Financial Eligibility and General Medicaid
ADRC Operations Manual

I. Introduction

While aging and disability resource centers (ADRCs) do not determine a customer's general eligibility for Medicaid, they often have a role in assisting customers with the application process. For this reason, it is important that ADRC specialists have a general understanding of Medicaid, including program requirements and the application process. Medicaid is often referred to by other names and acronyms including Medical Assistance or MA. There are several different programs that fall under the broad category of Medicaid.

General financial and other non-functional Medicaid eligibility is determined by county or tribal income maintenance agencies. County income maintenance agencies are organized into regional consortia. Individuals can apply for Medicaid online via ACCESS, by phone, by paper application, or in person at an income maintenance agency. Paper applications and supporting documentation can be faxed or mailed to a document-processing center. A map of the local income maintenance consortia and tribal agencies with agency contact information is available on the Income Maintenance and Tribal Agency Contact Information page of the Department of Health Services (DHS) website.

II. ADRC Role with Medicaid General and/or Financial Eligibility

A. ADRC Roles related to General Financial and Non-Functional Eligibility for Publicly Funded Long-Term Care Programs

ADRC specialists who perform options counseling have a role in assisting customers as they navigate the financial and non-functional eligibility determination process. ADRCs may also have other staff who support the ADRC specialists with this specific job function. ADRCs are responsible for the following:

- Verifying Medicaid status: ADRC specialists need to ascertain the Medicaid status of customers interested in enrolling in publicly funded long-term care programs. This is done by using the ForwardHealth interChange Partner Portal, also known as FHiC.

- Assisting with the Medicaid application process: ADRC specialists must help customers who do not currently have full-benefit Medicaid to apply for the program. They must assist by doing any of the following:

    - Providing an overview of the Medicaid financial eligibility requirements, including income and asset limits, cost share, spousal impoverishment protections, divestment, and estate recovery

    - Reviewing the customer's financial and non-financial circumstances to assess whether the customer is likely to be eligible for Medicaid and sharing this information with the customer

    - Informing the customer, when appropriate, that they may have a cost share, and discussing the process for determining the actual cost share amount

    - Providing information about the application process, including who to contact, how to apply, and what documents will be needed to support the application

        - Assisting the customer in gathering information to support the Medicaid application, including medical and remedial expenses

        - Assisting the customer in scheduling an appointment with the income maintenance consortium or completing the Medicaid application process online, via telephone, or via mail-in paper application

- Providing needed information to income maintenance as described in the Enrollment and Disenrollment Resource Guide (P-02997); the ADRC specialist will provide the income maintenance consortium with the following information to assist in eligibility determination and to ensure that the Medicaid filing date is set at its earliest possible date:
    - Long-term care functional screen results
    - Signed Medicaid application, if applicable
    - Information about the applicant relevant to financial eligibility, including current living arrangement and household composition; guardian or power of attorney; and life insurance, trusts, annuities, and other financial resources, when available
    - Any additional information as specified in the Enrollment and Disenrollment Resource Guide (P-02997).

B. Home and Community-Based Waiver Medicaid: Group A, Group B, Group B Plus

The Wisconsin Medicaid program has two sub-programs designed to provide coverage for long-term care needs:

- **Institutional Medicaid:** This program provides coverage to individuals residing in or expected to reside in a medical institution for at least 30 days. If an applicant is found eligible for Institutional Medicaid, their start date with the program may be backdated if necessary.
- **Home and Community-Based Waiver Medicaid Programs:** These programs allow people to receive coverage for long-term support while residing in the community. These programs include Family Care, Family Care Partnership, PACE (Program for All-Inclusive Care of the Elderly), and IRIS (Include, Respect, I Self-Direct). If an application is found eligible for Home and Community-Based Waiver Medicaid, their start date with the program cannot be backdated.

Eligibility for Home and Community-Based Waiver Medicaid is broken into the following categories:

- Group A: People who are currently eligible for a full-benefit Medicaid program fall into the Group A category. These individuals do not have a cost share; however, they may be responsible for a premium to maintain their Medicaid eligibility (for example, an individual who is eligible for the Medicaid Purchase Plan [MAPP] program may need to pay a monthly premium). A list of full-benefit Medicaid programs is available in the Medicaid Eligibility Handbook, Chapter 21.2.

- Group B and B Plus: People who are not currently eligible for a Group A full-benefit Medicaid program may still be eligible for Home and Community-Based Waiver Medicaid as a Group B or B Plus member. Individuals eligible through Group B or B Plus have higher income limits and are allowed additional income deductions not available in other Medicaid programs. They may have to contribute to the cost of their long-term care services by paying a cost share.

The income maintenance consortium determines the applicant's Medicaid eligibility and cost share amount, if applicable.

More detailed information about Groups A, B, and B Plus can be found in the Medicaid Eligibility Handbook, Chapter 28.6.

C. Cost Share

Applicants eligible for Home and Community-Based Waiver Medicaid in Group B or B Plus may have to contribute to the cost of their long-term care services. This is referred to as a cost share. Family Care members make their monthly cost share payments to the managed care organization (MCO) and IRIS participants make their monthly cost share payment to the fiscal employer agency (FEA). ADRC specialists may provide individuals with an estimate of their cost share, but the actual cost share is determined by income maintenance.

