BC+ Handbook Release 10-05

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PROGRAM OVERVIEW

1.1 BC+ INTRODUCTION

1.1.1 BadgerCare Plus Health Plans
1.1.2 Health Care Choice
1.1.3 How to Apply

BadgerCare Plus (BC+) is a state/federal program that provides health coverage for Wisconsin families. BC+ replaces the former AFDC-Medicaid, Healthy Start and BadgerCare. Potential BC+ members include:

- Children under 19 years of age,
- Pregnant women,
- Parents and caretakers of children under 19,
- Young adults leaving out of home care (such as foster care),
- Parents and caretaker relatives whose children have been removed from the home and placed in out of home care.

For information on income limits see Chapter 16.1 and Chapter 50.1.

Documented and undocumented immigrants who are children, parents or caretakers and who are ineligible for BC+ solely due to their immigration status may be eligible for coverage for BC+ Emergency Services.

Documented and undocumented immigrants who are pregnant and ineligible for BC+ solely due to their *immigration status* may be eligible for the BC+ Prenatal Program.

Women ages 15-45 may be eligible for limited benefits under the BC+ Family Planning Services program.

Women ages 35-65 diagnosed with cervical or breast cancer may be eligible for Well Woman Care.

A person is eligible if s/he meets all BC+ non-financial and financial requirements.

Individuals who are elderly, blind or disabled may be eligible for Medicaid. Medicaid is a state/federal program that provides health coverage for Wisconsin residents that are elderly, blind, or disabled (EBD). Medicaid is also known as Medical Assistance, MA, and Title 19. There are different subprograms of Medicaid:

- SSI Supplemental Security Income. A program based on financial need operated by the Social Security Administration that provides monthly income to low income people who are age 65 or older, blind or disabled.-related Medicaid
- MAPP Medicaid Purchase Plan
- Institutional Long Term Care
- Home and Community Based Waivers Long Term Care
- Family Care Long Term Care
- Partnership Long Term Care
- Program of All-Inclusive Care for the Elderly Anyone age 65 or older. (PACE)
- Katie Beckett
- Tuberculosis (TB Tuberculosis) -related
- Medicare Premium Assistance (MPA Medicare Premium Assistance): QMB Qualified Medicare Beneficiary, SLMB Specified Low-Income Medicare Beneficiary, SLMB+, QDWI Qualified Disabled and Working Individual;
- Emergency Medicaid
- SeniorCare

See the Medicaid Handbook for more information.

1.1.1 BadgerCare Plus Health Plans

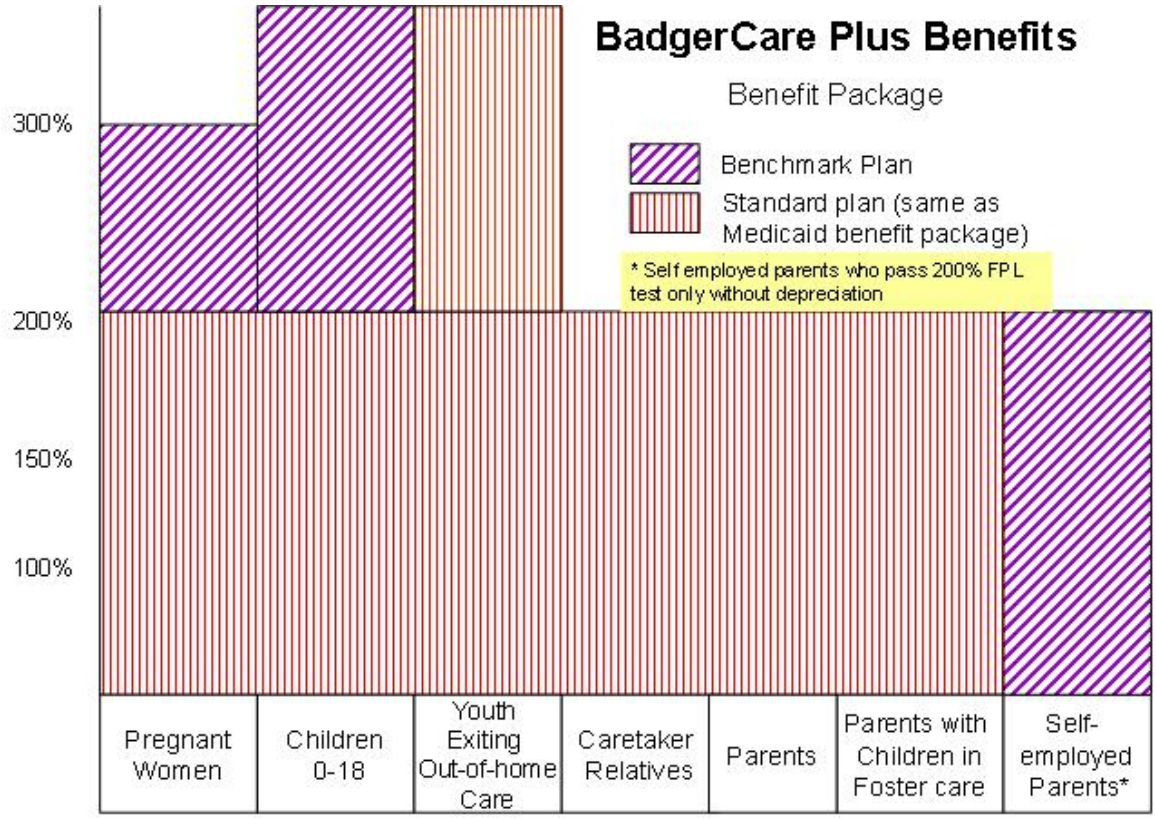
BC+ has two major health care benefit plans: Standard and Benchmark. The Standard Plan is for families with income at or below 200% of the Federal Poverty Level (FPL). The Benchmark Plan which provides more limited services than the Standard Plan, is for families with income above 200% of the FPL, and for self-employed parents and Caretakers. (See Table 50.1 for FPL limits)

In addition, BadgerCare Plus has several limited health plans. These include:

- Family Planning Waiver program
- Prenatal Care Services
- Emergency Services
- Well Women (cervical and breast cancer related) Care

Standard plan members may be asked to pay a share of the cost of services. The co-pay amount ranges from $.50-$3.00 per service.

Benchmark plan members will be asked to pay a share of the cost of services provided to them. The co-pay will be charged once per office visit. Under the Benchmark plan, the member may be required to pay co-pays and deductibles prior to receiving services.



1.1.2 Health Care Choice

It is possible for individuals to qualify for both BC+ and Elderly, Blind and Disabled Medicaid (EBD MA). In some circumstances, *CARES* will automatically enroll the individual in the program with the best benefit plan and lowest cost share. The individual has the right to request coverage under the program not chosen by CARES. See (49.1 Health Plan Choice). The change is effective in the next possible payment following *Adverse Action*, unless the member requests the change be effective in the month the request to change the health plan was made.

When CARES is unable to make an automatic choice between BC+ and EBD MA, a notice requesting the individual to make a choice will be generated. Once the member has made a choice the decision remains in effect until:

- The member requests a change,
- The member's benefit under the health plan of his or her choice ends. (This includes being placed into an unmet *deductible* assistance group.)

1.1.3 How to Apply

The following *application* options are available for anyone who is applying for BC+.

1. ACCESS online application at access.wi.gov .
2. Face-to-Face Interview at the local county/tribal office.
3. Mail-In.
4. Telephone Interview.

Click here to view the Directory of local county/tribal agencies in Wisconsin or call 1-800-362-3002.

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NON-FINANCIAL REQUIREMENTS (CHAPTERS 2-15)

2 BC+ GROUP

2.1 BC+ NON-FINANCIAL PROGRAM REQUIREMENTS

The following individuals are non-financially eligible for BC+ :

1. Children under 19.

2. Pregnant Women.

3. Parents/Caretaker Relatives of children under 19 years of age, including some parents and caretaker relatives whose children have been removed from the home and are in the care of the child welfare system. (Chapter 10).

4. Young adults exiting out of home care (such as foster care).

To meet conditions of eligibility, the *applicant* must:

1. Be a Wisconsin resident (Chapter 3),

2. Be a U.S. citizen or qualified immigrant (Chapter 4),

   Note: This is not a requirement for non qualifying immigrants receiving Emergency Services (Chapter 39) or women applying for the BC+ Prenatal Program (Chapter 41).

3. Provide documentation of citizenship and identity or *immigration status* (4.1),

4. Cooperate with establishing medical support and *third party liability (TPL)* (Chapter 5),

5. Sign over to the state his/her rights to payments from a third party for medical expenses (5.2),

6. Meet BC+ *SSN* requirements (Chapter 6),

7. Cooperate with verification requests when information is mandatory or deemed questionable (Chapter 9),

8. Meet Health Insurance Access and Coverage Requirements (Chapter 7).

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2.2 BC+ TEST GROUP

2.2.1 Parents
2.2.1.1 Paternity
2.2.1.2 Joint Placement
2.2.1.3 Essential Person
2.2.2 Caretaker Relative
2.2.3 Pregnant woman
2.2.4 Youth Exiting out of Home Care (YEOHC)
2.2.5 Child

The *BC+ Test Group* includes the primary person and any individuals living in his/her household whose income and/or needs are considered when determining financial eligibility. Inclusion in the Test Group is determined by qualifying relationships and legal responsibility.

Anyone in the home who meets the criteria of being in the BC+ Test Group, is always included in the group whether or not s/he requested BC+.

Persons in the home who do not meet the criteria to be in a BC+ Test Group must be excluded. However, they may be included in a BC+ Test Group in another case.

The primary person who applies for BC+ must meet one of the following requirements in order to form a BC+ Test Group. The primary person must either be:

1. A parent residing with his or her child under age 19 or residing with a spouse and his or her child who is under age 19.
2. A qualified relative *caretaker* relative residing with a child in the home who is under age 19, or residing with a spouse who is a qualified relative *caretaker relative* of a child in the home who is under age 19. (caretaker relative)
3. A pregnant woman, or the spouse of a pregnant woman,
4. A Youth under age 21 who was in out-of-home care (e.g., foster care) at age 18, or

5. A child.

The following are the relationships and legal responsibility which determine who is in the BC+ Test Group :

2.2.1 Parents

A parent is any natural or legally adoptive mother or father. A parent can be any age. There can be more than one parent of a certain gender in a household.

Note: Children under 19, who are applying for *FPOS*, are a group of one unless she is married and/or has children. Parents are not included in the group.

The BC+ Test Group for a primary person who is residing with his or her own child or with a spouse and the spouse's child will include the following individuals:

1. The primary person and the primary person's spouse.
2. A child under age 19 of the primary person or the primary person's spouse.
3. A co-parent of a primary person's child or the co-parent of the spouse's child.
4. Any spouse of a co-parent.
5. Any child under age 19 of a co-parent.
6. The other parent of a co-parent's child.
7. A child of the primary person's child or the spouse's child.
8. The spouse of an included child, if that child is a parent, or the spouse is under age 19.
9. The co-parent of an included grandchild.
10. A child under age 19 who is a qualified relative of, and residing with, the primary person, the primary person's spouse or another included adult.
11. An essential person (2.2.1.3)

A parent residing with his or her child under the age of 19 must be in the same BC+ Test Group. This is true even when the legal custody of the child has been transferred to someone living outside of the home. The only exception is when someone's parental rights have been legally terminated.

When a child moves from the home of a parent or caretaker relative who was eligible for BC+ to the home of another caretaker relative or caretaker relative who applies for BC+ in the same month, the new caretaker relative can be eligible as of the *application* date. The child, however, isn't eligible in the new household until the 1st of the month after the move.

Note: A child under age 19 residing with a parent may not apply separately from his or her parent. In addition, the parent must apply as the primary person for the case, unless the child filing the application is age 18.

2.2.1.1 Paternity

When a woman is married at the time that she gives birth, her husband is considered the legal father of the child unless a court later determines that someone else is the father.

When the parents of the child were not married at the time of the child's birth, paternity must be established in order to determine the parental relationship for the father. Paternity is legally established only by a court order or by a Voluntary Paternity Acknowledgment Form (DPH 5024) signed on or after May 1, 1998 and filed with the state Vital Records office. A father's name on a birth certificate issued in Wisconsin on or after May 1, 1998, is evidence that paternity has been established.

The following designations for a father are used in *CARES*. See the accompanying definitions to determine which designation is appropriate for a case.

1. Claimed Father

   A Claimed Father is someone claiming to be the father of a child but has not had his paternity established. **A claimed father is not the father for BC+ eligibility purposes.** His child should be referred to the Child Support Agency (CSA) so that steps to establish paternity can be taken.

2. Acknowledged Father

   An acknowledged father is someone who has not had his paternity adjudicated by a court, but has filed a formal paternity claim. An acknowledged father is one who fits one of the following criteria:

   a. Filed paternity papers prior to May 1, 1998, or
   b. Has his name on the birth certificate and the certificate is from another state, or from Wisconsin and for a birth prior to May 1, 1998.

   An acknowledged father is considered to be a parent for BC+ eligibility purposes. However, because there is still no evidence of a formal adjudication, refer acknowledged fathers to the CSA so that steps to establish paternity may be taken.

3. Father

A father who has had his paternity legally established is called the adjudicated father. Paternity is legally established by either a court order (adjudication) or by a Voluntary Paternity Acknowledgment Form signed by the father on or after May 1, 1998 that is filed with the Wisconsin Vital Records office.

Note: If a father's name appears on a Wisconsin Birth Certificate for a child born after May 1, 1998, it means paternity has been established. Do not refer adjudicated fathers to the CSA.

2.2.1.2 Joint Placement

When the natural or adoptive parents of a child do not live together, and have joint placement arrangements for the child (through a mutually agreed upon arrangement or court order), only one parent can be determined eligible at a time unless there is reasonably equivalent placement. Reasonably equivalent placement means that the child is residing with each parent at least 40% of the time during a month.

If the child is not residing with both parents at least 40% of the time, only the parent with the greater percentage of the placement time may apply on behalf of the child and/or for him or herself as the caretaker relative of that child.

If only one parent of a child is applying for BC+ and he or she is stating that they have placement of the child for at least 40% of the time, accept the declaration unless it is questionable.

If both parents are applying for BC+ and claim the child is residing with them, act on their BC+ cases as follows:

1. If both parents agree that they have a reasonably equivalent placement arrangement, ask under which parent’s case they want the child to be receiving BC+ benefits and determine eligibility for both parents’ cases.

2. If either parent disputes that the placement arrangement is reasonably equivalent, the eligibility worker must determine the monthly percentage of the physical placement based on the court order. If the court order does not show reasonably equivalent placement, consider the child to be with the parent s/he is residing with during the month in question and deny the other parent’s eligibility as a caretaker relative of this child.

3. If the parents can not agree on which case the child will receive benefits, put the child on the case with the family whose income is at the lower FPL level.

4. Document your decision in the case record.

In determining eligibility for the parents with equivalent placement, the child is considered to be residing in both of their homes. That means the child will be included in the group size for both cases and the child's income will also be counted in both cases.

If reasonably equivalent placement exists (as described above) and both parents apply for BadgerCare Plus for the child and the child has access to health insurance where an employer pays 80% or more of the monthly premium in one home but not the other, the child shall remain eligible for BadgerCare Plus on the case with the parent who does not have access to health insurance for which the employer pays 80% or more.

Example 1: Johnny, age 10, lives 50% of the time with his mom and 50% of the time with his dad. Both Johnny's dad and mom have applied for BadgerCare Plus. Mom is employed, but does not have access to health insurance coverage through her employer. Dad is employed and does have access to a family health insurance where his employer pays 81% of the monthly premium. Johnny can remain eligible on his mom's case.

If reasonably equivalent joint placement exists and both parents apply for BadgerCare Plus for the child and the income of either case requires that a premium be paid as condition of the child's BadgerCare Plus eligibility, then the parents can choose in which case the child will receive BadgerCare Plus coverage. A premium requirement in one case does not preclude eligibility in the other parent's case where no premium for the child would be owed.

Example 2: Billy, age 8, lives 40% of the time with his dad and 60% of the time with his mom. Both mom and dad are applying for BadgerCare Plus. In his mother's case, the family income is 220% FPL and in his dad's case, the family income is 180% FPL. Johnny's dad and mom decide that Johnny will be receiving his BadgerCare Plus coverage through the dad's case.

If joint placement exists with a parent who lives in another state, the child must be with the Wisconsin parent at least 50% of the time in a month to qualify for BC+.

2.2.1.3 Essential Person

To be included in a BC+ test group as an essential person, the designated person must:

1. Be related to a BC+ test group member, and

2. Be otherwise nonfinancially eligible, and

3. Provide at least one of the following to another BC+ member:

    a. Child care that enables a caretaker relative to:

        - Work outside the home, full time (30 hours or more a week), for pay,
        - Receive training full time (30 hours or more a week),
        - Attend HS or GED classes full time (as defined by the school).

    b. Care for anyone who is incapacitated.

    Consider a caretaker relative incapacitated if, due to physical, emotional, or mental impairment, s/he cannot:

        - Work full - time at employment paying at least Federal minimum wage, or
        - Perform customary, necessary homemaking activities or provide adequate care for his/her children without help from other persons.

Only IM agency staff in positions or with authority higher than a first line IM Worker may approve, deny, and review any essential person designation. The essential person designation must be reviewed at least every six months.

Only a caretaker relative who has a child under his/her care may designate an essential person.

To designate an essential person, the caretaker relative must submit a Designation of a BC+ Essential Person form to the IM agency. S/he must document the need for each essential person and that the person can provide the essential service.

More than one person may be designated as an essential person in the same BC+ group, but only for different children. No one, however, may be an essential person in more than one BC+ group. Also, there can be no essential person if there is no born child, as in a Maternity Care case.

2.2.2 Caretaker Relative

A caretaker relative a is non-legally responsible relative to the child under his/her care. Caretaker relatives and their spouses can be eligible for BC+ as caretaker relatives. To be considered a caretaker relative of a child in the home, a person must first have a qualifying relationship to the child (under age 19) and the child must also be under the care of that relative.

Qualifying relationships for caretaker relatives consist of the following:

1. Stepfather or stepmother

2. Natural full brother or sister, legally adopted, half- or stepbrother or sister.

3. Grandmother or grandfather, aunt or uncle, first cousin, nephew or niece, or any preceding generation denoted by the prefix grand-, great-, or great-great, and including those through adoption.

4. Spouse of any of the above even after the marriage ends by death, divorce, or separation.

Annulment of a marriage removes all relationships established by the marriage except parent.

A spouse is that person recognized by Wisconsin law as another person's legal husband or wife. Wisconsin does not recognize common law marriage.

Being "under the care" means the caretaker exercises primary responsibility for the child's care and control, including making plans for him/her. Once a child marries, s/he can no longer can be considered under the care of a caretaker relative.

In cases where a child resides with both a caretaker relative and a parent, the parent is considered the caretaker relative, unless legal custody has been given by a court to the caretaker relative. In that situation, the caretaker relative is considered the caretaker relative of that child and could be eligible for BC+.

NOTE: If a child lives with his/her parent(s), as well as an caretaker relative with legal custody, the child and parents are still part of the same BC+ Test Group, and the parents' income will be used to determine the child's eligibility. The parent(s) and child will not however, have their income counted when determining the caretaker relative's eligibility.

Example: Alice, age six, and her mother, Jane, live with Jane's parents. The grandparents have legal custody of Alice. Alice is considered to be under the care of her grandparents, not of her mother. Since the grandparents are the caretakers of Alice, they may apply for BC+ for Alice. In addition, Jane, as a parent of a child in the BC+ Test Group, must also be included in the Group.

If the primary person is a caretaker relative of a child under age 19 or the spouse of a caretaker relative of a child under age 19, the BC+ Test Group will include the following individuals:

1. The caretaker relative,
2. The caretaker relative's spouse,
3. The child under age 19 who is under the care of the caretaker relative.
4. A parent of the child, if the caretaker relative has legal custody of the child, and
5. Any essential person (2.2.1.3).
   http://dcf.wi.gov/children/Kinship/INDEX.HTM

Note: A child under age 19 residing with a caretaker relative may not apply as the primary person for the relative's benefits. For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BC+.

2.2.3 Pregnant woman

A pregnant woman is non-financially eligible for BC+. Marital status has no effect on her non-financial eligibility. If she is a pregnant minor, she does not have to be under the care of or related to the caretaker to be eligible for BC+.

If the primary person is:

- a pregnant woman or her spouse,
- not a parent or a caretaker relative and
- if under age 19, not residing with a parent or a caretaker relative ,

the BC+ Test Group will include the pregnant woman and her spouse.

If the pregnant woman is under 19 and residing with a parent or caretaker, the parent or caretaker would be the primary person and the BC+ Test Group would be built around the parent or caretaker.

Also include in the BC+ Test Group size each verified fetus the pregnant woman is carrying. If there is no verification on the number of fetus, add 1 to the group size.

2.2.4 Youth Exiting out of Home Care (YEOHC)

If the primary person is

- a YEOHC,

- not a parent or a caretaker relative of a child, and
- if under age 19, is not residing with a parent or caretaker relative

The BC+ test group will include the YEOHC and his/her spouse if the spouse is also a YEOHC.

If the YEOHC is under 19 and residing with a parent or caretaker, the parent or caretaker would be the primary person and the BC+ Test Group would be built around the parent or caretaker.

2.2.5 Child

If the primary person is a child under age 19, is not a parent or a caretaker relative of a child in the home, and is not residing with a parent or caretaker relative, the BC+ group consists solely of the child and his or her spouse if they are residing together. In this situation, the spouse of the child under 19 is not eligible for BC+ unless s/he is also under age 19 or there are other children in the household under the care of either the child who is the primary person or the spouse.

A child is non-financially eligible for BC+. Marital status has no effect on his/her non-financial eligibility. The child does not have to be under the care of or related to the caretaker to be eligible for BC+.

Note: A child under age 19 residing with a caretaker relative may not apply as the primary person for the relative's benefits. For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BC+. A child under age 19 residing with a parent may not apply separately from his or her parent. In addition, the parent must apply as the primary person for the case, unless the child filing the application is age 18.

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2.3 HOUSEHOLD

2.3.1 Not Living in the Household
2.3.2 Temporary Absence
2.3.3 Students
2.3.4 Child Welfare Parents/Caretakers

"Living in the Household" means all individuals residing in or temporarily absent (3.5.1) from the same residence. This includes:

1. People living in the home in a community residential confinement program. The Department of Corrections (DOC) electronically monitors them.

2. Huber law prisoners who are released from jail to attend to the needs of their families can become eligible for BC+. If the other parent is continuously absent, the Huber law prisoner may be the *caretaker* relative in the household if the prisoner:

    a. Intends to return to the home, and
    b. Continues to be involved in the planning for the support and care of the minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for BC+. Consider them to be absent parents.

2.3.1 Not Living in the Household

Do not consider the following to be living in the household:

1. Inmates of a public institution, even if they are temporarily absent from the home with the following exceptions:

    a. Pregnant inmates applying for the BadgerCare Plus Prenatal..
    b. If an inmate resides outside of a public correctional institution for more than 24 hours at any one time, s/he can qualify for BC+ during that time period if s/he meets all other eligibility criteria. For example, if an inmate is admitted as an inpatient to a non-prison hospital for 24 hours, that inmate could qualify for Medicaid for that day, if otherwise eligible.

2.3.2 Temporary Absence

A child and that child's parent or caretaker relative can be in the same *BC+ Test Group* even when not living together if either is temporarily absent, provided:

1. The continuous absence is expected to be for no more than six months.

The IM agency may approve an extension of a child's temporary absence beyond six months when the caretaker relatives meet the Child Welfare

Caretakers requirements.

and

2. The *caretaker relative* continues to exercise responsibility for the care and control of the child.

Children who are inmates of public institutions (3.6) are not temporarily absent.
Children who are placed in an institution for 30 or more days are not temporarily absent, unless they were placed there by a child welfare agency.

Children who are placed in an *IMD* are not temporarily absent, unless they were placed there by a child welfare agency.

2.3.3 Students

When a child under age 19 who is a student living away from their parent's home applies for BC+, the child and his/her family can determine whether the student will be a group of 1 on his/her own case, or a temporarily absent individual included in his/her parent's case.

2.3.4 Child Welfare Parents/Caretakers

Parents and caretaker relatives whose children have been placed in out of home care and who meet the criteria listed in (Chapter 10) are still considered caretaker relatives of the child. The child is considered temporarily absent from the home. The child(ren) is included in the BC+ test group and any unearned income the child has is budgeted. However, unlike others who are considered temporarily absent from the home, a child in a child welfare placement is not eligible for BC+ in the household that s/he was removed from.

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2.4 BC+ ASSISTANCE GROUPS

Within the *BC+ test group*, individuals may need to meet different eligibility criteria to receive BC+ or may receive different benefits, based on their income and whether they are an adult, a child under age 19, pregnant or meet some other specific criteria. Because of this, individuals within the BC+ test group are placed into a BC+ Assistance Group (AG).

Every BC+ AG will have at least one potentially eligible member. Besides these potentially eligible members, others in the household may be designated as a person whose income will be counted when determining financial eligibility. Still others may be counted only in the group size, or not considered at all when determining eligibility. Placement in the BC+ AG is dependent on age, and relationships to the primary person and other household members.

The following are the BC+ Assistance Groups:

AG	Description
BCPY:	Youth exiting out of home care
BCPP:	Pregnant women, including those who become eligible by meeting a *deductible*, or who are eligible for the BC+ Prenatal Program.
BCPB	Continuously Eligible Newborns
BCPN	Persons who are caretakers relatives, or the spouses of caretakers relatives in the home, and includes Child Welfare caretakers
BCPL	Children living with caretaker relatives
BCPC	Children under age 19, living alone or with a parent or parents
BCPA	Persons age 19 or older who are parents, or stepparents of a child in the home, including Child Welfare parents
BCPD	Children who are eligible through meeting a deductible
BCPE	Adults and children in Earned Income and Child Support Extensions
BCPT	Transitionally grandfathered parents

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2.5 PARTICIPATION STATUS CODES

The participation status code for each individual in the BC+ assistance group indicates whether the individual is eligible, counted or excluded in that assistance group.

Status Code		Description	Include in the Group Size?	Count income?
CA	Counted Adult	Ineligilbe for BC+ in this AG	Yes	Yes
CC	Counted Child	Ineligible for BC+ in this AG	Yes	Yes (Count unearned. Count earned if child is 18)
EA	Eligibile Adult	Non-financially eligible in this BC+ AG	Yes	Yes
EC	Eligible Child	Non-financially eligible eligible in this BC+ AG	Yes	Yes
TC	Test Child	Ineligible for BC+ solely because receives SSI or Adoption Assistance	Yes	No
TA	Test Adult	Ineligible for BC+ solely because receives SSI or 1619b	Yes	No
XA	Excluded Adult	Ineligible for BC+ in this AG and not legally responsible for an eligible group member	No	No
XC	Excluded Child	Ineligible for BC+ in this AG	No	No

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2.6 BC+ TEST GROUP FINANCIAL RULES

The income and/or needs of all *BC+ Test Group* members will be used to determine financial eligibility for all members of the BC+ Test Group.

> **Exception**: If a child is living with a *caretaker* relative, the child's financial eligibility is determined using only the child's income. The income from the *caretaker relative* and the caretaker relative's spouse is never used in the child's eligibility determination. Likewise, the child's income is never used when determining the eligibility of the caretaker relative and his/her spouse. In addition, caretaker relative and the children living with the caretaker relative do not count each other when determining the BC+ Test Group sizes.

All members in the BC+ Test Group will be counted when determining the BC+ Test Group size even when there is no health care request for a member.

The income of all counted adults and children in the BC+ Test Group is used when determining the financial eligibility for all Test Group members, except the income of SSI recipients or other Test Adults or Test Children.

Test Children and Test Adults are included in the group size but their income is not counted when determining eligibility for the group.

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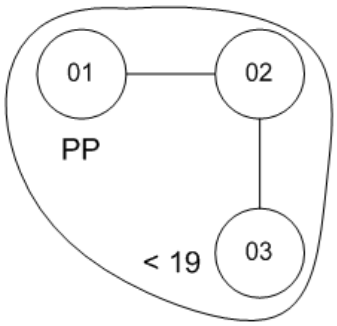
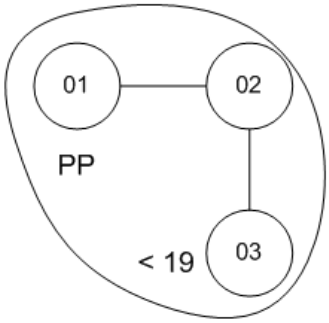
2.7 BC+ GROUP EXAMPLES

Example1

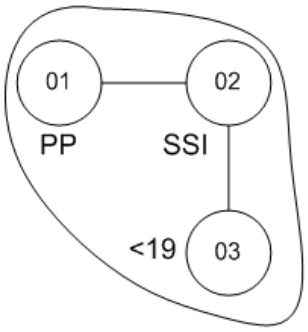


Individuals	01	02	03
Health Care Request	Y	Y	Y
Assistance Group	Individual Part status		
BCPA	EA	EA	CC
BCPC	CA	CA	EC

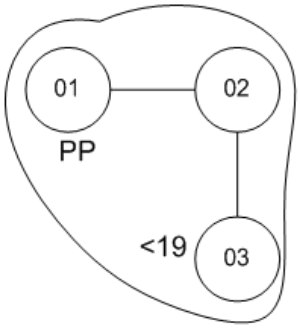


Individuals	01	02	03
Health Care Request	Y	N	Y
Assistance Group	Individual Part status		
BCPA	EA	CA	CC
BCPC	CA	CA	EC

Example 2

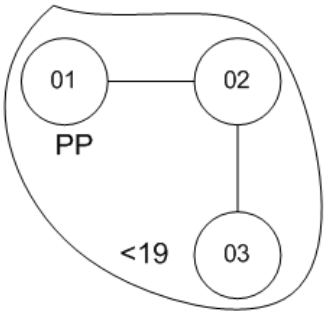


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPA	EA	TA	CC

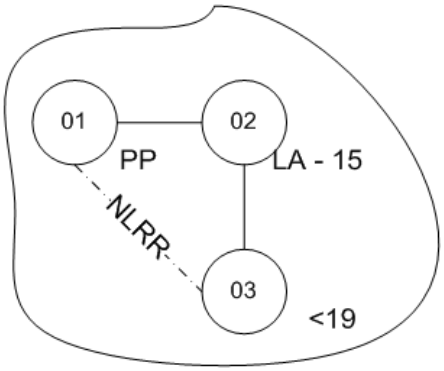


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPA	EA	EA	CC

Example 3

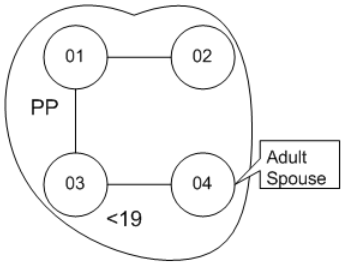


Individuals	01	02	03
Health Care Request	Y	N	N
Assistance Group	Individual Part status		
BCPA 01	EA	CA	CC

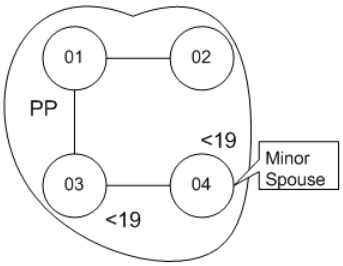


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPN 01	EA	XA	XC

Example 4

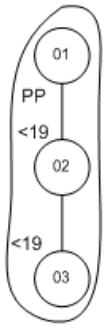


Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA 01	EA	EA	CC	CA
BCPC 01	CA	CA	EC	CA

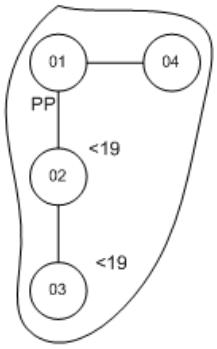


Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA 01	EA	EA	CC	CC
BCPC 01	CA	CA	EC	EC

Example 5



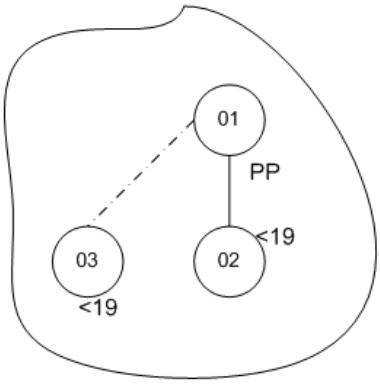
Individuals	01	02	03	
Health Care Request	Y	Y	Y	
Assistance Group	Individual Part status			
BCPA	EA	CC	CC	
BCPC	CA	EC	EC	



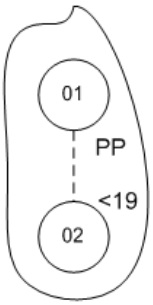
Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA	EA	CC	CC	EA
BCPC	CA	EC	EC	CA

Example 6

Example 7

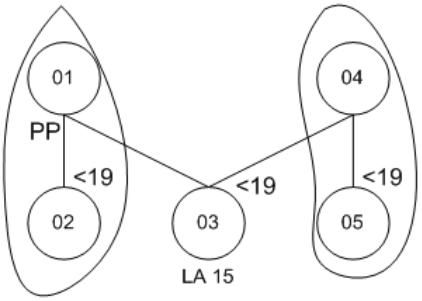


Individuals	01	02	03		
Health Care Request	Y	Y	Y		
Assistance Group	Individual Part status				
BCPA 01	EA	CC	XC		
BCPC 01	CA	EC	XC		
BCPL 01	XA	XC	EC		

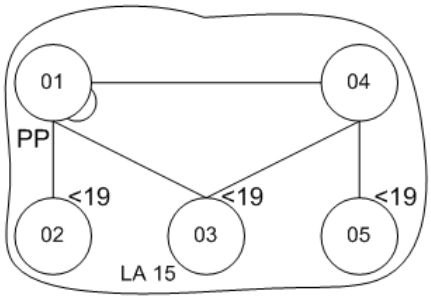


Individuals	01	02			
Health Care Request	Y	Y			
Assistance Group	Individual Part status				
BCPN 01	EA	XC			
BCPL 01	XA	EC			

Example 8



Individuals	01	02	03	04	05
Health Care Request	Y	Y	Y	Y	Y
Assistance Group	Individual Part status				
BCPA	EA	CC	XC	XA	XC
BCPC	CA	EC	XC	XA	XC



Individuals	01	02	03	04	05
Health Care Request	Y	Y	Y	Y	Y
Assistance Group	Individual Part status				
BCPP	EA	CC	XC	CA	CC
BCPA	CA	CC	XC	EA	CC
BCPC	CA	EC	XC	CA	EC

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3 RESIDENCE

3.1 RESIDENCE

A person must be a Wisconsin resident to be eligible for BC+. S/he must:

1. Be physically present in Wisconsin. (There is no minimum requirement for the length of time the person has been physically present in Wisconsin.) and
2. Express intent to reside in Wisconsin. (3.2).

Example: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For BC+ purposes, George is a Wisconsin resident.

Migrant Farm Worker

A migrant who meets the following conditions is a Wisconsin resident:

1. His/her primary employment in Wisconsin is in the agricultural field or cannery work,
2. S/he is authorized to work in the US,
3. S/he is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crew leader"), and
4. S/he routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

See (12.3) for Special Migrant Laborer Processing Instructions.

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3.2 INTENT TO RESIDE

The intent to reside requirement applies to any adult age 18 or older who is capable of indicating intent. An adult is incapable of, and thus exempt from, indicating intent when:

1. S/he is judged legally incompetent by a court of record; or

2. His/her I.Q. is 49 or less or s/he has a mental age of 7 or less, based on tests acceptable to Wisconsin's Department of Health Services (DHS); or

3. Medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability supports a finding that s/he is incapable of indicating intent.

If the *applicant*/member is incapable of indicating intent, the guardian or person acting on behalf of the applicant/member can indicate the applicant's/member's intent to reside.

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3.3 DETERMINING STATE RESIDENCY

3.3.1 Under Age 21
3.3.2 Age 21 and Over

3.3.1 Under Age 21

Not in an institution

A person under age 21 and not residing in an institution is a Wisconsin resident if s/he is:

1. Living in Wisconsin with the intent to remain living in Wisconsin.

2. Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.

3. Living in another state when Wisconsin or one of its county agencies has legal custody of him/her.

4. Living here and is eligible based on blindness or disability.

In an institution

The residence of an institutionalized person under age 21 when his/her parents or legal guardian lives outside of Wisconsin is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.

If the parents have abandoned him/her and no legal guardian has been appointed, his/her residence is the state in which the institution is located, and the person making the Medicaid *application* must reside in the same state.

If s/he is married, his/her residence is the institution's state.

3.3.2 Age 21 and Over

In an institution

The residence of an institutionalized person age 21 or over is the state in which s/he is residing with the intent to remain there.

If s/he is incapable of indicating intent, his/her residence is determined in the same way as the residence of an institutionalized person under age 21.

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3.4 SPECIAL SITUATIONS

3.4.1 SSP Payment
3.4.2 IV-E Children
3.4.3 Non IV-E Foster Children
3.4.4 Homeless Persons

3.4.1 SSP Payment

The State Supplementary Payment (SSP) is the portion of an SSI payment paid by a state, not by the federal government. A person receiving SSP payments is a resident of the state making the SSP payment.

3.4.2 IV-E Children

Federal financial participation is available under Title IV-E of the Social Security Act to pay for all or part of a person's foster care or subsidized adoption. IV-E eligible children are categorically eligible for BC+ in the state where they reside.

It does not affect any maintenance payments for substitute care.

These cases are certified manually outside of *CARES*.

3.4.3 Non IV-E Foster Children

Wisconsin certifies BC+ eligibility for non IV-E foster children living in another state when Wisconsin or one of its county/tribal agencies has legal custody of the child.

Non IV-E foster children are automatically eligible for BC+.

These cases are certified for BC+ manually outside of CARES.

3.4.4 Homeless Persons

A homeless person living in Wisconsin meets the requirement of being physically present in Wisconsin. The agency is responsible for using its own address or some other fixed address for purposes of mailing the BC+ card to eligible applicants who have no fixed dwelling place or mailing address.

