smith has incurred enough medically related expenses, the care manager can take into account costs that will be billed to Medicaid while Mr. Smith is in the hospital. Note: it is NOT allowable to count any costs that may be paid by Medicare, private health insurance or the VA when determining if he has incurred the full spenddown amount. With regard to Mr. Smith being held financially responsible for his entire spenddown amount – in the event he does not have enough OTC’s, COP (do not count COP funds that pay towards room/board or housing costs), Waiver, or Community Medicaid service costs for the month of March – it may mean Mr. Smith has to pay towards his institutional stay until the full spenddown is met. As a point of interest: If Mr. Smith were a Married Group C participant with a community spouse (therefore spousal impoverishment rules do apply), Mr. Smith would have to incur the entire spenddown amount (in our example, \$900.00), however Mr. Smith would not have to pay the spenddown amount. However, if it was determined that Mr. Smith had a cost share, he would have to pay the cost share up to the amount of waiver services he received in the month of March (similar to Group B participants who have cost shares).

As another point of interest: If Mr. Smith were a Married Group C participant and his spouse permanently resides in a nursing home (therefore spousal impoverishment rules do not apply), Mr. Smith would have to incur the entire spenddown amount in March, and, also be held financially responsible for the entire spenddown amount in March – similar to a Group C single participant.

The following chart is another way to illustrate this issue:

March
March 1 – 4 at home

March 5-14 in hospital

March 15<sup>th</sup> – discharged home

- Mr. Smith’s eligibility for the month of March is based on Group C waiver eligibility rules because on the first of March he was a waiver participant. When a Group C participant (married or single) is a waiver participant on the 1<sup>st</sup> day of any given month, eligibility is predicated on waiver rules.
- Mr. Smith must incur and be held financial responsible for the entire Spenddown amount for the month of March (in our example \$900).
- It is allowable to include the costs billed to Medicaid while the participant was in the institution during the month of March when documenting that the participant “incurred” the Spenddown amount. Do not include costs billed to Medicare, private insurance or VA.
- In order to be financially responsible for the full \$900 March Spenddown amount, in the event Mr. Smith’s OTC’s COP (don’t include Room and Board costs covered by COP), Waiver or regular community Medicaid services do not add up to \$900, it may mean that Mr. Smith has to pay towards the institutional stay until the full Spenddown amount is paid.

- **What happens when a Group C waiver participant, single or married, is institutionalized for a full calendar month?**

When a Group C waiver participant, single or married, is institutionalized for a **full** calendar month (example March 1 - March 31), the individual’s Medicaid eligibility is based on institutional rules. Therefore, from the waivers’ standpoint, a Group C participant who is institutionalized for a full calendar month does not have to incur his/her spenddown in the full month that the participant was in the institution. If the Group C participant is single, he or she does not have to pay or be held financially responsible for their spenddown in the full month that the participant was in the institution.

- **What happens when a Group C waiver participant (single or married) is institutionalized for a full calendar month, but is then discharged before the last day of the following month?**

*Important note: The following answer is correct. However, the Department is currently reviewing this policy. County waiver agencies will be notified in the event of a change.*

It is important to remember that in these situations, when the institutionalization ends before a full calendar month, there is no nursing home liability to the institution for the month the person is discharged. Therefore the Group C waiver participant is still required to meet Group C waiver eligibility by incurring the entire spenddown amount,

regardless of whether or not spousal impoverishment rules apply.

EXAMPLE 2: Mr. Otto Smart – a single Group C participant – has a monthly spenddown of \$1,000. Mr. Smart is hospitalized from January 9<sup>th</sup> until January 19<sup>th</sup>, when he is then transferred to a nursing home. Mr. Smart is then discharged from the nursing home back to his own home on March 20<sup>th</sup>.

See following page for further illustration and clarification.

January	February	March
<p data-bbox="285 243 526 327">Jan. 1-8 in home Jan. 9-19 in hospital Jan. 19-31 in N.H.</p> <ul data-bbox="204 369 602 1293" style="list-style-type: none"> <li data-bbox="204 369 602 485">Mr. Smart’s eligibility for the month of January is based on Group C waiver eligibility rules.</li> <li data-bbox="204 527 602 768"><b>This means that Mr. Smart must incur and be held financially responsible (because he is single) for the entire spenddown amount for the month of January (in our example - \$1,000).</b></li> <li data-bbox="204 810 602 1199">It is allowable to include the costs billed to Medicaid while the participant was in the institution during the month of January when documenting that the participant “incurred” the spenddown amount. It is <b>not</b> allowable to include the costs billed to Medicare, private insurance, or the VA while the participant was in the institution during the month of January.</li> <li data-bbox="204 1241 602 1293">In order to be financially responsible</li> </ul> <p data-bbox="204 1325 602 1808">for the full \$1,000 January spenddown amount, in the event Mr. Smart’s OTC’s, COP (do not include COP if COP is being used to towards room/board or housing costs), Waiver or regular community Medicaid services do not add up to \$1,000, it may mean that Mr. Smart has to pay towards the institutional stay until the full Spenddown amount is paid. <i>Note: When the individual is institutionalized for less than a full calendar month, the individual does not have a cost-of-care liability to the institution.</i></p>	<p data-bbox="703 243 907 268">Feb. 1-28 in N.H.</p> <ul data-bbox="634 369 976 726" style="list-style-type: none"> <li data-bbox="634 369 976 548">Mr. Smart is institutionalized the full month of February, therefore he does not have to incur or pay the Spenddown amount.</li> <li data-bbox="634 590 976 726">During the month of February, the IM worker will determine cost of care liability according to institutional rules.</li> </ul>	<p data-bbox="1073 243 1395 300">March 1-20 in N.H. March 20 discharged home</p> <ul data-bbox="1008 369 1455 1808" style="list-style-type: none"> <li data-bbox="1008 369 1455 485">Because Mr. Smart was institutionalized for less than a full month, he has no nursing home cost of care liability for March.</li> <li data-bbox="1008 527 1455 642">However, to be considered waiver eligible, he must incur the full spenddown amount in this month (in our example \$1,000).</li> <li data-bbox="1008 684 1455 1167">It is allowable to count all OTC’s, COP (except if COP is assisting with room/board or housing expenses), Waiver, and community Medicaid services. It is also allowable to include the costs billed to Medicaid while the participant was in the institution during the month of March when documenting that the participant “incurred” the spenddown amount. It is <b>not</b> allowable to include the costs billed to Medicare, private insurance, or the VA while the participant was in the institution during the month of March.</li> <li data-bbox="1008 1209 1455 1629">In addition, because he is single, Mr. Smart is also financially responsible for the full amount of his spenddown – in our example \$1000. He has to pay towards his OTC’s, COP (do not include COP if COP is being used to pay towards room/board or housing costs), Waiver or regular community Medicaid services do not add up to \$1,000, it may mean that Mr. Smart has to pay towards the institutional stay until the full Spenddown amount is paid.</li> <li data-bbox="1008 1671 1455 1808">Upon the date of discharge, the IM worker will have to manually complete a 3070 form to ensure that the medical status code is changed to waiver status.</li> </ul>

<b>January</b>	<b>February</b>	<b>March</b>

**IMPORTANT:** As a reminder, care managers should notify the IM worker in a timely manner about the individual's discharge date from the institution. This will enable the IM worker to change the Medical Status Code effective the date of discharge to indicate that the participant is now on community Medicaid. The change in Medical Status will be transmitted to EDS who will change the payment source from institutional Medicaid to waiver Medicaid.

- **If a single Group C waiver participant has to pay towards their Medicaid services to be financial responsible for his/her spenddown amount, how should this be done?**

Effective January 2006, the correct manner to pay towards Medicaid card service was outlined in DDES Info Memo 2006-01. That memo indicates that this depends upon the age of the waiver participant. If the participant is age 54 or under, the payment should be made to the county waiver agency and the county waiver agency reports the receipt of this on the Community Aids Reporting System (CARS) on line 909. If the participant is age 55 or older, the participant should write a check made payable to DHFS and the county waiver agency's fiscal unit will disburse the payment to the Estate Recovery Program.

- **A Group C applicant will have a waiver start date late in the month. In the month that the start date begins, does the participant have to incur the spenddown amount in full in the month of the person's start date?**

Yes. A person must incur the spenddown amount **in full** in the month of the waiver start date. How this can be achieved varies based upon the situation (e.g. is the person already in the community or being discharged from an institution?). See next question that outlines 2 different scenarios for further clarification.

- **Because a Group C participant has to incur his/her spenddown in full in the month of the participant's waiver start date, what kinds of services can the care manager use when determining if the participant has incurred the spenddown amount in the month of the waiver start date?**

(Reminder – this is the protocol for the first month of the eligibility only):

*If the waiver applicant is being discharged from an institution* and the waiver start date is going to be reflective of the day of discharge; the care manager can count 1) all waiver services, 2) COP services (except room/board or housing expenses), 3) over-the-counter supplies the person will receive and pay for, 4) any services that community Medicaid will pay for from the date of discharge to the end of the month, and 5) the care manager can also use the expenses/costs that were involved during the institutionalization itself in the month the person is discharged when documenting that the participant has incurred his/her spenddown. **Important note:** the care manager **cannot** count the portion that Medicare, or private insurance, or VA paid. It is thought that by counting all the above costs (except Medicare, private insurance, or VA) using the above mentioned means the applicant would meet the spenddown amount in full.\*

**Example when person is being discharged from a hospital:** *An applicant has been in the hospital from March 1 – 16<sup>th</sup>. He will have a waiver start date of March 16<sup>th</sup> (the day of discharge). It has been determined that his spenddown amount is \$1,500/month. The care manager determines that from March 16 – 31, the applicant will receive \$400 worth of waiver services (care management, SHC, HDM, and PERS), the applicant will pay \$50 towards over-the-counter supplies, and \$300 worth of services/items paid for by community Medicaid (personal care and, RN visit). The care manager then reviews the*

*applicant's institutionalization costs. The applicant has Medicare. From March 1-16<sup>th</sup>, Medicare paid the majority of the cost of care- around \$6,000. However, the care manager knows he/she cannot count what Medicare paid towards the institutional stay when determining if the applicant will incur the spenddown amount. However because Medicare does not pay the full amount, there is a remaining balance, which is the applicant's responsibility. In discussing this with fiscal personnel at the hospital, the remaining amount that Medicare did not pay comes to \$1,000. The waiver applicant does not have a Medigap policy that will pay this amount,, therefore the waiver applicant is responsible for this amount. The care manager determines that the applicant will incur the following dollar amounts in March:  $\$1,000 + \$400 + \$50 + \$300 = \$1,750.00$ . As a result, it is clear the applicant has incurred enough service costs in the month of March to meet the spenddown amount fully. It is appropriate that a March 16th waiver start date be given.*

Effective January 1, 2006, the care manager cannot count the costs of prescription medications as part of the Medicaid card coverable expenses for those participants who have both Medicare and Medicaid. However, if there are prescription costs that Medicare Part D will not cover **and the participant** (who has Medicare) **will be paying** for these drugs out of pocket, then it would be appropriate to count that expense when determining if the person has met his spenddown.

