

## CHAPTER III – FINANCIAL ELIGIBILITY

### 3.01 Medicaid Eligibility

In addition to the non-financial eligibility requirements outlined in Chapter II of this manual, each applicant to the Medicaid waivers must also be found to be financially eligible for Medicaid. If Medicaid financial eligibility is not present, the individual is not eligible for the waiver program. There are three major categories of Medicaid available in Wisconsin. These include Family Medicaid, Elderly/Disabled (EDB) Medicaid, and a “Special Status” category. While the majority of participants in the Home and Community Based Waivers covered in this manual by definition fall within the EDB group, persons who are Medicaid eligible in the remaining categories may also be Medicaid waiver eligible.

Eligibility for the Medicaid waiver programs is based on Section 1915 (c) of the Social Security Act, Wisconsin statutes, administrative rules and Wisconsin’s Medicaid state plan. Program implementation processes for the Medicaid waivers programs are outlined in the Medicaid Eligibility Handbook located at <http://www.emhandbooks.wi.gov/meh-ebd/>, the Income Maintenance Manual and this manual.

This chapter provides an overview of asset and income eligibility guidelines and a description of eligibility determination processing. Appendix C contains required forms, including the Medicaid Waiver Eligibility and Cost Sharing Worksheet (DDE-919) and the CARES sample screens and other required and/or model forms. Additional detailed information regarding financial eligibility may be found in the Medicaid Eligibility Handbook at the Medicaid handbook web site as noted above and in other program training materials.

#### A. General Requirements

Once initial program eligibility has been established, **all waiver participants** must have an **annual financial review** to ensure that his/her eligibility for Medicaid continues. To assure continued eligibility and ensure accuracy in cost sharing or spend-down calculations, any reported change in the waiver participant’s financial status must be reported to the waiver agency **within ten calendar days**. The participant may report changes to the Income Maintenance Worker (IMW) or to the Care Manager/Support and Service Coordinator (CM/SSC). If the change in financial status results in changes to the cost share or spend-down obligation, the participant must be sent a ten day written notice, informing them of the change, including appeal rights.

## B. Assets

Asset eligibility for the Medicaid waiver programs is the same as the Wisconsin Medicaid program. Asset eligibility determinations for SSI, SSI-E, 1619(a) and 1619(b) program participants are made by the Social Security Administration. The Income Maintenance Worker determines asset eligibility for most other waiver applicants. Generally, Medicaid waiver applicants who are single may have no more than \$2000 in countable assets. Exceptions to the \$2000 limit include those persons enrolled in the Medicaid Purchase Plan (MAPP) or those participating in the BadgerCare Plus program (**Note:** Badger Care Plus has replaced AFDC and AFDC-Related Medicaid as well as Healthy Start). MAPP enrollees may have up to \$15,000 in total countable assets. There is no asset test for persons participating in BadgerCare Plus.

For applicants who are married, spousal impoverishment protections available to the community spouse of an institutionalized person also apply to Medicaid waiver participants. For more information about Spousal Impoverishment, see Section 3.04 below.

In general, when children apply for the Medicaid waivers, only the countable assets of the child are considered. For Medicaid financial eligibility purposes, parental income and assets are considered to be unavailable to the child. The **parental payment limit**, when applicable, is separate from any financial eligibility and cost sharing calculations. For more detailed financial eligibility information specific to applicants who are children, see Section 3.02 below.

## C. Income

Income eligibility for Medicaid waiver participation is based on state and federal Medicaid criteria. Income eligibility limits for the Medicaid waiver programs are higher than some other types of Medicaid. As a result, many people residing in the community who would be otherwise ineligible for Medicaid may become eligible via the Medicaid waiver programs. Eligibility may occur in one of three income-based categories, referred to as Group A, Group B and Group C. Descriptions and eligibility criteria specific to each group are located in Section 3.05 below. (For up to date financial eligibility criteria, including income amounts, spousal impoverishment limits and other financial eligibility figures that change annually, see the “At a Glance” bulletin at [http://dhfs.wisconsin.gov/ltc\\_cop/COP\\_rates.htm](http://dhfs.wisconsin.gov/ltc_cop/COP_rates.htm) .)