Homeless Definition*

LIVING SITUATION	CONSIDERED HOMELESS?
An individual who lacks a fixed, regular, and adequate nighttime residence AND has a primary nighttime residence in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, such as: • Sleeping in a car • Sleeping on a bench • Sleeping under a bridge	Yes
An individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations including • Welfare hotels, • Congregate shelters, and • Transitional housing for the mentally ill.	Yes
Inpatient facilities for persons with mental or substance abuse disorders such as Hope Haven	Yes
An individual lives in an apartment that he/she doesn't own,	No

for example: • Stays with a girlfriend/boyfriend • Stays with a parent • Stays with a friend	
Prison	No
Staying in a motel/hotel due to lack of other alternatives	No
Persons living in housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded.	No

* Per federal HUD definition found in Title 42, Chapter 119, Subchapter I updated July 13, 2009.

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3.5 ABSENCE FROM WISCONSIN

Once established, Wisconsin residency is retained until :

1. The person notifies states that they no longer intend to reside in Wisconsin,

2. Another state determines the person is a resident in that state for Medicaid/Medical Assistance ,

3. Other information is provided that indicates the person is no longer a resident.

3.5.1 Temporary Absence

Temporary absence ends when another state determines the person is a resident there for Medicaid/Medical Assistance purposes.

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3.6 INMATES

Individuals who are inmates of a public institution are not eligible for BC+. An inmate is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate.

Exception: Pregnant women may apply for and enroll in the BC+ Prenatal Program (Chapter 41) while they are inmates.

3.6.1 Huber Law

Huber Law prisoners who are released from jail for the purpose of attending to the needs of their families can become eligible for BC+ if the prisoner.

1. Intends to return to the home, and

2. Continues to be involved in the planning for the support and care of the minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for BC+. Consider them to be absent parents.

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4 CITIZENSHIP AND IMMIGRATION STATUS

4.1 U.S. CITIZENS AND NATIONALS

4.1.1 Child Citizenship Act
4.1.2 Compact of Free Association States

All U.S. citizens and U.S. nationals are entitled to apply for and receive BC+ if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

A U.S. citizen is anyone who:

1. Was born in the United States, the Commonwealth of Northern Mariana Islands, Puerto Rico, Guam or the U.S. Virgin Islands.

2. Was born to a U.S. citizen who was living abroad.

3. Is a naturalized U.S. citizen.

A U.S. national is anyone who was born in American Samoa (including Swain's Island). The Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, therefore individuals from this country are not U.S. nationals.

4.1.1 Child Citizenship Act

The Child Citizenship Act (CCA) of 2000 amended the Immigration and Naturalization Act (INA) to provide derivative citizenship to certain foreign-born children of U.S. citizens. This applies to individuals who were under 18 years old on February 27, 2001 and anyone born since that date. The children included in the act are:

- Adopted children meeting the two year custody requirement
- Orphans with a full and final adoption abroad or adoption finalized in the U.S.
- Biological or legitimated children
- Certain children born out of wedlock to a mother who naturalizes

The CCA provides that foreign-born children who meet the conditions below automatically acquire U.S. citizenship on the date the conditions are met. They are not required to apply for a certificate of naturalization or citizenship to prove U.S. citizenship. These conditions are that the child:

- Has at least 1 parent who is a U.S. citizen (whether by birth or naturalization),
- Is under 18 years of age,
- Has entered the U.S. as a legal immigrant,
- If adopted, has completed a full and final adoption; and,
- Lives in the legal and physical custody of the US citizen parent in the U.S.

Adopted children automatically become U.S. citizens if the children meet all the above conditions and were:

a. **Adopted under the age of 16,** and has been in the legal custody of and has resided with the adopting parent or parents for at least two years.

b. **Adopted while under the age of 18,** and has been in the legal custody of and has resided with the adopting parent or parents for at least two years and is a sibling of another adopted child who is under 16.

c. **Orphans adopted while under the age of 16,** who have had their adoption and *immigration status* approved by the USCIS (Form I-171, "Notice of Approval of Relative Immigrant Visa Petition"). These children need not have lived with the adoptive parents for two years.

d. **Orphans adopted under the age of 18**, who have had their adoption and immigration status approved by the USCIS, and are siblings of another adopted child who is under the age of 16. These children need not have lived with the adoptive parents for two years.

4.1.2 Compact of Free Association States

Persons from the Compact of Free Association States are not considered U.S. citizens or nationals. The Compact of Free Association States include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the Compact of Free Association States (CFAS) have a special status with the US that allows them to enter the country, work here and acquire an *SSN* without obtaining an immigration status. They are not eligible for BC+, unless they have obtained a qualifying immigration status. Those CFAS citizens who do not have one of the immigration statuses listed in 4.3 may qualify for BC+ Emergency Services only.

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4.2 DOCUMENTING CITIZENSHIP AND IDENTITY

4.2. Documenting Citizenship and Identity
4.2.1 Covered Programs
4.2.1.1 Exempt Populations
4.2.2 Reasonable Opportunity Period

4.2.2.1 Applicants
4.2.2.2 Members
4.2.3 Good Faith Effort
4.2.3.1 For New BC+ Applicants
4.2.3.2 For Ongoing BC+ Members
4.2.4 Hierarchy of Documentation
4.2.5 Agencies Paying for Documentation
4.2.6 Policy For Special Populations
4.2.7 Situations which require Special Documentation Processing
4.2.7.1 Person Add
4.2.7.2 Presumptive Eligibility/Express Enrollment (EE)
4.2.7.3 Individuals Without Verification and Affect on Household Eligibility
4.2.7.4 Child Citizenship Act 2000
4.2.7.5 Non-citizens
4.2.7.6 Individuals in Institutional Care Facilities

The Federal Deficit Reduction Act of 2005 requires persons applying for or receiving Medicaid (MA), BadgerCare Plus (BC+), or Family Planning Only Services (*FPOS*) benefits, who have declared that they are a U.S. citizen, to provide documentation of their U.S. citizenship and identity.

Agencies must comply with the new BC+ requirement to document citizenship and identity in order for the State to obtain Federal matching funds. As part of on-going DHS quality assurance initiatives, periodic quality control reviews will be done on randomly selected cases throughout the state to monitor agency compliance. Cases will be examined to determine if proper documentation was used to verify citizenship/identity and if the proper verification code was used. The Department will work with non-compliant agencies to achieve compliance.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S., or that the person is otherwise a U.S. citizen. In addition, any document used to establish identity must show identifying information that relates to the person named on the document. For a list of all the allowable documentation, see the Acceptable Citizenship and Identity Documentation.

If an individual has provided proof of citizenship in a state other than WI, the IM worker can either request that the individual resubmit the documentation or request and obtain a copy or electronic copy of the original documentation reviewed by the other state to keep on file in WI.

Agencies may accept citizenship and identity documents from a woman whose last name has changed due to marriage or divorce if the documentation matches in every way with the exception of the last name. If there is any doubt, the agency may request that the individual provide an official document verifying the change such as a marriage license or divorce decree. If an individual has

changed his/her first and last name, s/he must produce documentation from a court or governing agency documenting the change.

Once the citizenship and identity requirement is met, it need not be applied again, even if the person loses BadgerCare Plus at some point and later re-applies. A person should ordinarily be required to submit evidence of citizenship and identification only once, unless other information is received causing the evidence to be questionable.

Applicants who are otherwise eligible and are only pending for verification of citizenship and identity must be certified for health care benefits, within the normal *application* processing timeframe (30 days from the *filing date*), as long as the *applicant* has notified the worker that s/he is taking steps to obtain the necessary documentation or has asked for the worker's assistance to obtain it.

The applicant will have 90 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 90 days, the eligibility will be terminated with *Adverse Action* notice. This 90 day period applies to applications, reviews and person adds.

Once the citizenship and identity requirement is met, it need not be applied again, even if the person loses Medicaid at some point and later re-applies. A person should ordinarily be required to submit evidence of citizenship and identification only once, unless other information is received causing the evidence to be questionable.

NOTE: Do not re-verify identity for a person who has had his/her identity verified through the signing of a Statement of Identity for Children Under 18 Years of Age, F-10154 (English) (Spanish).

Documentation submitted by the applicant or member to satisfy the new requirement must be maintained in the case record.

See Process Help Chapter 68.1 for tools that IM workers can use to assist clients and applicants in meeting this requirement.

4.2.1 Covered Programs

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

- BadgerCare Plus
- Medicaid

- Katie Becket

  Note: Eligibility for Katie Becket is determined by Division of Long Term Care staff, therefore they will be ensuring citizenship and identity verification.

- Tuberculosis-related Medicaid (TB MA) and,

- Wisconsin Well Woman Medicaid

  Note: TB and *WWW* MA eligibility is not determined in *CWW*, therefore it is important to ensure that citizenship and identity verification is done only once.

4.2.1.1 Exempt Populations

The following populations are exempt from the new citizenship and identity documentation requirement:

- Anyone currently receiving Social Security Disability Insurance (SSDI).
- Anyone who is currently receiving Supplemental Security Income (SSI) benefits.
- Anyone currently receiving Medicare.
- Anyone currently receiving Foster Care (Title IV-E and Non IV-E)
- Anyone currently receiving Adoption Assistance
- Anyone applying for or receiving BadgerCare Prenatal Program benefits.
- Anyone who has ever been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN)

Former SSI and Medicare Recipients
States cannot consider individuals who received Medicare or SSI in the past to be exempt. An individual is not required to be a citizen to receive these benefits. Since SSA does not share information regarding the reason benefits were lost, it is not possible to determine if the termination was due to citizenship status or not.

Note: Confirm the receipt of SSI, SSDI, and Medicare through the following data exchanges:

- For SSI: use DXSX
- For SSDI: use DXSA
- For Medicare: DXSA

Note: Qualified providers who conduct BC+ express enrollment determinations must not apply the new citizenship and identification documentation requirement to persons seeking eligibility through express enrollment. Persons determined eligible for BC+ through express enrollment are not subject to the documentation

requirement until they file a formal application with the local Income Maintenance Agency.

4.2.2 Reasonable Opportunity Period

All applicants and members must be given a reasonable period of time to present documents establishing that they are a U.S. citizen or national, and their identity. This newly designated time frame for purposes of citizenship and identity documentation is called the ”r;reasonable opportunity period.”

4.2.2.1 Applicants

An individual applying for BC+ currently receives the 30 day application processing period as the reasonable opportunity period in which to provide valid citizenship and/or identification verification. However, the reasonable opportunity period can be extended if s/he is trying to provide the necessary documentation, or has requested assistance from the IM worker. His/her application filing date will be honored if the necessary documentation is ultimately obtained. Unlike the policy for members, eligibility for BC+ is not granted to applicants until the requirement is met.

4.2.2.2 Members

The "reasonable opportunity period" for members begins when they are notified of the new requirement. At or about the same time that they are notified of their upcoming review, they will receive the newly developed Citizenship Documentation Requirement letter (English), (Spanish). This reasonable opportunity period starts with the receipt of the letter and ends at the end of the review month. As such, the reasonable opportunity period for members will be about forty-five days. Members making a good faith effort to secure the necessary documentation, but who are unable to do so during the reasonable opportunity period, may have their BC+ eligibility extended, even though the documentation requirement has not been satisfied.

If the member requests it, the IM worker must provide assistance to secure the necessary documentation. BC+ eligibility may continue for as long as the member is deemed by the IM worker to be making a good faith effort to comply.

4.2.3 Good Faith Effort

The "good faith effort" policy for the citizenship and identity documentation requirements provides more time during which the member can provide the necessary verification to meet this new requirement. This policy allows for the extension of the reasonable opportunity period without jeopardizing the original filing date or review date.

By "good faith effort" we mean the individual is taking steps to obtain the necessary documentation and has notified his/her worker of such efforts or has requested assistance from the worker to obtain the necessary documentation.

Utilizing the "good faith" policies for applicants and members does not impact an agency's timeliness performance that is reported to the state. Any cases that have a verification extension are not considered untimely until the extension date is past due with no final action taken by the worker. It is possible to provide several back to back extensions without a timeliness penalty as long as the worker takes action at the end of each extension period.

4.2.3.1 For New BC+ Applicants

The application processing period can be extended to allow an applicant who is making a good faith effort to supply the required documentation. The IM worker must provide assistance to secure the necessary documentation if the applicant requests it. When the applicant provides the documentation, the IM worker must run eligibility from the original application filing date.

Example 1: Mary applies for BC+ for herself and son on August 15, 2008. She has all of the necessary verification items for her son but does not have a copy of her Florida birth certificate. Her son's BC+ eligibility can be confirmed. Mary's worker enters the appropriate codes to pend BC+ eligibility for Mary. On September 5th, Mary informs her worker that she has contacted Florida and will receive a copy of her birth certificate in 3 to 4 weeks. Mary's worker extends the verification due date another 4 weeks to allow Mary to comply with the new requirement. Mary presents her worker with her birth certificate on September 29th. The worker enters <BC> in the MA Citizenship verification field, runs eligibility and confirms Mary's BC back to the original application date of August 15th.

Once an applicant supplies the documentation, certify his/her eligibility from the original filing date on the application. Under no circumstances, however, should applicants be certified as eligible for program benefits before the citizenship and identity documentation requirement is satisfied.

4.2.3.2 For Ongoing BC+ Members

Members making a good faith effort to secure the necessary documentation, but who are unable to do so during the reasonable opportunity period, may have their BC+ eligibility extended, even though the documentation requirement has not been satisfied. If the member requests it, the IM worker must provide assistance to secure the necessary documentation. BC+ eligibility may continue for as long as the member is deemed by the IM worker to be making a good faith effort to comply.

Example 2: Ben completes his BC+ review on September 5th. The only item he was not able to verify was his citizenship. He was born in Washington but does not have a copy of his birth certificate. Ben calls his worker Tom on September 15th and tells him that his father who still lives in Washington, will mail him his birth certificate. Because Ben has been communicating with Tom, Tom enters <GF> in the MA Citizenship verification field with <GF> for Good Faith effort, runs eligibility and confirms the case. Tom then goes back and pends the BC+ eligibility by entering a <?> in the MA Citizenship verification field to allow Ben additional time to provide the necessary documentation. Ben presents the birth certificate to Tom on October 15th. Tom changes the <?> code to <BC>, runs eligibility and confirms Ben's BC+ eligibility.

Note: Presumptive Eligibility members are not considered members for purposes of citizenship verification. Therefore someone applying for ongoing BadgerCare Plus or Family Planning Services after a presumptive eligibility period must be treated as an applicant and cannot be made eligible until the documentation has been provided.

4.2.4 Hierarchy of Documentation

The list of valid documents used to verify citizenship and identity is divided into five levels in accordance with federal regulations. Level 1 consists of documents of the highest reliability and can prove both citizenship and identity. Levels 2 through 4 consists of documents that can prove citizenship only with Level 2 being the most reliable and Level 4 the least reliable. Level 5 consists of documents that can prove identity only. Applicants and members must provide documentation from the highest level available that can be obtained during the reasonable opportunity period.

If an individual needs to verify citizenship and/or identity at the point of application or renewal s/he should try to fulfill the requirement with proof s/he already has available. If an applicant/member contacts the agency, work with him/her to check Documentation Levels 1 through 5 to determine if anything on the list is readily available to the applicant/member. If an applicant/member was born in Wisconsin, use the online Birth Query to verify citizenship.

In certain circumstances the agency can authorize payment of documentation for an applicant/member. See the 4.2.5, Agencies Paying for Documentation.

Level 1 - Evidence of Citizenship and Identity

Primary evidence documents both citizenship and identity. Primary evidence of citizenship and identity is the most reliable way to establish that the person is a U.S. citizen. If an individual presents documents from level 1, no other

information is required; however, relatively few BC+ applicants and members may be able to provide documents from this group.

Level 2 - Evidence of Citizenship

Secondary evidence of citizenship is the next most reliable way to establish someone is a US citizen. Many BC+ applicants and members will be able to present documents from level 2 during the reasonable opportunity period and should be encouraged to do so. Note, however, that a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

NOTE: Completing an on-line birth query (level 2 documentation) can be done for all persons born in Wisconsin. Enter tran code MNOS on *CARES* mainframe screen, hit enter, then F2. There is no cost to the agency to use this method of verification.

Level 3 - Evidence of Citizenship

Third level evidence of U.S. citizenship is acceptable and may be presented by applicants and members who are unable to obtain level 1 or level 2 evidence during the reasonable opportunity period. As with level 2 evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 4 - Evidence of Citizenship

Fourth level evidence of U.S. citizenship is acceptable evidence of the lowest reliability. While most BC+ applicants and members will be able to present documents at this level, they should do so only if unable to obtain evidence of citizenship from the other levels during the reasonable opportunity period. As with second and third level evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 5 - Evidence of Identity

Level 5 documentation can only be used to verify identity. Documentation of citizenship from levels two through four must be accompanied by evidence of the applicant's or member's identity from Level 5.

The applicant may provide three or more corroborating documents, such as a marriage license, divorce decree, high school or college diploma, property deed/title, death certificate, or employer ID card, to prove identity. This option can only be used if the applicant submitted level 2 or 3, not level 4, citizenship documentation. The applicant may not use a document that was also used for citizenship verification.

Naturalized Citizens

Naturalized citizens must provide level 1 or 2 citizenship documentation. The Citizenship Affidavit is also available for this population if no document from level 1 or 2 is available. This group cannot use level 3 or 4 documentation.

4.2.5 Agencies Paying for Documentation

The worker can authorize payment for a birth certificate from the state where the applicant was born and/or a WI State ID if an applicant/member:

- Has no documentation from Levels 1-5;
- Needs either an out of state birth certificate and/or has no identity documentation; and
- Requests financial assistance.

Note: If a member has obtained and already paid for his/her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement. If an individual has requested and paid for documentation before applying but does not yet have the documentation, do not confirm program eligibility for this individual. Eligibility can only be granted once the individual receives documentation and provides it to the agency.

If an individual was born in Wisconsin and not found in the Wisconsin online birth query, agencies may authorize payment for a WI birth certificate to verify citizenship.

IM agencies should pay for a birth certificate or state ID card before using the "Special Populations" option (4.2.6). If there is an opportunity to obtain a document that meets federal guidelines then that should be pursued.

However, when an applicant/member lacks any identity documentation needed to apply for a birth certificate or lacks any citizenship documentation to be able to apply for an ID card, it is appropriate to consider using the Written Affidavit for citizenship and/or "Special Populations Policy.

In order to obtain birth certificates or state ID cards for applicants/members, agencies need to follow the process outlined in Chapter (68.2.5) of Process Help.

4.2.6 Policy For Special Populations

It is expected that all non-exempt individuals requesting or receiving BC+ provide acceptable documentation to verify citizenship and identity from the federally

approved Levels 1 through 5 at application or review. However, certain special populations may be particularly disadvantaged with regard to providing the required documentation. For some persons within a special population, it will be allowable to accept other documents besides those listed in Levels 1-5, once it is determined that the person is unable to produce any Level 1-5 documentation.

This policy only applies when it is determined that an individual within a special population is in a situation where s/he does not have the ability to obtain citizenship or identity documentation from Level 1-5 This policy should be used with discretion and only when an individual has no other means of meeting the requirement.

Examples of individuals in special populations include, but are not limited to, persons who:

- Are physically or mentally incapacitated and whose condition renders them unable to provide necessary documentation.
- Are chronically homeless and whose living arrangement makes it extremely difficult to provide the necessary documentation.
- Are minors.
- Have religious beliefs that prevent them from securing the documentation.

There are two ways for individuals in special populations to meet the citizenship and identity documentation requirement:

1. Present other documents besides those listed in Levels 1-5 to meet the requirement as long as the document meets the general documentation requirement stated here:

   "Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen. Any document used to establish identity must show identifying information that relates to the person named on the document."

   Some examples of documents that could be used to establish citizenship for special populations as long the document shows a birthplace in the U.S. or that the person is otherwise a U.S. citizen are:

   - Hospital "souvenir" birth certificate
   - Baptismal certificate
   - Native American documentation

   Below are examples of documents that could be used to establish identity for special populations as long the document shows some identifying information (e.g., name, address, telephone number, etc.) that relates to the individual:

- Social Security Card
- Driver education course completion certificate
- School record or transcript
- Credit card with signature
- Voter registration materials
- Permanent Resident card

Example 1: Due to their religious practices, an Amish family is not able to present a birth certificate for their child because the child was not born in a traditional hospital setting and no record of the child's birth exists within the state system. In addition, the child is home schooled so there is no school identification card to present for identification verification. However, the family is able to produce a signed letter from their church leader that states the child's birth place and birth date. This document can be used to satisfy the citizenship and identification requirement under the policy for Special Populations.

2. The newly developed Statement of Citizenship and/or Identity for Special Populations form (F-10161) can be used to meet the new requirement only when no other documentation is available from Levels 1-5 or item #1 above.

This form can be completed by a related or unrelated individual who knows the applicant/member, an *authorized representative*, an IM Agency worker, a worker for a housing agency who is aware of the individual's living situation, a BC+ provider for a minor, etc. Additional requirements concerning the F-10161 are as follows:

- The person completing the form attesting to another person's citizenship must be a US citizen.
- IM agencies are not required to verify the citizenship of the person signing the form.
- Do not accept a form attesting to the citizenship of another individual when you know the person completing the form is not a US citizen.

Example 2: A 15 year old minor female applies for the Family Planning Only Services program. She does not have a copy of her birth certificate, but because she was born in Wisconsin, the IM worker is able to complete an online birth query to verify her citizenship. The applicant does not have a driver license. She does not have a school ID because the school district in which she lives does not issue a school identification card. Further, she does not have nor is she able to provide any other acceptable document from Levels 1-5. In this case, an F-10161 can be signed by a Family Planning Only Services program provider on the behalf of a minor female to verify her identity and meet the new federal requirement.

NOTE: An F-10161 can be signed by the authorized representative of an individual who is not able to procure any other documents on his/her own.

While an IM worker is obligated to assist an applicant or member who asks for help in meeting the citizenship and identity requirement, this does not necessarily mean the IM worker must sign the F-10161. The signatory to the F-10161 must know and be able to truthfully attest to the applicant/member's citizenship or identity. If an IM worker can do this for an applicant/member, then s/he may sign the form.

Maintain copies of any documents secured under this temporary policy in the case record. Enter Case Comments to document why this policy was used and note whether the F-10161 or another document was used to verify citizenship and identity.

NOTE: An individual who met the citizenship requirement by using documents obtained under the Special Populations policy or by using the F-10161 has complied with the federal requirement and is not required to provide other documentation at his/ her next review.

If you are aware of an individual who meets the special population category outlined above and whose BC+ application has been denied or eligibility has ended because of his/her inability to provide acceptable documentation, contact the individual to see if the new Special Populations policies may be applied. See Documentation Level 7 Acceptable Citizenship and Identity Documentation.

4.2.7 Situations which require Special Documentation Processing

4.2.7.1 Person Add

A person being added to a case is subject to the new verification requirement at the time of his/her application. Inform the applicant of the documentation requirement and give him/her the "r;reasonable opportunity period" to comply. Do not grant eligibility for the individual until he/she has submitted valid documentation. If documentation is not received timely, deny MA for that individual only. Do not require other non-exempt household members to submit citizenship or identification documentation until their next review.

4.2.7.2 Presumptive Eligibility/Express Enrollment (EE)

Qualified providers who conduct BC+ presumptive eligibility/express enrollment determinations must not apply the new citizenship and identification documentation requirement to persons seeking presumptive eligibility. Persons determined presumptively eligible for BC+ are not subject to the documentation requirement until they file a formal application with the local Income Maintenance agency.

4.2.7.3 Individuals Without Verification and Affect on Household Eligibility

IM workers should not delay an individual household member's eligibility when awaiting another household members' citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members. See Process Help Chapter 68.2 for processing instructions.

4.2.7.4 Child Citizenship Act 2000

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA). Within the context of the BC+ citizenship verification requirement, this means that for any applicant or member claiming citizenship through the CCA, IM workers should not request documentation for that person. In these cases, IM workers need to acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

For persons who meet the citizenship verification requirement through the means allowed in the CCA, this is considered level 2 evidence. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity. The code <CA> should be used in the BC+ Citizenship Verification field.

See 4.1.1 Child Citizenship Act of 2000

4.2.7.5 Non-citizens

As a reminder, do not request or require citizenship and identity documentation from individuals who have not declared that they are citizens. Non-citizens who apply for IM programs are not subject to this policy. Legal non-citizens are subject to the verification process through *SAVE* and undocumented non-citizens do not have any status that can be verified. Undocumented non-citizens can apply for Emergency MA or BC+ Prenatal Program and should not be subject to the citizenship verification policy.

When an individual who had legal non-citizen status subsequently gains US Citizenship, this is recorded in SAVE. Therefore SAVE can be used to verify these individuals' citizenship. The verification result from SAVE will be used to verify these individuals' citizenship. The verification result from SAVE will be "individual is a US Citizen". Please consult Operations Memo 04-10, for instructions on using SAVE. Use the <SV> code in the MA Citizenship verification field when using SAVE for this population. These individuals do still need proof of identity since the SAVE verification is considered to be Level 2 citizenship documentation.

4.2.7.6 Individuals in Institutional Care Facilities

Disabled individuals in institutional care facilities may have their identity attested to by the facility director or administrator when nothing else is available. Use the Statement of Identity for Persons In Institutional Care Facilities (F-10175) for this purpose. A medical institution can be, but is not limited to, skilled nursing facilities (SNF), intermediate care facilities (ICF Intermediate Care Facility), institutions for mental disease (*IMD* Institute for Mental Disease), and hospitals.

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4.3 IMMIGRANTS

4.3.1 Public Charge
4.3.2 INS Reporting
4.3.3 Continuous Presence
4.3.4 Immigration Status Chart
4.3.5 Iraqis & Afghans With Special Immigrant Status
- 4.3.5.1 Counting Refugee Related Income
- 4.3.5.2 Refugee Medical Assistance

Immigrants are persons who reside in the U.S., but are not U.S. citizens or nationals. The immigrants described below, who apply for BC+ and meet all eligibility requirements, are entitled to receive BC+ benefits.

1. A refugee admitted under Immigration & Nationality Act (INA) Section 207.

   A refugee is a person who flees his/her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

   An immigrant admitted under this refugee status may be eligible for BC+ even if his/her *immigration status* later changes.

2. An asylee admitted under INA Section 208.

   Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when s/he requests permission to stay.

   An immigrant admitted under this asylee status may be eligible for BC+ even if his/her immigration status later changes.

3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.

   An immigrant admitted under this status may be eligible for BC+ even if his/her immigration status later changes.

4. A Cuban/Haitian entrant.

   An immigrant admitted under this Cuban/Haitian entrant status may be eligible for BC+ even if his/her immigration status later changes.

5. An American Indian born in Canada who is at least 50% American Indian by blood, or an American Indian born outside the U.S. who is a member of a Federally recognized Indian tribe.

6. **Lawfully admitted for permanent residence under the INA. 8 USC 1101 et seq.

7. **Paroled into the U.S. under INA Section 212(d)(5).

8. **Granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].

9. **An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

10. **An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

11. **An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.

12. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).

**If these immigrants lawfully entered the U.S. on or after August 22, 1996, they must also be one of the following:

a. Lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces, or

b. Lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces, or

c. Lawfully residing in Wisconsin and the spouse, unmarried dependent child, or surviving spouse of a person described in "a" or "b" or

d. An Amerasian.

e. Resided in the U.S. for at least five years since his/her date of entry. See 4.3.3 Continuous Presence, or

Beginning, October 1, 2009, children under the age of 19, young adults under age 21 residing in an *IMD*, and pregnant women who are either:

- Lawfully Admitted for Permanent Residence (*CARES* TCTZ Code #1 in Immigration Status Chart below),
- Lawfully present under Section 203(a)(7) (Code #3 in Immigration Status Chart below),
- Lawfully present under Section 212(d)(5) (Code #6 in Immigration Status Chart below), or
- Who suffer from domestic abuse and are considered to be a battered immigrant (Code #16 in Immigration Status Chart below),

no longer have to wait 5 years to be eligible for full benefit Medicaid and BadgerCare Plus. This policy applies to both persons in existing open cases and new applicants. Women have the 5-year ban lifted when their pregnancy is verified and continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

In addition, children under the age of 19, young adults under age 21 residing in an IMD, and pregnant women who are legally present in the U.S, under any of the non-immigrant statuses listed in the table below may also qualify for BC+ if otherwise eligible.

USCIS Class of Admission Code or Section of the Federal Law Citation Authorizing Class	
Description	**Class of Admission Code (COA)/Section of Law Citation**
Aliens currently in temporary resident status pursuant to section 210 or 245A of the Act.	S16, S26, W16, W25, W26, W36 or 8 CFR 103.12(a)(4)(i)
Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the Act. Child accompanying or following to join a K-3 alien.	8 CFR 103.12(a)(4)(ii)
Family Unity beneficiaries pursuant to	8 CFR 103.12(a)(4)(iv)

section 301 of Pub. L. 101-649. (These are the spouses and unmarried children of individuals granted temporary or permanent residence under Section 210 or 245A above.)	
Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President.	8 CFR 103.12(a)(4)(v)
Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22).	8 CFR 103.12(a)(4)(vi)
Aliens who are the spouse or child of a United States citizen whose visa petition has been approved and who have a pending *application* for adjustment of status	8 CFR 103.12(a)(4)(vii)
Legal non-immigrants from the Compact of Free Association states (Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) who are considered permanent non-immigrants.	NA
An alien who is the fiancée or fiancé of a U.S. citizen entering solely to conclude a valid marriage contract.	K-1
Child of K-1	K-2
Spouse of a U.S. citizen who is a beneficiary of a petition for status as the immediate relatives of a U.S. citizen (I-130).	K-3
Child accompanying or following to join a K-3 alien.	K-4
Parent of an alien classified SK3 or SN3	N-8
Child of N-8 or of an alien classified SK1, SK2, SK4, SN1, SN2, SN4.	N-9
Temporary worker to perform work in religious occupations.	R1
Spouse and children of R1	R2
An alien who is in possession of critical reliable information concerning a criminal organization or enterprise, is	8 U.S.C. 1101(a)(15)(S)(i)

willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal organization or enterprise	
An alien who the Secretary of State and the Attorney General jointly determine is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation; is willing to supply or has supplied such information to Federal law enforcement authorities or a Federal court; will be or has been placed in danger as a result of providing such information; and is eligible to receive a reward from the State Department.	8 U.S.C. 1101(a)(15)(S)(ii)
An alien who is the spouse, married and unmarried sons and daughters, and parents of an alien in possession of critical reliable information concerning either criminal activities or terrorist operations.	8 U.S.C. 1101(a)(15)(S)
Individuals who have suffered substantial physical or mental abuse as victim of criminal activity.	U-1
An alien who is the spouse, child, unmarried sibling or parent of the victim of the criminal activity above.	U-2, U-3, U-4, U-5
An alien who are the spouses or children of an alien lawfully admitted for permanent residence and who have been waiting since at least December 2000 for their visa application to be approved.	V-1, V-2, V-3

Immigrants, who do not appear in the lists above, who apply for BC+ and meet all eligibility requirements except for citizenship are entitled to receive BC+ Emergency Services only (Chapter 39).

Pregnant immigrants who do not appear in the list above, who apply for the BC+ Prenatal Program (*BC+PP*) (Chapter 41) and who meet the eligibility requirements except for citizenship are entitled to receive those benefits.

Immigration status is an individual eligibility requirement. It does not affect the eligibility of the BC+ Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

Verify immigration status using the procedures in the SAVE Manual.

4.3.1 Public Charge

The receipt of BC+ by an undocumented, non-qualifying, or qualifying immigrant or by the children or spouse for whom the individual is legally responsible does not establish the person as a public charge.

Undocumented, non-qualifying, or qualifying immigrants are considered to be a public charge if while receiving BC+, s/he is in a medical institution for more than the length of a rehabilitative stay.

Undocumented, non-qualifying, or qualifying immigrants concerned about being considered a 'r;public charge', should be directed to contact the INS field office to seek clarification of the difference between rehabilitative and other types of institutional stays.

4.3.2 INS Reporting

Do not refer an immigrant to Immigration and Naturalization Service (INS) unless information for administering the BC+ program is needed. For example, if BC+ needs to determine an individual's location for repayment or fraud prosecution, or to determine his/her immigration status.

4.3.3 Continuous Presence

Certain non-citizens who arrived in the U.S. on or after August 22, 1996 are subject to a five year ban on receiving federal benefits (including BadgerCare Plus and Medicaid), other than emergency services. For these immigrants the five year ban is calculated beginning on the day on which an individual gains qualified immigrant status. However certain applicants who alleged an arrival date in the U.S. before August 22, 1996 and obtained legal qualified immigrant status after August 22, 1996, are not subject to the five year ban and may be eligible to receive federal BadgerCare Plus enrollment. The immigrants described below, who apply for BC+ and meet all eligibility requirements, are entitled to receive BC+ benefits.

1. A non-citizen who arrived in the U.S. before August 22, 1996 in a legal, but non-qualified, immigration status and changed their status to a qualified immigrant on or after August 22, 1996. This individual would not be subject to the five year ban if they remained continuously present from his/her date or arrival in the U.S. until the date s/he gained qualified immigration status.

2. A non-citizen who arrived in the U.S. before August 22, 1996 in undocumented status or who overstayed his/her original visa is treated the same as someone who arrived and remained in the U.S. with valid immigration documents. Therefore, if this individual remained continuously present from his/her date of arrival in the U.S. until the date s/he gained qualified immigration status, s/he would not be subject to the five year ban.

3. For those non-citizens who arrived in the U.S. with or without documentation on or after August 22, 1996 or those for who continuous presence cannot be verified, the five year ban applies from the date the individual obtained qualified immigrant status.

An individual meets the "continuous presence" test if they:

1. Did not have a single absence from the U.S. of more than 30 days, or
2. Did not have a cumulative number of absences totaling more than 90 days.

To establish continuous presence, require a signed statement from the *applicant* stating s/he was continuously present for the period of time in question. The signed statement will be sufficient unless a worker believes the information is fraudulent or further information received now indicates that it is questionable.

Below is one example of a signed statement:

> I, *first and last name*, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, *date here*, and the date I received qualified alien status, *date here*. I have not left the United States in that time for any single period of time longer than 30 days or for multiple periods totaling more than 90 days.
>
> Applicant/*Authorized Representative* Signature, Date

Verification

Primary verification is done through Systematic Alien Verification for Entitlement (*SAVE*) which is an automated telephone and computer database system. A worker processing an application can compare the date received from SAVE with

the date on the immigration documents presented. The primary verification query via SAVE most likely results in returning the latest date of any qualified alien status update for an individual, not his/her original date of arrival. The only way to obtain an accurate date of arrival for those who don't meet an exemption category and who allege a date of arrival prior to August 22, 1996 is through the secondary verification procedure.

It may be necessary to complete a secondary verification procedure with USCIS, including confirming the date of arrival, in the following situations:

- The applicant does not fall into any of the categories of non-citizens who are exempt from the five year ban (e.g. refugees, asylees, those with military service, etc).
- An IM worker has made an initial or primary verification inquiry using the SAVE database. The information from the inquiry conflicts with information on the applicant's immigration documents or what s/he is telling the IM worker.
- A non citizen applicant tells an IM worker s/he came to the U.S. prior to August 22, 1996. If s/he arrived in a legal or documented status, the IM worker needs to verify the date of arrival to ensure that the correct alien eligibility rules are being applied.
- Save returns the message, "Institute Secondary Verification".
- IM worker finds any questionable information in the initial verification process.

The secondary verification procedure is a manual Document Verification Request and includes two forms, the Form G-845S and Form G-845 Supplement. These two forms must be submitted together in order to obtain the accurate U.S. arrival date. When sending the forms, include any photocopies of immigration documents presented. Although USCIS maintains a sub-office in Milwaukee, this office does not process these requests. Send the forms to the following address:

US Citizenship and Immigration Services
ATTN: Immigration Status Verifier
10 West Jackson Blvd.
Chicago, IL 60604

An Immigration Status Verifier (ISV) will research the alien's records and complete the response portion of the verification request.

Note: An applicant who has provided documentation of his/her qualifying immigrant status is considered eligible, pending verification from INS.

Consult the SAVE manual for more information.

Undocumented Non-Citizens

In cases in which it is known that the applicant originally arrived in the U.S. in undocumented status, do not attempt to verify his/her status with the *U.S. Citizenship and Immigration Services (USCIS*) Undocumented immigrants do not have any official documentation regarding their date of arrival. Therefore, if a worker needs to establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, alternative methods need to be used. In such cases the applicant must provide at least one piece of documentation that shows his/her presence in the U.S. prior to August 22, 1996. This may include pay stubs, letter from an employer, lease or rent receipts, or a utility bill in the applicant's name.

The legal status conferred on a non-citizen by immigration law: Toshi entered the U.S. February 2, 2004 with qualified immigrant status. She is applying for BadgerCare Plus in February 2008. The IM worker should first determine whether she is in one of the immigrant categories exempt from the five-year ban. If Toshi is not exempt then she must wait five years before qualifying for BadgerCare Plus. She can be enrolled in BC Plus after February 2, 2009.

Example 2: Shariff arrived as a student in June 2002. On June 5, 2006 he was granted asylum. The five year ban does not apply because asylees are exempt from the ban. Secondary verification is not necessary. He is eligible to be enrolled in BadgerCare plus provided he meets other financial and non-financial criteria.

Example 3: Katrin entered the U.S. March 3, 1995 and gained qualified immigrant status June 20, 1995. She is applying for BadgerCare Plus in February 2008. She is a qualified immigrant who entered the U.S. prior to August 22, 1996. There is no need to apply the five-year ban. She is eligible for BadgerCare Plus provided she meets other financial and non-financial criteria.

Example 4 : Juan entered the U.S. as an undocumented alien on April 1, 1996. He applied for BadgerCare Plus on February 1, 2008. His immigration status changed to lawful permanent resident on March 3, 2005. He has signed a self declaration stating he remained continuously present in the U.S. between April 1, 1996 and March 3, 2005. Additionally Juan provided a copy of a lease showing a date prior to August 1996. He is eligible for BadgerCare Plus provided he meets other financial and non-financial criteria.