***If the waiver applicant was already in the community at the time of his/her proposed waiver start date***, the care manager can count 1) all waiver services, 2) COP services (except room/board or housing expenses), 3) over the counter supplies the person will receive, and 4) any services items paid for by community Medicaid from the waiver start date to the end of the month.\*\* In addition, the care manager can also count any assistance or services the participant may have received from outside home health/personal care or supportive home care agencies **that he/she paid for privately in that month**. It is thought that by counting all the above charges using the above mentioned means the applicant would meet the spenddown amount.\*

***Example when person was already in the community:*** An applicant will have a waiver start date of March 16<sup>th</sup>. It has been determined that his spenddown amount is \$1,500/month. The care manager determines that from March 16 – 31, the applicant will receive \$400 worth of waiver services (care management, SHC, HDM, and PERS), the applicant will pay \$50 towards over-the-counter supplies, and \$300 worth of services/items paid for by community Medicaid (personal care, and RN visit). The care manager also learns that the applicant paid \$600 to Northwoods Home Care agency for the care that agency provided to him from March 1 – 15<sup>th</sup>. The care manager also learns that the applicant paid a local gas station \$100 for snow removal of his driveway and walkway from March 1 – 15<sup>th</sup>. Lastly, the care manager learns the applicant paid \$200 for medications he received from March 1 – 15<sup>th</sup>. The care manager determines that the applicant will incur the following dollar amounts in March:  $\$400 + \$50 + \$300 + \$600 + \$100 + \$200 = \$1,650.00$ . As a result, it is clear the applicant has incurred enough service costs in the month of March to meet the spenddown amount in full. It is appropriate that a March 16th waiver start date be given.

**\*Important note: In either scenario, if it is apparent that the participant is not able**

**to meet his/her full spenddown in the first month of eligibility using these flexible means, it may be necessary for the participant to have a start date on the 1<sup>st</sup> of the next month.**

\*\*Effective January 1, 2006, the care manager will no longer be able to count prescription drugs as part of Medicaid card coverable costs for those participants that have Medicare and Medicaid. However, if there are prescription costs that Medicare Part D will not cover, **and the participant** (who has Medicare) **will be paying** for these drugs out of pocket, then it would be appropriate to count this expense when determining if the person has met his spenddown.

- **Sometimes a family member or friend may have provided care to the person. Can this type of service/assistance be counted when determining if the participant has “incurred” enough services to meet his/her spenddown in the month of the waiver start date?**

If the county’s LTC/COP Planning Committee allows such an expense, the care manager can put a monetary value on the long-term care that family members and/or friends may have provided to the applicant with or without pay (during the particular month prior to the institutionalization) and after discharge. To do this, the care manager should use the county’s usual and customary hourly rate when assigning a value to any assistance that a friend or family member may have provided.

- **How is the spenddown handled when a Group C participant dies?**

Technically, we anticipate that a Group C individual will incur their spenddown each month while he/she is on the waiver program. However, if the person should die during a particular month, end their waiver eligibility on the day of his/her death. The care manager should also communicate the date of death to the IM Worker, and the IM Worker will terminate the case effective the date of death.

As far as the spenddown liability, a Group C single person is responsible to pay up to the amount of services (OTC, waiver, and Medicaid) he/she received in the month that he/she died.

Example 1:

Single Group C has a spenddown of \$1,500. During the same month (May), the participant was institutionalized and then was discharged to the community for a brief time; he/she was subsequently readmitted to the institution where he/she died.

March	April	May
<p data-bbox="318 243 578 327">March 1-8 in home March 9-19 in hospital March 19-31 in N.H.</p> <ul data-bbox="266 369 630 1251" style="list-style-type: none"> <li data-bbox="266 369 630 485">▪ Mr. Brown’s eligibility for the month of March is based on Group C waiver eligibility.</li> <li data-bbox="266 527 630 768">▪ This means that Mr. Brown must incur and be held financially responsible (because he is single) for the entire spenddown amount for the month of March (in our example - \$1,500).</li> <li data-bbox="266 810 630 1251">▪ It is allowable to include the costs billed to Medicaid while the participant was in the institution during the month of March when documenting that the participant “incurred” the spenddown amount. It is <b>not</b> allowable to include the costs billed to Medicare, private insurance, or the VA while the participant was in the institution during the month of March.</li> </ul> <p data-bbox="266 1293 630 1619">In order to be financially responsible for the full \$1,500 March spenddown amount, in the event Mr. Brown’s OTC’s, COP, Waiver or regular community Medicaid services do not add up to \$1,500, it may mean that Mr. Brown has to pay towards the institutional stay until the full Spenddown amount is paid.</p> <p data-bbox="266 1661 630 1829"><i>Note: When the individual is institutionalized for less than a full calendar month, the individual does not have a cost-of-care liability to the institution.</i></p>	<p data-bbox="727 243 935 264">April 1-30 in N.H.</p> <ul data-bbox="659 369 1006 737" style="list-style-type: none"> <li data-bbox="659 369 1006 548">▪ Mr. Brown is institutionalized the full month of April, therefore he does not have to incur or pay the Spenddown amount.</li> <li data-bbox="659 590 1006 737">▪ During the month of April, the IM worker will determine cost of care liability according to institutional rules.</li> </ul>	<p data-bbox="1081 243 1380 306">May 1-20 in N.H. May 20 discharged home</p> <p data-bbox="1081 327 1390 369">Home from May 20<sup>th</sup> – 22<sup>nd</sup></p> <p data-bbox="1049 390 1422 453">Received \$500 worth of services in those 2 days</p> <p data-bbox="1049 485 1422 548">Readmitted to NH on May 23<sup>rd</sup>. Died in NH on May 25<sup>th</sup>.</p> <ul data-bbox="1049 579 1438 1858" style="list-style-type: none"> <li data-bbox="1049 579 1438 852">▪ <b>In this case</b>, because Mr. Brown was institutionalized for less than a full calendar month and discharged to the community, but was readmitted to the NH and died all during the month of May, he has no nursing home cost of care liability for May.</li> <li data-bbox="1049 894 1438 1251">▪ However, to be considered waiver eligible* for those 2 days when he was home, he must technically incur the full spenddown amount in this month (in our example \$1,500). <b>Important note:</b> in the event Mr. Brown does not incur the full spenddown amount, no adverse action should be taken against Mr. Brown.</li> <li data-bbox="1049 1293 1438 1682">▪ It is allowable to include the costs billed to Medicaid while the participant was in the institution during the month of May when documenting that the participant “incurred” the spenddown amount. It is <b>not</b> allowable to include the costs billed to Medicare, private insurance, or the VA while the participant was in the institution during the month of May.</li> <li data-bbox="1049 1724 1438 1858">▪ In addition, because he is single, Mr. Brown is also financially responsible to pay his spenddown, but only up to the amount of OTC’s,</li> </ul>

March	April	May
		waiver services and COP services he received in those 2 days he was in the community (in our example \$500). <b>Important note:</b> in the event this money cannot be collected, the county waiver agency cannot bill the cost of any provided waiver services to the waiver program. The county waiver agency may choose to bill these costs to a non-waiver funding source (BCA, COP, etc.)

\*Note: Policy about waiver liability during a partial month of institutionalization may be revised in the future. If and when that occurs, county waiver agencies will be notified.

Example 2:

Single Group C who passed away unexpectedly in a community setting. Specifically, participant dies in a CBRF on April 12<sup>th</sup>.

The following chart illustrates the answer:

April
Fact: Spenddown amount = \$1,700/month
April 1 – 11 – at CBRF April 12 <sup>th</sup> – dies in CBRF
<ul style="list-style-type: none"><li>• Technically, the participant must incur the full spenddown amount. However, during the month of death this may not be possible. Reason: the participant died.</li><li>• The participant’s waiver eligibility ended on the day of their death (in our example April 12<sup>th</sup>)</li><li>• The care manager should communicate the date of death to the IM Worker. The IM Worker will terminate the case effective with the date of death.</li><li>• The participant is only responsible to pay up to the amount of services (OTC, waiver, and community Medicaid) that he/she received in April prior to the participant’s death. <i>Example:</i> the participant’s Spenddown is \$1,700. However, if he only received \$1,000 worth of services (OTC, waiver and community Medicaid), the participant would only have to pay \$1,000. <b>Important note:</b> in the event this money cannot be collected, the county waiver agency cannot bill the cost of any provided waiver services to the waiver program. The county waiver agency may choose to bill these costs to a non-waiver funding source (BCA, COP, etc.)</li></ul>
FYI: in the event the participant incurred and received \$1,700 worth of services in the first 11 days of April, the participant would have to pay \$1,700 of his/her spenddown.

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## COMMUNITY SPOUSE INCOME ALLOCATION

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### ☞ PURPOSE OF INCOME ALLOCATION

Spousal impoverishment protection refers to special provisions in federal and state Medicaid laws that affect certain married people receiving long term care services. These provisions allow a couple to “set aside” some income and assets for the community spouse. The provisions help to prevent the community spouse from becoming impoverished because the institutionalized or waiver spouse needs long term care. For more information, please refer to “Spousal Impoverishment” Publication # PHC 10063 (revised 3/05), available on line at:

<http://dhfs.wisconsin.gov/medicaid1/recpubs/factsheets/phc10063.htm>

When spousal impoverishment applies, CARES computes the community spouse income allocation and dependent family member allowance and calculates the waiver participant’s cost share. Reminder: a Group C individual who is married must establish financial eligibility and determine his/her spenddown before he/she can allocate income to the community spouse.

### ☞ ALLOCATING INCOME

The care manager should have a basic understanding of the process CARES uses to allocate income to the community spouse and dependent family members. This process is best described by reviewing the Community Waivers Cost Share Budget Section of the CWB page.