## D. Divestment

State and federal law contain detailed regulations pertaining to assets, income and treatment of these resources in Medicaid applications. The term “divestment” means

the disposal or transfer of an applicant's income and/or any countable asset for less than fair market value. Federal regulations and state law preclude eligibility for certain long-term care Medicaid programs when a divestment has occurred and the divestment has not been "cured" (corrected). Divestment provisions apply to all eligibility groups covered in this manual. For Group A participants, when the DDE 919 is used to calculate financial eligibility, Section II must be completed. For all other applicants, divestment is addressed by the IMW (please refer to the Medicaid Handbook for detailed information concerning divestment).

### **3.02 Children Applying for the Waiver- Special Considerations**

When the child applies for a CLTS Waiver and is Medicaid-eligible through SSI, Katie Beckett Program, Special Needs Adoption, Foster Care or through a 1619 program, he/she is considered Group A eligible. Sections I, II and V of the DDE 919 are completed. The county IMW is only involved when the child who applies for the waiver has not already had his/her Medicaid eligibility established, or in cases where a divestment of the child's assets is alleged.

A child applying for the CLTS waiver in a state matched slot is required to have a disability determination completed. The SSC provides written notification to the county Income Maintenance agency indicating that the child is applying for a state matched CLTS waiver slot which requires a disability determination by the Disability Determination Bureau (DDB). A child applying for a locally match CLTS waiver slot is not required to have a disability determination however, the child must still meet an appropriate Level of Care. Children who receive Medical Assistance through SSI or the Katie Beckett Program have already had a disability determination completed. For additional information on disability determination requirements for children, refer to Chapter II, Section 2.05 (B).

### **3.03 Medicaid Waiver Income Groups**

#### **A. Group A**

##### **1. Description**

Eligibility Group A includes those persons who are currently Medicaid eligible in a full benefit program as well as others. Group A includes:

- SSI and SSI-E recipients,
- 1619 (a or b) SSI work incentive program recipients,
- 503 recipients
- Medicaid – Medically Needy recipients with a deductible that has been met,

- Katie Beckett Medicaid participants,
- BadgerCare Plus Medicaid participants (Income **at or below 200%** of the Federal Poverty Level (FPL))
- Wisconsin Medicaid Purchase Plan (MAPP) enrollees,
- Foster Care Medicaid participants,
- Special Needs/Subsidized Adoption Medicaid participants, and
- Healthy Start Medicaid participants

Persons eligible as Group A have no cost share obligation, although MAPP and BadgerCare Plus participants may pay a premium for those programs based on income. Other persons who may be eligible in Group A include persons receiving EBD Medicaid who are age 65 or older, or those who are less than 65 years old and have a disability determination or a presumptive disability determination (See Chapter II, Section 2.05).

**Not included in Group A** are persons who are receiving **partial benefit program** Medicaid, such as Badger Care Plus (participants with income above 200% of FPL) Qualified Medicare beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) and SLMB+, Qualified Disabled and Working Individuals (QDWI), Tuberculosis-related Medicaid, Presumptive Eligible Pregnant women and those receiving emergency services for non-qualifying aliens. While not eligible in Group A, some partial benefit Medicaid recipients may be waiver eligible in Group B or C. Please consult with the IM agency staff for more information about partial benefit Medicaid programs.

## **2. Group A Eligibility Determination Process**

For SSI, SSI-E, 1619a/b and Katie Beckett recipients the CM/SSC completes the DDE-919 form. For this group, the CM/SSC completes Sections I, II and V of the DDE-919. If, in Section II a possible divestment is indicated, the CM/SSC completes a DDE-919-D (see Appendix C) and refers the applicant to the IM staff for further investigation (see Section 3.01 (D) for additional information about Divestment).

For all other Group A applicants, the CM/SSC refers the applicant to the IM agency staff for processing through the Client Assistance for Re-employment and Economic Support (CARES) system. The referral to IM should be in writing, containing all of the necessary information for CARES processing (see the Model Referral form in Appendix C). The IM staff completes the Medicaid processing in CARES and forwards the resulting CARES screen printouts to the CM/SSC. The CM/SSC retains the completed DDE-919 or the CARES screen printout provided by IM in the participant record. (Refer to Appendix C for all forms described above.)

## **B. Group B**

### **1. Description**

Eligibility Group B includes persons who do not meet the Group A criteria and whose countable monthly income is equal to or less than 300% of the SSI Federal Benefit rate. This amount is adjusted annually and can be obtained from the Medicaid handbook at <http://www.emhandbooks.wi.gov/meh-ebd/>. For CY 2008 the gross monthly limit, including both earned and unearned income, is \$1911. The IM worker will establish Medicaid financial eligibility for **all** Group B applicants.