Example 5: Elena entered U.S. on July 15, 1999 on a temporary work visa and obtained qualified immigration status on October 31, 2004. She applied for BadgerCare Plus February 1, 2008 and has been in the U.S. now for over five years. Elena is not in one of the immigrant categories exempt from the five year ban. Therefore, the five-year ban would have to be applied in this case since Elena's original entry date is after August 22, 1996. The five-year clock starts from the date she obtained qualified immigration status. Therefore she will be able to apply for BadgerCare Plus after October 31, 2009.

Example 6: Tomas entered the U.S. on April 8,1996 on a visitor's visa. He obtained qualified alien status on September 22, 2003. Tomas applied for MA on May 5, 2008. The IM worker completed primary verification and USCIS responded with the date of entry as September 22, 2003 since that was the last updated date on his status. The IM worker needs to confirm with the applicant that this is the original date he arrived in the U.S. Tomas explained that he arrived in 1996; therefore, the IM worker needs to conduct secondary verification. USCIS responds and confirms that the original date of arrival was April 8, 1996. Additionally the IM worker needs to confirm that the applicant was continuously present between April 8, 1996 and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. Had the IM worker used September 22, 2003 as the date of entry in CARES, Tomas would have been incorrectly subject to the five-year ban and not eligible until September 22, 2008.

4.3.4 Immigration Status Chart

CARES TCTZ Code	Immigration Status	Immigration Status	Veteran* Arrived before 8-22-96	Arrived on or after 8-22-96	Veteran* Arrived on or after 8-22-96	Children under age 19 and pregnant women; Arrived on or after 08/22/96
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective 10/01/09 Eligible
02	Permanent resident under color of	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible

	law (PRUCOL)					
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective 10/01/09 Eligible
04	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective 10/01/09 Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Inreligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Alien	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective 10/01/09 Eligible

17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking	Eligible	Eligible	Eligible	Eligible	Eligible

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.

4.3.5 Iraqis & Afghans With Special Immigrant Status

Beginning December 19, 2009, Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI-1, 2, 3, 6, 7 and 8) are to be treated like they are refugees when determining their eligibility for BC+ for as long as they have this Special Immigration status. This policy applies to these immigrants regardless of when they received this status.

Class of Admission code	**Description**	**CARES Alien Registration Status Code**
SI1	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI2	Spouses of an SI1	Code 04
SI3	Children of an SI1	Code 04
SI6	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI7	Spouses of an SI6	Code 04
SI8	Children of an SI6	Code 04

4.3.5.1 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for BC+. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

Refugee "Reception and Placement" (R&P) payments are not counted as income for BC+. R & P payments are made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/ family or to a vendor.

4.3.5.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for BC+, s/he may apply for Refugee Medical Assistance (RMA), which is not funded by BC+. RMA is considered a separate benefit from BC+ but provides the same level of benefits as these programs. RMA is available only in the first eight months after a special immigrant's date of entry. If it is not applied for in that eight-month period, it cannot be applied for later. Iraqi immigrants may be eligible for RMA for eight months and Afghan immigrants may be eligible for RMA for six months.

While W-2 agencies have contractual responsibility for providing RMA, they need to coordinate with economic support agencies to ensure eligibility for all regular BC+ subprograms is tested first.

More information about this program is in the W-2 Manual Chapter 20

Note: The Federal Medicaid eligibility for all other refugees admitted under Alien Status Code 04 remains the same.

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5 MEDICAL SUPPORT AND THIRD PARTY LIABILITY

5.1 MEDICAL SUPPORT

Medical Support refers to the obligation that a parent has to pay for his or her child's medical care, either through the provision of health insurance coverage or direct payment of medical bills. The Child Support Agency (CSA) is responsible for establishing Medical support orders for some children receiving BC+ who have an absent parent. The CSA is also responsible for establishing paternity and establishing medical support obligations for unpaid and ongoing medical support (including recovery of birth costs.)

5.1.1 Recovery of Birth Costs

When the non marital father of the unborn child is not included in the BC+ group at the initial eligibility determination he could be held responsible for repayment of birth costs.

5.1.2 Referral to CSA

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services. At confirmation, *CARES* automatically sends a referral to the CSA for all BC+ applications and person adds that include minors, unless the referral field on the Absent Parent Page is answered 'No'. The information on the Absent Parent Page must be filled out completely and accurately.

Note: A Referral to Child Support form (DWSW 3080) only needs to be completed when the absent parent page cannot be completed in *CWW*.

BC+ NOTE: While IM agencies are to continue referring the following individuals who are receiving BC+, the CSA's will be determining on their own, which cases will be provided Child Support Services. Not all BC+ members will qualify for free Child Support services and be required to cooperate with CSA's.

The following individuals (including minors) for whom BC+ is requested or being received, must be referred to the local CSA unless an exception is noted:

1. **Pregnant woman** who is unmarried or married and not living with her husband.

   Pregnant women are not required to cooperate with the CSA during the pregnancy and for two months after the end of pregnancy. The woman's eligibility for BC+ will continue during this period, regardless of her cooperation.

Exception: Do not refer pregnant women receiving the BC+ Prenatal Benefit to CSA.

2. **Child receiving SSI** only if the *caretaker* relative requests child support services for the child. Do not sanction this *caretaker relative* if s/he does not cooperate with the CSA.

3. **Non Marital co parents** when paternity has not been legally established. This includes a non-marital co-parent even when:

   a. A Statement of Paternity (IMM, Ch. I, Appendix 29g) has been completed,
   b. Both parents are in the home.

      Exception: Do not refer parents to the CSA when both parents are in the home and the father's paternity has been legally established. (Paternity is legally established by a court order or by a Voluntary Paternity Acknowledgment Form signed on or after May 1, 1998 and filed with the Wisconsin Vital Records office.)

Note: If a father's name appears on a Wisconsin Birth Certificate for a child born after 5/11/1998, it means paternity has been established.

4. **Natural or adoptive parent(s)** not living in the household.

Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because s/he is in the military.

5. **Married natural parents** in the home, but:

a. Child was born prior to their marriage, **and**

b. Paternity was not established by court action, or the birth not legitimized after their marriage.

Do not refer the following individuals:

1. Youths exiting out of home care, unless the youth is also the parent of an eligible child in the household.

2. Pregnant women eligible under the BC+ Prenatal Program.

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5.2 MEDICAL SUPPORT / CSA COOPERATION

Unless the person is exempt, has *good cause* for refusal to cooperate (see 5.3), each *applicant*/member that is referred, must, as a condition of eligibility, cooperate in:.

1. Establishing the paternity of any child born out of wedlock for whom BC+ is requested or received, and

2. Obtaining medical support for the applicant and for any child for whom BC+ is requested or received.

Cooperation includes any relevant and necessary action to achieve the above. As a part of cooperation, the applicant may be required to:

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the applicant.

2. Appear as a witness at judicial or other hearings or proceedings.

3. Provide information, or attest to the lack of information, under penalty of perjury.

4. Pay to the CSA any court ordered medical support payments received directly from the absent parent after support has been assigned.

5. Attend office appointments as well as hearings and scheduled genetic tests.

Note: The applicant or member is only required to cooperate if the child under their care is eligible for benefits funded under Title XIX. If the child's BC+ benefit is funded through any other source (Title XXI or GPR) the *caretaker relative* is not required to cooperate and can not be sanctioned for non cooperation. Check the Medical Status codes to determine funding source. The CSA will monitor the child's BC+ funding source.

5.2.1 Failure to Cooperate

The CSA determines if there is non-cooperation for individuals required to cooperate. The IM agency determines if good cause exists (see 5.3). If there is a dispute, the CSA makes the final determination of cooperation. The member remains ineligible until s/he cooperates, establishes good cause, or cooperation is no longer required.

The following individuals are not sanctioned for non cooperation:

1. Pregnant women.
2. Minors.
3. Caretaker relatives, while family income is over 150% of the FPL.
4. Caretaker relatives while the family is in a BC+ Extension.

For a pregnant woman, failure to cooperate cannot be determined prior to the end of the month in which the 60th day after the termination of pregnancy occurs.

Note: If the local CS agency determines that a parent is not cooperating because court ordered birth costs are not paid, the parent or *caretaker* is not sanctioned.

Example: Mary, a disabled parent, is applying for BC+ for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for BC+ and EBD MA.

Mary is not eligible for EBD MA or BC+, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for BC+.

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5.3 CLAIMING GOOD CAUSE

5.3.1 Claiming Good Cause Introduction
5.3.2 Notice
5.3.3 Good Cause Claim
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5.3.7 Determination
5.3.8 Good Cause Found
5.3.9 Good Cause Not Found
5.3.10 Review

5.3.1 Claiming Good Cause Introduction

Any parent or other *caretaker* relative who is required to cooperate in establishing paternity and obtaining medical support may claim *good cause*. S/he must:

1. Specify the circumstance that is the basis for good cause , and

2. Corroborate the circumstance according to the evidence requirements in 5.3.5.

5.3.2 Notice

The IM agency must provide a Good Cause Notice (DWSP 2018) to all applicants and to members whenever a child is added to the BC+ case. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support.

The IM worker and the parent or caretaker must sign and date the notice. File the original in the case record and give the *applicant*/member a copy. The CSA refers anyone who wants to claim good cause back to the IM Agency for a determination of whether or not good cause exists.

5.3.3 Good Clause Claim

The Good Cause Claim form (DWSP 2019) must be provided to any BC+ parent or caretaker who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the claim in the presence of an IM worker or a notary public. The applicant/member's signature initiates the claim.

The original copy is filed in the case record, a copy is given to the parent or caretaker and a copy is attached to the referral document when a claim is made at *application*.

A copy of claims must be sent to the CSA within two days after a claim is signed. When the CSA is informed of a claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of your final determination.

5.3.4 Circumstances

The IM agency must determine whether or not cooperation is against the best interests of the child. Cooperation is waived only if:

1. The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to the:

    a. **Child.** This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected, or

    b. **Parent or Caretaker.** This means the impairment is of such a nature or degree that it reduces that person's capacity to adequately care for the child, or

2. At least one of the following circumstances exists and it is reasonably anticipated that proceeding to establish paternity or secure support or both would be detrimental to the child:

    a. The child was conceived as a result of incest or sexual assault, or

    b. A petition for the child's adoption has been filed with a court, or

    c. The parent or caretaker is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

5.3.5 Evidence

An initial good cause claim may be based only on evidence in existence at the time of the claim. There is no limit to the age of the evidence. Once a final determination is made, including any Fair Hearing decision, any subsequent claim must be based on new evidence.

The following may be used as evidence:

1. Birth certificates or medical or law enforcement records that indicate that the child may have been conceived as a result of incest or sexual assault.

2. Court documents or other records which indicate that a petition for the adoption of the child has been filed with a court.

3. Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records which indicate that the alleged father or absent parent might inflict physical or emotional harm on the member or the child.

4. Medical records which give the emotional health history and present emotional health status of the member or the child.

5. A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the member or the child.

6. A written statement from a public or private social agency that the agency is assisting the parent to decide whether or not to terminate parental rights.

7. A sworn statement from someone other than the member with knowledge of the circumstance on which the claim is based.

8. Any other supporting or corroborative evidence.

When a claim is based on emotional harm to the child or the member, the IM agency must consider the:

1. Person's present emotional state, and

2. Person's emotional health history, and

3. Intensity and probable duration of the emotional impairment, and

4. Degree of cooperation required, and

5. Extent of the child's involvement in the paternity or the support enforcement activity to be undertaken if the member submits only one piece of evidence or inclusive evidence, you may refer him/her to a mental health professional for a report relating to the claim.

When a claim is based on his/her undocumented statement that the child was conceived as a result of incest or sexual assault, it should be reviewed as one based on emotional harm.

The IM agency must conduct an investigation when a claim is based on anticipated physical harm and no evidence is submitted.

The member has 20 days, from the date the claim is signed, to submit evidence. The IM agency, with supervisory approval, may determine that more time is needed.
There must be at least one document of evidence, in addition to any sworn statements from the member.

The IM agency should encourage the provision of as many types of evidence as possible and offer any assistance necessary in obtaining necessary evidence.

When insufficient evidence has been submitted:

1. The member must be notified and the specific evidence needed must be requested.

2. The IM agency must advise that person on how to obtain the evidence, and

3. The IM agency must make a reasonable effort to obtain specific documents that are not reasonably obtainable without assistance.

If the parent or caretaker continues to refuse to cooperate or the evidence is still insufficient, a 10 day notice must be sent informing the parent or caretaker that if no further action is taken within ten days from the notification date, good cause will not be found and that s/he may first:

1. Withdraw the claim and cooperate, or

2. Exclude allowable individuals, or

3. Request a hearing, or

4. Withdraw the application or request that the case be closed.

If no option above has been taken when the ten days have expired the IM worker will deny BC+ to the applicant or disenroll the member from BC+. The sanctions remain in effect until there is cooperation or until it is no longer required.

5.3.6 Investigation

The IM agency must investigate all claims based on anticipated physical harm both when the claim is credible without corroborative evidence and when such evidence is not available.

Good cause must be granted when both the member's statement and the investigation satisfy you that s/he has good cause.

Any claim must be investigated when the member's statement together with any corroborative evidence does not provide a sufficient basis for a determination.

In the course of the investigation, neither the IM agency nor the CSA may contact the absent parent or alleged father without first notifying the member of your

intention. Once notified the parent or caretaker has ten days from the notification date to:

1. Present additional supporting or corroborative evidence of information so that contact is unnecessary, or

2. Exclude allowable individuals, or

3. Withdraw the application or request that the case be closed, or

4. Request a hearing.

When the ten days have expired and no option has been taken the IM Agency will deny BC+ to the applicant and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

5.3.7 Determination

The IM staff must determine whether or not there is good cause. This should be done within 45 days from the date a claim is signed. The time may be extended if it is documented in the case record that additional time is necessary because:

1. The IM agency cannot obtain the information needed to verify the claim within the 45 days, or

2. The parent or caretaker does not submit corroborative evidence within 20 days.

The good cause determination and all evidence submitted should be filed in the case record along with a statement on how the determination was reached.

If there is no evidence or verifiable information available that suggests otherwise, it must be concluded that an alleged refusal to cooperate was, in fact, a case of cooperation to the fullest extent possible.

If the parent or caretaker is cooperating in furnishing evidence and information, do not deny, delay, or discontinue BC+ pending the determination.

If a Fair Hearing is requested on a good cause determination, BC+ certification is continued until the decision is made.

The 45-day period for determining good cause is not used to extend an eligibility determination. The 30-day limit on processing an application is still a requirement.

The IM must notify the applicant/member in writing of the final determination and of the right to a Fair Hearing. Send the CSA a copy. The CSA may also participate in any Fair Hearing.

5.3.8 Good Cause Found

When good cause is granted, the IM worker must direct the CSA to not initiate any or to suspend all further case activities.

However, when the CSA's activities, without the member's participation are reasonably anticipated to not result in physical or emotional harm, the IM agency must:

1. First notify the person of the determination and the proposed directive to the CSA to proceed without his/her participation.

2. S/he has ten days from the notification date to:

    a. Exclude allowable individuals, or

    b. Request a hearing, or

    c. Withdraw the application, or request that the case be closed.

3. At the end of the ten days, direct the CSA to proceed if no option was taken. The CSA may decide to not proceed based on its own assessment.

The IM agency determination to proceed without the member's participation must be in writing. Include your findings and the basis for the determination. File it in the case record.

5.3.9 Good Cause Not Found

When good cause is not granted, the IM agency must notify the parent or caretaker. It must be stated in the notice that s/he has ten days from the notification date to:

1. Cooperate, or
2. Exclude allowable individuals, or
3. Request a hearing, or
4. Withdraw the application or request that the case be closed.

When the ten days have expired and if no option has been taken the IM agency must deny BC+ to the applicant or terminate the member's BC+ eligibility, and the sanctions remain in effect until there is cooperation or until it is no longer an issue.

5.3.10 Review

The IM agency does not have to review determinations based on permanent circumstances. Review good cause determinations that were based on circumstances subject to change at re-determination and when there is new evidence.

The parent or caretaker must be notified when it is determined that good cause no longer exists. It must be stated in the notice that s/he has ten days from the notification date to:

1. Cooperate, or
2. Exclude allowable individuals, or
3. Request that the case be closed, or
4. Request a hearing.

When the ten days have expired and if no option has been taken the IM agency must deny the individual's BC+ eligibility, and the sanctions remain in effect until there is cooperation or until it is no longer an issue.

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5.4 COOPERATION BETWEEN IM & CSA

5.4.1 Information
5.4.2 BC+ Discontinued
5.4.3 Failure to Cooperate
5.4.4 Fraud

The relationship between the IM agency and the CSA requires ongoing cooperation.

5.4.1 Information

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists

them in providing medical support services. Therefore, the CSA may request information from the IM agency in addition to that included in the referral and as contained in the case record.

CARES automatically shares information with *KIDS* so it is important to enter the data accurately.

5.4.2 BC+ Discontinued

The CSA is notified through CARES when BC+ is discontinued.

5.4.3 Failure to Cooperate

The CSA will determine if non-cooperation occurs. KIDS notifies CARES when an individual refuses or fails to cooperate. The IM Agency must then review eligibility.

5.4.4 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency... For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action (IMM, Ch. III, Public Assistance Fraud Program.

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5.5 THIRD PARTY LIABILITY

5.5.1 TPL Cooperation
5.5.2 TPL Cooperation Requirements
5.5.3 TPL Good Cause Claim
5.5.4 Assignment Process

Third Party Liability (TPL) refers to the obligation that a third party (not Wisconsin BC+ program or the BC+ member), has to pay the bills for a BC+ member's medical services. BC+ is the payer of last resort for the cost of medical care. This means that if a BC+ member also has coverage under a private health insurance plan, that plan is to be billed first for any medical services. BC+ then pays any amount remaining after the private insurer has paid what they owe, up to the BC+ reimbursement rate. Another common example of third party liability is when someone receives an insurance settlement resulting from an accident. If BC+ paid for any medical services resulting from that accident, the BC+ program is to be reimbursed the cost of those medical services from the proceeds of the insurance settlement. Third party payers include health insurers, court ordered medical support and any other third party that has a legal obligation to pay for medical services.

5.5.1 TPL Cooperation

All BC+ members must assign to the State of Wisconsin their rights to payments for medical services from third party payers. A member complies with this requirement by signing the *application* form. The assignment includes all unpaid medical support and all ongoing medical support obligations for as long as BC+ is received. In addition, BC+ members must cooperate in identifying and providing information to assist the State in pursuing third parties who may be liable to pay for care and services, unless the individual establishes *good cause* for not cooperating. If a member fails to cooperate with TPL requirements s/he could be sanctioned.

5.5.2 TPL Cooperation Requirements

The BC+ member must cooperate in providing TPL information unless s/he is exempt or there is good cause for refusing to cooperate. TPL information could include the name and address of an insurance company, insurance policy number, and the name and address of the policy owner.

If an adult refuses, without good cause, to provide health insurance information for themselves, or anyone for whom they are legally responsible and is receiving BC+, the adult is ineligible until s/he cooperates.

Do not sanction the following for non-cooperation:

1. Minors, including minor caretaker relatives.

2. A parent or *caretaker* relative requesting child support services for a child receiving SSI.

3. Pregnant woman – She may not be sanctioned during the pregnancy, or for two months after the pregnancy has ended, if the TPL source is the absent parent of her child(ren).

5.5.3 TPL Good Cause Claim

When good cause is claimed (5.3), the IM agency must review the circumstances and decide on whether it is an appropriate claim of good cause. The appropriate entry on the Medical Coverage page in *CWW* regarding the good cause determination must be made, and the reason for the decision must be documented in case comments.

TPL good cause reasons are the same as those for Medical Support.

5.5.4 Assignment Process

At application, the Income Maintenance Agency must give a Notice of Assignment (DWSW-2477) to each *applicant*. If the applicant refuses to sign this form, the Income Maintenance Agency must complete the lower portion of the form and file it in the case record. This must be done no later than at the time of the interview. The applicant must be given a copy of the notice. Processing a BC+ application must not be delayed while waiting for the form to be signed. The member should not be penalized for not signing this form. The original copy must be filed in the case record.

5.6 CASUALTY CLAIM PROCESS (SUBROGATION)

Casualty claims are those claims for BadgerCare Plus benefits resulting from an accident or injury for which a third party may be liable.

Example 1: Mike receives treatment for injuries suffered when he was hit by a car. The vehicle owner is the third party and may be responsible for reimbursing BadgerCare Plus for those benefits. If Mike is working with an attorney or insurance agency to settle the claim, he is legally obligated to give notification to the *local agency*.

BadgerCare Plus members should report any casualty claims before the case is settled. The BadgerCare Plus ID number of the BadgerCare Plus member, date of the accident, and the insurance company or name of the attorney to bill should be included with the referral.

5.6.1 Reporting Accident or Injury Claims

Members must report any cash award or settlement due to an accident or injury if BadgerCare Plus paid for part or all of the care received as a result of the accident or injury. Members must also report if s/he has hired an attorney or is working with an insurance agency to settle an accident or injury claim.

1. If a member reports a claim and is:

    a. getting Supplemental Security Income (SSI)

    or

    b. lives in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, Rock, Trempealeau, Vilas, Walworth, Waushara or Winnebago County,

s/he must report the accident or injury case to the Casualty Recovery Unit at :

Casualty Recovery
Bureau of Program Integrity
P.O. Box 6220
Madison WI 53716-0220

Telephone: (608) 221-4746 ext 80062
Fax: 608-221-4567

2. All other BadgerCare Plus members should report in person or by phone to his/her local agency before the case is settled. Refer casualty claims for Non-SSI recipients and members of agencies not listed in1b above to HP at 608-221-4567 or call at 608-221-4746 EXT 80062 with MA#, date of accident and insurance/attorney to bill.

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5.7 OTHER HEALTH INSURANCE

The IM Agency should collect insurance coverage information on both the custodial and absent parents and caretakers at *application*, review, person add, or when insurance changes and enter it into the Medical Coverage Page in *CWW*. The *fiscal agent* will complete an insurance search and return verified insurance information through the CWW / MMIS interface.

5.7.1 Policies Not to Report

The following policies should not be entered on the Medical Coverage Page in CWW or reported to the Fiscal Agency on the Health Insurance Information form (F-10115).

1. HMOs for which the State pays all or part of the premium.
2. Health Insurance Risk Sharing Plans (HIRSP).
3. Medicare (enter in CWW on the Medicare Page).
4. General Assistance Medical Program (GAMP).
5. Indian Health Service (IHS). IHS is the exception to the rule that MA is the payer of last resort. For Native Americans who are MA clients, IHS is the payer of last resort. Do not enter these policies on *CARES*.
6. Policies that pay benefits only for treatment of accidental injury.
7. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
8. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease s/he is insured against and if the benefits are assignable.
9. Life Insurance.

10. Other types of insurance types that do not cover medical services.

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6 SOCIAL SECURITY REQUIREMENTS

6.1 SSN REQUIREMENTS

BC + applicants must provide a Social Security Number (*SSN*) or be willing to apply for one.

If the *caretaker* relative is unwilling to provide or apply for the SSN of a minor or 18-year-old, the person who does not have the SSN is ineligible.

Do not require an SSN for:

a. Continuously eligible newborns.
b. Pre-adoptive infants living in a foster home.
c. Unqualifying immigrants receiving emergency services.
d. Women applying for BC+ Prenatal Program (*BC+PP*).

BC+ applicants and members who belong to a recognized religious sect that conscientiously opposes applying for or using a social security number are exempt from meeting the SSN requirements. A person who refuses to apply for or use a social security number due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

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7 HEALTH INSURANCE ACCESS AND COVERAGE REQUIREMENTS

View History

7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY

To prevent the crowd out of private insurance, BadgerCare Plus (BC+) benefits may be denied or terminated for individuals who have access to certain employer sponsored health insurance policies when those individuals:

1. Have countable household income that exceeds 150 percent of the FPL; or are eligible under the BC+ Prenatal Program at any income level and,

2. Are not in an exempt category (pregnant women, continuously eligible newborns and youths exiting out of home care); and,

3. Do not have a "*good cause*" reason for failure to enroll in an employer sponsored health insurance plan.

Individuals exempt from the policies related to health insurance access and coverage are:

1. Continuously Eligible Newborns;
2. Children under age 19 who have met a *deductible* (exempt only during the *deductible* period);
3. Youths who Exited Out-of-Home Care.
4. Pregnant women, other than BC+ Prenatal Program, are exempt from the policies for past and current access and current coverage.

BC+ Prenatal Program members are subject to different policies related to health insurance coverage. Refer to (7.4.1) (7.5) for the policies regarding the rules for current coverage and dropping coverage under the BC+ Prenatal Program.

Access to health insurance includes:

1. Past Access. (7.2)
2. Current Access. (7.3)
3. Coverage. (7.4)
4. Dropped Coverage. (7.5)

IM workers are not responsible for determining current or past access to health insurance. The process will be done through the EVHI database. See 9.9.6.1.

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7.2 PAST ACCESS TO HEALTH INSURANCE

Individuals who had access to health insurance, including access due to a *qualifying event*, in the twelve months prior to the *application* or review date are not eligible for BC+ benefits if the access was through the current employer of an adult family member who is currently living in the household and,

1. The access was to a *HIPAA* health insurance plan through a current employer for which the employer paid at least 80% of the premium, or through the State of Wisconsin's health care plan (regardless of plan type, or premium amount contributed by the employer); and

2. The *applicant* is a *caretaker* relative or child under age 19 with family income that exceeds 150 percent of the FPL and the *caretaker relative* or child is not exempt; and

3. There is no *good cause* reason for not signing up for the coverage.

The employed BC+ applicant/member and anyone else in the household that could have been covered by the health insurance are ineligible for BC+ for twelve calendar months from the date the health insurance would have begun.

Example: Marilyn applied for BC+ in January 2008 for herself and her children; they have family income that exceeds 150% of the FPL. She could have enrolled in a health insurance plan through her current employer in July 2007, and her employer pays 80% of the premium. Marilyn didn't sign up because she felt the premiums, co-payments and deductibles would be unaffordable. If she had signed up, coverage would have begun in September 2007.

Since Marilyn did not sign up for employer-provided coverage within the last twelve months when it was available, and she does not have good cause she and her child are ineligible for BC + through August 2008, 12 months from the date the coverage would have begun, unless they become exempt during that time.

7.2.1 Good Cause for "Past Access"

Good cause reasons for failure to enroll in an employer sponsored health insurance plan in the 12 months prior to application or review are:

1. Discontinuation of health insurance benefits by the employer;

2. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:

a. A private health insurance policy; or
b. Medicaid, or BC+;

And no one in the Test Group at that time was eligible for:

- BadgerCare, or
- BC+ with a family income above 150% of the FPL.

3. The employment ended.

4. Any other reason determined by DHFS as a good cause reason. Local agencies must contact the DHFS Call Center for approval before granting good cause for any reason not stated above.

Example: Olivia applied for BC+ in January 2008 for herself and her children. Although it was determined that she had access to employer sponsored health insurance in August of 2007 (past access), she has a good cause exemption because her children were enrolled in Healthy Start from July 2007 through November 2007.

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7.3 CURRENT ACCESS TO HEALTH INSURANCE

Individuals with access to health insurance, including access due to a *qualifying event*, through an employed family member who is currently living in the household are not eligible for BC+ benefits if:

1. The access is to a *HIPAA* health insurance plan through a current employer for which the employer pays at least 80% of the premium or the State of Wisconsin's health care plan (regardless of plan type, or premium amount contributed by state or local government); and

2. The *applicant*/member is a *caretaker* relative or child under age 19 with family income that exceeds 150 percent of the FPL and the *caretaker relative* or child is not exempt; and

3. The coverage would begin within three calendar months following:

   a. The month of BC+ *application filing date*; or
   b. Annual review month; or

c. Employment start date

The employed BC+ member and anyone else who could have been covered by the health insurance plan are ineligible for BC+ benefits. Children under 19 years of age can become eligible by meeting a *deductible*. (Chapter 17)

There are no *good cause* reasons for not enrolling in a health insurance plan when an individual has current access.

Example 1: Janelle applies for BC+ in January for herself and her child. She can enroll in a health insurance plan through her employer in March and her employer pays 80% of the premium. However, since coverage would not begin until May, Janelle does not have "current access" so she and her child are eligible for BC + until the next eligibility review (assuming there are no other changes that resulted in ineligibility). If Janelle's circumstances remain unchanged, she will be disenrolled at her next review because she had "past access".

Example 2: Bill applies for BC+ in January for himself and his family. He can enroll in family health insurance through his employer and the employer pays 80% of the premium. Coverage would start in April. Bill chooses not to sign up because he thinks he will be eligible for BC+. Bill and his family are not eligible for BC+ because Bill can sign up in this month and coverage would begin within the next three calendar months.

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7.4 CURRENT HEALTH INSURANCE COVERAGE

An individual who currently has individual or family health insurance coverage through an employed family member who is currently living in the household AND meets the following criteria is not eligible for BadgerCare Plus:

1. Has family income that exceeds 150 percent of the federal poverty level; and

2. Coverage is provided by an employer; and the employer pays at least 80% of the premium or

3. Coverage is available under the State of Wisconsin employee health plan (regardless of plan type, or premium amount contributed by state or local

government or the insurance).

Example: Dave applies for BC+ in March for himself and his family. They have income that exceeds 150% of the federal poverty level. He is currently covered by family health insurance through his employer and the employer pays 80% of the premium. Dave and his family are not eligible for BC+ because they are currently covered.

Children under 19 years of age who are ineligible due to current coverage can become eligible by meeting a *deductible*. (Chapter 17)

7.4.1 Current Coverage for BC+ Prenatal Program

Pregnant women who are otherwise eligible only for the BC+ Prenatal Program because of their inmate or *immigration status* are not eligible for the BC+ Prenatal program if covered by any *HIPAA* health insurance policy. The plan does not have to be employer sponsored.

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7.5 DROPPED HEALTH INSURANCE COVERAGE

With policy exceptions for pregnant women, (7.5.1) individuals are ineligible for BadgerCare Plus (BC+) benefits for three calendar months following the month in which coverage through an employer-provided health insurance plan, which meets the standards of a *HIPAA* standard plan, ended if:

- The employer paid 80% or more of the premium or the insurance was part of the Wisconsin state employees' health insurance plan; and,
- The *applicant* is a *caretaker* relative or child under age 19 with family income that exceeds 150 percent of the FPL and the *caretaker relative* or child is not exempt; and,
- The individual did not have *good cause* for dropping the coverage (7.6).

Example 1: Joanne is employed and has access to employer sponsored health insurance in which the employer pays 80% of the premium. Joanne's

family income exceeds 150% of the federal poverty level. In May, she dropped their family health insurance coverage through her employer. In June, Joanne applies for BC+ for herself and her family. Because Joanne still has access to health insurance in which the employer pays at least 80% of the premium, Joanne is not eligible for BC+.

Example 2: Joanne was employed with income that exceeded 150% of the federal poverty and had coverage under employer sponsored health insurance in which the employer paid 80% of the premium. In May, Joanne voluntarily quit her job. In June, Joanne applies for BC+ for herself and her family. Because Joanne had health insurance coverage in which the employer paid at least 80% of the premium, and she voluntarily quit her job, Joanne and her family are not eligible for BC+ in June, July and August because they dropped coverage. The family's past access to employer sponsored insurance is not affecting eligibility because the loss of employment is a good cause reason for access.

7.5.1 Dropped coverage policy for BadgerCare Plus Prenatal Program

If a pregnant woman applying for the BC+ Prenatal Program has dropped insurance coverage she is ineligible for three calendar months following the month the insurance coverage ended, unless she has good cause for dropping the insurance.

The ”dropped coverage” policy applies, regardless of the amount of the person or employer’s share of the premium:

If the coverage is under a major medical health insurance plan which meets the standards of a HIPAA standard plan. The insurance plan:

- Can be individual or family coverage.; and
- Does not have to be employer based; and
- Is not BadgerCare, BadgerCare Plus, Medicaid, Medicare Managed Care (aka Medicare Choice Plus), Medicare, Medicare Supplemental policies, HIRSP, General Relief, General Assistance, or Family Health Plan (Marshfield clinics).

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7.6 GOOD CAUSE REASONS FOR DROPPING INSURANCE COVERAGE

Any of the following reasons are considered "*good cause*" for dropping insurance coverage:

1. The individual was covered by a group health plan that was provided through his or her employer, and the employment ended for a reason other than voluntary termination, unless the voluntary termination was a result of the incapacitation of the individual or because of an immediate family member's health condition.

2. The individual was covered by a group health plan that was provided through his or her employer, but the individual changed employers and the new employer does not offer health insurance coverage.

3. The individual was covered by a group health plan that was provided through his or her employer, and the individual's employer discontinued health plan coverage for all employees.

4. The individual's coverage terminated due to the death or change in marital status of the policy holder.

5. For pregnant woman (enrolled or applying for Prenatal Services) only:

    a. Her coverage was COBRA continuation coverage and the coverage was exhausted in accordance with federal regulations concerning COBRA.
    b. The insurance does not pay for pregnancy-related services.
    c. The insurance is owned by someone not residing with the pregnant woman and continuation of the coverage is beyond her control.
    d. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

6. Any other reason determined by the department to be a good cause reason.

Example: Joanne applies for BC+ in June for herself and her family after being fired from her job. Although it was determined that she had "dropped coverage", she has a good cause exemption because her employment was

involuntarily terminated.

When good cause for dropping insurance coverage is approved, begin BC+ eligibility the day after the last day of the insurance coverage or the *application* date, whichever is later if the *applicant* applies prior to losing insurance. If the applicant applies after losing insurance, coverage can begin on the day after the last day of insurance if they apply in the same month insurance is lost.

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7.7 HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

Wisconsin's Health Insurance Premium Payment (*HIPP*) program helps BC+ families pay the employee contribution of their employer sponsored insurance. The HIPP program pays the family's share of the monthly premium, co-insurance, and deductibles associated with the family health plan along with any BadgerCare covered services not included in the family health plan through fee-for-service (wrap around).

HIPP will be considered for the following BadgerCare Plus members when it is cost effective to do so:

- Children and parents with incomes at or below 150 percent of the FPL even when the employer pays 80 percent or more of the premium.
- Children and parents with incomes above 150 percent of the FPL when the employer pays less than 80 percent of the premium.
- Pregnant women with incomes up to 300 percent of the FPL when the employer pays 80 percent or more of the premium (wrap around benefits).

In addition to families with employer sponsored health insurance plans, BC+ families that meet the above criteria with the following types of insurance plans may also be considered for HIPP:

- Farm and other self-employed families
- Members with Self-funded insurance plans
- Access to HIPP coverage will be allowed even if single or "plus one" coverage is the only coverage offered by an employer.

Minimum employer contribution requirements will be eliminated and employer-sponsored insurance (ESI) will be based solely on cost effectiveness.

7.7.1 Cost Effectiveness

The HIPP Unit of the *fiscal agent* determines if it is cost effective to buy the employer's insurance rather than enroll the individual in BC+.

For individuals and families with incomes under 200 percent of the FPL, the HIPP Unit will identify the cost of wrapping around the Medicaid services with the employer-sponsored plan and then determine cost effectiveness of buy-in on that calculation of cost comparability.

For individuals and families with incomes between 200 and 300 percent of the FPL, if the employer plan has benefits equal to the BadgerCare Plus Benchmark Plan, the State will buy-in to the employer plan when it is cost effective to do so. In this instance, the HIPP Unit will not look at the comparability of the cost sharing, e.g., amounts of co-pays but will determine the cost effectiveness based on comparability of the covered benefits.

This determination will be done on a per person basis. Thus, in any given BC+ group, it may be cost effective to enroll all BC+ members or only specific members. For example: it may be cost effective to enroll an adult in HIPP but to keep the children in BC+.

7.7.2 Participation in HIPP

Members participating in HIPP are enrolled in BC+ as a secondary insurance. If the employer's health insurance does not cover a service the BC+ covers, BC+ will cover the cost.

7.7.3 Cooperation

To remain eligible for BC+, the adult whose employer can provide insurance must:

1. Cooperate in providing information necessary to assess cost-effectiveness, and
2. Agree to enroll and actually enroll in the employer's health care plan if the plan is determined to be cost-effective.

Beginning, October 1, 2009, parents may no longer be sanctioned for failing to cooperate with the HIPP program. This policy applies to both current members and new applicants.

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View History

7.8 ACCESS/COVERAGE OVERVIEW

7.8.1 BC+ Prenatal Program Access/Coverage Overview

Families with income at or below 150% of the FPL are not subject to the BC+ insurance access/coverage requirements.

For all other applicants/members, BC+ insurance access/coverage requirements are determined on an individual basis.

Note: Do not use this overview for the BC+ Prenatal Program (Pregnant individual who is not eligible for BC+ solely due to *immigration status* or because she is an inmate). See the "7.8.1 for BC+ Prenatal Program Access/Coverage Overview".

To determine whether an individual passes BC+ insurance access/coverage requirements answer the following questions for each individual within a BC+ group.

1. Is the *applicant*/member pregnant, a continuously eligible newborn or youth exiting out of home care?

    - If yes, the applicant/member is not subject to the access/coverage requirements.
    - If no, continue to question #2.

2. Is the member a child under age 19 and is currently eligible for BC+, because a child's 150% *deductible* was met?

    - If yes, the applicant/member is not subject to the access/coverage requirements during the deductible period.
    - If no, continue to question #3.

3. Does the applicant/member have access to health insurance, including access due to a *qualifying event*, through a current employer or the current employer of an adult member of the *BC+ test group*?

    - If yes, continue to question #4.

- If no, continue to question #7.

4. Does the employer pay 80% or more of the premium?

   - If yes, continue to question #6.
   - If no, continue to question # 5.

5. Is the employer provided insurance the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government)?

   - If yes, continue to question #6.
   - If no, continue to question # 7.

6. Would the coverage begin in any of the three calendar months following:

a. The month of BC+ *application filing date*; or
b. The annual review month; or
c. The employment start date.

   - If yes, the applicant is not eligible for BC+ benefits.
   - If no, continue to question #7.

7. Did the applicant/member have access to employer provided health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult in the BC+ test group , in the twelve months prior to the application or review date?

   - If yes, continue to question #8.
   - If no, continue to question #11.

8. Would the employer have paid 80% or more of the premium (at any time in the last 12 months)?

   - If yes, continue to question #10.
   - If no, continue to question #9.