- **Community Spouse Income Allocation**

The minimum monthly community spouse income allocation equals \$2,428.33 (effective 1-1-10). When a community spouse has shelter costs in excess of \$728.50 (effective 1-1-10), per month, he or she may have a higher income allocation not to exceed \$2,739.00 effective 1-1-10. Please note: These figures change annually.

- **Line 19 - Dependent Family Member Income Allowance**

This amount equals \$607.08 (effective 1-1-10). Note: This figure changes annually.

## ☞ COMMON QUESTIONS AND ANSWERS

- **When are income allocation rules not applicable?**

Income allocation is not appropriate for a married applicant if any of the following conditions exist:

- The program participant is Group A eligible. Spousal income allocation is a post-eligibility function to determine cost-share liability for the waiver program. Group A participants have no cost share liability.
- The program participant's spouse is in a medical institution (i.e. nursing home).
- The community spouse's whereabouts are unknown.

- **Can a married waiver participant allocate money to his/her community spouse who resides in the same household, if the community spouse is *not on the waiver program* but receives SSI?**

Yes. The determination of how the income allocation will impact the community spouse's SSI will be made by the Social Security Administration (SSA). Either the care manager or the IM Worker, with the clients' authorization, will need to have a conversation with SSA to explain that the waiver spouse intends to allocate income to the SSI community spouse. Under SSI rules, allocated income will reduce or discontinue the SSI amount of the community spouse. The income allocation should be discussed with SSA prior to allocating, so the couple can decide the best course of action in their specific situation.

**Can a married waiver participant allocate money to his/her community spouse who resides in the same household, if the community spouse is *also on the waiver program* and is on SSI?**

Yes. The determination of how the income allocation will impact the community spouse's SSI will be made by the Social Security Administration. Either the care manager or the IM Worker, with the clients' authorization, will need to have a conversation with SSA to explain the waiver spouse intends to allocate income to the SSI community spouse. Under SSI rules, allocated income will reduce or discontinue the SSI amount of the community spouse. The income allocation should be discussed with SSA prior to allocating, so the couple can decide the best course of action in their specific situation.

**Can a married waiver participant allocate money to his/her community spouse who resides in the same household, if the community spouse is *not on the waiver program* but receives Medicaid through the county (i.e. 503 case, on a deductible, etc.)?**

Yes. The married waiver participant may allocate money to his/her community spouse who receives Medicaid through the county. The allocated income will not be added to the spouse's income because technically the income is not actually exchanging hands – it is just part of the household income – therefore it will not impact the community spouse's Medicaid benefit.

However, if the couple does not reside in the same household, the income allocation may have an impact on the community spouse's Medicaid eligibility. The IM Worker will make the determination.

**Can a married waiver participant allocate money to his/her community spouse who resides in the same household, if the community spouse is *on the waiver program* but also receive Medicaid through the county (i.e. 503 case, on a deductible, etc.)?**

Yes. The married waiver participant may allocate money to his/her community spouse who receives Medicaid through the county and who is also on the waiver program. The allocated income will not be added to the spouse's income, because technically the income is not actually exchanging hands – it is just part of the household income – therefore it will not impact the community spouse's community waiver Medicaid benefit.

However, if the couple does not reside in the same household, the income allocation may have an impact on the community spouse's Medicaid eligibility. The IM Worker will make the determination.

- **If an individual is legally separated from a community spouse, can income still be allocated?**

Yes. Individuals who are legally separated are still considered married. Consideration of income allocation acknowledges that spousal impoverishment protections were considered in the case.

- **What happens if the program participant has not transferred assets that were in excess of \$2,000 to the community spouse after being on the waiver twelve months?**

The program participant will lose his or her financial eligibility and services will be terminated.

- **Can a Group C married person allocate money to the community spouse and still have a cost share?**

Yes, although it is rare. First, CARES determines eligibility and calculates the spenddown amount. Then the spousal impoverishment procedures are applied to determine the amount that can be allocated to the community spouse and to calculate any cost share. CARES does not automatically apply spousal impoverishment protections to any married Group C waiver applicant who has a community spouse. The IM worker will have to manually complete the Spousal Impoverishment Income Allocation Worksheet to determine the participant's cost share obligation.

## Spousal Impoverishment Income Allocation Worksheet

Primary Person's Name & SSN \_\_\_\_\_

<b>Section A – Community Spouse Income Allocation</b>			
<b>Spouse's Name</b>			
<b>1. ENTER Maximum Community Spouse Income Allocation</b>		<b>\$</b>	
<b>2. MINUS Gross Income of Community Spouse</b>		-	
<b>3. EQUALS Community Spouse Income Allocation</b>		=	
<b>Section B – Dependent Family Member Income Allocation</b>			
	<b>Name</b>	<b>Name</b>	<b>Name</b>
<b>ENTER Dependent Family Member Income Allocation</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
<b>MINUS Dependent Family Member's Income</b>	-	-	-
<b>EQUALS Individual Allowance</b>	=	=	=
<b>ENTER Total Dependent Family Member Allocation</b>	<b>\$</b>		
<b>Section C – Cost of Care/Cost Sharing Collection</b>			
<b>1. ENTER Institutionalized Spouse's Gross Income</b>		<b>\$</b>	
<b>2. MINUS Personal Allowance</b>		-	
<b>3. EQUALS</b>		=	
<b>4. MINUS Community Spouse Income Allocation</b>		-	
<b>5. EQUALS</b>		=	
<b>6. MINUS Total Dependent Family Member Allocation</b>		-	
<b>7. EQUALS</b>		=	
<b>8. MINUS Any Court-Ordered Guardian or Attorney Fees</b>		-	
<b>9. EQUALS</b>		=	
<b>10. MINUS</b>	<b>Community Waivers Only: Medical/Remedial Costs and Cost of Community Waivers Person's Health Insurance Premiums</b>  Nursing Home Cases Only: Cost of Institutionalized Person's Health Insurance Premiums	-	
<b>11. EQUALS</b>	<b>Nursing Home Liability Amount/Community Waivers Cost Sharing Amount</b>	=	

(REV. 01/99)

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## NOTES

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## QUALIFIED MEDICARE BENEFICIARY (QMB) ELIGIBILITY

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### WHAT IS QMB?

A person with QMB status is one who, because of certain eligibility criteria, has Medicaid pay for their Medicare premiums, Medicare deductibles, and Medicare co-payments. An individual applies for QMB status through the county's Income Maintenance unit.

### ELIGIBILITY DETERMINATION

In addition to having to meet all the non-financial eligibility criteria for Medicaid, if the following three criteria are met, the person is eligible for QMB:

- The individual is entitled to Medicare Part A (Hospital Insurance)
- The individual's income is less than 100% of the Federal Poverty Level (FPL).
- The person's assets do not exceed twice the SSI asset limit.

### BENEFITS – YEAR 2010

An individual with QMB status receives a Medicaid card; however, it only pays for the following benefits:

- Medicare Part B premium benefit (currently \$96.40/month)
- Medicare covered services co-payment (generally, this is 20% of the Medicare approved amount)
- Deductible for inpatient hospital care (\$1,100.00 per benefit period)

### 2010 ASSET LIMIT

Single person	\$4,000
Married person	\$6,000

### 2008 INCOME LIMIT

Single person	\$902.50 effective 1-1-10
Married person	\$1,214.17 effective 1-1-10

\*Medicare is an area of expertise for Elderly Benefit Specialists. For person's age 60 or older, care managers are encouraged to seek help from their local Elderly Benefit Specialist.

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## **SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) ELIGIBILITY**

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### **WHAT IS SLMB?**

A person with SLMB status is a person who, because of certain eligibility criteria, have Medicaid pay their Medicare Part B premium. An individual applies for SLMB status through the county's Income Maintenance Unit.

### **ELIGIBILITY DETERMINATION**

In addition to having to meet the non-financial eligibility criteria for Medicaid, if the following three criteria are met, the person is eligible for SLMB:

- Must be receiving Medicare Part A.
- The individual's fiscal group's assets must not exceed the SLMB asset limit.
- The individual's income must not exceed the SLMB income limit.

### **BENEFITS**

An individual with this status only gets the Medicare Part B premium benefit paid for. They do not get a Medicaid card.

### **2008 ASSET LIMIT**

Single person	\$4,000
Married person	\$6,000

### **2008 INCOME LIMIT**

Single person	\$1,083.00 effective 1-1-10
Married person	\$1,457.00 effective 1-1-10

### **SLMB PLUS**

This has the same eligibility determination as SLMB as well as the same asset limit as SLMB. The only difference is the higher income limit. Please note: The individual has to be ineligible for Medicaid including community waivers.

### **2008 INCOME LIMIT**

Single person	\$1,218.38 effective 1-1-10
Married person	\$1,639.13 effective 2-1-10

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## DEPARTMENT OF VETERAN'S AFFAIRS (VA) PROGRAMS

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### PROGRAMS

The VA has two main subsistence grant programs for veterans: pension and compensation. Compensation is something the veteran will receive if he/she received a service-connected disability or disease during time of war. The amount of the payment is connected to the level or percentage of disability. The VA pension is a needs-based program for the veteran/surviving spouse and is reduced dollar for dollar if the recipient is also receiving Social Security or some other pension. If the individual is receiving SSI or Medicaid from some other source, the VA payment is reduced to \$90.

The VA has programs for those veterans/surviving spouses who have a disability and are able to demonstrate economic need. The Housebound Stipend is available to those veterans (or their spouses) that need some assistance with their personal cares but do not require 24-hour care or supervision. Another VA program is Aid in Attendance. Aid in Attendance is an additional stipend to the regular VA pension available for those veterans, or their surviving spouses, who may require 24-hour care or supervision in order to "maintain normalcy." For someone receiving SSI, the Aid in Attendance or Housebound money *is* NOT counted as income. But if the person is also receiving a regular VA pension or compensation, that income (the pension or compensation) is counted. For a Group B or C person, if he/she is receiving Aid in Attendance money or the Housebound Stipend that income is NOT counted (reference 20CFR 416.1103(7)(b)(1)). But again, if the person is receiving a regular VA pension or compensation, that income (pension or compensation) is counted.

Recipients can spend the money as they choose; it does not have to be spent on attendants or anything medically related. The intent is to provide the veteran/widow with some extra money to offset additional medical expenses he/she might have.