D. Estate Recovery

Applicants need to be aware that the cost of Medicaid services may need to be repaid to the state through the Estate Recovery program. ADRC specialists must provide applicants with the Estate Recovery Handbook (P-13032), refer applicants to the income maintenance consortium, or refer the applicant to Member Services 1-800-362-3002, voice or 711 TTY) for more information.

E. Divestment

Divestment is when someone gives away income or assets for less than fair market value; avoids taking income or assets that they are entitled to; or buys certain types of assets such as a life estate, loan, or annuity. For Medicaid purposes, a person who makes a divestment within the 60 months (five years) prior to applying for Medicaid may be asked to serve a penalty period. The penalty period is a period of time an applicant must wait until eligibility for public funding for long-term care services can begin.

The applicant must report any divestments of income or assets within the 60-month period prior to the application date for Institutional or Home and Community-Based Waiver Medicaid.

Divestment policies apply to all Home and Community-Based Waiver applicants, whether the individual is eligible through Group A, B, or B Plus. ADRC specialists must complete the Medicaid Waiver Eligibility and Cost Share Worksheet (F-20919) with the applicant; if the applicant indicates that divestment has occurred, then the ADRC specialist completes the Declaration Regarding Transfer of Resources (F-20919D) with the applicant and submits it to income maintenance following the requirements described in the Enrollment and Disenrollment Processes Resource Guide (P-02997).

If a customer is denied Home and Community-Based Waiver Medicaid due to divestment, the ADRC specialist should work with the customer to identify any other program and service options that may be available during the divestment period, unless the customer declines.

Income maintenance agencies are required to notify applicants about divestment penalties and, if applicable, instruct them to contact the ADRC 45 days prior to the end of the penalty period to re-engage in the Medicaid application process. The applicant does not receive any additional notice from the income maintenance agency when the divestment penalty period ends. Income maintenance is also required to send information to applicants about the Undue Hardship Waiver Request (F-10193) to gain eligibility despite the divestment penalty. The ADRC specialist may assist a customer to complete and submit this form and supporting documentation upon request.

Note: If the customer's divestment penalty period ends within 30 days of the date of the Medicaid eligibility decision, then the customer does not need to complete a new application. The customer can submit an updated signature (or signatures if there is a community spouse) to establish a new application date. Depending on the case circumstances, the income maintenance agency may need updated income and asset verification to re-determine eligibility.

More detailed information about divestment can be found in the Medicaid Eligibility Handbook, Chapter 17.2.

F. Spousal Impoverishment

Spousal impoverishment protections allow the spouse of an Institutional or Home and Community-Based Waiver Medicaid applicant to retain assets and income above the regular Medicaid financial limits. To qualify for spousal impoverishment protections, the applicant's spouse must live in the community (that is, not have been living in a medical institution for 30 or more consecutive days). The applicant's spouse is therefore referred to as a "community spouse." Spousal impoverishment protections apply only to individuals eligible for Home and Community-Based Waivers through Group B or B Plus or Institutional Medicaid.

An applicant who is separated or legally separated is considered married under Wisconsin law. Spousal impoverishment policies apply even when the community spouse does not reside with the applicant.

Spousal impoverishment policies provide asset and income protections through:

- Asset assessment. When spousal impoverishment rules apply, the income maintenance consortium determines the amount of assets the community spouse can retain without negatively affecting the applicant's eligibility. This is referred to as an asset assessment. The asset assessment provides a snapshot of the couple's total countable assets on a specific date. For Home and Community-Based Waiver applicants, that date is the date the applicant was determined functionally eligible or the beginning of the person's first continuous period of institutionalization of 30 days or more. The total countable assets are used to determine the community spouse's asset share. For example, if the couple's total countable assets are less than $100,000, then the community spouse's asset share is $50,000. The Medicaid Eligibility Handbook 18.4.3 provides a reference table for determining the community spouse asset share.

  In order to be eligible for Institutional or Home and Community-Based Waiver Medicaid, the couple's total countable assets must be below the sum of the community spouse's asset share, plus $2,000. After an applicant is determined eligible, the individual has 12 months to transfer assets to the community spouse. To retain Medicaid eligibility at the end of the 12-month transfer period, the individual's countable assets must be at or below $2,000.

- Income allocation. After an applicant is determined eligible for Institutional or Home and Community-Based Waiver Medicaid, the individual may choose to allocate income to the community spouse and dependent family members who live with the community spouse. The individual must decide how much to allocate, up to a maximum amount. The applicant may request a fair hearing in order to increase the spousal income allocation above the standard maximum limit if the spouse is not able to provide for their necessary and basic maintenance needs with the amount allocated. ADRC customers who would like help with the fair hearing in these situations may be referred to a benefit specialist. The individual does not have to allocate income to a community spouse. Allocating income to a community spouse reduces the individual's cost share. Income that is allocated to a community spouse must be given to the community spouse, and will be counted as income if the community spouse applies for Medicaid or other public assistance programs.