9. Would the employer provider insurance be under the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government)?

- If yes, continue to question #10.
- If no, continue to question #11.

10. Did the applicant/member have "good cause" for failure to enroll in an employer sponsored health insurance plan in the 12 months prior to the application (7.2.1)?

    - If yes, continue to question #11.
    - If no, the applicant is ineligible for BC+ 12 months from the date the coverage would have begun, unless s/he becomes exempt during that time.

11. Did the applicant/member lose employer provided health insurance coverage provided through an employer or an employer of an adult BC+ test group member the three calendar months prior to the application?

    - If yes, continue to question #12.
    - If no, the applicant/member passes the BC+ insurance/access coverage requirements.

12. Did the employer pay 80% or more of the premium?

    - If yes, continue to question #14.
    - If no, continue to question #13.

13. Was the employer provided insurance part of the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government)?

    - If yes, continue to question #14.
    - If no, the applicant/member passes the BC+ insurance access/coverage requirements.

14. Did the applicant/member have "good cause" for dropping the health insurance (7.6)?

    - If yes, the applicant/member passes the BC+ insurance access/coverage requirements.
    - If no, the applicant/member is ineligible for BC+ for three calendar months following the month in which the insurance coverage ended.

7.8.1 BC+ Prenatal Program Insurance Access/Coverage Overview

Use this overview only for the BC+ Prenatal Program. (Pregnant individual who is not eligible for BC+ solely due to immigration status or because she is an inmate.)

1. Does she have access to health insurance, including access due to a qualifying event, through a current employer or the current employer or an adult member of the BC+ test group.

    - If yes, continue to question #2.
    - If no, continue to question #5.

2. Does the employer pay 80% or more of the premium?

    - If yes, continue to question #4.
    - If no, continue to question #3.

3. Is the employer provided insurance the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government)?

    - If yes, continue to question #4.
    - If no, continue to question #5.

4. Would the coverage begin in any of the three calendar months following:

    a. The month of BC+ Prenatal application filing date; or
    b. The annual review month; or
    c. The employment start date.

    - If yes, the applicant is not eligible for BC+ Prenatal benefits.
    - If no, continue to question #5.

5. Did she have access to employer provided health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult in the BC+ test group, in the twelve months prior to the application or review date?

    - If yes, continue to question #6.
    - If no, continue to question #9.

6. Would the employer have paid 80% or more of the premium (at any time in the last 12 months)?

    - If yes, continue to question #8.

- If no, continue to question #7.

7. Would the employer provided insurance be under the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government)?"

   - If yes, continue to question #8.
   - If no, continue to question #9.

8. Did she have "*good cause*" for failure to enroll in an employer sponsored health insurance plan in the 12 months prior to application (7.2.1)?

   - If yes, continue to question #9.
   - If no, she is ineligible for BC+ Prenatal 12 months from the date the coverage would have begun, unless she becomes exempt during that time.

9. Is the woman covered by any HIPPAA health insurance policy?

   - If yes, she is ineligible to enroll in the BC+ Prenatal Program.
   - If no, continue to question #10.

10. Has the woman lost coverage under a major medical health insurance plan which meets the standards of a HIPPA standard plan in the prior three calendar months?

    - If yes, continue to question #11.
    - If no, she passes BC+ Prenatal insurance access/coverage requirements.

11. Did she have a "good cause" for losing the major medical health insurance which met the standards of a HIPPAA standard plan (7.6)?

    - If yes, she passes BC+ Prenatal insurance access/coverage requirements.
    - If no, she is ineligible for the BC+ Prenatal Program for three calendar months following the month the insurance coverage ended.

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8 PREGNANT WOMEN AND CONTINOUSLY ELIGIBLE NEWBORNS

8.1 PREGNANT WOMEN

A pregnant woman who is enrolled in BC+ stays eligible for:

1. The balance of the pregnancy, and

2. An additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs.

The decision about her eligibility need not be made prior to termination of pregnancy, but the *application* must be filed before the end of the pregnancy in order for her to remain enrolled as a pregnant woman for the 60 days after the pregnancy ends. If the application is not filed before the end of the pregnancy and the newborn is living with her or she is the *caretaker* relative of other children under 19, she should be tested as a caretaker relative once the pregnancy ends. An application for Express Enrollment does not meet this application test.

If a pregnant woman is covered under the standard plan at any time during her pregnancy she will remain in the standard plan while she is eligible as a pregnant woman.

A pregnant woman with income over 300% FPL can become eligible by meeting a *deductible*. (17.2)

A pregnant woman does not have to pay a premium. (19.1)

See (7.5) for the policy on dropping insurance coverage for pregnant women.

All pregnant women, except those eligible under BC+ Prenatal, may have their eligibility backdated to the first of the month up to three months prior to the month of application.

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8.2 CONTINUOUSLY ELIGIBLE NEWBORNS

Newborn children are automatically eligible for BC+ from the date of birth through the end of the month in which they turn one year old if:

1. They are under age 13 months.

2. The natural mother was determined eligible, in the State of Wisconsin, for one of the following programs.

    a. BC+ or
    b. Other full-benefit Medicaid (MEH 21.2) or
    c. Emergency Services BC+ or
    d. Emergency Services Medicaid (MEH 31.1) or
    e. BC+ Prenatal Plan (as a non-qualifying immigrant)

Note: Children born to incarcerated mothers or pregnant minors with family income over 300% of the FPL who were eligible for BC+ are still not eligible as a CEN.

The natural mother's eligibility could have been determined either prior to the date of delivery or retroactively to cover the date of delivery.

Example: Ms. M. gave birth on April 15. On June 15 she applied for BC+. Her eligibility was backdated to March 15. Her infant son is eligible from April 15 through April 30 of the following year, the end of the month in which he turns one year old.

The newborn child does not receive this automatic eligibility if the mother's BC+ enrollment is a temporary enrollment through the Express Enrollment program.

A newborn is no longer required to reside with his/her mother to be eligible as a CEN. This is true even if the newborn is being placed into foster care, adoption or is residing with a *caretaker relative*. A CEN who no longer resides with his/her mother but still resides in Wisconsin should remain eligible as a CEN through the end of the month in which s/he turns one year old.

The child is not required to have an *SSN*.

The child will be covered under either the Standard or the Benchmark plan, depending on the plan the mother was covered by at the time of the baby's birth.

Anyone who has ever been eligible as a Continuously Eligible Newborn (CEN) under Wisconsin Medicaid or BadgerCare Plus is exempt from the citizenship and identity documentation requirement.

The CEN will not have to pay premiums and is not subject to the health insurance access/coverage requirements.

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9 VERIFICATION

9.1 VERIFICATION

Proof of certain information is required to determine eligibility for BadgerCare Plus. Mandatory (9.9) and questionable items (9.10) must be verified at *application*, review, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. One time only verification items do not need to be re-verified.

Verification means to establish the accuracy of verbal or written statements made by, or about a group's circumstances. Case files or case comments must include documentation for any information required to be verified to determine eligibility or benefit levels.

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9.2 APPLICATION

The time period for processing an *application* for BC+ is 30 days from the application *filing date*. Advise the *applicant* of the specific verification required within the 30 day processing time. Give the applicant a minimum of ten calendar days to provide any necessary verification.

Eligibility should not be denied for failure to provide the required verification until the later of:

- 11th day after requesting verification, or
- 31st day after the application filing date.

If verification is requested more than ten days prior to the 30th day, the applicant must still be allowed 30 days from the application filing date to provide the required verification.

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9.3 ELIGIBILITY REVIEWS

The group's eligibility should not be denied for failure to provide the required verification until the 11th day after requesting verification or the end of the review month whichever is later.

Example 1: Fred's eligibility review is due in April. He submits a mail-in review form on April 10th. The eligibility worker requests verification of his income on April 11th. If the verification is not submitted by April 30th, his eligibility will end on April 30th.

Example 2: Shannon's eligibility review was due in June. At *Adverse Action* in June a notice was sent to Shannon to let her know her BC+ eligibility would end June 30th because she had not yet completed her review. A telephone interview was conducted on June 30th. A request for verification, with a July 10th due date, was sent to Shannon. Because the required verification (including signature) was not submitted by July 11th, her eligibility beginning July 1st was denied.

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9.4 CHANGES

When a change is reported that requires verification, the member must be notified in writing of the specific verification required and allowed a minimum of ten days to provide it.

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9.5 DOCUMENTATION

Documentation includes putting an original or copy of a piece of evidence in the case record.

Documentation also includes adding notations to case comments when copying is not possible. Notations must include enough information to verify eligibility, ineligibility, and benefit level determinations.

All documentation must be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

Documentation should include enough data to describe the nature and source of the information should any follow up be required. All documentation should be date stamped.

Document in the case comments:

1. Collateral contacts.
2. Observations in home visits.
3. Explanations of conversations.

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9.6 COLLATERAL CONTACTS

Collateral contacts consists of oral confirmations of circumstances by persons other than food unit (FS) or group (BC+) members. A collateral contact may be made either in person or over the telephone.

While performing a collateral contact:

1. Do not disclose that an individual has applied for public assistance.

2. Do not disclose more information than is absolutely necessary to get the information being sought.

3. Do not disclose any information supplied by the *applicant*.

4. Do not suggest that the applicant is suspected of any wrongdoing.

9.6.1 Documenting Verbal Statements and Collateral Contacts

Documentation of collateral contacts must include:

1. Name of collateral contact,
2. Title of Individual,
3. Organization the individual is affiliated with,
4. Address (if no phone, or information obtained in person),
5. Significance to household,
6. Date(s) of contact(s) and when pertinent information was obtained.

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9.7 RELEASE OF INFORMATION

Someone's written release to get information from a verification source is needed only when the source requires it.

When a source requires a written release:

1. The requirement must be explained to the member.

2. The individual, his/her spouse, or another appropriate adult in the household must sign the necessary release form(s). The forms that may be used are *CARES*-generated or alternate pre-printed *application* forms.

Benefits should be denied, discontinued or reduced only when:

1. The missing verification is necessary to determine eligibility, and
2. The individual is unwilling or unable to provide the verification directly, and
3. The source requires a release, and
4. The individual, his/her spouse or another appropriate adult in the household refuses to sign the release, and
5. The release is the only way the verification can be obtained.

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9.8 GENERAL RULES

1. Avoid over-verification (requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility). Do not require additional verification once the accuracy of a written or verbal statement has been established.

2. Do not verify information already verified unless there is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, determine if a referral for fraud or for front-end verification should be made (9.10.1).

3. Do not exclusively require one particular type of verification when various types are adequate and available.

4. Verification need not be presented in person. Verification may be submitted by mail, fax, e-mail, or through another electronic device or through an *authorized representative*.

5. Do not target special groups or persons on the basis of race, religion, national origin or migrant status for special verification requirements.

6. Do not require the member to sign a release form (either blanket or specialized) when the member provides required verification.

7. Do not require verification of information that is not used to determine eligibility.

Except for verification of access to employer sponsored health insurance (9.9.6), the member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the *applicant* to provide it.

Assist the member in obtaining verification if s/he requests help or has difficulty in obtaining it.

Use the best information available to process the *application* or change within the time limit and issue benefits when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and

2. Information is not obtainable timely even with your assistance.

Do not deny eligibility in this situation, but continue in your attempts to obtain verification. When you have received the verification, you may need to adjust or recover benefits based on the new information. Explain this to the applicant/member when requesting verification.

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9.9 MANDATORY VERIFICATION ITEMS

9.9.1 Social Security Number
- 9.9.1.1 Newborns
- 9.9.1.2 BC + Emergency Services
- 9.9.1.3 BC+ Prenatal Program

9.9.2 Immigrant Status
9.9.3 Pregnancy
9.9.4 Medical Expenses
9.9.5 Power of Attorney and Guardianship
9.9.6 Access To Employer Provided Health Insurance
- 9.9.6.1 Employer Verification of Health Insurance (EVHI) database
- 9.9.6.2 Other Forms of Health Insurance Access Verification

The following items must be verified for BC+:

1. *SSN (9.9.1)*
2. Citizenship and Identity (Chapter 4.2)
3. Immigrant Status (9.9.2)
4. Pregnancy, if eligibility is based on the pregnancy (9.9.3)
5. Medical Expenses (for deductibles only) (9.9.4)
6. Documentation for Power of Attorney and Guardianship (9.9.5)
7. Migrant worker's (eligibility in another state) (12.3)
8. Income
9. Health Insurance Access (Chapter 7)
10. Health Insurance Coverage (Chapter 7)
11. Family Re-unification plan for Child Welfare Parents (Chapter 10)
12. The placement status of a YEOHC (Chapter 11) on his/her 18th birthday

Unless determined questionable, self declaration is acceptable for all other items.

9.9.1 Social Security Number

Social Security Numbers (SSNs) need to be furnished for household members requesting BC +, but are not required from non-applicants.

An *applicant* is not required to provide a document or social security card. S/he only needs to provide a number, which is verified through the *CARES* SSN validation process.

If the SSN validation process returns a mismatch record, the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have an SSN s/he must be willing to apply for one.

Assist the member in applying for an SSN for any group member who doesn't have one (IMM, Ch. I, Part C).

Do not deny benefits pending issuance of an SSN if you have any documentation that an SSN *application* was made. At the next review, check to see if an SSN has been issued.

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker can not provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may:

1. Recommend further action be taken.

and/or

2. Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

9.9.1.1 Newborns

A parent of a newborn may begin an SSN application on the newborn's behalf while still in the hospital.

Do not require an SSN to be furnished or applied for on behalf of a newborn determined continuously eligible (8.2) for BC +. Accept the mother's statement about the existence and residence of the newborn.

9.9.1.2 BC + Emergency Services

Do not require or verify SSNs of members who receive BC+ Emergency Services only (Chapter 39).

9.9.1.3 BC+ Prenatal Program

Women applying for the BC+ PP do not need to apply for or provide an SSN. See 41.1 BC+ Prenatal.

9.9.2 Immigrant Status

A member who indicates s/he is not a citizen must provide an official government document that lists his/her immigrant registration number. Verification of the individual's *immigration status* is done through the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for BC+ Prenatal Program (Chapter 41) and persons applying for Emergency Services (Chapter 39) who do not provide proof of immigration status can still qualify for those benefits.

An immigrant that presents documentation of his/her immigrant status and meets all other eligibility criteria is eligible while any secondary verification of immigrant status is taking place.

Verification of immigrant status is not needed if the person already provided proof when s/he applied for an SSN.

Do not re-verify immigrant status unless the member reports a change in citizenship or immigrant status.

9.9.3 Pregnancy

If a woman wants to be considered pregnant for a BC+ or BC+ Prenatal Program (Chapter 39) eligibility determination, documentation from a health care professional attesting to the pregnancy is required. Fetus count and the expected pregnancy end date are not mandatory verification items.

Verification sources for pregnancy are:

1. Physician's statement.
2. Physician assistant's statement.
3. Licensed nurse practitioner's statement.
4. A written statement from a registered nurse (RN) working in a:

    a. Healthy Birth Identification of Pregnancy Project (EDP).
    b. Publicly funded family planning project.
    c. Certified Nurse Midwives.

5. A valid BC+ Temporary Enrollment card.

9.9.4 Medical Expenses

Medical expenses used to meet a *deductible* must be verified. The expense amount, any third party liability amount and date of service must all be verified.

9.9.5 Power of Attorney and Guardianship

Verify power of attorney and any guardianship type as specified by the court. Ask for any documentation regarding durable power of attorney or court-ordered guardianship.

9.9.6 Access To Employer Provided Health Insurance

Verification of access to health insurance is required at the following times, unless the individual has already verified health insurance access within the last 12 months with the same employer:

1. BC+ Application and Review.
2. Person Add - if adult (age 18 or over) is employed and part of the BC+test group.
3. When an adult (age 18 or over) in the *BC+ test group* gets a new job.
4. When a change is processed causing total income to exceed 150% FPL (generating a request for premium payment) for the BC+ assistance group.

9.9.6.1 Employer Verification of Health Insurance (EVHI) database

It is not the client's responsibility to verify access to employer-sponsored health insurance. For the majority of BC+ applicants and members the EVHI database will be used to verify insurance access. Information gathered from employers is stored in the database. The verification will be returned based on the employer details entered on the employment page. It will be critical for Income Maintenance workers to enter the correct FEIN number and all other employment details for each employment sequence so that all employers are correctly identified in the EVHI database.

If the employment details are not complete enough to verify access, the applicant will be sent a letter from the State requesting more information and the case will pend.

Example 1: Mary's employer has verified that permanent full-time employees have access to health insurance, however temporary employees do not. Mary did not indicate whether she is a permanent or temporary employee. Since that information is necessary to verify access to health insurance using the database, she will be sent a letter requesting the information.

If the employer has not provided information about the health insurance they offer to their employees, the BC+ eligibility will pend and a request will be sent from the State to the employer requesting that the information be provided.

BC+ eligibility can pend up to the end of the 30 day application processing period. At that point, regardless of whether the employer has responded or not, eligibility must be confirmed. If the employer has not responded assume there is not access to employer sponsored health insurance.

BC+ will not be terminated or denied due to an employer failure to respond to a request for verification of health insurance access. If BC+ eligibility begins and an employer later responds to the verification request indicating that health insurance access is available to the employee, BC+ eligibility will be terminated with adequate notice of *adverse action*. There will be no overpayment liability for the applicant.

9.9.6.2 Other Forms of Health Insurance Access Verification

Other types of verification can be used to document access to employer sponsored health insurance. If a BC+ applicant or member needs medical services, agencies may use other contacts with employers in these situations to speed the verification process. Other forms of verification include:

- EVF-H form
- Employer statement
- Collateral Contact with the employer

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9.10 QUESTIONABLE ITEMS

Information is questionable for BC+ when:

1. There are inconsistencies in the group's oral or written statements.
2. There are inconsistencies between the group's claims and collateral contacts, documents, or prior records.
3. The member or his/her representative is unsure of the accuracy of his/her own statements.
4. The member has been convicted of Medicaid or BC+ fraud or has legally acknowledged his/her guilt of member fraud. Do not require a member to provide verification for the sole reason that they have acknowledged or been convicted of fraud in any other public assistance or employment program.
5. The member is a minor who reports that s/he is living alone. This does not apply to minors applying solely for Family Planning Services.
6. Unclear or vague (i.e., information provided, but not clear).

9.10.1 Front End Verification

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. Refer a group for FEV only when its characteristics meet a designated profile. See 3.2 Fraud Prevention/ Front End Verification of the Income Maintenance Manual .

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9.11 PROCESSING TIMEFRAME

9.11.1 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate Income Maintenance agency or the next business day if verification is delivered after the agency's regularly scheduled business hours.

Income Maintenance agencies must stamp the receipt date on each piece of verification received.

9.11.2 Positive Actions

Begin or continue benefits when:

1. The member provides requested verification within the specified time limits and is otherwise eligible.

2. Requested verification is mandatory, but the member does not have the power to produce the verification and s/he is otherwise eligible. In this situation, the agency must also make an effort to obtain the verification (9.8).

9.11.3 Delay

Notify the member when the agency is not able to process the *application* within 30 days when:

1. Verification is needed, and

2. S/he has the power to produce the verification, and

3. The minimum time period allowed for producing the verification has not passed, and

4. Additional time is needed to produce the verification.

CARES provides a verification checklist, to notify the member of the reason for the delay, the specific verification required, and the date the verification is due.

9.11.4 Negative Actions

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

1. The member has the power to produce the verification.

2. The time allowed to produce the verification has passed.

3. The member has been given adequate notice of the verification required.

4. You need the requested verification to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility.

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10 CHILD WELFARE PARENTS

10.1 CHILD WELFARE PARENT OR CARETAKER RELATIVE

Qualifying parents and *caretaker* relatives of children who have been temporarily removed from the home and are in the care of the child welfare system may be eligible for BC+ benefits if they meet the following requirements:

1. Their child was placed (by the child welfare agency) in:

    a. Foster care, (both IV-E and non IV-E).
    b. Court Ordered Kinship Care.

2. The *caretaker relative* is cooperating with a permanency plan, the goal of which is family reunification. Cooperation is always presumed unless the court has determined that reunification will no longer be the permanency goal and

3. The caretaker relative meets all other BC+ financial and non-financial requirements.

The parents/caretaker relative who meet the above requirements are considered caring for a child who has been temporarily removed from the home. Even though the child's eligibility is not determined on the caretaker relative's case, the child is included in the group size in the eligibility determination and any unearned income the child has is budgeted.

Note: Children are not considered to be in the care of the child welfare system if they are an inmate in a public institution, such as a Type 1 Juvenile Correctional Institution.

If the Child Welfare System places a child with a Kinship Care relative, the Kinship Care relative may qualify for BC+ as the caretaker relative of this child even if the *Child Welfare parent/caretaker* is also determined eligible as the caretaker relative of this child.

See Process Help for information on processing the Child Welfare Parent or Caretaker relative cases.

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11 YOUTHS EXITING OUT OF HOME CARE

11.1 OUT OF HOME CARE (I.E., FOSTER CARE) AND YOUTHS EXITING OUT OF HOME CARE (YEOHC)

BadgerCare Plus Benefits are available for all youths placed in:

1. Foster Care (either IV-E or non IV-E)
2. Subsidized guardianship
3. Court ordered Kinship Care

An eligibility determination for these groups is not the responsibility of the IM agency.

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11.2 EXITING OUT OF HOME CARE

Youths who were in foster care, subsidized guardianships or court-ordered Kinship Care on their 18th birthday, qualify for a special status under BC+ when they leave out of home care if all the following conditions are met:

1. The youth was receiving foster care (either IV-E or non IV-E), subsidized guardianship, or court ordered Kinship Care on the date that s/he turned 18. It does not matter what state s/he was residing in when s/he turned 18.
2. The youth turned 18 on or after January 1, 2008 and is under age 21.
3. The youth meets the following BC+ eligibility criteria:

    a. No longer receiving foster care benefits (which includes subsidized guardianships and court-ordered kinship), but was receiving the

benefits on his/her 18th birthday. Verification of the placement status on his/her 18th birthday is required.

b. Provides a Social Security Number or cooperates in applying for one.
c. Is a U.S. Citizen, or National, or is a qualifying immigrant.
d. Provides verification of U.S. citizenship and identity or qualifying *immigration status* or makes a good faith effort to obtain it.
e. Cooperates with child support enforcement agencies in obtaining medical support (if a parent).
f. Cooperates with third party liability requirements
g. Physically resides in Wisconsin and intends to reside in the state.
h. Is not an inmate.
i. Cooperates with *HIPP* requirements (7.7).

There is no income or resource test for these youths while they are eligible under this status. In addition, they are not subject to the BC+ insurance access or coverage policy and they are not required to pay any premiums for themselves. Regardless of income, they are eligible for the BC+ Standard Plan until the end of the month in which they turn 21 or they are otherwise ineligible, whichever is sooner.

A 12 month recertification review is required to continue eligibility.

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12 MIGRANT WORKERS

12.1 MIGRANT WORKERS

When determining a migrant family's eligibility for BC+ include the adults (including non-marital co-parents) and their dependent children living in the migrant household.

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12.2 MIGRANT WORKER DEFINITION

A “Migrant worker” is a person who:

1. Temporarily leaves his/her principal place of residence (outside of Wisconsin) and

2. Comes to Wisconsin for not more than ten months per year in order to

3. Accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading or storing of any agricultural or horticultural commodity in its unmanufactured state.

“Migrant worker” does not include the following:

1. A person who is employed only by a state resident if the resident or the resident’s spouse is related to the person as the child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, nephew, or the spouse of any such relative.

2. A student who is enrolled in or, during the past six months has been enrolled, in any school, college or university unless the student is a member of a family or household which contains a migrant worker.

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12.3 SIMPLIFIED APPLICATION

Migrant workers and their families can have their eligibility for BC+ determined using a simplified *application* process if they:

1. Have current MA eligibility from another state. (“Current MA eligibility” means eligibility that includes at least months one and two of the application process.) Or had MA/BC+ eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.

2. And have the same members or fewer in the case as there were when the case had coverage in the other state.

The simplified application procedure is as follows:

1. For applicants with current MA eligibility from another state, verify the eligibility and the end date. Verify with a copy of the out-of-state MA card or by contacting the other state.

2. For applicants previously eligible in Wisconsin, determine the closure code and review date.

3. Determine if the same members, or fewer, are in the case compared to when the group was eligible in the other state.

4. Collect all non-financial information.

5. Do not collect any financial information.

6. Certify BC+ benefits for the migrant family.

Example 1: A migrant family consisting of dad, mom, and their three children comes to Wisconsin. On July 3, dad applies for BC+ in Wisconsin for his family.

The family has current MA eligibility from Texas with a certification period ending on November 30. That is, eligibility extends beyond application months one and two.

The household has the same five members listed on the MA card.

Because the two conditions described in 12.2 are met, the case should be processed using the simplified application procedure.

Example 2: The same migrant family comes in for the November review. Verify all mandatory and questionable verification items. The family is determined eligible through October 31 of the following year.

The family leaves Wisconsin in December. BC+ closes for failure to reside in the state. The next March, the family returns. There have been no non-financial changes and no changes in household composition. The family should be processed with the simplified application procedure because their case closed only for failure to reside in Wisconsin.

12.3.1 Review dates for simplified application

For migrant families that have been certified through the migrant simplified application process, the first review coincides with the date out-of-state eligibility ends. The next review is 12 months from the first review.

See example 1 above. The review date should be set for November since that is the last month of the *certification period* for the Texas MA.

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12.4 REGULAR APPLICATION

If migrant workers and their families have no current BC+/MA eligibility in Wisconsin or another state, or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular BC+ *application*, with the following exception:

Use annualized earned income. "Annualized earned income" is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family's income if it is anticipated that last year's income is the best estimate of the current year's prospective income.

Review dates for regular applications

For migrant families that have been certified through the regular application process, the first review is 12 months from the month of application.

12.4.1 Reviews

Offer the following three review choices for migrant families:

1. Mail.
2. Phone.
3. Face-to-face interview.

See Chapter 26 for information on reviews.

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13 - 15 RESERVED

CHAPTERS 13-15 (RESERVED)

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FINANCIAL REQUIREMENTS (CHAPTERS 16-24)

16 INCOME

16.1 INCOME

In general, all available gross income is counted when determining BC+ eligibility. See unavailable income below for exceptions to this rule.

Income Limits

The following table displays the BC+ income limits for potential BC+ members.

Pregnant Women	Children under 19	Parents/Caretaker Relatives	Child Welfare Parents
300% FPL**	No limit	200% FPL	200% FPL

** A pregnant woman with income above 300% of FPL can become eligible by meeting a deductible.

See Chapter 50.1 for the most recent Federal Poverty Level limits.

Gross income is the total income before any amounts are subtracted or withheld (i.e. taxes, garnishments, repayment amounts, etc.)

Net income is the amount of income after deductions are withheld.

Available income: Income is available when:

1. It is actually available, and
2. The person has a legal interest in it, and
3. The person has the legal ability to make it available for support and maintenance.

An example of an income source that someone can make available is unemployment compensation.

When it is known that a member of the group is eligible for income or an increased amount of income:

1. If the amount is known, count the income as if the person is receiving it.

2. If the amount is unknown, ignore the income.

Example: Ms. M. is entitled to Worker's compensation benefits of $430. However, she declined a $100 increase offered by the insurance company, and the amount of her check remains at $430. Since the full entitlement amount is known, the available income is $530.

Unavailable Income: Income is unavailable when it will not be available for 31 days or more. The person must document that it will not be available for 31 days or more.

Unavailability is documented by a letter from the source of the income stating when the person will receive the benefit. Thus, if s/he has just applied for benefits, the income would not be counted. The income is not ignored; it is just not counted until it becomes available. Schedule an eligibility review for no later than the 60th day.

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16.2 INCOME TYPES NOT COUNTED

1. Adoption Assistance
2. Agent Orange Settlement Fund
3. Combat Pay
4. Crime Victim Restitution Program
5. Disaster and Emergency Assistance
6. Earned Income
7. Foster Care
8. IDA
9. Jury Duty Payments
10. Kinship Care
11. Life Insurance policy dividends
12. Nutrition Benefits
13. Payments to Native Americans
14. Payments to Nazi Victims
15. Radiation Exposure Compensation Act (PL 101-426)
16. Refugee Cash Assistance (RCA)

17. Refugee "Reception and Placement"
18. Reimbursements
19. Relocation Payments
20. Repayments
21. Special Programs
22. Spinal Bifida Child
23. Susan Walker Payments
24. Student Financial Aids
25. Stipends from the UW Upward Bound Program
26. Tax Refunds (Income and EITC)
27. Unpredictable Income
28. VA Allowances
29. Wartime Relocation of Citizens
30. Workforce Investment Act Unearned Income
31. W2 Payments
32. General Relief and Charity
33. SSI/Supplemental Security Income
34. Interest and Dividend income
35. Lump Sum Payments
36. Property Settlements
37. Subsidized Guardianship
38. The American Recovery and Reinvestment Act (ARRA) of 2009

The following types of income are not included in the countable income when determining eligibility for BC+.

1. **Adoption Assistance**

2. **Agent Orange Settlement Fund** Do not count payments received from the Agent Orange Settlement Fund or any other fund established in settling "In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)". This is retroactive to January 1, 1989. Do not count these payments for as long as they are identified separately.

3. **Combat Pay** Do not count combat zone pay that goes to the household that is in excess of the military person's pre-deployment pay. The exclusion lasts while the military person is deployed to the combat area.

   If the amount of military pay from the deployed absent family member is equal to or less than the amount the household was receiving prior to deployment, count all of the income to the household. Any portion of the military pay that exceeds the amount the household was receiving prior to deployment to a designated combat zone should not be counted when determining the household’s income.

Example: John's wife Bonnie and their daughter have an open BC+ case. John is in the military stationed overseas, his monthly income is $1,000. John sends his wife $1,000 every month.

When John is deployed to a combat zone his pay is increased to $1,300 a month, which is deposited into a joint account. Because the $300 is combat zone pay, it is not counted in the determination. The pre-combat pay of $1,000 is budgeted as unearned income for BC+.

4. **Crime Victim Restitution Program** payments received from a state established fund to aid victims of a crime.

5. **Disaster and Emergency Assistance** payments made by federal, state, county, and local agencies, and other disaster assistance organizations.

6. **Earned Income** of individuals under 18 years of age. "Disregard the income until the month following the month in which the person turns 18 years of age."

7. **Foster Care**

8. **IDA** (Individual Development Account) payments that are made in the form of matching funds to buy a home, start a business, or to complete post-secondary education.

9. **Jury Duty Payments** Count any portion of a jury payment that is over and above expenses as earned income for the month in which it is received.

10. **Kinship Care**

11. **Life Insurance policy dividends**.

12. **Nutrition Benefits** received from the following:

    a. Emergency Food and Shelter National Board.

    b. Federal Emergency Management Assistance (FEMA).

    c. FoodShare allotment.

    d. Home produce for household consumption.

    e. National School Lunch Act.

f. Supplemental food assistance under the Child Nutrition Act of 1966.

g. Title VII Nutrition Program for the Elderly, Older Americans Act of 1965.

h. USDA Child Care Food Program.

i. USDA donated food and other emergency food.

j. WIC - the supplemental food program for women, infants, and children.

13. **Payments to Native Americans from**:

a. Menominee Indian Bond interest payments.

b. All judgment payments to tribes through the Indian Claims Commission or Court of Claims.

c. Payments under the Alaskan Native Claims Settlement Act.

d. Payments under the Maine Indian Claims Settlement Fund.

e. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000.

f. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000.

g. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge Munsee Indian Community of Mohicans.

h. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.

i. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.

j. For EBD MA cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also

disregard interest and investment income from these funds.

k. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan.

l. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, MN, reservations.

m. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.

n. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.

o. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000.

p. Disregard the first $500 of the monthly income from Tribal Per Capita payments from gaming revenue. If the payments are received less than monthly, prorate the gross payment amount over the months it is intended to cover and disregard $500 from the monthly amount.

This applies to eligibility determinations for BadgerCare Plus effective 12/01/2008.

6. **Payments to Nazi Victims** made under PL 103-286 to victims of Nazi persecution.

7. **Radiation Exposure Compensation Act (PL 101-426)** payments to persons to compensate injury or death due to exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000). The federal Department of Justice reviews the claims and makes the payments. If the affected person is dead, payments are made to his/her surviving spouse, children, parents, or grandparents. This is retroactive to October 15, 1990. Do not count these payments for as long as they are identified separately.

8. **Refugee Cash Assistance (RCA)** program payments. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

9. **Refugee "Reception and Placement"** (R&P) payments made to refugees during the first 30 days after their arrival in the U.S. R& P payments are made by voluntary resettlement agencies and may be a

direct payment to the refugee individual/family or to a vendor.

10. **Reimbursements** for out of pocket expenses which an assistance group member has incurred and/or paid. However, reimbursements for normal household living expenses (rent, clothing, or food eaten at home) are counted.

Examples of reimbursements that are not counted:

a. For job or training related expenses. The expenses may be for travel, food, uniforms, and transportation to and from the job or training site. This includes travel expenses of migrant workers.

b. For volunteers' out-of-pocket expenses incurred during their work.

c. Medical or dependent care reimbursements.

d. Reimbursement from the Indianhead Community Action Agency (Ladysmith) under its JUMP Start Program for start-up costs to set up an in-home child care business in the person's home.

e. Reimbursements received from the Social Services Block Grant Program for expenses in purchasing Social Services Block Grant services, for example, transportation, chore services, and child care services.

The reimbursement payment should not be more than the person’s actual out-of-pocket expenses. If it is more, count the excess amount as unearned income.

19. **Relocation Payments** Under s. 32.19, Wis. Stats., relocation payments are available to displaced persons. The following are examples of costs which the relocation payments are intended to cover: moving expenses, replacement housing and property transfer expenses. Do not count the amounts paid by any governmental agency or organization listed in s. 32.02, Wis. Stats. Do not count Title II, Uniform Relocation Assistance and Real Property Acquisition Policies Act payments. Its purpose is to treat persons displaced by federal and federally aided programs fairly so that they do not suffer disproportionate injuries as a result of programs designed for the public's benefit.

Do not count Experimental Housing Allowance Program (EHAP) payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

20. **Repayments** of money the member has received from an economic support program and must give back because of a program error or violation. Since s/he is not entitled to the money, s/he must repay it; therefore it should not be counted as income to the member.

Do not count the following repayments:

a. Money withheld from an economic assistance check due to a prior overpayment.

b. Money from a particular income source that is voluntarily or involuntarily paid to repay a prior overpayment received from that same source of income.

If money from a particular income source is mixed with money from other types of income, disregard only an amount up to the amount of the current payment from the particular source.

Example: Richard receives $50 a month from the Veteran's Administration (VA) and $250 from Social Security. The income from the two sources is mixed together in one lump of $300. If the VA overpays Richard by $200, he can pay back to the VA only the $50 a month he receives from the VA. If he repays more, for instance, $75 a month, disregard only $50.

c. Social Security income used to repay an overpayment previously received from the Social Security Administration, whether SSA or SSI.

21. **Special Programs** income received from any of the following:

a. Active Corp. of Executives (ACE).
b. Wages paid by the Census Bureau for temporary employment related to Census 2010.
c. Emergency Fuel Assistance.
d. Foster Grandparents Program.
e. Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing HUD housing rent.
f. Homestead Tax Credit.
g. Low Income Energy Assistance Program.
h. Programs funded under Title V of the Older Americans Act of 1965 (16.3.1 #6), except wages or salaries, which are counted as earned income.
i. Retired Senior Volunteer Program (RSVP).
j. Service Corp. of Retired Executives (SCORE).
k. University Year for Action Program (UYA).

l. Volunteers in Service to America (VISTA).
m. Wisconsin's Family Support Program (s. 46.985, WI Stats.) This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.

22. **Spinal Bifida Child** (PL 104-204) payments to any child of a Vietnam veteran for any disability resulting from the child's spinal bifida.

23. **Susan Walker Payments** received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products.

24. **Student Financial Aids** regardless of source. This includes student loans, grants, scholarships and work study, and any financial assistance provided by a public or private organization for the purpose of obtaining an education. Disregard the full amount of student financial aids, including any amounts earmarked for living expenses.

Count Income from an internship or assistantship that is not part of work study or another student aid, counts the income from the internship or assistantship as earned income.

Example: Clark is a journalism student. The University School of Journalism has arranged an internship for him to work 10 hours a week at The Daily Planet. The newspaper pays him $30 a week. Count this as earned income when you are determining Clark's eligibility.

25. **Stipends from the UW Upward Bound Program** paid to high school students to encourage low income students to further their education.

26. **Tax Refunds (Income and EITC)**

27. **Unpredictable Income** which is unpredictable, irregular, and has no appreciable effect on ongoing need.

28. **VA Allowances** for unusual medical expenses that are received by a veteran, their surviving spouse, or dependent. Do not count aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses. For institutionalized and community waiver cases, do not count these allowances in eligibility and post-eligibility determinations, except for residents of the State Veterans Home at King.

29. **Wartime Relocation of Citizens** (PL 100-383) restitution payments made to individual Japanese-Americans (or their survivors) and Aleuts who were

interned or relocated during WW II.

30. **Workforce Investment Act Unearned Income** (WIA) paid to any adult or minor participating in WIA, including:

    a. "Need-based payments" paid to persons as allowances to enable them to participate in a training program.

    b. "Compensation in lieu of wages" paid to persons in "tryout employment". This is arranged when private-for-profit opportunities aren't available and is generally limited to persons under age 22. Ask any *applicant* under age 23, or the local WIA staff if s/he is participating in "tryout employment". If s/he is, count this as unearned income.

    c. "Payments for supportive services" paid to persons in training programs who aren't able to pay for training related expenses (e.g., transportation, health care, child care, meals).

31. **W2 Payments** for Transitional Jobs and Community Service Jobs. Do not disregard payments for Trial Jobs.

32. General Relief and Charity

33. **SSI/Supplemental Security Income (SSI)**

SSI is not counted income for BC+. The following is a brief list of the potential codes for SSI.
SI – SSI/Supplemental Security Income
SISE – SSI-E/Supplemental Security Income – Expenditure
SISS – State Supplemental Security Income

34. Interest and Dividend Income

Interest and Dividend income is not counted income for BC+.

35. Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, inheritance, sale of property, Railroad Retirement, Unemployment Compensation benefits, retroactive corrective financial aid payments, etc. are counted as an asset when received. There is no asset test for BC+ (20.1). The payment can be either unearned or earned income.

However, do not include payments that are included in farm or self-employment income .

36. Property Settlement

Money received as a property settlement is always an asset, regardless of whether it is paid in one payment or installments. It is never income.

37. Subsidized Guardianship Payments

Subsidized guardianship payments are not counted for BadgerCare Plus (BC+).

38. The American Recovery and Reinvestment Act (ARRA) of 2009

Disregard the one time payments of $250 sent to SSI, Veterans, Railroad Retirement, and Social Security recipients as a result of The American Recovery and Reinvestment Act of 2009.

Effective 02/01/2009,disregard the $25 per week, temporary supplement benefits from Unemployment Compensation (UC).

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16.3 INCOME DEDUCTIONS

16.3.1 Support Payments

Deduct the amount of court ordered support a BC+ *applicant*/member is obligated to pay for the support or maintenance of another person. Non- court ordered payments are not deducted.

The income deduction for a monthly court ordered support expense is the amount that the member is "obligated" to pay as stipulated in the court order. The court ordered obligated amount is allowed even if actual payments are not being made. The deduction can only be made from the income of the person with the court ordered obligation. Do not allow payments for *arrearages* and annual receipt and disbursement (R & D) expenses.

Actual payments may be deducted for court ordered lying in costs (for the costs of the birth of the child). Unlike monthly court ordered expenses, actual payments for lying in costs are frequently paid at various times and are usually not tied to a regular payment schedule.

Note: If the court order stipulates that the individual must pay a monthly amount toward lying in costs, allow the court ordered monthly amount (obligated amount) as an income deduction. If the member is required to pay lying in costs, but no specific monthly amount is ordered, allow actual payments for lying in costs as an income deduction.

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16.4 EARNED INCOME

16.4.1 Specially Treated Wages
16.4.2 Room and Board Income
16.4.3 Self Employment Income
- 16.4.3.1 Income Sources
- 16.4.3.2 Calculating BC+ Self Employment Income
  - 16.4.3.2.1 IRS Tax Forms
  - 16.4.3.2.2 Worksheets
  - 16.4.3.2.3 Disallowed Expenses
  - 16.4.3.2.4 Anticipating Earnings

16.4.4 Verification
- 16.4.4.1 Self-Employment Hours

Earned income is income from gainful employment. Earned income for individuals under 18 years of age is not counted. The gross earned income before any deductions are taken out is counted.

1. **Contractual Income**

   This provision applies primarily to teachers and other school employees.

   When an employed BC+ group member is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, the income is prorated over the period of the contract. For example, if the contract is for 18 months, the income is prorated over 18 months no matter the number of installments made in paying the income. The income is prorated even if:

a. There are predetermined vacation periods, or
b. S/he will only be paid during work periods, or
c. S/he will be paid only at the end of the work period, season, semester or school year.

2. **Income In Kind**

Count in-kind benefits as earned income if they are:

a. Regular, and
b. Predictable, and
c. Received in return for a service or product.

Do not count:

a. Meals and lodging for armed services members.
b. In-kind services that do not meet all three of the above criteria.
c. To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits.

3. **Wage Advances** Count advances on wages as earned income in the month received.

4. **Severance Pay** Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee's request or through a mutual agreement with his/her employer as earned income when s/he would have received the amount had it not been deferred.

5. **Worker's Compensation** Count Worker's Compensation as earned income.

16.4.1 Specially Treated Wages

1. Income Received by Members of a Religious Order

a. Earned income: Count any compensation that a member of a religious order receives as earned income if the compensation is for gainful employment, even if the compensation is turned back over to the order.

b. Unearned income: Count any compensation that a member of a religious order receives, not related to gainful employment, as unearned income even if the compensation is turned over to the order.

2. Census 2010

Disregard all wages paid by the Census Bureau for temporary employment related to Census 2010.

3. **Jury Duty Payments**

Count any portion of a jury payment that is over and above expenses as earned income.

4. **Governor's Central City Initiative**

Count hourly income from the Governor's Central City Initiative as earned income. This program is only in Milwaukee County.

5. **AmeriCorps**

Count the living allowance or stipend as earned income. Disregard any child care allowance to the extent it was used to meet child care expenses to participate in AmeriCorps. Disregard any basic health insurance policy, child care services, auxiliary aid and services to people with disabilities and the national service educational award of $4,725 for each year of completed service.

6. **Title V - Older Americans Act of 1965**

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to:

a. Green Thumb.
b. Experience Works.
c. The National Urban League.
d. National Senior Citizens Education and Research Center (Senior Aides).
e. National Indian Council on Aging.
f. U.S.D.A. Forest Service.
g. Wisconsin Senior Employment Program (WISE).
h. Community service employment programs, such as the Older Americans Community Service Program.

Identify programs funded under the Title V of the Older Americans Act using documents provided by the member, contacts with the provider, or a local council on aging.

Do not count reimbursements (16.2 #19).

16.4.2 Room and Board Income

Calculate net amount by deducting one of the following from the gross amount received from each roomer/boarder: $15 roomer only, $111 Boarder only, $126 roomer and boarder.

16.4.3 Self Employment Income

Self-employment income is income derived directly from one's own business rather than as an employee with a specified salary or wages from an employer. "Business" means an occupation, work, or trade in which a person is engaged as a means of livelihood.

A business is operating when it is ready to function in its specific purpose. The period of operation begins when the business first opens and generally continues uninterrupted up to the present. A business is operating even if there are no sales and no work is being performed. Thus a seasonal business operates in the off season unless there's been a significant change in circumstances.

A business isn't operating when it can't function in its specific purpose. For instance, if a mechanic can't work for 4 months because of an illness or injury, he may claim his business wasn't in operation for those months.

Self Employment is identified according to the following criteria.

Organization

A farm or other business is organized in 1 of 3 ways:

1. A sole proprietorship, which is an unincorporated business owned by one person.

2. A partnership, which exists when 2 or more persons associate to conduct business. Each person contributes money, property, labor, or skills, and expects to share in the profits and losses. Partnerships are unincorporated.

3. A corporation is a legal entity authorized by a state to operate under the rules of the entity's charter. There may be one or more owners. A corporation differs from the other forms because a corporation:

a. Is taxed as a separate entity rather than the owners being taxed as individuals, and

b. Provides only limited liability. Each owner's loss is limited to their investment in the corporation while the owners of unincorporated business are also personally liable.

IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return. A person who will owe more than $400 in taxes at the end of the year must file quarterly estimates.

IRS tax forms for reporting self-employment income are listed below.

1. Form 1065 - Partnership
2. Form 1120 - Corporation
3. Form 1120S - S Corporation
4. Form 4562 - *Depreciation* & Amortization
5. Form 1040 - Sole Proprietorship

    a. Schedule C (Form 1040) - Business (non-farm)
    b. Schedule E (Form 1040) - Rental and Royalty
    c. Schedule F (Form 1040) - Farm Income
    d. Schedule SE (Form 1040) - Social Security Self-Employment

Employee Status

A person is an employee if s/he is under the direct "wield and control" of an employer. The employer has the right to control the method and result of the employee's service. A self-employed person earns income directly from his/her own business, and:

1. Does not have federal income tax and FICA payments withheld from a paycheck.

   Note: A baby sitter who works in someone else's home is considered an employee of that household, even if the individual employing him/her does not withhold taxes or FICA.

2. Does not complete a W-4 for an employer.

3. Is not covered by employer liability insurance or worker's compensation.

4. Is responsible for his/her own work schedule.

Examples of self-employment are:

a. Businesses that receive income regularly (for example, daily, weekly or monthly):
    a. Merchant.
    b. Small business.
    c. Commercial boarding house owner or operator.
    d. Owner of rental property.

b. Service businesses that receive income frequently, and possibly, sporadically:
Craft persons.
    a. Repair persons.
    b. Franchise holders.
    c. Subcontractors.
    d. Sellers of blood and plasma.
    e. Commission sales persons (such as door-to-door delivery).

3. Businesses that receive income seasonally:
    a. Summer or tourist oriented business.
    b. Seasonal farmers (custom machine operators).
    c. Migrant farm worker crew leaders.
    d. Fishers, trappers, or hunters.
    e. Roofers.

4. Farming, including income from cultivating the soil, or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time or hobby farming.

Calculating Self Employment Income

All self-employment income is earned income, except royalty income and some rental income (16.4.3.1 #3).

16.4.3.1 Income Sources

Self-employment income sources are:

1. Business. Income from operating a business.

2. Capital Gains. Business income from selling securities and other property is counted. Personal capital gains are not counted as income.

3. Rental.

Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income.

Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.

When a MA group member reports rental income to the Internal Revenue Service (IRS) as self-employment income, see **3A Reported to IRS as Self Employment Income.**

If s/he does not report it as self-employment income, add "net rent" to any other unearned income on the appropriate worksheet. Determine "net rent" as detailed in **3B Rental Income not reported as Self Employment Income.**

3A Reported to IRS as Self Employment Income

When the owner isn't an occupant, net rental income is the rent payment received minus the interest portion of the mortgage payment and other verified operational costs.

When a life estate holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

When the owner lives in one of the units of a multiple unit dwelling and does not file taxes for the rental income, compute net rental income as follows:

1. Add the interest portion of the mortgage payment and other operational costs common to the entire operation.

2. Multiply the number of rental units by the total in step 1.

3. Divide the result in step 2 by the total number of units, to get the proportionate share.

4. Add the proportionate share to any operational costs paid that are unique to any rental unit. This equals total expenses.

5. Subtract total expenses from the total rent payments to get net rent.

3B Rental Income not reported as self employment income

When a BC+ group member reports rental income to the Internal Revenue Service (IRS) as self-employment income, see 3A.

If s/he does not report it as self-employment income, add "net rent" to any other unearned income on the appropriate worksheet. Determine "net rent" as follows:

1. When the owner is not an occupant, "net rent" is the rent payment received minus the interest portion of the mortgage payment, and other verifiable operational costs. Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.

   Capital expenditures are not *deductible* from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring or cabinets, paving a driveway.

   If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

   When a life estate holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. Net rental income is the gross rental income minus taxes, insurance, and other operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

2. When s/he receives income from a duplex, triplex, etc. and lives in one of the units, determine "net rent" as follows:

   a. Add the interest portion of the mortgage payment and other verifiable operational costs common to the entire operation.

   b. Multiply the number of rental units by the total in "a."

   c. Divide the result in "b." by the total number of units. This is the proportionate share.

d. Add the proportionate share "c." to any operational costs paid by the member that are unique to any rental unit. The result is the total member expense.

e. Subtract the total member expense "d." from the total rent payments to get "net rent.

3. **Royalties**. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

16.4.3.2 Calculating BC+ Self Employment Income

Calculate BC+ income by either:

1. Using IRS tax forms (16.4.3.2.1) completed for the previous year, or
2. Anticipating earnings (16.4.3.2.4).

16.4.3.2.1 IRS Tax Forms

Don't fill out any IRS tax forms (or the Self-Employment Income Report form; F-00107) yourself. This is the responsibility of the member.

Consult IRS tax forms only if:

1. The business was in operation at least one full month during the previous tax year, and

2. The business has been in operation six or more months at the time of the *application*, and

3. The person doesn't claim a change in circumstances since the previous year.

If all three conditions aren't met, use anticipated earnings (16.4.3.2.4).

16.4.3.2.2 Worksheets

If you decide to use IRS tax forms, use them together with the self-employment income worksheets (F-16034, F-16035, F-16036 and F-16037).

The worksheets identify net income and depreciation by line on the IRS tax forms.

For each operation, select the worksheet you need and, using the provided tax forms and/or schedule, complete the worksheet. These are:

1. Sole Proprietor - Farm and Other Business
    a. IRS Schedule C (Form 1040) - Non-farm Business Income
    b. IRS Schedule E (Form 1040) - Rental and Royalty Income
    c. IRS Schedule F (Form 1040) - Farm Income
    d. IRS Form 4797 - Capital & Ordinary Gains

2. Partnership
    a. IRS Form 1065 - Partnership Income
    b. IRS Schedule K-1 (Form 1065) - Partner's Share of Income

3. Corporation

   IRS Form 1120 - Corporation Income

4. Subchapter S Corporation
    a. IRS Form - 1120S - Small Business Corporation Income
    b. IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

Next, divide IM income by the number of months that the business was in operation during the previous tax year.

The result is monthly IM income. Add this to the fiscal test group's other earned and unearned income. If, monthly IM income is a loss, add zero to the non self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Don’t apply a loss from unearned income to a gain in earned income. Losses from self-employment can’t be used to offset other earned or unearned income.

If you use more than one worksheet because there is more than one operation, combine the results of each worksheet into one monthly IM income amount before adding that total to any other income. Remember that while a salary or wage paid to a test group member is an allowable business expense, you must count it as earned income to the payee.

Continue to process the group through the balance of the Handbook, including some additional work-related expenses that IRS doesn't allow as business expenses.

16.4.3.2.3 Disallowed Expenses

Generally, expenses that are allowed by the IRS on business tax forms are considered allowed expenses for BadgerCare Plus. However, some specific expenses allowed in the calculation of Self Employment Income on the IRS tax forms but are not allowed for BadgerCare Plus. These are:

1. Depreciation: Net self employment income for BC+ groups is first determined without allowing depreciation expenses. If the group's total countable IM income exceeds 200% of the Federal Poverty Level, the self employed group is allowed a second income test. For the second test, net self-employment income is redetermined, this time deducting depreciation expenses. If the total countable IM income minus the depreciation is less than 200% of the Federal Poverty Level,, the adults and children are eligible for the Benchmark Plan. The premium for the parents and children in the household is 5% of the household's total countable gross income including depreciation. (i.e., depreciation expenses are not deducted)
2. Net loss carryover from previous periods (long term capital loss)
3. Federal, State, and local income taxes
4. Charitable donations
5. Work-related personal expenses, such as transportation to and from work
6. Employer work-related personal expenses such as pensions, employee benefit and retirement programs and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not).
7. The purchase price of income producing real estate, capital assets/equipment, and durable goods or payments on the principal of loans for the purchase of these assets.
8. Guaranteed payments to partners

16.4.3.2.4 Anticipating Earnings

If past circumstances don't represent present circumstances, calculate self-employment income based on anticipated earnings. A change in circumstances is any change that can be expected to affect income over time. It is the person's responsibility to report changes.

The date of an income change is the date you agree that a change occurred. You must also judge whether the person's report was timely to decide if the case was over or underpaid. Changes are then effective according to the normal prospective budgeting cycle. Don't recover payments made before the agreed on date.

Other instances when you would use anticipated earnings:

1. The business wasn't operating at least one full month during the previous tax year.

2. The business wasn't operating six or more months at the time of the interview.

Examples of changed circumstances are:

- The owner sold or simply closed down the business.
- The owner sold a part of his business (e.g., one of two retail stores).
- The owner is ill or injured and will be unable to operate the business for a period of time.
- A plumber gets the contract on a new apartment complex. The job will take nine months and his/her income will increase.
- A farmer suffers unusual crop loss due to the weather or other circumstances.
- There's a substantial cost increase for a particular material such that there will be less profit per unit sold.
- Sales, for an unknown reason, are consistently below previous levels. The relevant period may vary depending on the type of business (consider normal sales fluctuations).

The Self-Employment Income Report form (SEIRF) (F-00107) simplifies reporting income and expenses when earnings must be anticipated. It's modeled after IRS Form 1040, Schedule C, and can be used to report income for any type of business with any form of organization. However, some, especially farm operators, may find it easier to complete the IRS tax form when income and expense items are more complex.

To compute anticipated earnings, the person must complete a SEIRF for those months of operation since the change in circumstances occurred following the guidelines below (remember, the beginning of a business is a change in circumstances). S/he may complete the SEIRF for each month separately or combine the months on one SEIRF.

When a new self-employment business is reported or when a change in circumstance occurs and the past circumstances no longer represent the present, recalculate self-employment income:

1. When two or more months of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information beginning from the date self employment began or the date of the significant change. See example 1.

2. When at least one full month but less than two full months of actual self-employment income information is available, calculate a monthly net income average using the actual net income received in any partial month

of operation, the one full month of operation and an estimate of net income for the next month. See example 2.

3. When there is less than one full month of actual income information available, calculate a monthly net self-employment income average using the actual net income received in the partial month (since the change in circumstance occurred) and estimated income and expenses for the next two months. See example 3.

Use the average until the person's next review or if a significant change in circumstances is reported between reviews.

Example 1: Bonnie applies for CC and BC+ on April 5, 2007. She reports that she started self-employment in January 2007. The agency uses a SEIRF for January, February and March to determine the prospective self-employment income estimate for Bonnie's BC+ and CC certification period (April 2007 - March 2008).

On Bonnie's September SMRF, no change in self-employment income is reported and the worker continues to use the average determined at the time of application.

Example 2: Ricardo is applying for FS and BC+ eligibility on February 5, 2007. He started self-employment on December 15th. To calculate his prospective self-employment income, he completes a SEIRF for December, January, and February including his actual and expected income and expenses for three months. The worker divides this total by three to determine an anticipated monthly average income amount. This amount is used until a change in self-employment is reported, or until Ricardo completes a new application or a review.

Example 3: Jenny is a BC+ member and CC recipient who has been self-employed as a hair dresser since 2002. Jenny's BC+ and CC *certification period* is December 2006 to November 2007. The worker used Jenny's 2005 tax return to establish a monthly income amount.

In March 2007 Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she'll be able to return to work, but it will not be until at least May. The worker has Jenny complete a SEIRF for February 17- February 28 (actual income since the change in circumstance occurred) and for March and April using the best estimate of income to establish her prospective self-employment income. The worker will use these three months to determine a prospective self-employment income estimate for the remainder of the certification period. Jenny does not need to submit any additional SEIRFs.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a change in circumstances.

16.4.4 Verification

Self employment income is not available through data exchange and therefore questionable (9.10). Completed and signed IRS tax forms (16.4.3.2.1) are sufficient verification of farm and self-employment income. If anticipated earnings are used, a completed and signed SEIRF is sufficient verification.

It isn't necessary to collect copies of supportive items such as receipts from sales and purchases. However, you can require verification when the information given is in question. Document the reason for the request.

16.4.4.1 Self-Employment Hours

Count the time a self-employed person puts in on business related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

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16.5 OTHER INCOME

1. Unemployment Compensation (UC)
2. Child Support
3. Social Security Benefits
4. Federal Match Grants for Refugees
5. Gifts
6. Land Contract
7. Loans
8. Profit Sharing
9. Retirement Benefits
10. Sick Benefits
11. Trusts
12. Gambling Winnings

Other income is any payment that the member receives from sources other than employment. Unless it is disregarded income, count the gross payment in the person's income total.

1. **Unemployment Compensation (UC)** — Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars.

2. **Child Support** — Count child support income as unearned income.

3. **Social Security Benefits** — Count Social Security Benefits as unearned income in the month received.

   Supplemental Security Income (SSI) is not counted (16.2.33).

The following is a brief list of the potential codes that should be used in coding Social Security income types:

SSDC – Social Security Disabled Child
SSDI – Social Security Disability/Wage Earner
SSDW – Social Security Disability/Wife
SSRE – Social Security Retirement
SSSC – Social Security Surviving Child
SSSS – Social Security Surviving Spouse
SSWW – Social Security Disabled Widow(er)

4. **Federal Match Grants for Refugees** — Some refugee resettlement agencies have grants available for refugees for their second, third, and fourth month after arrival in the U.S. These are cash grants and can vary in the amount issued. Count these payments as unearned income.

5. **Gifts** — A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Count Monetary gifts over $30 a calendar quarter. A Calendar quarter is three consecutive months beginning with January, April, July or October.

6. **Land Contract** — Count any portion of monthly payments received that are considered interest from a land contract as unearned income. Do not count the principal as income, because it is the conversion of one asset form to another. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

If the income is received less often than monthly, prorate the income to a monthly amount. Do not begin budgeting this monthly amount until the person first receives a payment after becoming eligible.

Example 1: Bob receives land contract payments from Farmer Brown twice a year, one $500 payment in March and another $500 payment in September.

If Bob is applying in February prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a $500 land contract payment, divide the total income ($500) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month ($500/6 months = $83.33). Begin budgeting this amount in March.

7. **Loans** — If an BC+ member makes a loan (except a land contract), treat the repayments as follows:

    a. Count the interest as unearned income in the month received. In the months following the month the interest payment was received, count the interest payment as an asset.

    b. **Do not count any repayments** toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.

    If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

8. **Profit Sharing** — Count profit sharing income as unearned income.

9. **Retirement Benefits** — Retirement benefits include work-related plans for providing income when employment ends (e.g. pension disability or retirement plans administered by an employer or union).

Other examples of retirement funds include accounts owned by the individual, such as Individual Retirement Accounts (IRA) and plans for self-employed individuals, sometimes referred to as KEOGH plans.

Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt. Payments from an ineligible spouse's work related pension account are also counted as income to the ineligible spouse.

Any periodic payments from individually owned accounts (e.g., IRA) should not be counted as income in the month of receipt. They are considered the same as withdrawals from an applicant's savings account.

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another. BC+ does not

count assets in eligibility determinations.

10. **Sick Benefits** — Count Sick benefits received from an insurance policy such as an income continuation policy as unearned income.

11. **Trusts** — A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term “trust” includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee holds, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

a. The BC+ member.

b. The spouse of the BC+ member.

c. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member’s spouse. This includes a power of attorney or guardian.

d. A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member’s spouse. This includes relatives, friends, volunteers or authorized representatives.

All regular payments, excluding dividends and interest, made under the terms of the trust, from the trust to the beneficiary are unearned income to the beneficiary.

12. Gambling Winnings — Gambling winnings are counted as unearned income in the month of receipt. Gambling losses cannot be used to offset the winnings.

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16.6 FLUCTUATING INCOME

If the amount or frequency of regularly received income is known, average the income over the period between payments. If neither the amount nor the frequency is predictable, do not average; count income only for the month in which it is received.

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16.7 PRORATING INCOME

Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, must be converted to a monthly amount or prorated.

Prorate means "to distribute proportionately."

Example 1: Sally receives a $1,500 Tribal Distribution Payment quarterly. This payment should be prorated for the months between payments. $1,500 is distributed over three months by dividing the amount of money by the number of months between payments. The prorated amount is $1,500/3= $500 a month.

Prorating is applied to a member's income when the income is received less often than monthly. By prorating, income is distributed evenly over the number of months between payments

When an assistance group applies, do not count the prorated income until it is received.

Example 2: Joe receives semi-annual land contract installments of $900. This equals a monthly income of $150 ($900 prorated over six months). He becomes eligible in May. He receives payments in January and July each year. Do not budget any prorated income until July, the first month of receipt after Joe becomes eligible.

If the group becomes ineligible and reapplies before they receive the next installment, use the same prorated amount as before.

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16.8 MIGRANT WORKER'S INCOME

Use annualized earned income for migrant worker's income. "Annualized earned income" is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family's income if it is anticipated that last year's income is the best estimate of the current year's prospective income.

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17 DEDUCTIBLES

17.1 DEDUCTIBLES

Children (under age 19) with income above 150% of the FPL who have access to insurance and pregnant women with incomes above 300% of the FPL can qualify for BC+ by meeting a *deductible*. The deductible amount is calculated for a six month period using the amount of income that exceeds either 150% FPL for children or 300% FPL for pregnant women. The deductible is met by incurring medical expenses that equal the deductible amount.

Disabled pregnant women and disabled children may be eligible for a deductible through BC+ and EBD Medicaid. *CARES* will automatically assign the individual to the deductible with the lowest spend-down amount. The member may choose the deductible of his/her preference.

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17.2 PREGNANT WOMEN

The *deductible* amount for a pregnant woman is the amount of countable income above 300% of the FPL for a six month period. To meet the deductible she or other family members included in the BC+ group must incur medical bills equal to her deductible amount. Once the deductible is met she will be covered under the Benchmark plan with no premium until two months after giving birth.

Note: For eligibility regarding BadgerCare Prenatal for inmates of a public institution or *non-qualifying immigrants*, see 41.2 for that specific policy.

Note: If there is more than one pregnant woman in the BC+ group, all of them become eligible when a deductible is met.

A self employed pregnant woman with income over 300% FPL, who is also the parent or *caretaker* relative of a child, does not have to meet a deductible. She is eligible with no premium under the benchmark plan. If she is not the parent or *caretaker relative* of a born child, she would have to meet a deductible to become eligible for BC+.

A pregnant minor with family income over 300% FPL has the option to either prepay the pregnancy deductible, wait to meet the deductible, or be enrolled as a child with a monthly premium.

If the pregnant woman applies after the birth of her baby and becomes eligible by meeting a deductible in the back dated months, she is only eligible as a pregnant woman until the end of the month she gives birth.

Example: Janet applies for BC+ in July and requests a BC+ deductible period from April through September. She gave birth on June 30th. Janet paid the full deductible amount, so is certified from April 1st through June 30th. She should be tested as a caretaker relative effective July 1st if she is living with the newborn or any other child under her care.

17.2.1 Deductible Period

The pregnant woman can choose to begin the BC+ deductible period as early as three months prior to the month of *application*, and as late as the month of application.

A pregnant woman can choose a BC+ deductible period which includes a month in which, if s/he had applied, s/he would have been ineligible for a non-financial reason. Although excess income is still calculated over a six month period, the individual can only be certified for BC+ during the dates when he or she was non-financially eligible.

Example 1: Luanne applied for BC+ on June 1st and requests a BC+ deductible period from April through September. She gave birth on June 2nd and gave the baby up for adoption. Luanne paid the full deductible amount, so is certified from April 1st through June 30th.

A new deductible period can be established at any time before the current deductible has been met.

Example 2: Julie is pregnant and due November 15th. She applied for BC+ April 1st and a deductible period was set up for April through September. She did not incur enough expenses to meet the deductible. In July, Julie's income decreased and she requested a new deductible period from July through November. Because she had not met the original deductible, the new deductible period could be established.

A pregnant woman who is ineligible for excess income in some backdate months, but has no excess income in others, does not have to choose to have a BC+ deductible. She can choose to be certified in the months she is eligible and to accept the ineligibility of the other months when she had excess income.

Example 3: Rachel is pregnant and applied for BC+ in July. She had no income and did not expect any income in the future. She was eligible in July. She also requested BC+ eligibility for April to cover some medical expenses she had in April. In April and May she had income in excess of 300% of the FPL. In June she would have been eligible because she had no income.

In April and May her income was over 300% of FPL by $200 a month. She has 2 choices:

1. Choose a BC+ deductible period of April through September. After meeting the BC+ deductible of $400 she would be certified for BC+ from April through September or 60 days past the birth of her baby, with no premium.

2. Not choose a BC+ deductible period. She would not have to meet a BC+ deductible. She could be certified immediately for June through 60 days past the birth of her baby but would have to forego BC+ for May and June because of the excess income in May and June.

17.2.2 Calculating the Deductible Amount

To calculate the dollar amount of the BC+ deductible for a pregnant woman:

1. Determine the BC+ deductible period
2. Find the BC+ group's total countable income for each month in the deductible period.
3. Compare the total countable income of each month with 300% of the FPL limit. If a month's countable income is less than or equal to 300% FPL, ignore it. If a month's countable income is more than the income limit

(300% FPL), find the excess income by subtracting the income limit from the countable income of that month.

4. Add together the excess income of the months in the deductible period. The result is the pregnant woman's BC+ deductible amount.

When calculating a deductible amount for backdated months, use the actual, not prospective, income received in the backdated months.

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17.3 CHILDREN UNDER 19

The *deductible* amount for a child under 19 is the amount of countable income above 150% of the FPL for a 6 month period. To meet the deductible, the child or other family members included in the BC+ group must incur medical bills equal to the deductible amount. Once the deductible is met, the child and all other children under 19 in the BC+ group will be covered under the Standard plan without a premium, for the remainder of the deductible period.

17.3.1 Deductible Period

The deductible period for a child under 19 begins with the month the request for a deductible was made. There is no backdating option for a child under 19.

Example: On July 1st, John's mother and step-father apply for BC+ for themselves, John and John's two step-brothers. The family's countable income is above 150% FPL. John's mother has employer sponsored insurance that covers her and John. John is ineligible for BC+ due to the insurance access. John's step brothers and step father are eligible for BC+ with a premium, in the benchmark plan. Because the health insurance does not cover all of John's medical expenses, in August John's mother requests a deductible for John. The deductible period is August through January. John has medical bills that will meet the deductible as of September 1st. John and his two step-brothers will be covered under the standard plan with no premium from September through January.

The BC+ deductible period for a child can include a month in which, if s/he had applied, s/he would have been ineligible for a non-financial reason other than health insurance access or coverage. Although excess income is still calculated over a six month period, the child can only be certified for BC+ during the dates when he or she met all non-financial criteria other than health insurance access or coverage.

A new deductible period can be established at any time before the current deductible has been met.

17.3.2 Calculating the Deductible Amount

To calculate the dollar amount of the BC+ deductible for children under age 19:

1. Determine the BC+ deductible period.

2. Find the BC+ group's total countable income for each month in the deductible period.

3. Compare the total countable income of each month with 150% of the FPL limit. If a month's income is less than or equal to 150% FPL, ignore it. If a month's income is more than the income limit (150% FPL), find the excess income by subtracting the income limit from the countable income of that month. The child could choose to drop the deductible for months his/her income drops below 150% FPL and enroll in BC+ for those months.

4. Add together the excess income of the months in the deductible period. The result is the child's BC+ deductible amount.

Example: John, age 14, is ineligible for BC+ because his household's countable income is over 150% of the FPL and he is covered under his mother's employer sponsored health insurance plan. The household's size is 5. Their countable income is $3466.25 per month, which is $366.25 over the 150% FPL for a group size of 5. John's six month deductible amount is $2197.50.

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17.4 MEETING THE DEDUCTIBLE

17.4.1 When expenses can be counted toward a Deductible
17.4.2 Countable expenses
17.4.3 Expenses that can not be counted toward a Deductible

The BC+ member or group meets the *deductible* by incurring medical or remedial costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the

deductible, the pregnant woman or child under 19 can be certified for BC+ through the end of the deductible period.

If an expense was applied to a prior deductible but did not result in BC+ certification, it can be applied to a later deductible, as long as it still meets the criteria listed in (17.4.1).

17.4.1 When expenses can be counted toward a Deductible

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be incurred by a member of the child's or pregnant woman's BC+ group.

   Expenses may also be counted if incurred for someone the pregnant woman is legally responsible for if that individual could be counted in the member's BC+ group. The medical bill may be used even if the family member is no longer living or no longer in the current BC+ group.

Example 1: Sally's minor child Ida died of leukemia in April. In September, Sally requests that a medical bill incurred for Ida be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long as it did not result in a BC+ certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense described in 17.4.2.

3. Meet one of the following four conditions:

   a. Still be owed to the medical service provider sometime during the current deductible period.

   Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a BC+ deductible.

   - The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
   - If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
   - Because many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred

charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 2: In May, Helen resided in an Institute for Mental Disease (*IMD*) and incurred a $14,000 bill. In October, Helen becomes pregnant and applies for BC+.

Helen turned in the bill for the stay in the IMD which shows the amount as ’r;deferred charges’ which means the member would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can use this "deferred" charge toward her deductible.

Example 3: Lestat’s parent applies for BC+ in July 2008. A BC+ deductible of $700 is calculated for him. In January 2003, he had a blood transfusion. The bill for the transfusion was $800. The bill was never paid. Lestat can use the unpaid bill to meet his BC+ deductible, but must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

b. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 4: Estelle applies for BC+ in March. A deductible period is set up for March through August. In April, she had a two-year-old medical bill of $300 written off. She can apply the $300 toward the March - August deductible because it was written off during the deductible period.

c. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 5: Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 6: Malcolm is in his second deductible period which began March 1, 2007. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February 2006. He may not apply this toward his current deductible.

Example 7: Norah is in her second deductible period which began in September. In June, Norah met her deductible and was certified for BC+. After certification, and before the prior deductible period ended in August , Norah paid for medical services that were not BC+ covered services. Norah can apply these paid bills to the deductible period that began in September.

d. Paid or written off some time during the three months prior to the date of *application*. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 8: Julie applies for BC+ in August. Her deductible for the period from August through January is $1500. On May 10th she paid off a $2000 outstanding medical bill. She can use that expense to meet her deductible because it was paid in the three months prior to the date of her application. The remaining $500 cannot be applied to future deductible periods.

17.4.2 Countable expenses

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by BC+. Medical expenses for services or prescriptions acquired outside of the U.S. may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles, co-payments and premiums for BC+, Medicare, private health insurance; and bills for medical services which are not covered by the Wisconsin BC+ program.

   Note: MMIS data may be used to calculate BC+ co-payments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying or reducing a medical or health condition. Some examples of remedial expenses are:

   a. Case management.

   b. Day care.

   c. Housing modifications for accessibility.

d. Respite care.

e. Supportive home care.

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- Assistance with activities of daily living
- Attendant care
- Supervision
- Reporting changes in the member's condition,
- Assistance with medication and medical procedures which are normally self-administered, or
- The extension of therapy services, ambulation and exercise.
- Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the member's safety, well being and care at home.

f. Transportation.

g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

Remedial expenses do not include housing or room and board expenses.

3. Ambulance service and other medical transportation including attendant services

4. Medical insurance premiums paid by a member of the BC+ Group. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible...

Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).

6. The cost of medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.

7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.

8. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in # 1 through 7 above.

Examples include:

- General Assistance
- Community Options Program
- AIDS Drug Assistance Program (ADAP)

Example 1: Jenna receives a medical service which will be paid by ADAP. When Jenna becomes pregnant and applies for BC+ she has a deductible to meet. This medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 2: Sally received a medical service in January which was paid by the state administered; state funded Community Options Program in the same month. In February Sally applies for BC+ for herself and her son, James. Sally has access to health insurance so James must meet a deductible. Since the medical bill was paid by COP within three months of Sally's BC+ application it can be used to meet James' BC+ deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in (17.4.2).

Example 3: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for BC+ on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 4: Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February Charlie's mother applies for BC+. Charlie has to meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's BC+ application, it can be used to meet Charlie's BC+ deductible.

17.4.3 Expenses that can not be counted toward a Deductible

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.

2. Medicare Supplemental Medical Insurance (Plan B) premiums since they are deducted from the income prior to the deductible calculation

3. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by BC+, Medicare or other Insurance.

Example 1: The costs of medical services provided to an incarcerated person are not allowed as expenses to meet a deductible. The incarcerating authority is the legally liable third party.

4. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in (17.4.1).

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17.5 ORDER OF BILL DEDUCTION

When applying medical bills to the *deductible*, start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

17.5.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is sometimes difficult to know when the patient met the deductible.

For this reason, if the patient's hospital bill for one continuous stay in the hospital is equal to or above the deductible amount on the date of admission, the first day of admission is the date of service for the entire bill. The hospital bill is applied to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example: Linda submits a $2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for $2,500 with a date of service of July 12th. Apply the $2,000 hospital bill to the deductible first.

17.5.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

The entire "global" pregnancy fee is counted as an expense as of the date an agreement was signed.

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17.6 PREPAYING A DEDUCTIBLE

17.6.1 Insufficient Funds
17.6.2 Payment of Entire Deductible Amount
17.6.3 Combination of Payment and Incurred Expenses
17.6.4 Combination of Payment and Outstanding Expenses
17.6.5 Calculation Errors

Anyone can prepay a BC+ *deductible* for him/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment prior to the begin date of the corresponding deductible period.

Instruct the member to make the payment payable to the local Income Maintenance Agency. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and BC+ ID number.

17.6.1 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

17.6.2 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example: Laura's deductible period is from March 1st through August 31st. The total deductible amount is $1,000. Laura submits payment of $1,000 on August 15th. Laura's BC+ eligibility begins on March 1st.

17.6.3 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example: Gloria's deductible period is from March 1st through August 31st. The total BC+ deductible amount is $1,800. Gloria submits a medical bill with a March 8th date of service for $800. On July 15th, she submits payment of $1,000. Gloria's BC+ eligibility begins March 8th. A BC+ Remaining Deductible Update (F-10109) must be submitted to identify the provider of service on March 8th and the $800 member share amount.

17.6.4 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example*:* Roberta's deductible period is from March 1st through August 31st. The total BC+ deductible amount is $1,500. She submits an outstanding bill

from January 10th for $500. On August 15th, she submits payment of $1,000. Roberta's BC+ eligibility begins March 1st

Enter the first date of the deductible period on AGTM as the date the payment was received.

17.6.5 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS. If the error was caused by an *applicant*/member error, see (28.2) for determining the overpayment amount.

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17.7 REMAINING DEDUCTIBLE

When the member receives a medical bill that is equal to or greater than the amount s/he still owes on the *deductible*, s/he can be certified for BC+. However, s/he is still responsible for the part of the bill that equals the deductible. BC+ will consider the remainder of the bill for payment. See (Process Help Chapter 19 Deductibles).

A BC+ Remaining Deductible Update (F-10109) must be sent to the fiscal agenct indicating the amount of the bill that the member owes. The *Fiscal Agent* subtracts this amount from the bill and BC+ pays the rest.

Fill out the BC+ Remaining Deductible Update (F-10109) only if:

1. A BC+ certified provider has provided the billed services.

2. The person, having met the deductible, is being certified. If s/he is not being certified, BC+ will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the member is not eligible until s/he has met the deductible, s/he still owes for all bills prior to that date.

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17.8 CHANGES IN INCOME

Once the *deductible* has been met, changes in income do not affect the group's eligibility for the remainder of the deductible period.

If there are income changes reported during the BC+ deductible period but prior to meeting the deductible, recalculate the BC+ deductible amount.

1. Add together the monthly excess income of the months of the BC+ deductible period that have already gone by.

2. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.