### ELIGIBILITY

To be eligible, a veteran must have served honorably on active duty. There may be differing eligibility standards depending on the dates of active duty served. To receive a veteran's pension, a person needs to be a veteran or the surviving spouse of a veteran. In addition, VA will make a determination of disability and economic need. The VA has made changes in eligibility criteria in the past few years that make it easier for veterans to qualify for service-connected disability. The people most affected by this change are those WWII veterans who served in the South Pacific. (Note: If a veteran served in the South Pacific and he/she applied for service-connected disability previously and was denied, he/she should apply again because the criteria have changed.)

**2008 PENSION LEVELS (Effective 12/01/08)**

	<u>VETERAN</u> (no dependents)	<u>WIDOW</u> (no dependents)
Basic	\$985	\$661
Housebound	\$1,204	\$808
Aid in Attendance	\$1,644	\$1056

Note: If the veteran/surviving spouse has ongoing, re-occurring, medically-related expenses (e.g. health insurance premium, Ensure, Depends, etc.), the VA will reimburse for those expenses. The veteran/surviving spouse needs to submit those re-occurring expenses to the VA, and the VA will increase the pension benefit by 95% of the monthly medically-related expense.

Care managers should contact the County Veteran's Service Office or call the State of Wisconsin Department of Veteran Affairs at 1-800-947-8387 with questions or for additional information. For additional information about the VA and all the services they offer, a care manager can access the information at [www.va.gov](http://www.va.gov).

FYI: Any veteran who enrolls in the Veteran's Health Care System may receive comprehensive medical care or medications at a fraction of the costs. Veterans are encouraged to contact their County Veteran's Service Office to discuss this benefit further, and to determine if they are eligible.

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## MEDICAID ESTATE RECOVERY

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### SUMMARY

The Estate Recovery Program began in Wisconsin in 1991. At that time it only affected nursing home residents. Since July 1, 1995, the Estate Recovery Program affects any recipient who receives certain services from the Medicaid program after reaching 55 years of age. These estate recovery rules differ from the earlier "lien law," which affected only nursing home Medicaid recipients.

The following text is an excerpt of the Medicaid Handbook Section 22.1 Estate Recovery

The state seeks repayment of certain correctly paid home health and long-term care benefits by:

1. Liens against a home.
2. Claims against estates.
3. Affidavits.
4. Voluntary recoveries.

These procedures are the Estate Recovery Program (ERP). No ERP recovery may be made for Medicaid services provided before 10-1-91.

Not all services provided by Medicaid are recoverable. Services recoverability depends on what was provided and the client's age and residence when he/she received the benefit.

Following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by clients age 55 or older on or after July 1, 1995 consisting of:
  - a. Skilled nursing services.
  - b. Home health aide services.
  - c. Home health therapy and speech pathology services.
  - d. Private duty nursing services.
  - e. Personal care services received by clients 55 or older on or after April 1, 2000.

4. All home and community-based waiver services (COP Waiver, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver) received by clients age 55 or older on or after July 1, 1995 and,
  - a. Prescription/legend drugs received by waiver participants.
  - b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are non-covered hospital services.
  
5. In pilot counties, Family Care services received by clients age 55 or older on or after February 1, 2000 and:
  - a. Prescription/legend drugs received by waiver participants.
  - b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.
  
6. Costs that may be covered through a lien are:
  - a. Medicaid costs for services received on or after October 1, 1991 during a nursing home stay.
  - b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000 by clients 55 or older as of the date of the service.

QMB payments for the Qualified Medicare Beneficiary (QMB) Medicare Part B premium are not recoverable through ERP.

QMB co-payments and deductibles paid by Medicaid are recoverable through ERP. They are only recoverable if the co-payment or deductible was used to pay for a Medicaid service that is recoverable.

Estate Recovery website: <http://dhfs.wisconsin.gov/medicaid1/recpubs/erp/phc13032.htm>

Also pamphlet PLS-3165 "Understanding Liens and Estate Recovery" can be ordered through the Forms Center.

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## MEDICAL AND REMEDIAL EXPENSES

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### Important Note:

The Centers for Medicare and Medicaid Services (MS) has approved a State Plan Amendment that affects the types of medical/remedial expenses that will be allowed when determining cost-shares or spenddowns in Family Care, Partnership and Home and Community Based Medicaid Waivers. The change will also affect institutional Medicaid cases. Counties were notified through an Action Memo.

See [NumberedMemos/DLTC/CY2008/NMemo2008-02.pdf](#)

The amendment states that the following types of bills **may not** be used as medical/remedial expenses to offset the cost-share or to meet the spenddown obligation:

1. Bills that remain unpaid, but were previously used to meet a Medicaid deductible,
2. Bills that were incurred as the result of imposition of a transfer of assets penalty period,
3. Bills that were for a cost share obligation during some previous period of institutionalization and Medicaid eligibility,
4. Bills that will be paid by a legally liable third party, e.g. private health insurance, Medicare, Medicaid, etc., or,
5. Bills that were previously used to reduce a cost share.

### **GROUP B**

Out of pocket medical and remedial expenses are used to *offset* a Group B participant's cost share obligation. A cost share obligation is the amount of money the participant must contribute to his or her cost of waiver services each month to maintain waiver eligibility.

#### ▪ **Definitions**

Medical/Remedial expenses are monthly costs that directly relate to the person's care needs, and/or costs incurred while treating, preventing or minimizing the effects of illness, injury or other impairments due to the individual's physical or mental health.

**Medical expenses** include costs the person incurs for items or services that are prescribed or recommended by a medical practitioner licensed to practice in Wisconsin or another state. Medical expenses also include costs incurred for items or services that are prescribed or recommended by a practitioner of the healing arts who engages in the

practice or his/her profession within the scope of his/her license, permit or certification in the state of Wisconsin or another state. Medical expenses may include:

- Over the counter remedies;
- Medical or therapeutic supplies;
- Deductibles or co-payments for Medicaid, Medicare or other health insurance;
- Bills for medical equipment, items, or services that are not covered by Medicaid or by another payer;
- Allowable outstanding bills for medical services that were incurred prior to Medicaid eligibility and which are currently being paid by the participant.

**Remedial expenses** include services or items that are identified in the individual's assessment, deemed necessary to assist the person in community living and may be included in the service plan, but will not be covered by Medicaid, a community waiver program, COP, or another payer. **Medical and remedial expenses cannot include housing or room and board services regardless of who is paying for them.**

Examples of allowable medical/remedial expenses are provided at the end of this section.

#### ▪ **Care Manager Responsibilities**

Care managers should identify and document what the medical and remedial items are and the dollar amount the applicant will spend for those items during the next year. Medical and remedial expenses should be explored *before* the packet is sent to TMG. (See the Medical and Remedial Checklist provided on the next two pages for a method of documenting medical/remedial expenses.) When preparing this estimate, the care manager should count only those expenses that will be incurred and paid by the Group B participant. Eliminate any expenses that will be covered by the Medicaid card once the individual becomes eligible for Medicaid, or by another program.

Because of the changes in the types of allowable medical/remedial expenses, care managers and IM workers will need to collaborate to ensure that the types of medical/remedial bills are in fact allowable.

The care manager is responsible for giving the medical and remedial dollar amount to the IM Worker, who uses this dollar amount in CARES to determine the cost-share for Group B participants.

Once the individual is on the waiver program, the Medicaid Waiver Manual reads in Chapter III, page III-1, "To assure continued eligibility and ensure accuracy in cost share or spenddown calculations, any reported change in the waiver participant's financial status must be reported to the waiver agency **within ten calendar days.**" As such, "best practice", would suggest that a care manager monitor at least quarterly, or at a minimum, during the six- month service plan review, examine the expenses the

participant has been paying after the participant is on the waiver program for three months to check the accuracy of the estimate.

Waiver participants should be reminded, preferably in writing, that changes that may affect eligibility, including changes in medical/remedial expense which may impact a cost share (up or down), must be reported within ten days. If the changes are reported to the care manager, the care manager must relay the new dollar amounts to the IM worker right away. In turn, the IM worker will run the information in CARES and will provide an updated Community Waivers Budget (CWB) page to the care manager. This updated screen prints should be kept in the participant's case file.

A Group B participant's medical and remedial expenses must be reviewed at least annually to ensure those expenses, which are used to reduce the cost share, are both incurred *and* paid. It is best to do the annual review when financial eligibility is being re-determined by the IM worker. In addition, if the participant has a cost share, the care manager must document every three months that the participant has paid the monthly cost share contribution.

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## NOTES

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## Medical/Remedial Expenses

The following tables guide the care manager/support and service coordinator in their review of what items/services paid by the participant might be counted as a medical/remedial expense.