Group B Medicaid waiver applicants are allowed certain deductions from their income in the eligibility and post-eligibility determination processes. When applicable, married Group B applicants may also have spousal impoverishment protections applied. Because the CM/SSC will often collect much of the financial information provided to the IM worker, it is important to understand the allowable deductions from income, such as medical remedial expenses, as well as cost sharing and spousal impoverishment provisions.

### **2. Group B Eligibility Determination Process**

The CM/SSC refers the Group B applicant/participant to IM for Medicaid waiver eligibility determination in CARES. The IM worker enters the gross monthly income, any allowable income disregards and if spousal impoverishment applies, the community spouse income allocation. The IM worker then calculates a Personal Maintenance Allowance, and the Family Maintenance Allowance, as applicable. Additional deductions entered in CARES include Special Exempt Income, health insurance premiums, and allowable medical/remedial expenses, provided to IM by the CM/SSC.

After processing the application the IM worker provides the CM/SSC with copies of the CARES screens. Because Medicaid waiver eligibility is not yet confirmed, CARES results may show the application as “pending.” The CM/SSC sends the CARES screens as part of the completed application packet to the appropriate quality assurance entity. After review, the quality assurance entity sends an approval letter to the CM/SSC. Once the CM/SSC provides this letter to IM, the “pending status” is removed. CARES generates a notice of eligibility which is sent to the applicant and to EDS.

#### **a) Medical/Remedial Expenses**

Medical/remedial expenses for Group B are those re-occurring, monthly costs that directly relate to the person’s care needs and/or costs incurred while

treating or preventing or minimizing the effects of illness, injury or other impairments to the individual's physical or mental health. Medical/remedial expenses are compiled at the initial application and **must be reviewed at least annually** by the CM/SSC and the participant.

Allowable medical/remedial expenses include items and services that are purchased by the applicant that are not covered by the Medicaid state plan or other insurance and not paid for by COP or another funding source or by the Medicaid waivers. Items or services that are allowable under the Medicaid waiver program should not be counted as a medical or remedial expense.

1) Medical Expenses

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 of 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, as well as deductibles or co-payments for Medicaid, Medicare or other health insurance. Allowable expenses may also include bills for medical equipment, items or services that are not covered by Medicaid or by another payer; or bills for such medical costs that were incurred prior to Medicaid eligibility and which are being paid by the applicant.

**Note:** Certain Medical bills may not be counted. See DLTC Memo 2008-02 at [http://dhs.wisconsin.gov/dsl\\_info/NumberedMemos/DLTC/CY2008/NMemo2008-02.pdf](http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DLTC/CY2008/NMemo2008-02.pdf)

2) Remedial Expenses

Remedial expenses for Group B 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 on the service plan, but will not be covered by Medicaid, a community waiver program or by COP or another payer. A listing of examples of common medical and remedial expenses is located in Appendix C.

**Note:** Room and board costs may not be counted as a medical or remedial expense.

When determining the person's monthly total amount of medical/remedial expenses for Group B eligibility, the CM/SSC should count allowable

expenses that are both **incurred and paid** by the applicant. Items or services that may be paid for by COP, the Medicaid waiver, the Medicaid card or any other program are not counted. (This differs from Group C calculations, discussed below.) The CM/SSC provides the total monthly medical/remedial expenses to the IM worker to complete the eligibility and cost sharing determination.

#### b) Cost Sharing

If after the allowances and expenses described above are deducted, there is any remaining income, the person will have a cost share obligation.

There are certain situations that affect the participant's Medicaid waiver program cost share liability. They include:

- No cost share is required in those months in which no waiver program service is received.
- No cost share is required when an admission to a hospital, nursing home or ICF-MR is long enough for the person to incur a patient liability cost.
- 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.

Waiver cost share payments must be entered as a payment toward waiver service costs, and may not be applied to other program costs. For persons participating in additional service programs such as COP, only the waiver cost sharing criteria should be applied. Therefore, for persons served by multiple programs, after the waiver program cost share is determined there is no additional cost share obligation.

#### 1) Monitoring the Cost Share

When a Group B participant has a cost share, the CM/SSC must monitor ongoing medical/remedial expenses and other deductible expenses to ensure that cost share amounts are correct. Any change in these expenses must be reported to the IM worker within ten days. After receiving the reported change and entering the updated information in CARES, the IM agency notifies the participant of any increase or decrease in the cost share amount. When such a change occurs, the CM/SSC obtains a new CARES screen for the participant file and also updates the ISP with the new cost share amount.