3. Add the results of #1, #2 and #3.

Example 1: Cicely, a pregnant woman with income over 300% FPL, applied for BC+ in July. She had excess income of $20 a month. Her BC+ deductible was $120. On October 8th, she reports a pay increase of $10 a month. The change is effective for November. The BC+ deductible amount is recalculated by:

1. Adding together the excess income of months July through October. The result is $80.

2. Calculating her November excess income. The result is excess income of $30.

3. Prospective excess income for December is $30.

4. Cicely's new BC+ deductible amount is: $80 + $30 + $30 = $140.

If the income change results in lower excess income in the month of change, the *applicant* can choose to:

1. Recalculate the current BC+ deductible, or

2. Create a new deductible period.

Example 2: Mary, a pregnant woman, goes from full time to part time

employment in the fourth month of her BC+ deductible period. She still has excess income, but it is lower than in the previous three months. She can choose either to recalculate her BC+ deductible to a lower amount or to start a new deductible period.

If she chooses to start a new deductible period, she will forfeit any eligibility she might have acquired in the previous deductible period if she had met the previous deductible.

If the income change results in no excess income the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. Begin eligibility immediately.

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17.9 NON-FINANCIAL CHANGES

If there is a change in non-financial eligibility during the *deductible* period, discontinue BC+ eligibility for those persons who have become non-financially ineligible.

If a child enters the BC+ group after the deductible for another child in the group has been met, that child will also be eligible for the remainder of the deductible period.

If an adult *caretaker* relative who is EBD, or is medically verified as pregnant, enters the BC+ group, his/her name will appear on the BC+ card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, the member may choose:

- To continue with the current deductible period.

OR

- To reapply and establish a new deductible period if his or her income still exceeds the appropriate BC+ income limit.

17.9.1 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, and the deductible is not met, you must recalculate the deductible. Compare the new group's countable monthly income with the new group's 150% FPL limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes.

17.9.2 Death

If the member dies during the deductible period, and is not already certified, look at all countable expenses prior to death. If those countable expenses meet the deductible, certify the person. The time period for the deductible remains six months. All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

If the member prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the member prepays and dies before the deductible period starts, the deductible pre-payment is refundable.

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17.10 LATE REPORTS OF CHANGES

If the member turns in late reports on income changes or medical costs, recalculate the *deductible* as of the date the change took place or the medical cost was incurred. See what would have been the deductible had s/he reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin BC+ certification on that date.

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18 BC+ EXTENSIONS

18.1 BC+ EXTENSIONS

A BC+ extension is a period of eligibility given to a person when the countable household income increases above 100% FPL for the BC+ group size either due to an increase in earned income, an increase in child support income or both; and otherwise meets the BC+ eligibility criteria for persons with incomes below 100% FPL. For example, having access to employer health insurance when the family income increases from 80% to 175% FPL will not make them ineligible for the extension. Access in not an eligibility factor for anyone under 100% of the FPL. However, if a family is also moving out of the State of Wisconsin at the time of the income increase, they would not be eligible for the extension. While on the extension, the member is covered under the standard plan without a premium and is not subject to the insurance access and coverage requirements.

Youths exiting out of home care are eligible for a BC+ extension when they have a natural or adoptive child in the household and that child meets the criteria for an extension. The Youth would be included in the extension when they turn 21 and are no longer eligible as a Youth.

The BC+ extension lasts 12 months when the earned income increases which results in the household income exceeding 100% FPL.

The BC+ extension last 4 months when the income goes above 100% FPL solely due to an increase in child support.

18.1.2 Pregnant Women

A Pregnant woman who is not a parent or *caretaker* relative of a child during her pregnancy, can only become eligible for an extension if she was enrolled in BC+, with income at or below 100% of the FPL, for 3 months once her pregnancy reaches the 8th month. Look back 60 days from her due date or the date the pregnancy ended to determine the 8th month. If she was a parent or caretaker relative and enrolled with income at or below 100% FPL in 3 of the past 6 months she would be eligible for an extension.

Example 1: June, a single woman with no children under her care, was pregnant with a due date of September 8th. She applied for and was enrolled in BC+ effective March 1st. Her income was below 100% of the FPL for the entire time she was enrolled. She gave birth on September 8th and reported the birth and her marriage to the father of the baby to her worker. His income put the countable household income over 100% of the FPL. Since the eighth month of her pregnancy was July (September 8th minus 60 days), she was enrolled in BC+ with income less than 100% for three months (July, August and September), beginning with the 8th month of her pregnancy. She is eligible for a 12 month BC+ extension.

Example 2: Judith and her 2 children have been enrolled in BC+ with income below 100% FPL since January. In March, she reported that she was pregnant with a due date of October 5th. On August 10th, Judith reported she received a raise which caused her countable household income to exceed 100% FPL. Since she was enrolled with income at or below 100% FPL for 3 out of the past 6 months, she and her children are eligible for an extension. Since Judith is eligible as a BCPP, she will retain that status in the Standard Plan with no premium until the end of the month 60 days after the pregnancy ends. At that time she will be put into the extension with her children.

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18.2 INCREASE IN EARNINGS/DECREASE IN GROUP SIZE EXTENSIONS

To receive a 12 month BC+ extension due to an increase in earnings a person must meet the following requirements:

1. The income increase which caused the countable income to exceed 100% FPL must be due solely to:

    a. Increased earnings or,
    b. Increased earnings along with other income (changed or unchanged).

2. S/he must be a BC+ member with income at or below 100% FPL, at the time the income increased to over 100% FPL.

3. At least 1 member of the AG must have been enrolled in BC+ with income that was at or below 100% FPL for at least 3 of the 6 months immediately preceding the month in which the income went above 100% FPL, and

4. S/he must otherwise meet the BC+ eligibility criteria for persons with income below 100% FPL.

At least one member of the BC+ group must remain employed throughout the 12 month extension. If s/he loses employment, end the extension, unless the loss of employment is temporary. Temporary loss of employment occurs for reasons such as equipment break-downs, slack periods, weather restrictions, fire, and retooling of work areas and if the worker is laid off for a definite period of time, or

for an unspecified period, but the employer states s/he will be called back to work eventually.

Example 1: Mary and her two children had been enrolled in BC+ with income below 100% FPL, since January. Her husband Denny moved back into the house in June. When Denny was added to the case with his additional earned income the group's countable income went over 100% FPL. Because Mary and the two children were enrolled in BC+ with income below 100% FPL for three of the prior six months, at the time the income went above 100%, they are eligible for a 12-month BC+ extension. Denny is not included in the extension, because he was not enrolled in BC+ at the time the income increased. The extension continues as long as Denny or another member of the BC+ group remains employed.

A pregnant woman with no born children under her care may be eligible for a 12 month extension, if she was enrolled in BC+ with income at or below 100% FPL for three months beginning with the 8th month of her pregnancy.

Example 2: Mary is a single pregnant woman with no born children. She was enrolled in BC+ effective January 1st, with income at or below 100% FPL for a group size of two. Her due date was April 15th and she gave birth on April 24th. She contacted her worker to report both the birth of the baby and her marriage to the baby's father. When the worker added the newborn and husband to the case, the husband's earned income caused the group's countable income to exceed 100% FPL for their group size. Since Mary was enrolled in BC+ with income at or below 100% FPL for three of the past six months and those three months were from the 8th month of pregnancy on (March, April and May), she is eligible for a 12 month extension. The baby is eligible for the newborn extension and her husband would be tested for BC+.

18.2.1 SSI Exception

A person who was eligible for SSI benefits may be eligible for a BC+ extension if s/he loses SSI and would have been eligible for BC+ with countable income at or below 100% if she had not been an SSI recipient.

Example 1: Mary is receiving SSI. Her two children are enrolled in BC+ with countable income at or below 100% FPL. Mary started a job and her earnings put her above the SSI income limit. Her earned income also caused the BC+ countable income to exceed 100%FPL. Both Mary and her two children are eligible for a 12 month BC+ extension

18.3 INCREASE IN CHILD SUPPORT INCOME EXTENSIONS

If a BC+ member's countable income increases above 100% FPL and all or part of the excess income consists of child support income, grant an extension of either four or 12 months depending on the case circumstances.

18.3.1 Four Month extension

The four month BC+ extension applies only if at least one member of the BC+ group was enrolled in BC+ with countable income at or below 100% FPL for at least three of the six months immediately preceding the month in which the countable income exceeded 100% FPL.

Give the four-month child support extension when all four of the following conditions exist:

1. There is countable income in excess of 100% FPL for the group size,
2. Child support income is included in the countable income (changed or unchanged),
3. There has been no increase in earned income, and
4. S/he must otherwise meet the BC+ eligibility criteria for persons with incomes below 100% FPL.

18.3.2 Twelve Month extension

The 12 month BC+ extension applies only if at least one member of the BC+ group was enrolled in BC+ with countable income at or below 100% FPL for at least three of the six months immediately preceding the month in which the countable income exceeded 100% FPL.

Give the 12 month child support extension when

1. Earned income increased but child support income remained the same or
2. Both earned income and child support income increased.

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18.4 INCOME CHANGES DURING THE EXTENSION

During an extension, a group or individual's income may decrease to an amount at or below 100% FPL for the group size and then increase again to exceed the 100% FPL. When the income decreases, the individual will be removed from the extension and placed in regular BC+. The remaining months of the extension will continue to run in the background. If the individual's countable income again increases above the 100% FPL, s/he would be eligible under the previous extension for any remaining months. If the individual is eligible for a new extension when the income again increases, because s/he meets all of the criteria above, choose the extension which gives the longest coverage, and cancel the other.

Example 1: A BC+ group with a 12-month extension from January through December has a decrease in income in February that puts them back below 100% FPL. The extension continues to run while the group is on regular BC+. In October the group's countable income again increases to above 100% FPL, this time due to an increase in Child Support income. They are now eligible for a four-month child support extension which would run from November through February. Since the four month extension would be longer than the current extension, apply the new four-month extension.

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18.5 LOSING AN EXTENSION

A BC+ member loses an extension if one or more of following happens:

1. S/he fails to cooperate in providing third party health insurance coverage (TPL). Children under 19 are exempt from any penalty for not cooperating with this requirement.

2. S/he loses employment when the extension requires that someone in the group remain employed.

3. All children under the parents or caretaker relative's care have either left the household or turned 19.

If a condition necessary for an extension is lost, the extension is not regained solely by recovering the lost condition.

Example: A group has an extension that requires someone in the group to remain employed. Since no one in the group is currently employed, the extension is lost. The group does not regain the extension if someone goes back to work.

18.5.1 Leaving Wisconsin

If a BC+ member is eligible for an extension and moves out of Wisconsin, s/he loses the extension. S/he can regain the extension if s/he returns and becomes a Wisconsin resident again during any month in the original extension period.

Example 1: Earl, a Wisconsin resident, received a 12-month extension beginning January 1, 2008. He moved out of state, thus losing his extension. On May 1, 2008, he moved back to Wisconsin and became a Wisconsin resident again. He regained the extension at the time he moved back to Wisconsin and became a Wisconsin resident.

If the time period of the extension expires while the person is out of state, s/he does not regain the extension.

Example 2: Gloria, a Wisconsin resident received a 12-month extension beginning January 1, 2008. She moved out of state, thus losing her extension. In February 2009, she moved back to Wisconsin and became a Wisconsin resident again. She does not regain the extension because the time period has expired.

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18.6 TRANSITIONAL GRANDFATHERED INDIVIDUALS

Any individual who was eligible for Family Medicaid or BC at the time of the implementation of BC+ who was determined, at implementation, to be ineligible for BC+ solely due to excess income, will be eligible for BC+ under the Transitional Grandfathered (BCPT) program.

As long as s/he continues to meet all non-financial criteria the individual will remain BCPT eligible for 12 months after the implementation of BC+ unless s/he becomes eligible for BC+, other than as BCPT.

While eligible as BCPT, the member will be covered under the Standard Plan. Once the member loses BCPT eligibility s/he will not be able to regain BCPT eligibility.

If the BCPT individual owed a BC premium in the month prior to implementation of BC+, the BC+ premium amount will remain the same as the BC premium. See Chapter 19 for more specific rules on premiums for BC+.

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19 PREMIUMS

19.1 BC+ PREMIUMS

The following individuals must pay a premium to become or remain eligible for BC+:

1. Children in families with income over 200% of the Federal Poverty Level (FPL).
2. Parents, stepparents and *caretaker* relatives with income from 150% through 200% of the FPL; and
3. Self-employed parents, stepparents and caretaker relatives with income over 200% of the FPL.
4. Former BadgerCare recipient parents who were paying premiums in December 2007 and are eligible for BC+ as transitional grandfathered.

The following individuals are not required to pay a premium:

1. Children who are verified members of an American Indian tribe or an Alaskan Native with family income at or below 300% of the FPL;
2. Pregnant women age 19 and above;
3. Pregnant women under age 19 with income at or below 300% of the FPL;
4. Youths exiting out of home care. (Chapter 11)
5. Children who have met a BC+ *deductible*, during the remainder of the deductible period;
6. Children and caretaker relatives in a BC+ Extension, and
7. Parents during the one year of Transitional coverage and who did not owe a premium in December 2007.
8. Continuously Eligible Newborn (Chapter 8.2) .

For FPL limits see Chapter 50.1.

Note: Persons who are members of families receiving BC+ benefits, but who are individually certified for EBD Medicaid, Well Woman Care, Family Planning Only Services or Emergency Services, are not charged a BC+ premium.

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19.2 PREMIUM CALCULATIONS

Under BC+, premiums are initially calculated on an individual basis and then a total for the case is determined. *CARES* will calculate the premium for each case. The general rules for calculating the premium amounts are as follows:

1. The minimum monthly premium amount is $10 per person.

2. For children with a family income above 300% of the FPL, the individual premium shall not exceed the full per member per month cost of coverage for a child.

3. For parents, stepparents and *caretaker* relatives, with a family income above 150% and not exceeding 200% of the FPL, the individual premium shall not exceed the full per member per month cost of coverage for an adult.

4. For self-employed parents, stepparents and caretaker relatives, with incomes above 200% of the FPL before subtracting the *depreciation* but below 200% of the FPL after subtracting the depreciation, the caretaker relative's share of the premium shall be 5% of the family's net income, before subtracting depreciation from the self-employment income.

5. For families with income between 150%-300% of the FPL, the combined total of all family members' premiums may not exceed 5% of the family's countable income. One exception is for families that include a child living with a *caretaker relative*. The 5% cap will apply to each child living with a caretaker relative separately as well as to the caretaker relative, his or her spouse and children.

6. For families with income over 300% of the FPL, if at least one member of the case is eligible for BC+ as a self-employed adult or as a grandfathered individual, the combined total of all family members' premiums will be

either the total of all children's premiums, or 5% of the family's income, whichever amount is greater. One exception is for families that include a child living with a caretaker relative. If the only BC+ eligible members are children under 19, the 5% cap does not apply and the family owes the per member per month premiums for the children.

7. For families with income below 300% of the FPL, the combined total of all family members' premiums, including the 5% premium cap will be rounded down to the nearest whole dollar amount.

8. For families with income at or above 300% of the FPL, premium amounts and the 5% caps will not be rounded.

9. For pregnant women under age 19 with income over 300% of the FPL, the individual premium shall not exceed the full per member per month cost of coverage for a child with a family income of 300% of the FPL.

10. For grandfathered caretaker relatives, the total assistance group premium shall equal the premium amount they paid in December 2007.

Pregnant women may sometimes fall into one of the other premium groups. In those cases, the following rules apply:

1. Pregnant minors with income between 200% and 300% of the FPL are not charged a premium.

2. Pregnant minors with income over 300% of the FPL are charged the child's premium rate.

3. Pregnant parents, stepparents or caretaker relatives with income between 150% and 200% of the FPL are not charged a premium.

4. Pregnant self-employed parents, stepparents or caretaker relatives with income between 200% and 300 % of the FPL are not charged a premium.

5. Pregnant parents, stepparents or caretaker relatives with self-employment income above 300% FPL are not charged a premium and do not have to meet a *deductible*.

For those individuals with a calculated premium less than $10, the premium will be $10. All premium amounts are for eligible individuals in the group.

The premium for the BC+ group is the total of the individually calculated premiums for the children and adult caretaker relatives included in the group. For example, a household with three children and family income between 200%

and 210% of the FPL will owe $30, or $10 per eligible child in the family.

The total amount of gross premiums after being compared to the 5% limit is then rounded down to the nearest whole dollar for families with incomes at or below 300% of the FPL.

Premium amounts are not rounded down for households with family incomes over 300% of the FPL.

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19.3 PREMIUM LIMITS

With three exceptions (listed below), families with incomes at or below 300% of the FPL will never have to pay in excess of 5% of the family income for their total premiums.

The 5% caps will be calculated for income ranges of 10% of the FPL. For example, the 5% cap would be the same for a family with income at 151% of the FPL as it would for a family with an income at 158% of the FPL.

1. Children living with caretaker relatives exception: Unlike children living with their parents, eligibility for children living with caretaker relatives is determined separately from their caretaker relatives and from other children living with the *caretaker relative*. The amount of their premium is based solely on their income. The 5% cap on the child living with a caretaker relative premium is calculated separately from the caps on the premiums for other children living with caretaker relative in the household and from the cap on the premium for the *caretaker* relative and the caretaker relative's immediate family.

2. Exception for children and self-employed parents with incomes over 300% of the FPL: Usually the 5% premium owed for self-employed parents will not exceed the amount of the per member per month (PMPM) cost of the children's premiums. However, some larger families with more than five children will have PMPM costs greater than 5% of the family's income. For those families, collect the full PMPM per cost for those children even though it exceeds the 5% limit. For those families, no additional premium amount will be owed for the self-employed parents.

3. Exception for cases with adults in a transitional grandfather group that includes children. The total per member per month premiums for the children and the premium for the transitional grandfathered individual(s)

will never exceed 5% of the family income or the total of the children's per member per month cost, whichever is greater.

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19.4 PREMIUM PAYMENT METHODS

Upon request from the member, the *fiscal agent* (1-888-907-4455) will provide members with instructions for choosing their preferred payment method from the list below.

Approved payment methods include:

1. Direct payment by check or money order.
2. Electronic Funds Transfer (EFT).
3. Wage withholding from each paycheck received.

Agencies are responsible to provide members with the Wage Withholding (F-13025) and EFT (F-13026) forms upon request, to facilitate the choice of payment method other than direct payment. Instruct the member to mail the completed forms to the address listed on the forms once s/he has chosen a payment method. Direct premium payments must be made until the fiscal agent informs the family the EFT and wage withholding has been set up.

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19.5 INITIAL PAYMENTS

Payment of the BC+ premium is a non-financial condition of eligibility. Initial premium payments must be made before eligibility is confirmed and the members are enrolled. The first month is free if no one in the BC+ group was eligible for BC+ or Medicaid in the previous month, and the BC+ AG has not received a free month in the previous 12 months. Consider someone with an unmet *deductible* as not being eligible for BC+.

The Income Maintenance agency is responsible for collecting the initial payments and recording the payment in *CWW*. Acceptable payment types include: check (personal, cashiers, travelers, etc.) or a money order. Check must be issued to

BC+.

A BadgerCare Plus Premium Information/Payment form (F-10139) must be sent to the *fiscal agent* along with the payment. The BC+ AG *CARES* case number must be included on the form (F-10139) and on the check. The BadgerCare Plus Premium Information/Payment form (F-10139) can be found at http://dhs.wisconsin.gov/forms/F1/F10139.pdf. Mail the initial BC+ premium payment (check or money order) and completed form directly to the BC+ lockbox at:

BC+
c/o Wisconsin Department of Health and Family Services
Box 93187
Milwaukee, WI 53293-0187

The eligibility policy and timeframe procedures for premium payments are as follows:

1. Initial eligibility date and confirmation occur in the month of *application*.

   When an application is processed in the same month it was received, and a premium for the initial month of eligibility is not due because they are eligible for a free month, the premium for the second month of eligibility must be paid in advance before a family can be enrolled in BC+.

Example 1: Lisa and her family applied for BC+ on January 25th. On January 31st, the worker determined that the family met eligibility requirements effective January 1st. Since the family had not been previously eligible for BC+, a premium for January was not assessed since they were eligible for the free month. However, Lisa had to pay the February premium for her family before their eligibility could be confirmed.

2. Eligibility begins in the month of application - confirmation occurs in a future month.

   When an application is not processed within the 30-day application processing period and the family is eligible for a free month, the family must pay both the second and third months' premium before enrollment. CARES requires that premiums for both the second and third months be paid before confirmation when eligibility is processed any time in the third month.

Example 2: Cheryl and her family applied for BC+ on March 25th. No one in her family was eligible for BC+ in the previous month. At Cheryl's request, the IM worker extended the 30-day processing time period by ten days for additional verification. The application for BC+ was processed on May 2nd, but the family was determined eligible effective March 1st. A premium is not

due for March because it is a free month. However, Cheryl had to pay the premium amount for April and May before BC+ eligibility could be confirmed.

3. Eligibility begins in a future month, but application is processed in the month of application.

   When an application is processed within 30 days but eligibility does not begin until a future month, the free month is the first future month of eligibility. The family will receive an invoice for the premium amount through the mail. S/he must pay the premium due for the second month by the tenth of the benefit month to remain eligible for BC+.

Example: Arnie and his family applied for BC+ on April 12th. He and his family were determined to be eligible for BC+ beginning May 1st. A premium is not assessed for May. A coupon for Arnie's June premium was mailed on May 20th with payment due by June 10th.

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19.6 ON-GOING PAYMENT

BC+ premiums are due on the tenth of the benefit month, regardless of which payment method is chosen.

1. For families who have chosen "direct pay" as their payment method, the *fiscal agent* sends out the BC+ premium coupons on the 20th of the month before the benefit month.

2. Electronic funds transfer occurs on the third business day of the benefit month.

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19.7 ADVANCE PAYMENTS

Payments can be made in advance (further than the next month), but the payment cannot exceed the current *certification period*.

If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial month payments). If the income amount changes, the premium amount will be recalculated and the member will be notified through *CARES* that his/her premium amount has changed. If the premium amount has decreased, the *fiscal agent* will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the member will receive a coupon with the new premium amount. If the premium coupons have already been sent, the member will need to pay the additional amount owed. The member will not receive a coupon for the difference that is owed.

19.7.1 Refunds

Contact the BadgerCare Plus Unit at 1-888-907-4455 to issue a refund if the premium was paid in advance and the premium is for a month in which the:

1. Individual/family was ineligible for BC+.

2. The group's countable income decreased and they no longer owe a premium, if the income change was reported timely.

3. A lower premium amount is due to a change in circumstances which was in effect for the entire month as long as the change was reported within ten days of the date it occurred. The lower premium amount due is the first day of the month in which the change was reported. A refund for the difference will be issued.

Example: A child without any income is added to the BC+ group. Based on the group's income compared to the new group size, a premium is no longer owed. The fiscal agent will refund the premium that was paid in advance.

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19.8 NON-PAYMENT

The failure to pay a premium does not affect the eligibility of any person in the household who does not have a premium obligation. If an individual or family with a premium obligation fails to pay the premium by *adverse action* of the benefit month, BC + will close for those individuals who owed a premium and those individual(s) are not eligible for six calendar months following the date on which their coverage terminated, unless there was *good cause*.

If a late payment is received by the end of the month after the benefit month, lift the *Restrictive Re-enrollment Period (RRP)* (19.11) and reinstate eligibility.

While premiums are initially calculated on an individual basis, the total family premium for a case must be paid to avoid being considered late or unpaid. No partial premium payments will be accepted.

19.8.1 Insufficient Funds

If a BC+ member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds it is considered a non-payment and the BC+ eligibility will terminate. A restrictive re-enrollment (see 19.11) will be applied unless there is good cause (19.8.2). The RRP begins with the first month after closure. If an overpayment occurred, a benefit recovery claim should be established.

19.8.2 Good Cause for Non-Payment

Do not apply an RRP for non-payment if good cause exists. Good cause reasons for not paying the BC premium are:

1. Problems with the financial institution.
2. *CARES* problem.
3. *Local agency* problem.
4. Wage withholding problem.
5. Fair hearing decision.

The member must still pay the arrears before eligibility will begin again.

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19.9 LATE PAYMENTS

Late payments impact eligibility differently, depending on when the late payment is received. Members must pay the overdue payment(s) that resulted in case closure, but do not have to pay the premium owed for the following month, unless the late payment is made after the benefit month.

Example 1: If a premium was owed for September, but is not paid until October, the premiums for both September and October must be paid before eligibility is restored. October eligibility remains in pending status until the payment is received by the agency and recorded in *CARES*.

The case will remain open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by *adverse action* in the benefit month.

If the member pays between adverse action of the benefit month and the last day of the benefit month, eligibility can be restored.

Example 2: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He pays on September 26th. The case closed effective September 30th. Eligibility for October will be restored. He is not required to pay the October premium until October 10th.

If the member pays the owed premium any time in the month after the benefit month, eligibility can be restored. If s/he owes a premium for the following month, s/he must pay that premium before CARES will restore eligibility for BC+. The member must pay the IM agency directly (not *Fiscal Agent*). You can check with the Fiscal Agent to see if a premium has already been collected for that month.

Example 3: Adverse action is September 16th. Jim has not paid his September premium by September 16th. He finally pays on October 26th. His case closed on September 30th. Jim must pay both the premiums for September and October before eligibility can be restored. The November premium is not due until November 10th and does not have to be paid in advance.

If the member pays in the second month after the benefit month, it's considered a non-payment.

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19.10 PREMIUM CHANGES

19.10.1 Decreased premium amount
19.10.2 Increased premium amount
19.10.2.1 Person adds:
19.10.2.2 Effective dates of premium increase (Person Add)

19.10.1 Decreased premium amount

When a change is reported that results in a lower premium amount, it is effective during the month in which the change occurred or the month in which it was reported, whichever is later. The *fiscal agent* will refund any excess premium that was paid.

19.10.2 Increased premium amount

You must give a 10-day notice to the member when the group is required to pay a premium for the first time or is required to pay a higher premium. The increase is effective the following month if BC+ eligibility is confirmed before *adverse action*. If the change is confirmed after adverse action, the increase is not effective until the month after the following month.

Example: Jessica has BC+ with a premium for her and her family. She reports a change in income to her worker on April 23rd that results in a higher premium amount. Jessica's premium amount will increase effective June 1st. She will receive the coupon for the new premium amount at the end of May.

19.10.2.1 Person adds:

If the person add will cause an increase in the premium, *CARES* will not allow eligibility confirmation if the notice requirement cannot be met. Certify eligibility for new members by completing and returning the F-10110 (formerly DES 3070) for the days that cannot be confirmed in CARES.

- Mail:
  HP Enterprise Services
  P.O. Box 7636
  Madison, WI 53707

- E-mail: veds3070@wisconsin.gov

- Fax: (608) 221-8815

19.10.2.2 Effective dates of premium increase (Person Add)

1. If the person was added to the case before adverse action, the increase is effective the next month.

2. If the person was added to the case after adverse action, the increase is not effective until the second month.

Example 1: Rachel's husband Mike moved back into the home on June 1st. She reported the change on June 6th and the agency processed the change

on June 10th (before adverse action). Inclusion of Mike's income resulted in a premium increase. The increase is effective July 1st. Certify Mike's BC+ eligibility effective June 6th by sending in a F-10110 for the dates between June 6th and June 30th.

Example 2: Ann moved back to her parent's home on December 12th and reported it on the 22nd (after adverse action). The agency acted to process the change on the same day. Inclusion of Ann's income resulted in a premium increase. The premium increase is not effective until February 1st. Certify Ann's BC+ eligibility effective December 22nd by submitting an F-10110 for the dates between December 22nd and January 31st.

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19.11 BADGERCARE PLUS RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

19.11.1 Household Changes
19.11.2 Reapplying
19.11.3 Quitting BC+
19.11.4 Good Cause for Quitting BC+

A member for whom a premium is owed for the current month who leaves BC+ by quitting or not paying a premium may be subject to a restrictive re-enrollment period. A *restrictive re-enrollment period (RRP)* means the member cannot re-enroll in BC+ for six months from the termination date while their income remains high enough to owe a premium.

One member in a household may be in an RRP while other members in the same household are still eligible for BC+ or ineligible under a separate RRP. For example, children in the same household as a member on RRP may remain eligible for BC+ if no premium obligation was owed for the children.

Example: Jack, Jill and their three children are open for BC+. Jack and Jill have individual premiums of $30. The children are eligible without a premium. The total family premium is $60. They fail to pay the December premium so Jack and Jill are in a RRP from January through June. The children are still eligible. In March, Jack reports an increase in income and the children now each have a $10.00 ($30.00 total) premium,beginning in April. They also fail to pay the premium for the children, so the children are put in an RRP, from May

through October.

19.11.1 Household Changes

End the RRP when an adult member of the former BC+ group leaves the home during the RRP for one full calendar month. BC+ eligibility may begin the first of the month after the month the adult left or the BC+ group has paid any arrears still owed, whichever is later. The individual does not have to make payments for months they were ineligible.

Example: Dad leaves the home on May 20th. On June 20th, he has been out of the home a full calendar month. Mom may be BC+ eligible starting July 1st, if she pays the arrears owed.

19.11.2 Reapplying

An individual who applies for BC+ before the end of the RRP is ineligible, as long as their income is high enough to require a premium. If the family's income drops to the point where the individuals in an RRP no longer owe BC+ premiums, they may again become eligible for BC+. If the income rises and the members again owe premiums, the individuals are still in the RRP and they are ineligible for BC+.

Example 1: Jackie, John and their three children are open for BC+. J ackie and John have individual premiums of $70. The children are eligible without a premium. The total family premium is $140. They fail to pay the June premium so Jack and Jill are in a RRP from July through December. The children are still eligible. In September, Jackie reports a decrease in income and the family's net income is now at 120% of the FPL. The change was effective in September. Beginning September 1, Jackie and John are again eligible for BC+ without a premium. In addition, because their income is below the premium threshold (150% of FPL), they are not required to pay their arrears first.

Example 2: Same example as the last one, except Jackie reports in November that the family's income in October increased back up to 155% of the FPL. Since the RRP lasted until December 31, Jackie and John are ineligible for BC+ for the month of December. Their three children remain open for BC+. If their income remains above 150%, they must first pay their arrears before becoming eligible at the end of the RRP on January 1.

The individual must serve the full six-month penalty period. Eligibility may begin again in month seven, provided the arrears are paid in full. S/he must pay all arrears for months s/he was eligible with a premium. In addition, if another group in the case has unpaid premiums and are in a different RRP, no one is eligible after the RRP until all the arrears for the case are paid.

Arrears are only forgiven, that is they no longer have to be paid, after the member has not been required to pay BC+ premiums for 12 months. For example, if a family where the parents failed to pay premiums had income below 150% of the FPL for a year after the failure to pay, the parents could again be eligible when they owe a premium and will not have to pay the old arrears.

19.11.3 Quitting BC+

In order for BC+ to be cost-effective, premium-paying members will not be able to pick and choose when they want to pay premiums and receive BC+ benefits. Therefore, if a premium-paying BC+ member decides to quit the program, they will remain ineligible for 6 months or until their income drops below the premium threshold, whichever happens first.

An RRP will not apply if a BC+ member requests to quit BC+ prior to when an initial premium would be owed. If the request is not made in time to terminate eligibility with timely notice, the member is still entitled to the benefit and is not required to pay the premium. However, any arrears must be paid before they can again be eligible with a premium, unless the BC+ group has not been required to pay BC+ premiums for 12 months.

If the request to quit BC+ is made in the premium benefit month, an RRP will be applied if the premium is not paid by *Adverse Action* of the benefit month unless there is a *good cause*.

Example: The member had an income increase which resulted in a November premium. Previously s/he did not owe a premium. S/he tells the worker October 20th, (after Adverse Action), that s/he does not want BC+ for November. Since the member does not owe a premium in October, s/he does not receive an RRP, even though s/he will receive an additional month of BC+ in November. (It is too late to close BC+ for November.)

Note: If s/he does not pay the November premium, s/he will have to pay it before s/he can be eligible for BC+ with a premium again

For this same case, if the member did not tell the worker until November 2nd that they do not want BC+ for November, s/he receives an RRP beginning in December because s/he owed a premium in the current month (November).

19.11.4 Good Cause for Quitting BC+

Do not apply the RRP when an individual who owes a premium for quitting BC+ in the current month voluntarily quits BC+ for these reasons:

1. No person is non-financially eligible for BC+.

2. The individual moved out of Wisconsin.
3. Health insurance became available for the individual.
4. The individual is now eligible without a premium.
5. The individual has an increase in income that makes them BC+ ineligible.

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20 ASSETS

20.1 ASSETS

There is no asset limit for BC+.

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21 - 24 RESERVED

CHAPTER 21-24 (RESERVED)

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PROGRAM ADMINISTRATION (CHAPTERS 25-37)

25 APPLICATION

25.1 APPLICATION

Anyone has the right to apply for BC+; however, individuals under 18 years of age must have a parent or a legal guardian apply for BC + on his/her behalf unless s/he is living independently.

The *applicant* may be assisted by any person s/he chooses in completing an *application*.

Note: Individuals less than 18 years of age have the right to apply for BC+ Family Planning Only Services on his/her own behalf.

Encourage anyone who expresses interest in applying to file an application as soon as possible. When an application is requested:

1. Suggest the applicant use the ACCESS online application at the following site ACCESS.wi.gov ; or

2. Mail the paper application form; or

3. Schedule a telephone or face-to-face interview.

Provide any information, instruction and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP-2477) and *Good Cause* Claim form (DWSP-2019) to each applicant with children applying for BC+ or to anyone that requests either of these.

Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to: http://dhfs.wisconsin.gov/forms/paperfpc.htm.

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the 3 months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than 4 months after the date of death, s/he is not eligible.

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25.2 APPLICATION TYPES / METHODS

BC+ applicants have the choice of one of the four following *application* methods:

1. ACCESS access.wi.gov.
2. Mail-In using the BadgerCare Plus Application Packet (F-10182).
3. Telephone Interview.
4. Face-to-Face Interview.

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25.3 WHERE TO APPLY

The *applicant* must apply in the county in which s/he resides:

The applicant's county of residence at the time of admission must receive and process applications for persons in these state institutions:

1. Northern, Central, and Southern Centers.
2. Winnebago and Mendota Mental Health Institutes.
3. The University of Wisconsin Hospital.

When an applicant contacts the wrong agency, redirect him/her to the agency responsible for processing the *application* immediately. Anytime an application is received in the wrong agency, it must be date stamped and redirected to the agency responsible for processing that application no later than the next business day. The *filing date* remains the date originally received by the wrong agency.

25.3.1 Intercounty Placements

When a county 51.42 board, 51.437 board, human services department or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the applicant's BC+ eligibility. A congregate care facility is a:

1. Child care institution.

2. Group home.
3. Foster home.
4. Nursing home.
5. Adult Family Home (AFH).
6. Community Based Residential Facility (CBRF).
7. Any other like facility.

The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in BC+ and reviews for BC+ members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility. If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

1. The applicant's name, age, and *SSN*.
2. The date of placement.
3. The applicant's current BC+ status.
4. The name and address of the congregate care facility in which the applicant has been placed.
5. The name of the county and agency making the placement.

When there is a dispute about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health Services' Area Administration office for resolution. Pending a decision, the county where the person is physically present must process the application, any changes and reviews.

25.3.2 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when s/he is living outside of Wisconsin. An exception is when a Wisconsin resident becomes ill or injured outside of the state or is taken out of the state for medical treatment. In this case, the application may be taken, using Wisconsin's application forms (25.1), by the public welfare agency in the other state. The forms should be forwarded to the welfare agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.

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25.4 VALID APPLICATION

A valid *application* for BC+ must include the applicant's:

1. Name, and
2. Address, **and** a
3. Signature in the Rights and Responsibilities section of a Wisconsin Medicaid for the Elderly, Blind and Disabled Application / Review Packet (F-10101), on the Medicaid, BadgerCare Plus and Family Planning Services Registration Application (F-10129), the BadgerCare Plus Application Packet (F-10182), the BadgerCare Plus Supplement to FoodShare Wisconsin Application (F-10138) or an electronic signature in ACCESS.

The date the application is received by the IM agency with the applicant's name, address and a valid signature (25.5) is the *filing date*. Applications must be processed within 30 days of the filing date. (See 25.7)

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25.5 VALID SIGNATURE

25.5.1 Witnessing the Signature
25.5.2 Telephone Signature Requirements

The *applicant* or the applicant's *caretaker* relative must sign (using his/her own signature):

1. The paper *application* form,
2. The signature page of the CAF (telephone or face to face) or
3. The ACCESS application form with an electronic signature.

Except when:

1. A guardian signs for him/her. When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on his/her behalf. File the copy of the document in the case record.

   Your agency's social services department determines the need for a guardian or *conservator* (IMM, Ch. I, Part A, 19.0.0). Determine the guardian type specified by the court.

Only the person designated as the guardian of the estate (IMM, Ch. I, Part A, 19.2.0), guardian of the person and the estate, or guardian in general may sign the application. You may not require a conservator (IMM, Ch. I, Part A, 19.4.0) or guardian of the person (IMM, Ch. I, Part A, 19.1.0) to sign the application.

2. An *authorized representative* signs for the applicant. The applicant may authorize someone to represent him/her (IMM, Ch. I, Part A, 18.3.0). An authorized representative must be an individual, not an organization.

If the applicant wishes to authorize someone to represent him/her when applying by mail, instruct him/her to complete the authorized representative section of the application form.

If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Authorization of Representative form (F-10126).

An authorized representative is responsible for submitting the signed application (completed insofar as able) and any required documents.

When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

3. The applicant's durable power of attorney (§ 243.07, Wis. Stats.) signs the application. A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated.

When a submitted application is signed by someone claiming to be the applicant's durable power of attorney:

a. Obtain a copy of the document the applicant used to designate the signer of the application as the durable power of attorney.

b. Review the document for a reference that indicates the power of attorney authority continues notwithstanding any subsequent disability or incapacity of the applicant.

Do not consider the application properly signed unless both of these conditions are met. File a copy of the document in the case record. An individual's Durable Power of Attorney may appoint an authorized representative for purposes of making a BC+ application, if authorized on the

power of attorney form. The Durable Power of Attorney form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent an individual from filing his/her own application for BC+, nor does it prevent the individual from granting authority to someone else to apply for public assistance on his/her behalf.

4. Someone acting responsibly for the individual signs the form on behalf of the individual, if the individual is incompetent or incapacitated.