ALLOWABLE FOR ALL ELIGIBILITY GROUPS	ALLOWABLE IN SOME CIRCUMSTANCES
<p>Co-payments</p> <p>Dental products and services:</p> <ul style="list-style-type: none"> <li>• alveoplasty and stomatoplasty</li> <li>• bitewing x-rays</li> <li>• drugs</li> <li>• fluoride mouth rinses</li> <li>• panoramic radiographs including bitewings</li> <li>• partial dentures and adjustments</li> <li>• surgical removal of erupted teeth</li> <li>• teeth cleanings not reimbursed by Medicaid</li> <li>• other dental services not covered by Medicaid</li> </ul> <p>Dietary supplies:</p> <ul style="list-style-type: none"> <li>• salt substitutes (the cost difference between “regular” salt and the salt substitute)</li> <li>• sugar substitutes (the cost difference between regular sugar and the sugar substitute)</li> <li>• dietary supplements: Ensure, Metrecal, Vivonex, Nova, etc</li> </ul> <p>Payments made on allowable outstanding medical bills</p> <p>Transportation cost (federal rate) for social, recreational, or medical purposes that Medicaid or Waiver will not fund</p> <p>Vision products:</p> <ul style="list-style-type: none"> <li>• anti-glare coating</li> <li>• anti-scratch coating</li> <li>• contact lens cleaning supplies</li> <li>• eyeglass lenses and frames, prescription sunglasses or contact lenses beyond the original pair and one unchanged prescription replacement pair from the same provider in a 12-month period denied by Medicaid</li> </ul> <p>Long distance phone calls to medical and service providers on landline phones</p> <p>Cellular telephone charges: Determine percentage of calls to medical &amp; service providers and calculate costs based on monthly service plan cost.</p> <p>Support and maintenance of trained support dogs:</p> <ul style="list-style-type: none"> <li>• dog food, regardless of type or cost</li> <li>• immunizations</li> <li>• veterinary costs</li> <li>• medications prescribed by a veterinarian</li> </ul>	<p>Clothing modification (e.g. Velcro) and certain adaptive clothing purchases</p> <p>Food Costs: the cost difference between “regular” canned or microwavable goods and low/no sodium or low/no sugar canned or microwavable goods.</p> <p>Food Costs: the added expense of purchasing more than a reasonable amount of high fiber products, fruit juices, fresh fruits and vegetables based on MD/health professional orders (do not count what is normally part of the grocery bill).</p> <p>Home modifications that improve accessibility but are not covered by the waiver – must be participant specific</p> <p>Room and board (r/b) expenses for a live-in attendant can be counted under the following circumstances:</p> <p><b>For Group B:</b> (1) when the attendant isn’t paying for their food or living supplies or (2) when r/b cost exceeds the personal maintenance allowance maximum, the difference may be counted.</p> <p><b>For Group C single:</b> Please note, only certain costs can be counted (e.g. the difference between a 1- bedroom and a 2- bedroom apartment, ½ of utility bills).</p> <ul style="list-style-type: none"> <li>• Water softener (equipment service and salt purchase when skin condition requires soft water)</li> </ul> <p>The following items could be categorized as a Medical/Remedial expense. Any amount remaining after the cost share is eliminated may be covered under waivers as a Specialized Medical Supply.</p> <p>Over-the-counter medical supplies:</p> <ul style="list-style-type: none"> <li>• alcohol: rubbing, swabs, and antiseptic</li> <li>• antiseptics: Betadine, Iodine, Mercurochrome, etc.</li> <li>• enema administration apparatus</li> <li>• diapers (participant older than four years)</li> <li>• distilled water used with oxygen</li> <li>• hydrogen peroxide</li> <li>• incontinence pads and briefs (adults)</li> <li>• lemon or glycerin swabs</li> <li>• lubricating jellies: Vaseline, KY Jelly, etc.</li> <li>• non-expendable, reusable materials: bedpans, rubber pants, thermometers, etc.</li> <li>• phosphate enemas</li> <li>• tincture of Benozin</li> <li>• tongue depressors</li> </ul>

ALLOWABLE FOR ALL ELIGIBILITY GROUPS	ALLOWABLE IN SOME CIRCUMSTANCES
<p><b>Note:</b> The following over-the-counter medical supplies may be considered medical or remedial expenses if they are not covered by MA. The case manager must confirm they are uncovered, since MA may pay for these items with a physician's order:</p> <ul style="list-style-type: none"> <li>• analgesic rubs: Ben Gay, Infrarub, Vicks, Vaporub, etc.</li> <li>• catheters (Foley or condom), catheter sets, and component parts including tubing and urine collection bags</li> <li>• cotton balls and cotton-tipped applicators</li> <li>• dressings: adhesive pads, abdominal pads, gauze pads and rolls, eyepads, stockinette, Opsite, etc.</li> <li>• gloves: latex or vinyl</li> <li>• irrigation solutions, sets, and component parts: sterile water, normal saline, Urologic G</li> <li>• stomas supplies: creams, tapes, gloves, etc.</li> <li>• syringes and needles: disposable and reusable</li> <li>• tracheotomy care sets and suction catheters</li> <li>• tube feeding sets and component parts</li> </ul> <p>Over-the-counter remedies:</p> <ul style="list-style-type: none"> <li>• aspirin or aspirin substitutes</li> <li>• anti-diarrhea agents</li> <li>• cold and sinus medications: antihistamines, cough suppressants, etc.</li> <li>• digestive aids</li> <li>• hemorrhoid products</li> <li>• herbal remedies</li> <li>• laxatives and stool softeners</li> <li>• ophthalmic products</li> <li>• quinine sulfate preparations</li> <li>• saliva substitutes</li> <li>• topical steroids, antibiotics, antifungal agents, pediculicides, etc.</li> <li>• vaginal preparations</li> <li>• vitamins/mineral products</li> <li>• other prescribed over-the-counter medications</li> </ul>	<p><b>The following items may not be counted as medical/remedial expense:</b></p> <p>Home-related costs:</p> <ul style="list-style-type: none"> <li>• homeowner's or renter's insurance</li> <li>• property taxes</li> <li>• cable television costs</li> </ul> <p>Life insurance</p> <p>Private insurance, Veterans' Administration or Medicare services</p> <p>Vehicle-related costs:</p> <ul style="list-style-type: none"> <li>• driver's license renewal fee</li> <li>• insurance</li> <li>• loan payments</li> <li>• maintenance costs: repair, gas, oil, etc.</li> <li>• registration and title fees</li> </ul> <p>Any item or service that is funded by the Waiver</p> <p>Room and Board or Housing expenses</p> <p>Congregate meal donations</p> <p>Annual membership dues to support groups where the participant receives a newsletter/information only</p> <p>Diabetic candy, cookies, ice cream, or like foods</p> <p>Fat free/low sugar/low carbohydrate/low cholesterol candy, cookies, ice cream, or like foods</p> <p>Diet soda</p>

# MEDICAL AND REMEDIAL CHECKLIST

The following checklist was developed as an optional tool for case managers to track medical and remedial expenses over time and report them to the economic support specialist. A regular review of actual out-of-pocket expenses insures the cost share is an actual reflection of the individual's care costs and verifies the spenddown obligations are met.

Expense Item	Date:			Date:			Date:		
	Annual Expense	Monthly Expense	Verification Notes	Annual Expense	Monthly Expense	Verification Notes	Annual Expense	Monthly Expense	Verification Notes
Copayments									
Dental Procedures									
Dietary Supplements									
Medical Supplies									
Medications (That MA does not cover)									

Expense Item	Date:			Date:			Date:		
	Annual Expense	Monthly Expense	Verification Notes	Annual Expense	Monthly Expense	Verification Notes	Annual Expense	Monthly Expense	Verification Notes
Outstanding Medical Bills									
Transportation (Social, Recreational, Medical)									
Vision Products									
Miscellaneous									
TOTALS									
MED/REM = (Anl Exp + 12) + Mo. Exp									

## GROUP C

Medical and remedial expenses of a Group C individual are used to establish waiver eligibility as a medically needy person. *After* financial eligibility has been established, the individual's spenddown obligation is determined. The spenddown obligation is a combination of medical/remedial expenses and certain other expenses. These expenses may include: COP services (except in instances where COP funds are being used to pay for room/board or housing expenses), Waiver services and Medicaid card services. A single person must both incur and be held financially responsible for the spenddown on a monthly basis. A married individual with a community spouse must incur the spenddown obligation but does not have to pay the spenddown amount. Depending upon how much income the waiver participant is going to allocate to his/her community spouse, a married Group C individual may have a cost-share obligation toward waiver services instead. A married Group C participant with an institutionalized spouse (as a result spousal impoverishment rules do not apply) must both incur and be held financially responsible for the spenddown on a monthly basis.

Reminder: **all Group C participants must incur the spenddown amount every month** in order to maintain financial eligibility for the waiver program.

### ▪ Definitions

Medical/Remedial expenses are monthly costs that directly relate to the person's care needs, and/or costs incurred while treating, preventing or minimizing the effects of illness, injury or other impairments due to the individual's physical or mental health.

**Medical expenses** include costs the person incurs for items or services that are prescribed or recommended by a medical practitioner licensed to practice in Wisconsin or another state. Medical expenses also include costs incurred for items or services that are prescribed or recommended by a practitioner of the healing arts who engages in the practice or his/her profession within the scope of his/her license, permit or certification in the state of Wisconsin or another state. Medical expenses may include:

- Over the counter remedies;
- Medical or therapeutic supplies;
- Deductibles or co-payments for Medicaid, Medicare or other health insurance;
- Bills for medical equipment, items, or services that are not covered by Medicaid or by another payer;
- Allowable outstanding bills for medical services that were incurred prior to Medicaid eligibility and which are currently being paid by the participant.

**Remedial expenses** for Group C participants include services or items that are identified in the individual's assessment, deemed necessary to assist the person in community living and may be included in the service plan, and are not covered by Medicaid, Medicare or other health insurance, and are not funded by community waivers or COP or another payer.

**Medical and remedial expenses cannot include housing costs or room and board service costs.**

For **Group C** applicants, remedial expenses include the cost of waiver program services and COP services (except room/board or housing costs). It is assumed Group C individuals would pay for these services out of pocket if they were not found eligible for the waivers. Medical/Remedial expenses reimbursed through programs that are funded in full or in part by federal dollars should not be counted. For example, medical/remedial expenses reimbursed under Medicare or the VA program should not be counted. In addition, medical/remedial expenses paid for by private insurance should not be counted. Medical/remedial expenses reimbursed under Alzheimer's Family Support Program may be counted, but only if these funds were not matched with federal dollars.

- **Care Manager Responsibilities**

Care managers should identify and document what the medical and remedial items are and the amount the participant will spend for those items during the next year. The care manager is responsible for giving the medical and remedial dollar amount to the IM worker, who uses CARES to determine financial eligibility.

Since medical and remedial expenses are considered part of the spenddown, the care manager must *review and document monthly* that the medical and remedial expenses have been incurred/spent every month. (A spenddown Tracking Tool developed by Green Lake County and slightly modified by BLTS and TMG is provided on the next page, followed by an example of a completed spenddown Tracking Tool.)

A **single person** must incur and be held financially responsible for the spenddown amount each month.

A **married individual with a community spouse** must incur the spenddown amount each month but may not have to pay it if income is being allocated to the community spouse. Depending on how much income the waiver participant is allocating to the community spouse, a married Group C may have a cost-share obligation toward waiver services instead.

Please note: a married person who is not allocating money to their community spouse for whatever reason (either cannot allocate because the community spouse has too much income; or, the waiver applicant/participant chooses not to allocate any income to the community spouse;) must incur the spenddown amount each month, and in the event he/she has a cost share, pay the monthly cost share amount.

A **married individual with an institutionalized spouse** (as a result spousal impoverishment rules do not apply) must incur and be held financially responsible for the spenddown each month – similar to a Group C single person.