**Every three months** the CM/SSC must monitor and document in the participant file that the monthly cost share payments have been paid. Appropriate documentation may include a case note indicating that the cost share has been received or an agency developed form on which the CM/SSC "logs in" the payments as they are received.

The waiver agency may develop an alternative method to monitor receipt of monthly cost share payments. The alternative method of cost share monitoring must include a process to log in the payments received by the agency fiscal unit and a means to promptly notify the CM/SSC of any payment error or any payment not received. The alternative methodology must include a written quarterly report to the CM/SSC, which verifies the payments have been made. The cost share report must be maintained in the participant record or kept in an accessible location within the agency.

For cost share payments made directly to waiver service providers, the alternative method may include a payment log maintained by the service provider. Per contract or written agreement with the waiver agency, the provider then forwards quarterly documentation of payments received and must promptly notify the CM/SSC and/or waiver agency in the event any monthly cost share payment is not received. A copy of the agency provided cost share report must be maintained in the participant file or kept in an accessible location within the agency.

## C. Group C

### 1. Description

Group C includes persons who do not meet Group A or B criteria and whose countable income exceeds 300% of the current Federal SSI benefit rate. This amount is adjusted annually. For CY 2008 the amount is \$1911 (refer to the Medicaid Eligibility Handbook for current amounts at <http://www.emhandbooks.wi.gov/meh-ebd/>).

Group C income eligibility is met if the applicant/participant's **net monthly income**, after deductions for allowable expenses, is equal to or less than the Medicaid Medically Needy income standard (\$591.67 in 2008).

After Group C eligibility is established, the IMW calculates the monthly spenddown amount (see Section IV of the DDE-919 in Appendix C). To remain eligible, the participant **must incur and be financially responsible for** sufficient countable expenses to meet the spenddown amount every month.

For Group C participants who are **single**, spousal impoverishment rules do not apply. Married participants who have an institutionalized spouse are considered "single" for spousal impoverishment purposes. In addition, these participants must **incur and be financially responsible for** the spenddown every month.

Requirements differ for Group C participants who are **married** and for whom spousal impoverishment rules apply. These participants must **incur** sufficient

countable expenses to meet the spenddown requirement and may or may not have a cost share obligation, depending on spousal income allocation and other deductions.

## **2. Group C Eligibility and Post-Eligibility Determinations**

The CM/SSC refers the Group C applicant/participant to the IM agency for eligibility processing in CARES. The IM worker enters the gross income, and applicable income disregards. In the next step the Group C medical/remedial expense information provided by the CM/SSC is entered (See Appendix C for the Model Referral to ESS form). Additional deductions entered include any special exempt income, the basic needs allowance, and health insurance premiums, and if spousal impoverishment applies, the community spouse income allocation.

### **(a) Group C Medical/Remedial Expenses**

Allowable medical/remedial expenses for Group C include out-of-pocket medical/remedial expenses (as defined in Group B above) **and** also include the costs of any planned services that would otherwise be funded by the Medicaid waiver program or COP.

### **(b) Medicaid State Plan (Medicaid Card) Covered Services**

In addition, Group C allowable expenses include expected Medicaid state plan (Medicaid card) covered services. These include any of the participant's monthly medical expenses that would be covered by the Medicaid state plan.

### **(c) The Spenddown and Cost Share**

After receipt of the list of medical/remedial expenses, service plan costs and Medicaid state plan costs, the IM worker calculates the applicant's eligibility and spenddown amount using CARES. The calculations to determine the participant income allocation and cost share, if any, are completed next and are shown on the completed screen. Because CARES does not enter all of the dollar amounts for Group C spousal impoverishment cases, the dollar amounts must be manually written on the screen printout by the IM staff.

After completing the calculation, the IMW will provide a copy of the CARES screen print(s) or a completed income allocation worksheet to the CM/SSC. As in Group B, CARES will show the status as "pending" until the IM agency receives the waiver approval letter from the CM/SSC. The participant's eligibility and spenddown amount will be listed on the CARES printout (See Appendix C for a Model Referral form and CARES screen print examples.) CARES will generate a notice to the participant of the calculated spenddown amount and cost share as applicable.

After eligibility is established, the CM/SSC is responsible for monitoring and verifying that the participant's spenddown obligation is met **every month**. Medicaid waiver eligibility is lost when the participant does not meet his/her spenddown obligation at any time.