Example: Carl is in a coma in the hospital. Sherry, a nurse who works at the hospital, can apply for BC+ on Carl's behalf.

5. A superintendent of a state mental health institution or center for the developmentally disabled signs on behalf of a patient.

6. A warden signs the application for an applicant that is an inmate of a state correctional institution that is out for more than 24 hours .

7. The director of a county social or human services department delegates, in writing (retain a copy of this written authorization), to the superintendent of the county psychiatric institution the authority to sign and witness an application for residents of the institution.

The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.

25.5.1 Witnessing the Signature

The signatures of two witnesses are required when the application is signed with a mark.

An agency staff person is not required to witness the signature of a mail-in, online or telephone application.

Note: This does not affect the State of Wisconsin's ability to prosecute for fraud nor does it prevent the BC+ program from recovering benefits provided incorrectly due to an applicant or member's misstatement or omission of fact.

25.5.2 Telephone Signature Requirements

1. An audio recording of the following:
- Key information provided by the household during the telephone interview;
- Signature statement that includes:
    i. Rights and responsibilities;
    ii. Attestation to the accuracy and completeness of information provided;
    iii. Attestation to the identity of individual signing the application;
    iv. Release of information.

2. Store the audio recording in the electronic case file (ECF).
3. Send a written summary of the information provided during the interview. Include a cover letter that outlines the applicant or member's responsibility to review the information provided and notify the agency within ten calendar days if any errors are noted.
4. Store a copy of the written summary and cover letter in the electronic case file (ECF).

Note: Applications that are submitted through ACCESS are signed electronically, so an additional signature (telephone or pen-and-paper) is not needed.

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25.6 FILING DATE

The *filing date* is the day a signed valid *application*/registration form is delivered to the Income Maintenance agency or the next business day if it is delivered after the agency's regularly scheduled business hours.

The filing date on an ACCESS application is the date the application is electronically submitted or the next business day if submitted after 4:30 PM or on a weekend or holiday.

When an application is submitted by mail or fax, record the date that the IM agency received the valid application form.

When a request for assistance is made by phone, the filing date is not set until a signed application and/or *page one* is received by the agency.

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25.7 TIMEFRAMES

All applications received by an agency must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from the *filing date*. This includes issuing a notice of decision.

IM workers should not delay eligibility for an individual in a household when waiting for another household member's citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members. (See 2.2)

Extend the 30-day processing time up to an additional 10 days, if you are waiting for the *applicant* to provide additional information. *CARES* will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due Page.

Deny the *application* for failure to provide information or verification, if:

1. Requested information or verification is required by program policy to determine eligibility (Chapter 9), and

2. The applicant had the power to produce the information or verification, within the period, but failed to do so, and

3. The applicant had a minimum of 10 days to produce the verification.

Example 1: A signed application was received on March 15th. The worker processed the application on April 7th and requested verification. Verification was due April 17th, but was not received by that date. Even though the end of the 30-day application processing period was April 13th, the application should not have been denied until April 18th to allow at least 10 days to provide verification.

If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, determine eligibility using the original filing date.

Example 2: A signed application was received on May 15th. The first day of the 30-day period was May 16th. The end of the 30-day period would have been June 14th. The application was approved on June 20th, and the applicant is determined eligible beginning May 1st.

25.7.1 Changes

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For changes that occur after the confirmation date, follow the adequate and timely notice requirements outlined in IMM Chapter 1.2.2.

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25.8 BEGIN DATES

25.8.1 Backdated Eligibility
25.8.1.1 BC+ Family Planning Only Services
25.8.1.2 Pregnant Women

BC+ eligibility begins the first day of the month in which the valid *application* is submitted and all eligibility requirements are met, with the following exceptions. Those begin dates are the date a valid application is submitted, all eligibility requirements are met, and:

1. *Deductible* — The date the deductible was met.
2. Inmates — The date the member is no longer an inmate of a public institution.
3. Newborn — The date the child was born.
4. Person Adds — The date the person moved into the household.
5. BC+ Prenatal Program — The first of the month in which a completed application is received and the pregnancy is verified.
6. Recent Moves — The date the member moved to Wisconsin.
7. Insurance Coverage ends with *good cause* — The begin date for BC+ is the date following the coverage end date.

25.8.1 Backdated Eligibility

All pregnant women, except those eligible under the BC+ Prenatal program, may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application.

All youth exiting out of home care that meet the criteria in Chapter 11 may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application.

Children, parents and caretakers may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 150% of the FPL.

If certifying for retroactive BC+, do not go back further than the first of the month, three months prior to the application month. Certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month. In the case of children, parents and caretakers, certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month and in addition, family income was at or below 150% of the FPL.

A backdate request can be made at any time, except in the case where the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

If a member has incurred a bill from a BC+ certified provider during a backdate period, instruct the member to contact the provider to inform them to bill BC+. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example: Mary who is pregnant with an August due date, applied for BC+ on April 6th, and was found eligible. At the time of application, Mary did not request a backdate.

In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for BC+ for both months.

25.8.1.1 BC+ Family Planning Services

There is no backdating for BC+ Family Planning Only Services (Chapter 40).

25.8.1.2 Pregnant Women

Except those women eligible only under the BC+ Prenatal Program, backdate a pregnant woman to whichever is more recent:

1. The first of the month in which the pregnancy began.

2. The first of the month, three months prior to the month of application. If a woman was pregnant before the date of her application, backdate her BC+ even though she is not pregnant on the date of application. Do not, however, continue her eligibility as a pregnant woman beyond the end of

the pregnancy. Before backdating her BC+, verify that she has met all the eligibility requirements during the backdated period.

See (41.5) for the BC+ Prenatal *eligibility begin date* policy.

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25.9 DENIALS AND TERMINATIONS

25.9.1 Termination
25.9.2 Denial

25.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, the *applicant* can provide the necessary information to reopen BC+ without filing a new *application*.

If more than a calendar month has passed since a member's enrollment was terminated, the applicant must file a new application to reopen his/her BC+.

25.9.2 Denial

If less than 30 days has passed since the client's eligibility was denied, allow the client to re-sign and date the application or *page one* of the CAF to set a new *filing date*.

If more than 30 days has passed since a client's eligibility was denied and the client is not open for any other program, the client must file a new application to reopen his/her MA.

If the client is open for any other program of assistance, do not require him/her to re-sign his/her application or sign a new application.

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26 REVIEW

26.1 REVIEWS

A review is the process during which you reexamine all eligibility factors subject to change and decide if eligibility continues. The group's continued eligibility depends on its timely completion of a review. Each review results in a determination to continue or discontinue eligibility.

The first required eligibility review for a BC+ case is 12 months from the certification month, except for:

1. **CENS** — The review date is 12 months from the date of birth.

2. **Pregnant women** — The review date is two calendar months after the date the pregnancy ends.

   Note: Women on BC+ Prenatal lose eligibility on the date the pregnancy ends. However, they are automatically eligible for emergency services for two months after eligibility for BC+ Prenatal ends. (Chapter 41.6)

3. **Deductibles** — A review is not scheduled for a case that did not meet its *deductible*, unless someone in the case was open for BC +. For cases that did meet the deductible, the review date is six months from the start of the deductible period.

Note: For manually certified BC+ cases, make sure the member receives a timely notice of when the review is due.

Agency Option

The agency may review any case at any other time when the agency can justify the need. Examples include:

- Loss of contact
- Member request

Note: Shortening certification periods in an attempt to balance agency workload is not permissible.

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26.2 CHOICE OF REVIEW

The member has the choice of the following methods for any BC + review:

1. Face-to-Face Interview.
2. Mail-In (paper *application* or pre-printed renewal packet).
3. Telephone Interview.

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26.3 REVIEW PROCESSING

A BC+ eligibility review notice is generated on the first Friday of the 11th month of the *certification period*. The notice states that "some or all of your benefits will end" if a review is not completed by the end of the following month. Do not schedule a review until after *adverse action* in the month prior to the month of review.

Example 1: *CARES* sends out the review letter on July 7 for a review due in August, do not schedule the review for a date prior to July 18.

Do not require a new *Authorized Representative* form at review, if the person signing the review is the Authorized Representative on file.

If the review is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES, at adverse action in the review month.

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27 CHANGE REPORTING

27.1 CHANGES REPORTED DURING THE APPLICATION PROCESSING PERIOD

For applications, changes that occur between the *filing date* and confirmation date must be reported and considered in the eligibility determination. Changes that are reported after certification must be acted on in the same manner as any other reported change.

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27.2 NON- FINANCIAL CHANGE REPORTING REQUIREMENTS

BadgerCare + members must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy and changes to the pregnancy of a BC+ member
- Living arrangement (e.g. institutionalization, incarceration, etc.)

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27.3 INCOME CHANGE REPORTING REQUIREMENTS

BadgerCare +members are only required to report income changes when their total monthly gross income exceeds the following percentages of the Federal Poverty Level (FPL) for their group size. The income change must be reported by the 10th of the month, following the month, in which the total income exceeded the following thresholds:

- 100% FPL
- 150% FPL
- 200% FPL
- 250% FPL
- 300% FPL

The *CARES* notice will indicate the dollar amount associated with each FPL level, for the BC+ group size.

Example 1: Sally's countable family income has been at 80% of the FPL since she applied in January. In June her income increased to 107%, so she must report the change by July 10th.

Example 2: Heidi's countable family income is 128% of the FPL. In September it increased to 164% of the FPL. Heidi must report this change by October 10th.

Example 3: Steve's countable family income is 265% of the FPL. In December it increased to 411% of the FPL. Steve must report this change by

January 10th.

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27.4 OTHER REPORTED CHANGES

Any other change that is reported, or becomes known to the agency (i.e. through data exchange) must be acted upon.

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27.5 CHANGE REPORTING REQUIREMENTS FOR BC+ FAMILY PLANNING SERVICES MEMBERS:

There are only two changes that BC+ Family Planning Wavier members need to report during the *certification period*:

- Address or
- Living arrangement (e.g. incarceration, institutionalization)

These changes must be reported within ten days after occurrence.

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28 CORRECTIVE ACTION

28.1 OVERPAYMENTS

An “overpayment” occurs when BC+ benefits are paid for someone who was not eligible for them or when BC+ premium calculations are incorrect. The amount of recovery may not exceed the amount of the BC+ benefits incorrectly provided. Some examples of how overpayments occur are:

1. Concealing or not reporting income.
2. Failure to report a change in income.
3. Providing misinformation at the time of *application* regarding any information that would affect eligibility.

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28.2 RECOVERABLE OVERPAYMENTS

Initiate recovery for a BC+ overpayment, if the incorrect payment resulted from one of the following:

1. *Applicant*/Member Error

Applicant/Member error exists when an applicant, member or any other person responsible for giving information on the member's behalf unintentionally misstates (financial or non-financial) facts, which results in the member receiving a benefit that s/he is not entitled to or more benefits than s/he is entitled to. Failure to report non-financial facts that impact eligibility or cost share amounts is a recoverable overpayment.

Applicant/Member error occurs when there is a:

a. Misstatement or omission of facts by a member, or any other person responsible for giving information on the member's behalf at a BC + *application* or review.

or

b. Failure on the part of the member, or any person responsible for giving information on the member's behalf, to report required changes in financial (27.3) (income, expenses, etc.) or non-financial (27.2) information that affects eligibility, premium, patient liability or cost share amounts.

An overpayment occurs if the change would have adversely affected eligibility, the benefit plan or the premium amount.

Note: When a member with health insurance access or coverage fails to report an increase in household income that would put the household's countable income over 150% of the FPL, the change in income results in ineligibility due to insurance access or coverage, not just an increase in the premium or a change in the benefit plan.

Example 1: Joe and his family were determined eligible for BC+ with a

$100.00 total group premium in July. In November, Joe's worker learned that Joe had received a raise September 1st that Joe was required to report by October 10th. The amount of the new family income increased the premium amount to $130.00. The worker entered the new income in *CARES* and confirmed the increase in the premium amount for December.

What can now be recovered?

Because Joe did not report the increase in income to his worker, the premium amount for November is incorrect. The overpayment amount would be the difference between the correct premium for November and the premium amount that was paid.

Example 2: Sally was determined eligible for BC+ Standard Plan in January. In May, the worker discovered that at application Sally had not reported the income from a part time job. The unreported income would have put Sally into the Benchmark Plan with a $30.00 premium. The worker entered the income in CARES and confirmed the premium and the change from the Standard plan to the Benchmark plan effective June 1st.

What can now be recovered?

The overpayment for the months of January through May is the $30.00 per month premium amount plus the difference in the co-pays and *deductible* amounts for services that she should have paid under the Benchmark plan.

Example 3: Shana was determined eligible for Well Woman Services (WWS) in February. She had private insurance, but due to a waiting period for pre-existing conditions, her treatments weren't covered. The waiting period ended July 31st, and the private insurance began to cover Shana's treatment effective August 1st. Shana did not report this to her worker so WWS continued to pay some service costs for Shana until the worker closed the case effective November 30. Since her case would have closed August 31st, if she had reported the change timely, Shana has an overpayment for September through November.

What can now be recovered?

Giving AA notice, WWS would have closed August 31, 2008. The Fee-For-Service claims paid for September, October and November are recoverable, unless her private insurance covers the costs.

Example 4: John and his family were determined eligible for BC+ in June. John accepted a new job in South Carolina and the family moved out of state on July 20th. Since they were no longer residents of Wisconsin, they were no longer eligible for BC+. However, because their move to South Carolina was

not reported, capitation payments continued to be made for John and his family until the worker closed the case effective December 31st.

What can now be recovered?

Giving 10 days to report and following AA logic, the case would have closed August 31, 2005. Fee-For-Service claims and/or HMO capitation payments for September, October, November and December are recoverable.

Example 5: Susan was determined eligible for BC+ in January. She was pregnant with a due date of August 15th. On February 3rd, she miscarried but did not report this change to her worker. Her BC+ eligibility continued until the worker closed the case effective October 31st. Once she was no longer pregnant, she would only have remained eligible for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. Susan was not eligible for the months May through October.

What can now be recovered?

The change should have been reported in February. Allowing for the 2 month extension, BC+ should have closed April 30. The overpayment amount is the amount of the Fee-For-Service claims and the capitation payment made for her from May through October.

2. Fraud

Fraud is also known as Intentional Program Violation (IPV).

Fraud exists when an applicant, member or any other person responsible for giving information on the member's behalf does any of the following:

1. Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.

2. Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.

3. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.

4. Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

If there is a suspicion that fraud has occurred, see 28.6 for information about referral to the District Attorney (DA).

3. **Member Loss of an Appeal**

Benefits a member receives as a result of a fair hearing request order can be recovered, if the member loses the appeal.

A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share,or premium, recover the difference between the initial amount and the new amount.

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28.3 NON-RECOVERABLE OVERPAYMENTS

Do not initiate recovery for a BC+ overpayment if it resulted from a non-member error, including the following situations:

1. The member reported the change timely, but the case could not be closed or the benefit reduced due to the 10-day notice requirement.
2. Agency error (keying error, math error, failure to act on a reported change, etc).
3. Normal prospective budgeting projections based on best available information.

Example: Susan and her daughter Kathy are open for BC+. Susan reported a change in income on April 1st. The worker did not process the change until April 28th, so it was not effective until June 1st. There is no overpayment for May since the change was reported timely, but not acted on by the worker until after *Adverse Action*.

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28.4 OVERPAYMENT CALCULATION

28.4.1 Overpayment Period

28.4.2 Overpayment Amount
28.4.3 Overpayments for Individuals Eligible for Family Planning Services (FPS)
28.4 4 Determining Liable Individual

28.4.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial BC+ *application* or review, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (28.4.2).

Failure to Report

For ineligible cases, if the overpayment is a result of failure to report a required change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

Fraud/IPV

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.

The ineligible period should begin with the application month.

28.4.2 Overpayment Amount

Use the actual income that was reported or required to be reported in determining if an overpayment has occurred.

If the case was ineligible for BC+, recover the amount of medical claims paid by the state and/or the capitation rate. Use the ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

If the case is still eligible for BC+ for the timeframe in question, but there was an increase in the premium, recover the difference between the premiums paid and the amount owed for each month in question. To determine the difference,

determine the premium amount owed and view the premium amount paid on *CARES* screen AGPT.

The overpayment amount is the difference between the premium paid and premium owed even if the premium that was paid was $0.

Example: Tom and his family became eligible for BC+ in June 2008, without a premium. In his application Tom failed to disclose income from a second job which would have resulted in $100 per month group premium. All individuals in the group remained eligible for BC+. This new information was discovered in July 2008.

Overpayment Calculation
$100 premium owed for June
+ $100 premium owed for July
$200 Total premium owed
- $ 0 premium paid
$200 Overpayment

If the unreported information would have placed the individual in the Benchmark plan instead of the Standard plan, the overpayment amount would be the difference in the co-pays and deductibles for the services provided.

If a member error increases a *deductible* amount before the deductible is met, there is no overpayment. Recalculate eligibility and notify the member of the new deductible amount.

If the member met the incorrect deductible and BC+ paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount or the amount of claims over the six month period (whichever is less).

If the member was ineligible for the deductible, determine the overpayment amount. If the member prepaid his/her deductible, deduct any amount s/he paid toward the deductible from the overpayment amount.

28.4.3 Overpayments for Individuals Eligible for Family Planning Only Services (FPOS)

If an individual or case was ineligible for MA or BC+ but would have been eligible for *FPOS*, the calculation of the BC +overpayment amount is as follows:

1. If the incorrect/overpaid FPOS costs were “fee for service” medical claims paid by the state, recover the amount of benefits that were actually paid by the state minus any BC+ premiums which the member may have paid and the amount of any actual FPOS services that were provided.

2. If the incorrect /overpaid BC+ benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the member may have paid and the “average” (currently $19.04) monthly cost of the FPOS.

28.4 4 Determining Liable Individual

Except for minors, collect overpayments from the BC+ member, even if the member has authorized a representative to complete the application or review for him/her.

If a minor received BC+ in error, make the claim against the minor’s parent(s) or legally responsible relative, if the parent or legally responsible relative was living with the minor at the time of the overpayment.

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28.5 MEMBER NOTICE

Notify the member or the member’s representative of the period of ineligibility, the reason for his/her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

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28.6 REFER TO DISTRICT ATTORNEY

See IMM Chapter 11 Program Fraud Overview for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

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28.7 FAIR HEARING

The IM agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

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28.8 AGENCY RETENTION

The IM agency can retain 15% of the payments recovered. See IMM Chapter 3.3.8 *Local Agency* Retention.

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28.9 RESTORATION OF BENEFITS

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his/her BC+ from the date of the incorrect denial or termination through the time period that s/he would have remained eligible.

If the member was incorrectly denied or terminated for BC+ with a premium obligation, allow the member to pick which months s/he would like to receive benefits. Collect all premiums owed for those prior months before certifying the member for the months s/he chose.

If a member already paid for a BC+ covered service, inform the member that s/he will need to contact his/her provider to bill BC+ for services provided during that time. A BC+ provider must refund the amount that BC+ will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

28.9.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BC+ and would result in a refund for the member, determine the correct premium amount

for each month in which it was incorrect and report the error to the fiscal agent's BC+ Unit. The *fiscal agent* will refund the amount of the premium the member overpaid. The report can be made either by:

1. Telephone: 1 (888) 907-4455 or
2. Fax: (608) 251-1513

When submitting a fax, write "Attn: BC+ Premium Refunds".

When reporting the refund to the BC+ Unit, include the:

1. The member's Social Security Number.
2. Months for which a refund needs to be issued.
3. New premium amount.
4. Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

Occasionally, a BC+ member is certified for retroactive Katie Beckett or SSI eligibility for a period of time in which they were also certified for BC+. If the BC+ member paid a premium during this time frame, they are entitled to a refund of any BC+ premiums that they paid during the retroactive Katie Beckett or SSI *certification period*.

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29 NOTICES AND FAIR HEARINGS

29.1 NOTICES

A member must receive a notice at least ten days (see 1.2.2 IMM) prior to a negative action such as a termination of benefits, a change from the Standard plan to the Benchmark plan or an increase in premium.

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29.2 FAIR HEARINGS

Members have the right to a fair hearing, timely case decisions, and accurate notices of decision. See Chapter 1.2 of the IMM for specifics.

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30 AFFIRMATIVE ACTION

30.1 AFFIRMATIVE ACTION AND CIVIL RIGHTS

The Rehabilitation Act of 1973, requires a person with impaired sensory, manual or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Assistance must be provided to all BC+ members to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the Wisconsin BC+ Enrollment and Benefits brochure (P-10167).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

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31 INTERAGENCY TRANSFER

31.1 INTERAGENCY TRANSFER

A case transfer occurs when the primary person receiving benefits from a county or tribal Income Maintenance agency for a particular month, applies for aid from another Income Maintenance agency for the same or next month. The primary person must be a member of a currently open BC+, Child Care, EBD Medicaid, Food Share, or W2 Assistance Group or one that has been closed for less than a calendar month.

The agency to which the member reports the move must collect information about the changes, for example, the new address. If the agency does not have

sufficient information about the changed circumstances, it must request information from the member, according to the BC+ verification policy (Chapter 9).

CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of the *certification period* that was in effect at the time of the transfer. Run eligibility in CARES.

Do not require a review or new *application* for case transfers, except in the following programs:

- Community Waivers (EBD-MEH Chapter 28.1)
- Family Care (EBD-MEH Chapter 29.1)
- *Deductible* Met (EBD-MEH Chapter 24.2)

See 6.1 of the Process Help for information on how to process case transfers.

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32 EXPRESS ENROLLMENT

32.1 EXPRESS ENROLLMENT (EE) FOR CHILDREN

Children can be temporarily enrolled in the BC+ Standard Plan through the Express Enrollment program, if they meet the following financial and non-financial criteria:

1. Under age 19 (Minors under age 18 must apply with a parent/guardian)
2. A U.S. citizen.

    - If the child is younger than age 1, the family's gross income must be at or below 300% of the Federal Poverty Level.
    - If the child is age 1 through 5, the family's gross income must be at or below 185 % of the Federal Poverty Level.
    - If the child is age 6 through 18, the family's gross income must be at or below 150 % of the Federal Poverty Level.

Express Enrollment can begin on the day on which a qualified provider determines that the child meets the criteria listed above by completing an Express Enrollment for Children *application*.

A child is allowed to have only one period of temporary enrollment in a 12 month period. Qualified certifying agencies who can enroll children include:

1. Medicaid Providers.
2. Head Start programs.
3. Authorized Child Care providers.
4. WIC agencies.
5. Faith-based organizations such as the YMCA.
6. Certain Community-based organizations such as the Boys and Girls Club.
7. Authorized agencies offering emergency food and shelter.
8. Elementary and secondary schools.
9. Any other entity the state so deems as approved by the Secretary.

Once certified by *fiscal agent* to temporarily enroll children, the EE certifying agencies will:

1. Complete an online EE application through the ACCESS Partners/Providers portal designed for EE determinations.

2. Provide a temporary BC+ card for the child if s/he meets the non-financial and financial criteria for EE.

3. Provide a denial notice to the child if s/he does not meet the requirements for EE.

4. Advise the *applicant* that a ForwardHealth card will replace the temporary card and provide BC+ benefits for up to two months. (The card will be received within 3-5 business days.)

5. Stress the importance of applying through the local county/tribal agency for continued BC+ eligibility. In addition, they will advise applicants that they may apply for BC+ via the Internet through the ACCESS web site, over the telephone, through the mail or in person.

Once a certifying agency determines a child temporarily enrolled, the child will remain enrolled for up to two months.

If an application is made for BC+ at the local IM agency by the end of the month following the month in which the child was temporarily enrolled, the enrollment period ends the day on which the agency completes processing the BC+ application (if found eligible or if denied).

If a BC+ application is not submitted by the end of the month following the month in which the child was temporarily enrolled, the EE period ends the last day of the month following the month in which the child was enrolled.

If you are unable to finish processing an application by the end of the enrollment period for the child, extend his/her enrollment period for an additional calendar month. Prior to the last date of the enrollment, complete a Medicaid/BadgerCare Plus Certification form (F-10110, former DES 3070) and send to the fiscal agent. Enter the extended date for the enrollment for the child. The medical status code is BU.

If the child is found ineligible for BC+, the enrollment will end with the denial of BC+ eligibility.

Example Joe Green applied for BC+ EE for his son Jim on February 4th, 2008 at the Center Street Boys Club. Jim was temporarily enrolled in BC+ from February 4th through March 31st. Joe submits a BC+ ACCESS application to the local IM agency on February 10th. Jim is found ineligible for BC+ for February and March and the applicant is denied. A notice is sent to Joe informing him Jim is not eligible for BC+ and his BC+ enrollment is terminated effective March 1st.

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32.2 EXPRESS ENROLLMENT (EE) FOR PREGNANT WOMEN

A Medicaid Qualified Provider certified under contract with the Division of Health Care Access and Accountability (DHCAA) can temporarily enroll a pregnant woman in BC+ through the Express Enrollment program.

BC+ Express Enrollment (EE) for pregnant women provides pregnancy related out patient care, including pharmacy services, to pregnant women who meet the following financial and non-financial criteria:

1. Pregnant
2. U.S. Citizen
3. Family income at or below 300% of FPL

If her income is at or below 200%, she will be eligible for prenatal services under the Standard plan, if it is between 201% and 300%, she will be eligible for prenatal services under the Benchmark plan.

The provider will:

1. Medically verify the pregnancy.
2. Complete a BC+ EE for Pregnant Women *application*.

3. Provide a temporary BC+ card if she meets the non-financial and financial criteria for EE.
4. Provide a denial notice if she does not meet the requirements for EE.
5. Advise the *applicant* that a ForwardHealth Card will replace the temporary card and provide prenatal services through BC+ for up to two months. (The new card will be received within 3-5 business days.)
6. Stress the importance of applying through the local county/tribal agency for continued BC+ eligibility. And, advise that the application can be submitted through ACCESS.wi.gov, over the telephone, through the mail or in person.

Note: Non-citizens will be referred to the IM agency for a *BC+PP* eligibility determination.

The qualified provider will also:

1. Submit the completed EE application form to the fiscal agent.
2. When circumstances allow, assist the woman in completing and submitting the BC+ application with the IM agency.

If she applies for BC+ by the end of the month following the month in which she was temporarily enrolled, the enrollment period ends the day on which the agency determines her eligibility.

Example: Sandra's pregnancy was confirmed on January 10th, 2008. She was enrolled in BC+ through the EE program from January 10th through February 28th. She applied for regular BC+ eligibility through the IM agency on January 15th and was found eligible effect January 1st. Her EE will end because the BC+ eligibility will retroactively cover her with full benefits.

If she does not apply by the end of the month following the month in which she was enrolled through EE for pregnant women, the EE for pregnant women period ends the last day of the month following the month in which she was determined eligible for EE for pregnant women. If she is found ineligible for BC+, her enrollment will end following *adverse action* notice.

32.2.1 At the IM Agency

If the woman applies for BC+ at the IM agency on or before the last day of her EE for pregnant women period:

- Verify she is temporarily enrolled by checking her temporary BC+ ID card or MMIS.
- Assist her in filing the application. Consider the application filed if her name, address and signature are on the application.

- If you are unable to finish processing her application by the end of her EE for pregnant women period, extend her enrollment period for an additional calendar month.

Prior to the last date of her temporary enrollment complete a Medicaid/BadgerCare Plus Certification form (F-10110, former DES 3070) and send to the fiscal agent. The medical status code is "BV" for those eligible under the Standard Plan, "BW" for those eligible under the Benchmark Plan. Enter the extended date for the EE for pregnant women.

If she is found ineligible for MA, complete a negative notice (F-16001) to end the EE for pregnant women segment. Check box three and complete the sentence to read: "Your temporary enrollment for pregnant women benefits will be stopped effective (write in date)". Under "Explanation of Action," write the reason BC+ is being denied. Indicate the statutory authority is S. 49.471, Stats.

Mail one copy to the woman and one to the qualified provider. Complete a Medicaid/BadgerCare Plus Manual Certification form F-10110 (formerly DES 3070), indicating the EE for pregnant women end date, and send to the *fiscal agent*. The EE end date is the day the woman is found ineligible for BC+.

If the woman does not apply for BC+, or applies after the end of the month following the month in which she was determined eligible for EE for pregnant women, her EE for pregnant women ends with no extension. Sending a negative notice is not necessary. If she applies after the end of the month following the month she was determined eligible, process the application as you would a standard BC+ application.

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33-37 RESERVED

CHAPTER 33-37 (RESERVED)

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PROGRAM COVERAGE (CHAPTERS 38-47)

38 COVERED SERVICES

38.1 COVERED SERVICES

A covered service is any medical service that BC+ will pay for an eligible member, if billed. The Division of Health Care Access and Accountability (DHCAA) certifies qualified health care providers and reimburses them for providing BC+ covered services to eligible BC+ members. Members may receive BC+ services only from certified providers, except in medical emergencies. BC+ reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-certified provider.

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38.2 STANDARD AND BENCHMARK PLANS

38.2.1 Copayment

BC+ members can be covered under either the Standard or Benchmark Plan. The following chart shows a comparison of some of the covered services and co-payments for each plan. Which plan the member is enrolled in depends on the member's status or the countable income used to determine eligibility for that member.

Services	BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Chiropractic Services	Full coverage. Co-payment $.50 to $3 per service (varies by service provided).	Full coverage. Co-payment $15 per visit.
Dental	Full coverage of preventive, restorative and palliative services.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, extractions for

	Co-payment $.50 to $3 per service (varies by service provided).	both pregnant women and children. Coverage is limited to $750 per year. A $200 *deductible* applies to all services except preventive and diagnostic services. Co-payment is equal to 50% of allowable fee on all services as defined by DHS.
Disposable Medical Supplies (DMS)	Full coverage. Co-payment $0.50 per item.	Coverage of syringes, diabetic pens and DMS that is required with use of a durable medical equipment.) item. No co-payment.
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Co-payments: $0.50 for OTC Drugs $1.00 for Generic Drugs $3.00 for Prescription Drugs Co-payments are limited to $12.00 per member, per provider, per month. OTCs are excluded from this $12.00 maximum.	Generic drug only formulary with a few generic OTC drugs. Co-payment $5 with no limit. Brand name drugs: Members will be automatically enrolled in the Badger RX Gold Plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.
Durable Medical Equipment (DME)	Full coverage. Co-payment $0.50 to $3.00 per item (varies by item provided).	Full coverage up to $2,500 of paid amount in an enrollment year. Co-payment $5 per item.

	Rental items are not subject to a co-payment.	Rental items are not subject to co-payment but count toward the $2,500 cap.
Health Screenings for Children	Full coverage of Health Check screenings and other services for individuals under age 21 years. Co-payment $1 per screening for those 18, 19 and 20 years of age.	Full coverage of HealthCheck screenings. No co-payment. Not covered: HealthCheck "Other" services and Interperiodic services for those under 21 years of age.
Hearing Services	Full coverage. Co-payment $.50 to $3 per procedure. No co-payments for hearing aid batteries.	Limited coverage of services provided by an audiologist. Co-payment $15 per procedure, regardless of the number of procedures performed during one visit. Not covered: Hearing aids, hearing aid batteries, cochlear implants and bone-anchored hearing devices.
Home Care Services (home health, private duty nursing and personal care)	Full coverage. No co-payment.	Full coverage of home health services. Co-payment $15 per visit. Coverage is limited to 60 visits per enrollment year.
Hospice	Full coverage. No co-payment.	Full coverage. Co-payment $2 per day. Services limited to 360 days lifetime.
Hospital - Inpatient	Full coverage. Co-payment $3 per day with a $75 cap per year.	Full coverage with the following dollar amount limits per enrollment year: • $6,300 for stays in a general acute care

		hospital for substance abuse. • $7,000 for stays in an Institute for Mental Disease (*IMD*) for substance abuse treatment. Co-payment $100 for medical stays and $50 per stay for mental health and/or substance abuse treatment. Hospital stays for mental health and substance abuse services have a 30 day limit.
Hospital - Outpatient	Full coverage. Co-payment $3 per visit.	Full coverage. Co-payment $15 per visit.
Hospital - Outpatient Emergency Room	Full coverage. No co-payment.	Full coverage. Co-payment $60 per visit (waived if member is admitted to the hospital).
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). Co-payment $.50 to $3 per visit (limited to the first 15 hours or $500 of services, whichever comes first, provided per calendar year). Co-payment not required when services are provided in a hospital setting.	Coverage of this service is based upon coverage in the Wisconsin State Employees' Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, child/adolescent mental health day treatment, and inpatient hospital stays for mental health and substance abuse.

		Mental health services have no dollar maximum. Inpatient hospital stays (mental health and substance abuse) have a 30 day limit. Substance abuse services are limited to a $7,000 limit. Costs of mental health services apply to this overall limit. Also, there are separate dollar limits for specific substance abuse services: • $4,500 for outpatient substance abuse services including $2,700 for outpatient services (including narcotic treatment) for substance abuse day treatment. • $6,300 for inpatient hospital stays in a general acute care hospital. Co-payment $10 to $15 per visit for all outpatient services: • $10 per day for all day treatment services. • $15 per visit for narcotic treatment services (no co-payment for lab tests). • $15 per visit for outpatient mental health diagnostic interview exam,

		psychotherapy - individual or group (no co-payment for electroconvulsive therapy and pharmacological management). • $15 per visit for outpatient substance abuse services. Services ***not covered*** are crisis intervention, community support program (CSP), Comprehensive Community Services (CCS), out patient services in the home and community for adults, and substance abuse residential treatment.
Nursing Home	Full coverage. No co-payment.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No co-payment.
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage. Co-payment $.50 to $3 per provider, per date of service. Co-payment obligation is limited to the first 30 hours or $1,500 whichever occurs first, during one calendar year (co-payment limits are calculated separately for each discipline.)	Full coverage up to 20 visits per therapy discipline per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. The cardiac rehabilitation visits do not count towards the 20 PT visits. Co-payment $15 per visit. There are no monthly or annual co-payment limits.
Physician Visits	Full coverage, including laboratory and radiology.	Full coverage, including laboratory and radiology.

	Co-payment $.50 to $3 co-payment per service (varies by service provided). Co-payments are limited to $30 per provider per calendar month. No co-payment for emergency services, anesthesia or clozapine management.	Co-payment $15 per visit. No co-payment for emergency services, preventive care, anesthesia or clozapine management.
Podiatric Services	Full coverage. Co-payment $.50 to $3 per service.	Full coverage. Co-payment $15 per visit.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems. No co-payment.	Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems. No co-payment.
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization. No co-payment for family planning services.	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization. No co-payment for family planning services.
Routine Vision	Full coverage including coverage of eye glasses. Co-payment $.50 to $3 per service (varies by service provided).	Full coverage of one eye exam every two years, with refraction. Co-payment $15 per visit.
Smoking Cessation Services	Coverage includes prescription and over-the-counter tobacco cessation products.	Coverage includes generic prescription and over-the-counter tobacco cessation products.

	Co-payment (see drugs)	Co-payment (see drugs)
Transportation	Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service. Co-payments are: • $2 for non-emergency ambulance trips. • $1 per trip for transportation by an SMV. No co-payment for transportation by common carrier or emergency ambulance.	Full coverage of emergency transportation (ambulance). Co-payment $50 per trip.

If you or the member has additional questions, contact Member Services at 1-800-362-3002.

38.2.1 Copayment

A BC+ member may be required to pay a part of the cost of a service. This payment is called a "co-payment" or "co-pay".

Exempt from Co-payments

- Children under age 19 with family income up to 100% of the FPL.
- Children under age 6 with family income above 100% up to 150% of the FPL, except for Continuously Eligible Newborns.
- Children ages 1 through 5 who are Tribal members with family income from 185% to 300% of the FPL.
- Children ages 6 through 18 who are Tribal members with family income from 150% to 300% of the FPL.
- Children under age 19 eligible through Express Enrollment.
- Children under age 19 in an institution.
- Children under age 19 eligible under a BadgerCare Plus Extension
- Pregnant women, except for pregnant girls under age 19 with family incomes above 300% of the FPL.
- Pregnant women eligible through Express Enrollment.
- Pregnant women eligible for the prenatal benefit.

Standard Plan - Nominal Co-payments

- Continuously Eligible Newborns with family incomes above 100% up to 200% of poverty.
- Children under age 6 with family income above 150% up to 200% of poverty.
- Children ages 6 through 18, with family income above 100% up to 200% of poverty.
- Children under age 19 with family income above 150% of poverty who have met a deductible.
- Parents and caretakers up to 200% of poverty.
- Parents and caretakers in BC+ Extensions.
- Youths Exiting Out-of-Home Care.
- Transitional Grandfathered parents and caretakers.

Members covered under the Standard plan will have co-payments ranging from $0.50 to $3.00. Providers are required to make a reasonable effort to collect the co-payment but may not refuse services to a member who fails to make that payment.

Benchmark Plan - Co-payments

- Continuously Eligible Newborns with family incomes above 200% of the FPL.
- Children under age 19 with family incomes over 200% of the FPL.
- Pregnant women under age 19 with family incomes over 300% of the FPL.
- Self-employed parents and caretakers with family incomes above 200% of the FPL.

Members covered under the Benchmark plan may be refused services if the co-payment is not paid in advance.

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38.3 TRANSPORTATION

38.3.1 Ambulance
38.3.2 Specialized Medical a Specialized Medical Vehicle (SMV)
38.3.3 Managed Care
38.3.4 Common Carrier
38.3.5 Transportation to Out-of-State Providers
38.3.6 Transportation Administration

38.3.7 Reimbursement
38.3.8 Transportation Waiver

Federal regulations require that BC+ programs provide transportation to members who need to obtain BC+ services. Transportation by ambulance, specialized medical vehicle (SMV) or IM agency approved common carrier is a covered BC+ service when provided in accordance with the appropriate sections below.

38.3.1 Ambulance

Ambulance transportation is a covered service, if it is provided by a BC+ certified ambulance provider, and the member is suffering from an illness or injury that rules out other forms of transportation, and only if it is for:

1. Emergency care when immediate medical treatment or examination is needed to deal with or guard against a worsening of the person's condition.
2. Non-emergency care when authorized in writing by a physician, physician assistant, nurse midwife or nurse practitioner.

The IM agency is not responsible for prior authorization for ambulance services.