## SPENDDOWN TRACKING TOOL

*Developed by Green Lake County HSD  
Modified by BLTS and TMG*

Participant's Name		Month/Year
Case Manager's Name		Spenddown Amount on ECED or CWB  Does the participant still have wages from employment?; private health insurance that he/she is responsible for paying, or, is a covered member?; excess self employment expenses?; or special exempt income? Yes No NA
EXPENSES	TOTAL	DESCRIPTION
Out-of-Pocket Medical/Remedial	\$	
<u>COP Services</u> (Except for room and board)	\$	
<u>Waiver Services</u>	\$	
Medicaid Card Services	\$	
<b>TOTAL</b>	<b>\$</b>	

# SPENDDOWN TRACKING TOOL

Developed by Green Lake County HSD

Modified by BLTS and TMG

Participant's Name <b>George Fuller</b>		Month/Year September 2008
Case Manager's Name Sharon Miller		Spenddown Amount on ECED or CWB \$1,318.33/month  Does the participant still have wages from employment?; private health insurance that he/she is responsible for paying, or, is a covered member?; excess self employment expenses?; or special exempt income? Yes No NA
EXPENSES	TOTAL	DESCRIPTION
Out-of-Pocket Medical/Remedial	\$ 20.00 20.00 40.00 <u>40.00</u> \$120.00	Co-pays on medications, Metamucil Basic phone service per month Payment to Dean Clinic Payment to Gunderson Clinic
<u>COP Services</u> (Except for room and board)	\$ 0.00	
<u>Waiver Services</u>	\$ 86.00 30.00 775.00 129.00 <u>96.00</u> \$1,116.00	Care management PERS Adult Day Care Transportation to/from ADC Residential Respite at Sunset Manor
Medicaid Card Services	\$ 97.00 <u>65.00</u> \$162.00	Clinic Visit to Dr. Spelling Medical Van Transportation
<b>TOTAL</b>	<b>\$1,398.00</b>	

## ☞ COMMON QUESTIONS AND ANSWERS

- **Can the care manager do a verbal review of medical and remedial expenses?**

A verbal review of expenses is acceptable but not recommended since people often over or under report. It is preferable to review the checkbook ledger, canceled checks, billing statements, or receipts.

- **How far should the care manager go to verify payment of medical and remedial expenses?**

The system or level of verification used should be tailored to the participant. Some people are very aware of the cost of items they routinely use and they know where every dollar of their budget goes. Other people are less aware of their routine expenses and do not keep receipts.

One option is to ask the participant to save his or her receipts and review them regularly with you. Other options could include reviewing the participant's checkbook ledger, canceled checks, money order receipts, and other receipts or billing statements that list past payments made on the account.

It is good practice to schedule another visit three months after the assessment to check the original medical and remedial estimates for accuracy.

- **If an individual has difficulty keeping a "paper trail" that verifies expenses are incurred and paid, what might the care manager do to monitor expenses? (This assumes the person is not incompetent or a candidate for guardianship.)**

a. If a person has difficulty keeping accurate records you might do the following:

- Ask the participant to keep his or her receipts for medical and remedial expenses in a designated place like an envelope, a shoebox, or a drawer.

OR

- Ask a supportive home care worker to shop with the participant and collect the receipts for medical and remedial items purchased.

b. If receipts aren't available, you could do the following:

- Ask the participant what medical and remedial expenses he/she regularly incurs and pays for, then verify the costs.
- Ask the home care agency staff what over-the-counter medications and/or supplies the participant uses and how frequently and then verify the costs.

- Ask the supportive home care workers and family members who shop for the participant what over-the-counter medications and/or supplies they purchase and how often they do so.
- Request a printout of the pharmacy's customer profile listing the customer's co-pays. Note: It would be necessary to obtain a release of information from the participant.
- Ask the pharmacist or drug store clerk to keep a list of over-the-counter medications, and/or supplies Medicaid does not pay for and review this annually.
- **What unpaid medical bills can be counted as medical expenses? How should these expenses be monitored?**

There has been a change with regard to what type of unpaid medical bills can be counted as a medical expense. As has always been the case, the outstanding medical bill must: 1) have been incurred by the applicant/participant and 2) the participant actually makes monthly payments to the medical provider. However, in addition, these bills must now meet the requirements spelled out in DLTC Memo Series 2008-2 dated January 23, 2008. Care managers need to verify with the IM worker to learn if the medical bill the applicant/participant is paying is an allowable medical expense. If it is, care managers should monitor monthly payments for outstanding medical expenses to ensure that they are actually occurring. A review of canceled checks, money order receipts, or monthly statements from the medical provider(s) is most often used to verify the dollar amounts paid on an outstanding debt. It may be helpful to have the applicant/participant sign a statement as follows:

Example:

*I, \_\_\_\_\_, owe \$\_\_\_\_\_ as of 10/1/08 for a medical bill I incurred at the Sauk Prairie Hospital (copy attached). I understand that actual monthly payments made by me on this medical bill can be used to reduce my cost-share liability toward waiver services.*

*I hereby attest that I am making monthly payments in the amount of \$\_\_\_\_\_ per month to Sauk Prairie Hospital and plan to continue making these payments until the bill is paid in full. When the bill is paid in full, I will notify the care manager promptly.*

*If, for any reason, I am unable to continue making payments toward my outstanding medical bills, or if the amount of the monthly payment should change, I will also notify the care manager promptly. I understand that failure to notify the care manager of these changes may result in an overpayment of waiver services, and that overpayment can be later recouped from me with proper notice.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

- **If the participant received a cash advance from a credit card company, or, took out a second mortgage or a reverse mortgage to pay off his/her own medical bills; or charged his/her clinic visits to a credit card; or paid for a piece of medical equipment with a credit card and is now paying off these expenses on his/her credit card - can these monthly payments to the credit card company or bank be considered a medical expense?**

If these debts do not fall under one of the five types of bills which will no longer be allowed as discussed in the previous question, and if these debts meet the criteria enumerated below, then "yes". Effective December 2002, monthly payments to a credit card company or bank may be considered a medical expense **if** certain criteria are met. These criteria include: 1) the service/item purchased was a legitimate medical/remedial expense for the waiver applicant/participant, 2) the charges were for services/items that would qualify as an allowable medical/remedial expense or as a waiver allowable item or service, and 3) the original invoice/receipt or a copy of the original invoice/receipt can be obtained to confirm both the date and that the service/item was obtained. For more information about this issue and how to calculate the number of months a care manager can count this monthly expense as a medical/remedial expense, please see Waiver Wise Volume 02, Issue 07. A complete listing of Waiver Wise bulletins are available at:

[http://dhs.wisconsin.gov/LTC\\_COP/waiverwise/waiverwise.htm](http://dhs.wisconsin.gov/LTC_COP/waiverwise/waiverwise.htm)

**Medicaid services have co-payment amounts. Can payment of co-pays be considered a medical expense?**

Yes. As a point of information, certain services are exempt from co-payment (e.g. emergency services, services provided to nursing home residents, etc.)

- **If an average was used when paying off a medical bill that the IM worker confirmed was an allowable/acceptable medical expense and then the participant makes a lump sum payment towards that medical bill thereby paying off the bill, does the average medical and remedial expense need to be recalculated? Does a new CWB page need to be generated based on this change in medical/remedial expenses?**

Yes. If the care manager is informed a Group B or Group C participant paid off a bill that was to have been paid in monthly installments, the expense **cannot** continue to be averaged throughout the remainder of the year. The lump sum payment can only be counted as a medical and remedial expense in the month that it was paid. The care manager is required to inform the Income Maintenance worker that medical and remedial expenses have changed and the CWB page needs to be recalculated for the Group B participant, and perhaps financial eligibility for the Group C individual.

- **If a lump sum payment was made to pay off a medical bill before a person became waiver eligible, can this be used to reduce the cost share?**

No. Medical and remedial expenses are meant to represent an estimate of *future* expenses that the participant will pay over the next twelve months. If an applicant paid off a \$3,000 medical bill one month before starting on the waivers, the amount of the payment *cannot* be applied toward the cost share deduction because the debt was eliminated before the cost share obligation was established. However, note that this medical/remedial expense may be used by the IM worker to establish Medicaid eligibility under the Medicaid deductible program.

- **Can a projection of expected private pay medical bills be counted as a medical expense?**

*Example: the participant anticipates that he/she will be having dental services provided in the next 12 months by a dentist that does not accept Medicaid, or the participant anticipates that he/she will be obtaining new prescription eyeglasses in the next 12 months that will not be covered by Medicaid.*

Yes. A dollar amount that reflects a monthly payment to the vendor may be accepted if the following criteria are met: 1) The care manager must obtain documentation from the medical provider confirming the needed service/item is scheduled to be provided/obtained in the coming 12 months, and 2) the anticipated total cost. In addition, a written agreement should be developed to confirm the arrangement. See below for suggested text. Important note: If the participant does not obtain the needed item/service that he/she indicated would be provided, the care manager should relay to the participant that the participant would be subject to having to repay the waiver program a calculated sum that reflects what his/her cost share would have been if he/she did not have this anticipated expense.

<b>Suggested text:</b>	
<i>I, Pamela Brown, hereby confirm that I will be having the following service provided to me by _____ for _____. As indicated by this estimate, the total cost of the service will be \$_____. Because neither Medicaid or Waiver or any other funds are available to assist in obtaining this service/item, this will be a personal expense to me. I project that I will need to "set aside" \$_____/month effective ____ for _____ number of months in order to pay this bill. As a result, I am using this "set aside" dollar amount as one of my monthly medical/remedial expenses.</i>	
<i>In the event that I do not obtain this service/item within the next 12 months as agreed upon, I understand that I may have to repay the waiver program for waiver services paid on my behalf.</i>	
<i>By my signature I attest that I understand this statement and that I have received a copy of it.</i>	
_____ Signature of Participant, or Guardian of Estate, or Conservator, or Representative Payee	_____ Date

- **Can the cost of a Group B applicant's prescription medications be counted as a medical expense?**

This would be very unusual. However, if the participant's Medicare Part D plan formulary does not cover a particular medicine, and the **participant pays** for the medication out of pocket, then the out of pocket expense can be used as a medical/remedial expense thus reducing a potential cost share, or, to incur the Group C spenddown.