### 3.04 Spousal Impoverishment

Spousal Impoverishment refers to the way in which the resources of a married couple are counted for purposes of Medicaid eligibility. To prevent the impoverishment of both persons the rules allow the allocation of a portion of income or assets to the community spouse. A "community spouse" is a person who is married to a waiver participant **and** who is not living in a nursing home or other medical institution for 30 or more consecutive days. When both spouses are Waiver applicants/participants, each spouse may allocate resources to the other. Spousal Impoverishment rules apply to all married couples except those where the non-applicant spouse resides in a nursing home, ICF-MR or medical institution and has lived there for 30 or more days (see Medicaid Eligibility Handbook at <http://www.emhandbooks.wi.gov/meh-ebd/> .)

#### A. Asset Allocation

The asset allocation process determines the amount of assets the married applicant may retain and still be considered eligible for Medicaid. The term "asset allocation" refers to the way assets are "allocated" to each spouse in the marital relationship for the purpose of establishing Medicaid eligibility under spousal impoverishment rules. Assets are counted on the date the applicant first requests Medicaid Waiver service or is institutionalized for 30 days or more whichever is earlier.

Asset allocation will establish the community spouse asset share (CSAS), the amount of countable assets greater than the \$2000 allowed for the applicant's spouse. Spousal impoverishment asset limits are adjusted annually and the maximum amount the applicant spouse may allocate varies depending on the couple's total assets. In addition, when the community spouse asset share is a court-ordered amount or set by an Administrative Hearing, the total amount of assets allowed may be greater than the spousal impoverishment limit.

Refer to the Medicaid Handbook at <http://www.emhandbooks.wi.gov/meh-ebd/> for the most current asset allocation information or consult with the IM agency staff.

**Note:** The CSAS is based on the amount of assets the couple owns when they initially inquire about waiver services. An applicant may request to have his/her assets assessed prior to making a formal application for Medicaid. When this request is

made, the applicant is referred to the county Income Maintenance agency for a resource assessment. This point in time assessment may affect any future asset allocation.

### **B. Income Allocation**

Income allocation occurs **after** the applicant spouse is determined to be Medicaid eligible. The IM worker completes the Spousal Impoverishment Income Allocation Worksheet (see Appendix C) to determine the amount of monthly income the waiver applicant spouse may allocate to the community spouse.

Depending on the amount, the income allocation may reduce or eliminate the applicant cost share. After the eligibility determination is made, the applicant spouse may choose to allocate all or part or none of the available income to the community spouse who, in turn, may choose to receive all or part or none of the allocation. If SSI or Medicaid eligibility would be jeopardized, the community spouse may forego the allocation. If both spouses are waiver applicants, each may allocate income to the other. The applicant spouse must actually make the income available to the community spouse in order for the allocation to occur.

The maximum amount of income that may be allocated to the community spouse is adjusted annually. Please refer to the Medicaid Handbook or consult with the IMW for more detailed information and current income allocation limits.

### **3.05 New Applicants Leaving an Institution**

When the waiver applicant is moving from a nursing home or another institution and is not already receiving Medicaid, the CM/SSC makes a referral to the county IM agency. The county IMW reviews the medical/remedial expense information and determines Medicaid eligibility together with any applicable cost-share and/or spend-down obligation using the DDE-919. The IM worker may assign the applicant a “pending” Medicaid eligibility status. In these cases the individual applicant is eligible “pending” their move to a waiver allowable setting.

If the individual is potentially SSI eligible, the applicant should also be referred to the local Social Security Administration (SSA) office. If the applicant is already receiving SSI, the SSA office must be informed of the move from the institution to the community and the CM/SSC should explore eligibility for the SSI-E supplement.

### **3.06 Payments, Prepayments or Repayments to Medicaid**

The participant, his/her family or other interested person may choose to pay an amount to Medicaid to maintain eligibility, prepay a Medicaid deductible or reduce any potential claim to an estate. The payment is made to the Wisconsin Medicaid program, which cannot accept more than what Medicaid has paid out for that individual.

### **3.07 Other Payments**

The waiver agency is prohibited from seeking payment from or collecting any funds from the participant which are in excess of the participant's calculated Medicaid liability (e.g., cost share) See Section 3.03 above. This includes any payment made by the participant or any other person or entity, where the payment is intended to pay for or contribute to the cost of any waiver allowable service. This prohibition is in addition to the rules prohibiting providers from seeking payments from the participant or others that would supplement the Medicaid rate. See also Section 4.07, Participant Contributions, in Chapter IV of this manual.