There are special considerations to keep in mind when assisting a married individual with the Medicaid application process. The income maintenance worker will not know until eligibility is determined whether the applicant is eligible for another Medicaid program and therefore eligible for Group A. When a married individual applies for Home and Community-Based Waiver Medicaid, it is assumed that spousal impoverishment protections apply. Medicaid requires the community spouse to sign the Medicaid application and provide information about their income and assets. If a community spouse refuses to sign the application or cooperate by providing information and the applicant's eligibility for long-term care services is denied or terminated, then the applicant can submit an Undue Hardship Waiver Request (F-10193) to the income maintenance agency. The ADRC specialist may assist a customer to complete and submit this form and supporting documentation upon request.

The couple is responsible for providing asset information and needed verification for the month in which the applicant was first determined functionally eligible for Home and Community-Based Waiver Medicaid or the beginning of the individual's first continuous period of institutionalization of 30 days or more, whichever is earlier. This information is used to determine the community spouse's asset share and the applicant's asset limit for establishing Medicaid eligibility.

G. ADRC Role in Assisting People to Apply for Other Medicaid Programs

ADRC specialists do not have the primary responsibility for assisting people to apply for any Medicaid programs other than Home and Community-Based Waiver Medicaid. ADRC specialists will provide customers who appear likely to be eligible for or want to apply for Medicaid with basic information about how to apply for Medicaid and refer them to the appropriate agency for application assistance, eligibility determination, and enrollment.

ADRC customers who request help in establishing eligibility for Medicaid programs other than Home and Community-Based Waiver Medicaid can be referred to a disability benefit specialist or an elder benefit specialist for counseling and assistance. For more information about benefit specialist program services, refer to P-03062-05 and P-03062-06 of the ADRC Operations Manual.

ADRC specialists may assist customers with the application process when they determine that the assistance that is available from the local or regional income maintenance agency or other sources is not timely or sufficient to ensure access. Assistance should include one or more of the following when the ADRC specialist determines that it's necessary:

- Reviewing the customer's financial and non-financial circumstances to determine whether the customer is likely to be eligible for Medicaid
- Gathering information to support the Medicaid application, including medical and remedial expenses
- Scheduling an appointment with the income maintenance agency
- Helping the customer complete the application online, via telephone, or by mail

ADRCs are not responsible for assisting nursing home residents with Medicaid applications unless they are transitioning to a home or community-based residential setting.

H. Systems

Training for the systems described in this section can be found in the learning management system.

a. CARES or CARES Worker Web (CWW)

The CARES or CWW system is used by the income maintenance agency to determine eligibility for public assistance programs including Home and Community-Based Waiver Medicaid. ADRC specialists can obtain query-only access to the CWW system in order to view current and historical eligibility status, current

application status, notices, case comments, and income maintenance case entries. For more information about establishing access to this system, refer to the ADRC/Aging/Tribal User System Access Request Form Instructions (F-02000a).

b. ACCESS

The ACCESS website is an online portal where Wisconsin residents can get information and apply for help getting health care coverage through Medicaid or other related programs, paying for groceries or child care costs, finding a job, or building career skills. Through ACCESS, individuals can apply for and renew benefits, view letters, report changes, submit documents, and more. ADRC specialists and other community providers can assist people in creating an ACCESS account and completing and submitting an application through ACCESS.

c. ForwardHealth interChange (FHiC)

The FHiC system is a portal through which ADRC specialists can view Medicaid eligibility history. For more information about establishing access to this system, refer to the ADRC/Aging/Tribal User System Access Request Form Instructions (F-02000a).

If an ADRC specialist finds that an individual is currently enrolled in a health maintenance organization and would like their enrollment date to occur sooner than the first of the month, then they should contact their assigned regional quality specialist.

III. Operational Policies and Procedures

A. Statutory References

1915 (b) waiver

1915 (c) waiver

Medicaid Managed Care Rule

Wis. Stat. 46.283

Wis. Stat. 46.286

Wis. Stat. 46.287

Wis. Admin. Code ch. DHS 10

B. Allowable Funding Sources and Expenses

ADRC Grant *(link pending)*

C. Policy Requirements

Confidentiality Policy (P-02923-06)

Conflict of Interest Policy (P-02923-03)

Appeal Policy for Adverse Benefit Determinations (P-02923-01)

IV. Additional Resources and Tools

Medicaid Eligibility Handbook

Elderly, Blind, and Disabled Medicaid Application Packet (F-10101)

Wisconsin Medicaid—Home and Community Based Services Waiver Programs (P-10059)

Wisconsin Medicaid Spousal Impoverishment Protection (P-10063)

Wisconsin Medicaid Divestment (P-10058)

Wisconsin Medicaid Purchase Plan (MAPP) Consumer Guide (P-00181)

Estate Recovery Transfers by Affidavit Brochure (P-13009)

Request for Community Spouse Signature (F-02733)

BadgerCare Plus Eligibility Handbook (P-10171)

FoodShare Forms

Adult Long-Term Care Programs: Enrollment and Disenrollment Resource Guide (P-02997)

Enrollment and Disenrollment Desk Aid for Publicly Funded Long-Term Care Programs (P-02915)