- **If a participant has made arrangements with a neighbor, friend, family member (not a spouse), etc. for non-medical transportation, and privately pays for this service, can this be counted as a remedial expense?**

*Example: waiver applicant/participant, Mrs. Virginia Green, informs the care manager that she gives her daughter, Carol, \$20.00/month for transporting her to the bank, to the nursing home so she can visit with her sister, to church, general errands, etc. Mrs. Green says – “I am so appreciative that she does it – and the money I give her is the least I can do”. The care manager talks to the daughter, Carol, and Carol confirms Mrs. Green gives her this money. Carol said, “I have told her a thousand times she does not have to give me anything but she insists, so I have stopped arguing with her. If it makes her feel good to do that, that’s fine with me.” When the care manager asks Carol if she would like to be paid by the waiver program for the transportation she provides to Mrs. Green, Carol says “No.” Can the \$20.00 be counted as a remedial expense?*

Yes. This is one of those *rare* instances where it would be allowable for the waiver participant to count as a remedial expense a service that would ordinarily be paid by waiver funds. In order for a care manager to use a dollar amount as a remedial expense under these circumstances, the care manager should confirm with the person who is providing the transportation that he/she does not wish to be employed by an agency, or be paid with waiver funds through a fiscal agent.

In this example, the care manager would allow the \$20.00 as a monthly remedial expense.

- **If a participant has made arrangements with a neighbor, friend, family member (not a spouse), etc. for medical transportation, and privately pays for this service, can this be counted as a remedial expense?**

*Example: waiver applicant/participant, Mr. Thomas Bell, informs the care manager that he gives his neighbor, Wally Jackson, \$15.00/month for transporting him to the clinic once a month. Mr. Bell says – “Wally helps me in and out of the car. He is a good driver. I trust him. I don’t want anyone else to drive me around.” The care manager talks to Wally and Wally confirms Mr. Bell gives him money for taking him to the clinic. When the care manager informs both Mr. Bell and Wally that Wally could get reimbursed through the county’s Income Maintenance Unit for transporting Mr. Bell to*

*medical appointments, both say: "That's a lot of rigmarole. This works for us." Can the entire \$15.00 be counted as a medical expense?*

No, only a portion of it can be counted, as explained below.

If it is determined that the neighbor, friend, family member (not a spouse) is providing **medical transportation**, the care manager must calculate the appropriate dollar amount and subtract that amount from the dollar amount the waiver participant indicates he/she is paying the person for this transportation. Reason: persons providing medical transportation can be reimbursed with Medicaid through the county's IM unit. Check with the IM worker about Medicaid criteria for coverage of medical transportation. Check with your local IM worker to learn what the reimbursement rate for medical transportation is in your specific county.

In our example: It is determined that the distance between Mr. Bell's residence and the clinic is 25 miles round trip. The county's IM unit reimburses medical mileage at 35 cents/per mile. If Wally were to submit appropriate documentation of the medical transportation he provided to Mr. Bell to the IM Unit, he would be reimbursed \$8.75 by Medicaid. (25 miles x .35 cents = \$8.75.) But because Mr. Bell gives Wally \$15.00 to transport him to the clinic, the care manager will only be able to count \$6.25 as a medical expense. (\$15 what he pays - \$8.75 what Wally could be reimbursed by the IM unit = \$6.25).

- **Can a waiver participant's payment for a life insurance policy be used as a remedial expense?**

No. Life insurance policies benefit the estate and/or any surviving family members. They do not help to keep the waiver participant in the community.

- **Can the cost of basic phone service be a remedial expense for a recipient utilizing a PERS?**

Yes. Since a PERS is required to meet the health and safety needs of a participant, and a phone line is necessary to provide this service, it is considered a remedial expense. If the individual does not have a PERS, the cost of the phone line cannot be counted as a remedial expense.

As an aside, effective with the Medicaid Waiver Manual release dated April 2005, it is also possible for waiver funds to pay for the base monthly charge for basic telephone service if the participant has PERS. However certain conditions must be met. These conditions are: 1) it is in the best interest of the participant's health, safety or security to have the PERS, 2) the base monthly charge for the telephone services is an economic hardship for the participant, 3) the telephone service is in the name of the participant, and 4) the participant resides in his/her own home or apartment.

- **Can the cost of a cellular telephone service be a remedial expense for a participant?**

Yes. A certain percentage of it can be counted, as explained below. Effective Spring 2008, BLTS now allows this as a remedial expense. However because there are so many different cellular telephone service plans and rates available, with different nuances involving available minutes, and including or not including long distance telephone calls as part of their plan, etc. BLTS has decided to simplify the manner by which a care manager will determine the appropriate dollar amount that can be used as a remedial expense.

BLTS will allow a percentage of the cost of the monthly service plan that the participant makes to medical or service providers. For example: a participant has a plan with Verizon cellular phone service and pays \$53/month for this service. The participant relays to the care manager that on average, 30% of the calls he makes in a month are to medical and/or service providers. As a result, the care manager would allow \$15.90 as a remedial expense – not \$53.00.  $30\% \text{ of } \$53 = \$15.90$ .

- **What expenses may be counted as remedial expenses when a participant has a live-in attendant?**

In most cases, the cost of housing for a live-in attendant is not considered a medical/remedial expense. Generally housing costs are considered part of the special housing amount, which is a component of the personal maintenance allowance. However, there are some exceptions.

In the case of Group B waiver participants, when housing costs exceed the personal maintenance maximum, and the waiver participant is paying for all of his/her own room and board costs and for all of the room and board costs of the living attendant, the difference between the special housing amount and the maximum personal maintenance allowance may be counted as a remedial expense. In addition, a live-in attendant's food and household supplies (incidentals for example: toilet paper, Kleenex, laundry soap, etc), **if paid in full by the participant**, can be counted as remedial expenses and recorded on the medical/remedial line of the CWB page. The wages for a live-in attendant are waiver allowable and should be funded by the waiver program.

For a **single Group C** participant, the food and household supplies (incidentals for example: toilet paper, Kleenex, laundry soap, etc), of an attendant can be considered "remedial" expenses and can be used to meet the spenddown, as long as the Group C participant is paying for these expenses in full. In addition, certain housing costs paid by the Group C participant, when necessitated by having a live-in attendant (e.g. the difference in cost between a one-bedroom and two-bedroom apartment, half of the basic phone and utility bills) can be counted as medical and remedial expenses. All of these are recorded as medical/remedial expenses on the CWB page because there is no other area to count these costs on the CWB.

***Example:** Group C single waiver participant, Mary Brown, needs and has a live-in attendant. The cost of a one-bedroom apartment is \$500/month and the cost of a two-bedroom apartment is \$800/month. Mary needs a two-bedroom apartment to accommodate her live-in attendant. Mary pays the full \$800 rent with her funds alone. In addition, the monthly basic phone is \$28/month, and the utility bill averages \$60/month. Mary pays for these costs with her funds alone also. What can the care manager count as "remedial" expenses for Ms. Brown?*

Because Ms. Brown pays these costs in full with her funds alone the care manager uses the expenses necessitated by a live-in attendant, as follows:

- \$300 (the rent cost difference between a one-bedroom apartment and a two-bedroom apartment)
- \$14 for the telephone costs (half of \$28)
- \$30 for utilities (half of \$60)

As a result, the care manager would be able to use \$344 as a remedial expense for Ms. Brown.

- **If a participant provides his/her own non-medical transportation in his/her own vehicle, can this be counted as a remedial expense?**

Yes. While the waiver participant cannot be directly reimbursed with waiver funds for this expense, mileage costs can be counted as remedial expense, regardless of whether the waiver participant is driving his own vehicle, or a friend/neighbor, etc. is driving the waiver participant's vehicle. In order to determine the appropriate remedial expense, the care manager should estimate the number of miles per month the participant is transported for community purposes and multiply this figure by the federal reimbursement rate of 50.5 cents/mile for cars (effective 1-1-08.) Please note, these federal reimbursement rates change annually according to the standard mileage reimbursement rate for a privately owned automobile established by the Internal Revenue Service (IRS). As a point of information, unlike transportation reimbursement under the Medicaid card, under the Waiver program it is a requirement to use the federal transportation reimbursement rate when determining eligibility. To maintain consistency, BLTS made a decision to use the same amount when determining a participant's cost share.

If the participant's vehicle in an accessible van, BLTS allows 60 cents/mile (effective yr. 2008). The participant may be either a driver or a passenger. It is **not** acceptable to calculate the cost of owning and operating the vehicle (e.g. insurance, title, license, registration, gas, repairs, and maintenance) and divide those annual costs by 12 months.

- **If a participant provides his/her own medical transportation in his/her own vehicle, can this be counted as a medical expense?**

Yes – however there are some calculations involved. Important note: Medical transportation is generally covered under Medicaid. As such the participant could get reimbursed for the transportation he/she provides to him/herself. However, in the event he/she does not wish to do this, when Medicaid reimburses the participant's medical miles for less than the waiver reimbursement rate, the care manager can multiply the number of medical miles by the difference between the two rates and count the calculated dollar amount as a medical/remedial expense.

Example: In River County, the IM unit reimburses at a rate of 19 cents/mile for medical mileage. The waiver reimbursement rate (based on the federal reimbursement rate) is 50.5 cents/mile. The difference between these two numbers is the amount the care manager will use when calculating the appropriate medical expense.  $50.5 - .19 = 31.5$  cents. The participant drives, on average, 100 miles a month for medical appointments.  $100 \times 31.5 \text{ cents} = \$31.50$ . That is the dollar amount the care manager will allow as a medical expense.

- **What kind of documentation is required for medical and remedial expenses?**

The care manager should have a written breakout of all medical and remedial expenses and their costs in the participant's file. When plans are submitted for review, send a breakout of these costs to TMG, especially if they are over \$100. If a breakout is not included in the application, a COP-Waiver/CIP II Quality Assurance Reviewer will call to verify those expenses.

If the CWB page (a required CARES screen print for all Group B's, or a completed Spousal Impoverishment Income Allocation Worksheet for married Group C's when spousal impoverishment rules apply) in a new application demonstrates that the participant has a cost share and no medical and remedial expenses, a COP-Waiver/CIP II Quality Assurance Consultant will call the care manager to explore this issue. Care managers should explore medical and remedial expenses with the participant and give the IM worker that information. (See earlier page in this section for examples of medical and remedial expenses.) If you have explored medical and remedial expenses and have not found any, indicate that in your assessment/supplement, or on the cover sheet, or on the CARES printouts.

- **How are the records for medical and remedial expenses monitored?**

The participant's file must include a breakout of medical and remedial expenses in a participant's file. **During the review of new application service plan packets, a reviewer will look for this breakout.** If the cited expenses exceed \$100, the expenses may be reviewed with the care manager over the telephone. The printout of the CWB page and the impact of the medical and remedial expenses on the cost share or spenddown amounts will also be examined. If the participant has a cost share and no medical and remedial expenses are cited, a reviewer will check with the care manager to make sure the participant was explained the option of using medical/remedial expenses as a deduction.

If the participant decided to waive the deduction, this should be written on the printout of the CWB page in a case note, or noted in the assessment/supplement.

During the monitoring review process, the reviewer will look for case notes or other written notation from the care manager verifying what the medical and remedial expenses are and the dollar amounts for Group B participants. In the event it is determined that a care manager used as an expense an item that is not a legitimate medical/remedial expense, if this cost had an impact on the participant paying a lower cost share than necessary, the county waiver agency may be at risk of a disallowance.

During the monitoring review process, the reviewer will look for case notes or other written notation from the care manager verifying that the medical and remedial expenses were reviewed monthly for Group C participants. The documentation should include a breakout of expenses.

- **If a participant wants to supplement the wages of his/her supportive home care worker (who is funded by the waiver), can the supplementation be counted as a medical/remedial expense?**

No. Supplementing the worker's wage **cannot** be used as a medical/remedial expense because it is prohibited under Medicaid rules. An option for the county waiver agency is to increase the worker's hourly wage.

- **Can you count a widow's payments on her deceased husband's medical debt as a medical/remedial expense?**

No. This is not allowable for the Medicaid Waivers program. This is a personal debt. It is not *her* medical debt. Unlike the Medicaid deductible program, under the waiver program we consider the "individual", not the fiscal group when determining medical/remedial expenses. Moreover, under the waiver program, any paid off bill cannot be counted even if it is in the applicant's name. However, it is possible for the IM worker to simultaneously screen an applicant under the Medicaid deductible program to see if a medical bill for a member of the fiscal group can be considered under that program.

- **Does the care manager need to monitor medical/remedial expenses that are listed on the CWB page, when these medical/remedial expense(s) are not needed to eliminate a monthly cost share obligation for a Group B participant?**

No. Medical/remedial expenses listed on the CWB page need only be monitored by the care manager if they are actually being used to reduce a cost share obligation. When medical/remedial expenses are not needed to reduce the cost share but are still listed on the CWB page, the care manager should either write a case note, or write on the CWB page itself to indicate the reason these medical/remedial expenses are not being monitored.

- **An applicant/participant purchases various herbs, minerals, and other alternative remedies (shark cartilage, bee pollen, St. John's Wort, etc.) for their long term physical illness and/or disability. Can these out of pocket expenses be counted as medical/remedial expenses to reduce a Group B cost share obligation?**

Maybe. The first thing the care manager needs to do is determine if the county's Long Term Support/COP Planning Committee has approved these types of expenses under its county plan. If yes, then these expenses could potentially count as a remedial expense. The care managers should familiarize themselves with the items/expense allowable under their county's COP plan: items/expense that are listed there can be counted as remedial expenses. Note that when county waiver agencies add remedial expenses to their county COP Plan, these must be submitted to the State for review and approval. County waiver agencies usually add new information when they update their COP Plans annually.

If the LTS/COP Planning Committee has approved these types of items, then it can be counted as a medical/remedial expense.

Another note: For Group C applicant/participants, these types of expenses – as long as they meet the criteria delineated above – can be counted to determine *eligibility* or to meet the spenddown. For single Group C participants, it is also allowable for these expenses to be used when paying towards their spenddown.

- **What should a care manager do if a practitioner of the healing arts, e.g., an acupuncturist, has recommended herbal remedies, but the applicant/participant has not discussed these remedies with his/her medical doctor? Can the out of pocket expenses still be counted as medical/remedial expenses?**

Maybe. The first thing the care manager needs to do is determine if the county's Long Term Support/COP Planning Committee has approved this type of "remedial" expense under their county plan. If so, then these herbal remedies could potentially count as a remedial expense.

If an applicant/participant chooses to take remedies recommended by a practitioner of the healing arts who holds a valid state license or certification from Wisconsin or another state, and pays for these remedies "out of pocket", the care manager may count the expenses. However, the care manager should always recommend that the applicant/participant discuss these remedies with their medical doctor to prevent potential adverse effects that may occur when certain supplements or herbal remedies are taken in conjunction with prescribed medication.

- **An applicant/participant is taking a health or disability related remedy that was neither prescribed nor recommended by a medical doctor or a practitioner of the healing arts. Can the care manager count the expenses as a medical/remedial expense?**

Maybe. If the person is taking a remedy that the county's Long Term Support/COP Committee has approved as a type of "remedial" expense under their county plan, then the remedial expense could count to reduce the cost-share. The care manager should familiarize themselves with the items/expenses allowable under their county's COP Plan: items/expenses that are listed there can be counted as remedial expenses.

Note also that whenever alternative medicine supplements are used, the care manager should advise the participant to share the information with their medical practitioner, to prevent potential adverse effects that may occur when certain supplements are taken in conjunction with prescribed medications.

- **Recognizing that the Waivers do not allow payments to spouses for any services provided to participants, can the value of such services be counted as a remedial expense?**

Yes. The value of the service provided to the participant by his/her spouse may be counted as remedial expense. The decision to allow such expenses must be affirmed by the local Long Term Support/COP Planning Committee, and the value attached must be consistently applied. For example, the Committee may determine that a type of service provided is comparable to a similar service provided by a home care agency and set the hourly rate value at or near the level paid to such agency by the program. For example, if the program pays the agency \$12 per hour for a comparable service, then the same “value” of \$12 can be assigned to the spouse’s hourly service.

The care manager would need to determine the amount of hours the spouse provides the services to the participant each month, and the value of those services. In our example above, the value is set at \$12.00/hour. If the care manager determines the spouse provides 30 hours of a service per month, the total monthly remedial expense would be \$360.00 ( $\$12 \times 30 = \$360$ ). The care manager would include this amount in the total monthly medical/remedial expenses reported to the IM worker for both Group B and Group C participants. Thereafter, the care manager would be responsible for ongoing monitoring appropriate to the participant’s Group B or C status.

- **An applicant/participant purchases diabetic candy, cookies, ice cream or like foods; or low fat/low sugar/low carbohydrate/low cholesterol candy, cookies, ice cream, or the like – can this expense to the applicant/participant be counted as a medical/remedial expense?**

No. While it is recognized that the participant is making a better food choice when choosing these types of food items that are low in sugar, fat, carbohydrates, etc., these types of foods are not consistent with following a healthy diet.

- **An applicant/participant relays to the care manager that he/she has to follow a special diet. Can any food expense be counted as a medical/remedial expense?**

Yes, as long as the special diet is prescribed or recommended by the participant’s MD or practitioner of the healing arts (if within the scope of his/her license). In addition, the food choices should not be part of a regular food list that promotes healthy eating in general. Having said that, the care manager could proceed in one of two ways:

1) The care manager could take the cost difference between “regular” food and food that is low sodium/low sugar. For example: a can of “regular” canned corn is 38 cents, a can of “no salt/low sodium” canned corn is 42 cents – the care manager could count 4 cents towards medical/remedial expenses. As a point of information: in many instances there is no cost difference between “regular” canned goods and “no/low salt or low/no sugar” canned goods.

2) The care manager could count the extra expense of certain required and recommended foods that is above and beyond what a person would ordinarily consume. For example: a participant's MD recommends that the participant drink six 8 oz glasses cranberry juice a day to reduce the risk of urinary tract infections (UTI's). As a result, the participant drinks approximately 10 gallons of cranberry juice a month. The average consumption of cranberry juice is about 2 gallons/month. The care manager would be able to count the full cost of the extra 8 gallons of cranberry juice as a medical/remedial expense.

- **An applicant/participant relays to the care manager that he/she drives his/her children to school, picked the child up from school, take his/her child to little league practice, choir practice, drives the child to and picks the child up at the child's work, etc. Can this mileage be counted as a remedial expense?**

Maybe. If the county's Long Term Support/COP Planning Committee has approved this type of expense under the county plan, then this expense could be counted as a remedial expense. If the county's LTS/COP Planning Committee has not approved this type of expense, then the care manager cannot count it.

- **Wisconsin Medicaid covers the \*generic products of specific categories of OTC drugs from manufactures who have signed rebate agreements with HCFA (as required by OBRA '90). In order for Wisconsin Medicaid to pay for one of these OTC, a prescription must be obtained. \*Wisconsin Medicaid covers *all* brands of insulin, ophthalmic lubricants, and contraceptive products. A waiver participant has an OTC that meets all of these criteria 1) it is on the list of covered items, 2) he/she is able to take the generic brand, and 3) he/she has a prescription from her physician ordering the item. However the pharmacy that the waiver applicant/participant goes to will not bill Medicaid for these items. Can their cost be used as a medical/remedial expense?**

Best practice is for the waiver participant or the care manager to find a pharmacy that will bill Medicaid covered OTC's to Medicaid. The list of Medicaid covered OTC's can be found under the Over-the-Counter Maximum Allowable cost list at:

[http://dhs.wisconsin.gov/medicaid4/pharmacy/data\\_tables/index.htm](http://dhs.wisconsin.gov/medicaid4/pharmacy/data_tables/index.htm)

If the participant cannot find a pharmacy that will bill Medicaid, the cost of the OTCs could be used as a medical/remedial expense. Although note the county waiver agency could use COP funds to pay for these OTC's. However, if COP funds are used to pay for the OTC's, the cost of these OTC's cannot be counted as a medical/remedial expense to the participant.

- **A waiver participant takes an OTC that her doctor has prescribed. It is not on the list of items that Medicaid would fund. Can the cost of this item be used as a medical/remedial expense?**

Yes. This is an allowable medical/remedial expense. Important note: since a medical professional is recommending the item because it has a direct medical or remedial benefit to the health or safety of the participant, it is also possible for waiver funds to pay for this item under SPC 112.55 – Specialized Medical Supply. In the event waiver funds are going to fund the item, the cost of the OTC's cannot be counted as a medical/remedial expense to the participant.

- **An applicant/participant resides in a substitute care facility. The applicant/participant does not need medical/remedial expenses to offset a cost share obligation. Does the care manager still need to determine the amount of any medical/remedial expenses?**

Yes. Even though the medical/remedial expenses are not needed to reduce or eliminate a cost share obligation, these costs need to be tabulated in order to determine how much income the applicant/participant has available to pay towards the facility's room/board costs. This would include medical/remedial expenses for Group A waiver applicant/participants.

To determine the amount of income a participant has available to pay towards the cost of room/board, the care manager should use form [F-20920](#).