38.3.2 Specialized Medical a Specialized Medical Vehicle (SMV)

An SMV is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of an SMV must have first aid training and CPR certification.

SMV transportation is a covered service if the person is legally blind, or indefinitely or temporarily disabled as documented in writing by a physician, physician assistant, nurse midwife or nurse practitioner. The documentation from the provider must indicate why the person's condition prevents him/her from using a common carrier or private vehicle. In the case of a temporary disability, the documentation must indicate the expected length of time SMV services will be necessary, as well as why the person cannot use common carrier transportation.

SMV services are available only for transportation to a BC+ covered service (including community waiver services if transportation is included in the per diem). A member's age, place of residence, lack of parental supervision or lack of a driver's license are not qualifying criteria for SMV services.

The IM agency is not responsible for prior authorization for SMV services, but may refer a member who is unable to use common carrier to a BC+ certified SMV provider.

38.3.3 Managed Care

BC+ HMOs and special managed care programs authorize and reimburse transportation providers for ambulance and SMV services. Care Management Organizations (CMOs) do not cover common carrier or ambulance service, but do contract for SMV services. If a member is not in an HMO, s/he can call 1-800-362-3002 with questions on ambulance or SMV providers.

38.3.4 Common Carrier

Common carrier means any mode of transportation approved by an IM agency, except an ambulance or an SMV.

Standard Plan

Policy and procedures for common carrier services are the same under the BadgerCare Plus Standard Plan as they are under the current Wisconsin Medicaid program.

Benchmark Plan

Policy and procedures for common carrier services are the same under the BadgerCare Plus Benchmark Plan as they are under the current Wisconsin Medicaid program. See "Transportation" in 38.2 Standard and Benchmark Plans.

Family Planning Only Services (See definition in chapter 40.1)

Common carrier services are not covered under BC+ Family Planning Only Services (*FPOS*). Under the current Special Terms and Conditions (STC) for this Medicaid Waiver, transportation services are no longer covered. The current STC are effective for the period January 1, 2008 through December 31, 2010.

38.3.5 Transportation to Out-of-State Providers

Except for services provided by BC+ certified "border-status" providers, all non-emergency out-of-state services require prior authorization from the BC+ program. According to s. HFS 101.03, a border-status provider is, "a provider located outside of Wisconsin who regularly gives service to Wisconsin recipients and who is certified to participate in BC+."

If the BC+ program approves a request for out-of-state health care services, the transportation to receive the service may be covered if authorized by the IM agency. The IM agency may approve a request for the transportation only if prior authorization has been granted for the health care service that the member will be receiving from the out-of-state provider. The IM agency should not approve

requests for out-of-state transportation if the BC+ program has not authorized the out-of-state health care service.

As with other travel, approve the least expensive means of transportation, which the member can use, and which is reasonably available when the service is required. The IM agency may provide reimbursement up to the charges of the common carrier, for mileage expenses or a contracted amount the IM agency or its designated agency has agreed to pay the transportation provider. Related travel expenses may be covered as described below. The IM agency may request verification of expenses, or documentation that the trip occurred.

38.3.6 Transportation Administration

When providing common carrier transportation, the IM agency should use the most cost-effective mode of transportation possible. The IM agency reimburses transportation by common carrier. Members may contact the IM agency with questions on common carrier reimbursement.

Common carrier transportation requires authorization by the county/tribal agency prior to departure. The member or someone acting on his/her behalf may request the authorization. The request can be made by phone, in person, or in writing to the IM agency. Denials must be in writing and must explain why the request was denied. The county/tribal agency may delegate common carrier authorization to another county/tribal, or other *local agency*, provided members are assured of transportation to BC+ covered services.

Issue authorizations and denials with reasonable promptness. For authorizations, specify the means of transportation authorized. If recurring medical care is needed, you may authorize all of the trips needed for a specific time period.

38.3.7 Reimbursement

Follow these guidelines when approving or reimbursing transportation services:

1. Approve the least expensive means of transportation, which the member can use, and which is reasonably available when the service is required. If neighbors, friends, relatives or voluntary organizations have routinely provided transportation at no cost, the county or tribal agency does not have to approve that transportation.

2. Do not restrict approval according to the type of covered service. For example, you may not limit reimbursement for transportation to only urgent medical services or physician provided services.

3. Reimburse transportation only to and from a location where the member receives a BC+ covered service.

The IM agency may request documentation that a BC+ covered service was provided:

   a. If provision of covered services is questionable or

   b. The member was unable to obtain prior approval.

4. The county/tribal agency may limit reimbursement for mileage to the nearest provider if the member has reasonable access to health care of adequate quality from that provider.

Example 1: There is a pharmacy 11 miles from the member's home that could have filled his/her prescription. But s/he went to one 32 miles from home. Reimburse him/her on the basis of the shorter distance. The county or tribal agency may require provider documentation of the need for a specialized service at the location requested.

5. The IM agency may reimburse members who use their own vehicle up to $0.24 a mile, and may bill up to $0.26 a mile and keep up to $0.02 a mile for administration.

If the vehicle is lift/ramp equipped, you may reimburse up to $0.50 a mile. The IM agency may bill $0.52 a mile and keep up to $0.02 a mile for administration.

6. A volunteer driver (someone who provides service to another person) may be reimbursed up to $0.33 a mile. If they carry more than one member on a single trip, volunteer drivers may be reimbursed up to $0.35 a mile. The county or tribal agency may bill up to $0.36 a mile ($0.38 for more than one member on a single trip) and keep up to $0.03 a mile for administration.

7. You may reimburse public carriers, such as taxis and buses for non-contracted trips, up to their usual and customary charges to the general public. Reimburse the provider directly, or have the member pay for the transportation and reimburse him/her.

8. When no alternative transportation arrangements are available or when it is the most cost effective alternative, the IM agency may contract with SMVs or Human Service Vehicles (HSVs).

Limit reimbursement to no more than $1.05 per loaded mile for each member. Loaded mileage is the mileage driven when the member is on board.

When an agency contracts with a SMV, HSV, taxi company or similar entity, the agency may charge administrative costs of up to five percent of the amount paid. The amount paid must not exceed $1.05 per loaded mile for each member.

9. County or tribal agencies may operate their own program to transport members. They may claim reimbursement as follows:

    a. Car. Up to the rate per mile allowed for state employees who use their own car, and keep up to 3 cents per mile for administration.

    b. Van. Up to $.0.50 per mile and keep up to $0.05 per mile for administration. If the agency hires a driver for transporting members exclusively, it may claim up to $1.05 per mile. Do not claim additional amounts for the driver's salary or for administrative expenses.

    For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf. The information in this page should be updated annually.

10. The county or tribal agency may not use common carrier transportation funds to pay drivers while they are not actively providing direct transportation services. Do not claim reimbursement for the cost of purchasing the vehicle.

11. The county or tribal agency may cover travel-related expenses if the travel is "other than routine". Travel that is other than routine may be defined as trips that are significantly beyond the distances typically traveled to obtain health care services in a particular locality.

Related travel expenses may also include the cost of meals and commercial lodging en route to and from, and while receiving, a BC+ covered service. Related travel expenses may also include the cost of an attendant to accompany the member if, the member's age and/or physical condition warrants an attendant. If the member is age 16 years or older, the need for an attendant must be determined and documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner.

Only reimburse the cost of one attendant, unless the physician, physician assistant, nurse midwife, or nurse practitioner documents in writing, that the member's condition requires the physical presence of more than one

attendant. The IM agency or its designated agency must maintain the statement of need.

Parking fees are not reimbursable as a "related travel expense".

12. An attendant is a person, in addition to the driver, that is specifically trained in procedures that are necessary for care and transportation of the member. An attendant's costs may include transportation, lodging, meals, and a salary.

When the attendant is a member of the BC+ member's family, limit reimbursable costs to transportation, commercial lodging and meals. A member's family consists of the member, his/her spouse, parent, stepparent, foster parent, half-siblings, the member's natural, adoptive, and stepchildren, grandparent, and grandchildren.

County/tribal agencies may approve up to four weeks of expenses without DHS approval. A request for attendant care over four weeks requires prior authorization by DHS. Send prior authorization requests to:

Transportation Policy Analyst
Division of Health Care Access and Accountability
P.O. Box 309
Madison, WI 53701-0309

Reimbursement for the member's and/or attendant's meals and lodging must be no greater than the amounts paid by the state to its employees for those expenses. Reimburse multiple night stays at state rates for employees. The minimum salary for an attendant must be the minimum federal hourly wage. For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf. The information in this page should be updated annually.

13. The county/tribal agency may establish their own procedures for cash advances to members.

14. Apply these reimbursement guidelines for members who are retroactively certified for BC+. They are entitled to request reimbursement of medical transportation costs that occurred during the retroactive period.

15. Medicare beneficiaries who are ineligible for BC+ are not eligible for BC+ transportation reimbursement.

16. For common carrier transportation, BC+ will reimburse IM agency's for transportation costs that have prior authorization. The IM agency may also work with an HMO to coordinate the common carrier transportation.

BC+ encourages IM agency's that choose not to contract with an HMO for transportation to work with the HMO so that the member's transportation needs can be met.

38.3.8 Transportation Waiver

When you deny a request for transportation expenses, tell the member that s/he can ask for a waiver. If s/he asks for a waiver, write up the waiver request.

In your waiver request

1. Refer to the Administrative Rule permitting waivers (HFS 106.13).

2. If the denial is for a family member's attendant services, note the waiver request is to waive Administrative Rule HFS 107.23 (3).

3. Describe the specific case situation.

4. Give your reason(s) for requesting the waiver. An example of a reason would be that enforcement of the requirement would result in unreasonable hardship for the person.

5. Sign the request and send it to:

Transportation Policy Analyst
Division of Health Care Access and Accountability
P.O. Box 309
Madison, WI 53701-0309

The Transportation Policy Analyst will contact the IM agency with a decision to the waiver request.

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38.4 HMO ENROLLMENT

38.4.1 Change of Circumstances
38.4.2 Disenrollment
38.4.3 Fiscal Agent Ombuds

Most BC+ members who are eligible for BC+ and reside in a BC+ HMO service area must enroll in an HMO.

Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the member's family must choose the same HMO. However, individuals within a family may be eligible for an exemption from enrollment.

This is the enrollment process:

1. Members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.

2. If the member does not choose an HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in an HMO.

3. If the member has not chosen an HMO after four weeks, and lives in an area covered by two or more HMO's, s/he will be assigned an HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

4. S/he will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, s/he should contact the Enrollment Specialist at 1-800-291-2002.

Exemptions: A member may qualify for an exemption from HMO enrollment if s/he meets certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.

If the member believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at 1-800-291-2002. The number is also in the enrollment materials s/he receives.

38.4.1 Change of Circumstances

Members who lose BC+ eligibility, but become eligible again may be automatically re-enrolled in their previous HMO.

If the member's eligibility is re-established after a Restrictive Re-enrollment Period (*RRP*), s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.

38.4.2 Disenrollment

Members are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a BC+ subprogram that does not require enrollment in an HMO.

2. They become eligible for Medicare.

3. They lose eligibility.

4. They move out of the HMO's service area.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member's new area, s/he remains fee-for-service.

38.4.3 Fiscal Agent Ombuds

Members with questions about their rights as HMO members may call 1-800-760-0001 or write:

HMO Ombudsman
P.O. Box 6470
Madison, WI 53791-9823

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38.5 BC+ CARDS

38.5.1 Appeals
38.5.2 Homeless
38.5.3 Pharmacy Services Lock-in Program
38.5.4 Temporary Cards
38.5.5. Lost/Stolen Cards

ForwardHealth cards are issued to BC+ members. These cards are plastic and display the words "ForwardHealth" on them. Members use the same ForwardHealth card each month. Monthly cards are not issued.

Each person in the family who is eligible for BC+ receives his/her own card. The cards do not display eligibility dates. All BC+ services are paid for under the BC+ ID number on the card

Members will know if they are eligible based on positive and negative notices sent from the IM agency. Members who receive a notice that they are no longer eligible for BC+ should keep their ForwardHealth cards. Cards should not be thrown away. If a member becomes eligible again, s/he will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can call Member Services at 1-800-362-3002.

38.5.1 Appeals

Keep a BC+ case in appeal status open if the member makes a request prior to the closure date. The member can continue to use his/her ForwardHealth card until a decision is made regarding his/her eligibility.

38.5.2 Homeless

Make ID cards available to homeless BC+ members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

38.5.3 Pharmacy Services Lock-in Program

Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce unnecessary physician and pharmacy utilization and to discourage the non-medical or excessive use of prescription drugs. The Pharmacy Services Lock-In program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services

Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth identification card or excessive use of emergency room services.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services at (800) 947-9627 or by writing to the following office: Division of Health Care Access and Accountability Bureau of Program Integrity PO Box 309 Madison WI 53701-0309 .

38.5.4 Temporary Cards

The following cards are the only paper BC+ cards:

1. Green Cards
2. Temporary Enrollment Cards issued by the TE provider.

38.5.4.1 Green Cards

The *fiscal agent* does not issue temporary cards. The IM Agency issues them. Each agency must issue a temporary card if the member does not already have a Forward Health card and needs health care within the two to three days before s/he receives one in the mail. The green temporary card is the only way the member may be able to receive services without having to pay out-of-pocket, since eligibility is not on ForwardHealth interChange yet for the provider to verify.

Order the green temporary BC+ ID card stock from:

Medicaid Eligibility Maintenance
P.O. Box 7636
Madison, WI 53707-7636
Phone: (608) 221-4746
Fax: (608) 221-0885

When ordering, indicate the agency, contact person, and number of blank cards desired.

Include the following on each temporary ID card you issue:

1. BC+ ID number.
2. Agency code.
3. Medical status code.
4. Member's full name.
5. Member's date of birth.
6. Member's sex (M or F).
7. Member's address.
8. Valid dates: Do not use future dates beyond the current benefit month.
9. Other insurance coverage. If private insurance, include the name. If Medicare, include the Medicare number as it appears on the member's Medicare card with "A" for Part A and/or "B" for Part B.

Do not issue a temporary card to members who would not normally receive a ForwardHealth card. Members in the following categories do not get a Forward Health card, so should not be issued temporary cards:

1. AE - Immigrant Emergency services. No card is necessary because only services directly related to the emergency are reimbursable by BC+.
2. Medicare Premium Assistance Programs (for members who are not eligible for Medicaid or BadgerCare+)
    a. SB - SLMB only
    b. SLMB+ - Qualified individual, group 1
    c. QW - QDWI

38.5.5. Lost/Stolen Cards

If a member needs a replacement card, s/he or an *authorized representative*, should call Member Services at 1-800-362-3002. A new ForwardHealth card will be issued and will be sent out the following business day. The 16-digit number on the card is unique to each card. If a new card is issued, it will have a new card number to help prevent fraud and monitor card stock.

Replacement cards are issued automatically when:

1. The member's name changes.
2. The card was returned as undeliverable and the member's address changes.

A replacement for any other reason must be requested through Member Services, 1-800-362-3002.

You cannot request replacement cards using a F-10110 (formerly DES 3070) or *CARES*.

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38.6 GOOD FAITH CLAIMS

38.6.1 Definition of Good Faith Claims
38.6.2 Denials
38.6.3 Causes and Resolutions
38.6.4 Process
38.6.5 Instructions

38.6.1 Definition of Good Faith Claims

A Good Faith claim is a claim that has been denied by BC+ with an eligibility-related Explanation of Benefits (EOB) code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to HP Enterprise Services to be processed as a Good Faith claim. If the eligibility file has been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, HP Enterprise Services will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact the IM agency to verify eligibility. The Good Faith form (F-10111) is used for this purpose. A Good Faith claim cannot be reimbursed until the HP Enterprise Services member file is updated.

38.6.2 Denials

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a Good Faith claim

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.
614	Medicaid number doesn't match recipient's first name.

38.6.3 Causes and Resolutions

Causes and a Good Faith claim can occur when:

1. A member presents an ID card that is invalid because:

a. You issued a temporary ID card for a prior period or manually determined case and didn't update *CARES* or send HP Enterprise Services an F-10110 (formerly DES 3070) to update the member's eligibility file. HP Enterprise Services will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the member is eligible for the dates on the card. The letter will include instructions on how to complete an F-10111 and the information that is needed.

b. The provider suspects the member of misusing or abusing a ForwardHealth card (i.e. using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and HP Enterprise Services can tell that it was altered, HP Enterprise Services will contact you to verify that the member was eligible or forward it to the Division of Health Care Access and Accountability (DHCAA) for review.

2. The member's name has changed since the card was issued. HP Enterprise Services can usually resolve claims that are denied with code "029" and "614". If necessary, HP Enterprise Services will contact you to confirm the information.

With the implementation of the ForwardHealth cards, providers are less likely to receive one of the eligibility-related denials used for Good Faith claims submission. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When the provider verifies the member's eligibility, they are getting the most current information available on the ForwardHealth interChange. Therefore, it is unlikely that they will be told the member is eligible when s/he is not.

The most likely reason a Good Faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill BC+ before

the eligibility is updated on ForwardHealth interChange, or perhaps the eligibility was never sent to ForwardHealth interChange. In either case, if the member presents a valid temporary BC+ ID card for the dates of service, and the provider sends a copy of the card with the Good Faith claim, HP Enterprise Services will update the member's eligibility file with a good faith segment and pay the claim immediately.

HP Enterprise Services will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider doesn't send a copy of the ID card with the claim, HP Enterprise Services must confirm eligibility with you before the claim can be paid.

The definition of a 'valid' card is either a:

1. Forward card that indicates eligibility for the dates of service through the EVS.
2. A temporary paper card showing dates of eligibility.

38.6.4 Process

HP Enterprise Services initiate claim process by sending you a Good Faith form (F-10111) that they have partially completed, and one or two letters, depending on what documentation of eligibility the provider included with their claim. Complete the F-10111 form if this is a new member (cert. 1) or return a new F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

HP Enterprise Services
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed 3070 forms by:

1. Mail: HP Enterprise Services
P.O. Box 7636
Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us
3.
3. Fax: (608) 221-8815

38.6.5 Instructions

Agency Denial

If the member identified on the Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Recipient Did Not Have ID Card After Date of Service
Place an "X "in this box if you are certain that the member did not possess a valid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible
Place an "X" in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found
Place an "X" in this box if the member has never been eligible for BC+ in your agency.

Dates of Services
HP Enterprise Services enters the dates of service for the claim.

Partial Deny
Use this field only if the member had eligibility for some of the dates of service. Enter the "from" and "to" dates which cover the portion of the dates of service for which the member did not have eligibility.

Type of Certification
HP Enterprise Services will check one of these boxes:

1. Initial Certification
   HP Enterprise Services will place an "X" in this box when the member and BC+ ID number submitted on the claim cannot be found on the eligibility master file.
2. Amended Certification
   HP Enterprise Services will place an "X" in this box when the member is on interChange, but no eligibility exists for the claimed dates of service.

Agency Number
HP Enterprise Services will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number
HP Enterprise Services will enter the known or suspected inteChange case number (primary person's *SSN* + tie-breaker) of the member listed on the provider's claim.

Action Date
HP Enterprise Services enters the date they completed the Good Faith form.

Medical Status Code
When HP Enterprise Services receives the provider's claim along with a photocopy of an ID card, a hard copy response received through EVS or a transaction log number from the Automated Voice Response (AVR). HP Enterprise Services compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, HP Enterprise Services enters a "71" medical status code and pays the claim immediately. HP Enterprise Services then enters the eligibility dates for the entire month in which services were provided.

If the member was eligible for the entire period of certification shown on the Good Faith form (F-10111) , remove the "71" medical status code and write in the correct code. Attach an F-10110 (formerly DES 3070) to add the *certification period* and appropriate medical status code for the time when the member was eligible for BC+.

Period of Certification
If HP Enterprise Services has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete an F-10110 (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth
HP Enterprise Services will enter the suspected control name and year of birth (YOB) for the member. This control name must be the first four letters of the member's last name. The YOB is the last two digits in the member's year of birth. Both of these items must match the information currently in the member's HP Enterprise Services file.

Current ID Number
HP Enterprise Services will enter the member's current ID number.

Date of Birth
HP Enterprise Services completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birth date as MM/DD/CCYY.

Signature of Agency Director
Good Faith forms must have an authorized signature for initial certifications.

Worker ID

On initial certifications, enter the six-digit worker code of the certifying IM worker.

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39 EMERGENCY SERVICES

39.1 EMERGENCY SERVICES

BadgerCare Plus Emergency Services is a limited BC+ benefit for documented immigrants who have not been in the U.S. for 5 years or more and for undocumented immigrants.

A citizen is not eligible for BadgerCare Plus Emergency Services even when s/he cannot produce citizenship and/or identity verification.

Example 1: Jill applies for BadgerCare Plus, declares U.S. citizenship and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services BadgerCare Plus does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However, the IM worker cannot process BadgerCare Plus Emergency Services eligibility for persons declaring to be U.S. citizens. BadgerCare Plus Emergency Services is reserved for non-qualifying non-citizens.

Because Emergency Services is funded through Title XIX only those who would receive their BC+ benefits under Title XIX are eligible for BC+ Emergency Services. Therefore, not everyone who meets the income limits for BC+ qualifies for BC+ Emergency Services.

An immigrant who only meets the eligibility criteria for the BadgerCare Plus Core Plan is not eligible for Emergency Services.

An immigrant who is ineligible for BC+ because of his/her *immigration status* is eligible for BC+ Emergency Services coverage if:

1. S/he meets the income limits listed in the chart below and
2. Meets all other eligibility requirements, except having or applying for an *SSN*.

BC+ Emergency Services Income Limit

Group	Income
Pregnant Women	Up to 300% FPL
Newborns to age 1	Up to 300% FPL
Children ages 1 - 5	Up to 185% FPL
Children ages 6 - 18	Up to 150% FPL
Youths Exiting Out of Home Care	Any FPL Level
Parents and Caretakers	Up to 200% FPL

Note: Pregnant *non-qualifying immigrants* may be eligible under the BC+ Prenatal Program.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical treatment could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

BC+ Emergency Services covers :

- Only those medical services needed for the treatment of an emergency medical condition.
- All labor and delivery services for eligible non-qualifying immigrants.

See Process Help Chapter 11.1, for BC+ Emergency Services manual *application* processing.

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39.2 DETERMINING IF AN EMERGENCY EXISTS

It is not the responsibility of the IM agency to determine if the applicant's condition is or was an emergency condition and reimbursable under BC+ Emergency Services. The medical provider submits claims for emergency medical services to the *fiscal agent*. The fiscal agent then determines if a

condition is an emergency medical condition covered by BC+ Emergency Services.

39.2.1 Determining eligibility

It is the IM agency's responsibility to manually determine if the non-qualifying immigrant meets all eligibility requirements during the dates of service and to certify if s/he is eligible for Emergency Services.

Medicaid providers who have treated non-US citizens for emergency services can provide them with a form verifying that the services provided were to treat an emergency medical condition. The form is "Certification of Emergency for Non-US Citizens (F-01162). Providers are instructed to have the patient present this to the local IM agency when applying for assistance.

Note: The F-01162 is not required to certify Emergency Services eligibility.

If a non-qualifying immigrant provides a "Certification of Emergency for Non-U.S. Citizens" at the time of *application*, his/her eligibility for BC+ Emergency Services is determined for the dates of the emergency indicated on the form.

If a non-qualifying immigrant does not have the form at the time of application, ask him/her for the dates that s/he received emergency services.

Emergency Services coverage begins at the time of the first treatment for the emergency and ends when the condition is no longer an emergency.

Determine eligibility of a pregnant immigrant on the date emergency services were provided. The pregnancy due date is required to determine eligibility for pregnant immigrants. (See 39.3 for Emergency Services certification dates for pregnant women.)

> *If a non-qualifying immigrant would only qualify for BC+ if s/he was disabled, follow disability determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

Certification of Emergency Services is not done through *CARES* and must be done manually. However, all applications should be processed through CARES to determine BC+ eligibility. If the immigrant does not have an *SSN*, CARES will assign a pseudo SSN. That pseudo SSN should be used when submitting the manual certification. When an immigrant is determined eligible for Emergency Services, complete and submit a manual certification form F-10110 (formerly DES 3070). The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

The F-10110 may be submitted to the fiscal agent in the following ways:

1. Mail: HP Enterprise Services
   P.O. Box 7636
   Madison, WI 53707

2. E-mail: eds_3070@dhfs.state.wi.us

3. Fax: (608) 221-8815

An individual eligible for BC+ Emergency Services will not receive a ForwardHealth card because BC+ Emergency Services eligibility ends when the emergency ends.

However, women determined eligible for BC+ Prenatal Services will be issued a ForwardHealth Card, which can also be used to access emergency services under Emergency Services after BC+ ends.

39.2.2 Providing manual positive or negative notice

The IM agency must provide a manual positive or negative notice regarding the applicant's eligibility. Positive notices must provide the dates of eligibility for BC+ Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

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39.3 EMERGENCY SERVICES FOR PREGNANT WOMEN

A pregnant non-qualifying immigrant may apply for emergency services up to one calendar month before her due date (See 39.5 for pregnant *non-qualifying immigrants* who lose eligibility for the BC+ Prenatal Services). Certify an eligible pregnant non-qualifying immigrant from the date of *application*, if she applies no more than one calendar month prior to her due date, through the end of the month in which the 60th day occurs following her due date. Adjust the *certification period* based on the actual pregnancy end date, once it is known.

Example 1: Sara is a pregnant non-qualifying immigrant applying for BC+ Emergency Services. Sara has two weeks until her due date, which is March 3rd. Certify Sara for BC+ Emergency Services from the date of application through the end of May.

Example 2: Erica applied for BC+ Emergency Services because she was a pregnant non-qualifying immigrant on March 13th. Her expected due date is April 5th. Erica is certified for BC+ Emergency Services from March 13th through the end of June. Erica delivers her son on March 15th. Her certification period should be adjusted from March 13th through the end of May.

If a pregnant non-qualifying immigrant applies prior to the calendar month, before her due date, and she has not received a service, deny her BC+ Emergency Services eligibility because she has not received a service.

If a woman applies for BC+ Emergency Services, within three months after her pregnancy has ended, certify her from the pregnancy end date through the end of the month in which the 60th day occurs.

Example 3: Vienne miscarries on April 5th, which is more than one month from her due date of July 15th. Vienne applies on April 6th for BC+ Emergency Services. Certify Vienne for BC+ Emergency Services from April 5th through the end of June.

Example 4: Guadeloupe was in a car accident and admitted to a Fort Atkinson Hospital on February 18, 2006. On March 15, 2006, Guadeloupe applied for BC+ Emergency Services for both the February hospital stay and her pregnancy, with a verified due date of April 15, 2006. Certify Guadalupe for BC+ Emergency Services from February 18 through the end of June.

An immigrant who gives birth while enrolled in BC+ Emergency Services remains eligible for emergency services for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. The emergency does not have to be related to the pregnancy.

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39.4 NEWBORNS

Babies born to mothers covered under BC+ Emergency Services are BC+ eligible as continuously eligible newborns, if all other eligibility conditions are met. (Chapter 8.2)

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39.5 ELIGIBILITY BEGIN DATE FOR NON-QUALIFYING IMMIGRANTS WHO LOSE ELIGIBILITY FOR THE BC PRENATAL PROGRAM.

A non-qualifying immigrant, who loses eligibility for the BC+ Prenatal Program (Chapter 41) when her pregnancy ends, or for any reason other than moving out of state, is eligible for BC+ Emergency Services from the date she lost BC+ Prenatal Program eligibility. Like other pregnant immigrants, these women should have BC + Emergency Services coverage through the end of the month in which the 60th day occurs, following her due date or the pregnancy end date, if that is known.

Example 1: A pregnant non-qualifying immigrant is found eligible for the BC+ Prenatal Program. Her expected due date is July 10, 2006. She is terminated effective April 30th from the BC+ Prenatal Program due to non-payment of the BC premium. *CARES* will send the *fiscal agent* a record terminating her BC+ on April 30th, and send a record to certify her as eligible for BC+ Emergency Services from May 1st through September 30th.

Pregnant *non-qualifying immigrants* who are not found eligible for the BC Prenatal Program should have BC+ Emergency Services eligibility determined according to the instructions in 39.3.

Example 2: A pregnant non-qualifying immigrant applies January 15, 2006. Her expected due date is May 10, 2006. She is denied BC+ Prenatal Program eligibility due to access to health insurance through her employer. To receive Emergency Services, she must re-apply no earlier than April 10, 2006. BC+ Emergency Services eligibility continues through the end of the month following the 60th day after the pregnancy ends.

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39.6 BC+ DEDUCTIBLE

Immigrants who apply for emergency services and who are under 19 years of age and ineligible due to access to health insurance or who are pregnant and have countable household income over 300% of the FPL, may become eligible for BC+ Emergency Services through a BC+ *deductible*. If, on the date s/he

applies and s/he meets all other eligibility criteria, apply the same deductible policies to him/her as any other *applicant*. (Chapter 17)

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40 FAMILY PLANNING ONLY SERVICES (FPOS)

40.1 FAMILY PLANNING ONLY SERVICES PROGRAM

BC+ Family Planning Only Services program (*FPOS*) provides limited benefits for family planning services for women and men with income at or below 300% of the Federal Poverty Level (FPL) and who are:

1. 15 years of age or older, and
2. Not enrolled in BC+ without a premium or receiving other full benefit Medicaid.

Individuals who are eligible for (FPOS) may be eligible to receive more than one limited benefit program.

These include:

1. Tuberculosis-related (MEH 25.7)
2. Qualified Medicare Beneficiary (MEH 32.2)
3. Specified Low-Income Medicare Beneficiary (MEH 32.3).

In certain circumstances, women enrolled in FPOS may be eligible for the WWWMA plan. (See MEH chapter 36)"

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40.2 FPOS TEMPORARY ENROLLMENT/ PRESUMPTIVE ELIGIBILITY (TE)

40.2.1 Introduction

40.2.2 Qualified Providers
40.2.3 IM Agency

40.2.1 Introduction

FPOS temporary enrollment through a presumptive eligibility determination provides family planning services beginning on the day that a qualified provider determines that the individual has income at or below 300% of the FPL, and is:

1. 15 years of age or older, and
2. A Wisconsin resident, and
3. A citizen of the U.S., and
4. Not enrolled in BC+ without a premium or receiving other full benefit Medicaid.

The qualified provider should refer non-citizens to the Income Maintenance Agency (IM) for a BC+ eligibility determination.

FPOS TE extends from the date that an individual is determined eligible by the qualified provider through either:

1. The last day of the month following the month in which s/he was determined presumptively eligible, **or**
2. If the individual applies for FPOS by the end of the month following the month in which s/he was temporarily enrolled, the enrollment period ends the day on which the agency determines his/her eligibility.

FPOS TE can only be received once within a rolling 12-month period.

40.2.2 Qualified Providers

Qualified providers are certified by the Division of Health Care Access and Accountability (DHCAA). A qualified provider will determines if an individual is eligible to be temporarily enrolled for the FPOS. If the member is eligible, the qualified provider will:

1. Complete and sign the Temporary Enrollment for FPOS form (F-10119).
2. Complete the temporary ID card (F-10119) and give it to the member. The certification dates are from the date FPOS TE is determined through the end of the month following the month in which the determination is made.
3. Explain that the duration of a FPOS temporary enrollment period depends on when the member applies for BC+ and ongoing FPOS benefits through the ESC or local IM agency.
    a. If the member applies for ongoing FPOS by the end of the month following the month in which s/he was determined eligible for FPOS TE, the ongoing FPOS period begins the first of the month in which

the member applied and is found eligible. The FPOS temporary enrollment period ends the day before the members ongoing FPOS period begins.

Example 1: Amber applied for FPOS TE on September 19th. She is temporarily enrolled through October 31st.

Amber applied for ongoing FPOS on November 2nd and was found eligible. Amber's ongoing FPOS begins November 1st, and ends October 31st of the following year. Amber did not request a three month backdate.

b. If the member does not apply by the end of the second month following the month in which s/he was determined eligible for FPOS TE, the FPOS temporary enrollment period ends the last day of the second month following the month in which the member was determined eligible for FPOS TE.

Example 2: Brenda applied for FPOS TE on April 3rd 2011. Her FPOS TE continues through May 31. Brenda does not apply for ongoing FPS until August 15th and is found eligible. Brenda requests a backdate of the FPOS for three months and is found eligible. Her FPOS is backdated to May 1, 2011.

4. Send a copy of the completed F-10119 to the *fiscal agent* within five days of completion.

40.2.3 IM Agency

If an individual applies for ongoing FPOS at the IM agency on or before the last day of the FPOS temporary enrollment period:

1. Verify the member is Temporarily Eligible by checking ForwardHealth interChange for a medical status code of PF.
2. Consider the application filed if the member's name, address and signature are on the application.
3. If you are unable to finish processing the application, by the end of the FPOS temporary enrollment period, submit an F-10110 to extend the FPOS temporary enrollment for an additional calendar month.

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40.3 FPOS APPLICATION

Eligibility for *FPOS* begins on the first of the month of *application*, if all non-financial (40.4) and financial (40.5) eligibility requirements are met. FPOS may be backdated up to three months from the month of application

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40.4 FPOS NON-FINANCIAL REQUIREMENTS

The following are *FPOS* specific non-financial requirements:

1. Be 15 years of age or older.
2. Not be enrolled in BC+ without a premium or receiving other full benefit Medicaid.
3. Meet all non-financial criteria listed in the Non-Financial Chapter with the exceptions listed below:
    - An individual applying for or receiving BC+ FPOS is not subject to the health insurance access or coverage policies.

- An individual applying for or receiving BC+ FPOS is not required to cooperate with Medical Support, unless s/he is also applying for or receiving BC+ for any child for whom s/he is the *caretaker relative*.
- An individual applying for or receiving BC+ FPOS is not required to cooperate with *Third Party Liability (TPL)*, unless s/he is also applying for or receiving BC+ for any child for whom s/he is the caretaker relative.

- Any individual applying for or receiving FPOS who refuses to cooperate with MSL or TPL requirements when s/he has a child in the home who is receiving BC+ or Medicaid, is ineligible for FPOS unless s/he is under 19 or has *good cause*.

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40.5 FPOS FINANCIAL

40.5.1 Income

Use the BC+ budgeting rules to calculate countable income. The following are specific *FPOS* financial eligibility requirements:

1. Countable income calculated in the *application* month is used to determine the member's financial eligibility for the entire 12-month eligibility period. Income changes do not need to be reported until the next review.
2. Any change in income or household size reported after confirmation for FPOS during the 12-month eligibility period is only applied if it results in enrollment in BC+ with no premium or eligibility for other full benefit Medicaid.
3. All changes in income or household composition that result in enrollment in BC+ with no premium or eligibility for other full benefit Medicaid will result in FPOS closure prior to the 12th month.

Example: Erin applies for BC+ for herself and her son Mike, in January 2011. Erin was eligible for BC+ with a premium, but chose to receive FPOS instead. On May 6th she reports a decrease in income that resulted in her being eligible for BC+ without a premium. Erin's BC+ eligibility began June 1st and her FPOS ended May 31st.

4. All changes in income and household composition will be applied at the 12-month FPOS eligibility review.

When a child under 19 is applying, do not count the income of the parents in the eligibility determination. Count any money that is provided to a minor by a member of the household, such as an allowance, as unearned income in the month received.

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40.6 FPOS GROUP

40.6.1 Fetus
40.6.2 Children 18 Years of Age

The *FPOS* test group is formed using the rules for regular BC+. (Chapter 2)

40.6.1 Fetus

Increase the FPOS group by one for each fetus a pregnant woman in the FPOS group is carrying.

Example: Samantha and Howard are married, and have two minor daughters, Shannon and Colleen. Shannon is pregnant. Samantha is only requesting FPOS for herself, and is requesting BC+ for her two daughters.

Shannon and Colleen are found eligible for BC+. In building the FPOS group, Shannon, Shannon's fetus, and Colleen are counted children. Howard is part of the FPOS group, because he is legally responsible for Samantha. The FPOS group size is five for Samantha.

40.6.2 Children 18 Years of Age

Children under 19, who are applying for FPOS are a group of one, unless s/he is married and/or has children. Parents are not included in the group.

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40.7 FPOS PROGRAM CHOICE

An individual applying for both BC+ and *FPOS* may request at any time to discontinue enrollment in BC+ in order to receive only FPOS. Change the health care request on the program request page to "No" in order to receive the FPOS.

An individual applying for both BC+ and FPOS is not given a choice at the time of confirmation if s/he meets the eligibility for both benefits.

An individual found to be eligible for a *deductible* may also be eligible for FPOS benefits during a deductible period. The member may receive FPOS benefits until s/he has met a deductible. The member can report any out-of-pocket medical bills incurred while s/he is receiving services through FPOS, in order to meet a deductible. Once a deductible has been met, s/he is receiving full-benefit BC+/ MA, and is no longer eligible for FPOS, but continues to receive the same services through BC+/MA.

Example: Theresa is an 18-year-old woman applying for MA, BC+ and FPOS for herself and her daughter Sara (age six). She is found to be eligible for BC+ with a premium or a deductible. If Theresa chooses BC+, she is required to pay a premium but would be able to receive family planning services through

BC+ as well as having coverage for her whole family. If she chooses the deductible, she can receive family planning-related services through FPOS until her deductible has been met.

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40.8 FPOS CHANGES

Member receiving *FPOS* only are not required to report changes in income or household composition during the 12-month *certification period*. However, FPOS members are still required to report all other changes that would result in ineligibility such as a moving out of state, incarceration, etc. within 10 days of the change.

Changes reported in income or household composition resulting in ineligibility will not affect FPOS benefits for the remainder of the 12-month certification period. Eligibility is put into an extension phase until the end of the 12-month certification period or until the member reports an income decrease that is again below the FPOS income limit.

Changes reported in income or household composition resulting in eligibility for BC+ should be applied. If there is a request for BC+ on file, s/he will be found eligible for BC+. At that time, FPOS will end.

FPOS eligibility terminates when an member loses non-financial eligibility. Terminate eligibility, using *adverse action* logic, when she:

1. Moves out of state.
2. Is 19 years or over and is no longer cooperating with TPL, MSL, or Social Security Number (*SSN*) requirements.
3. Enrolls in BC+ with no premium or becomes eligible for other full benefit Medicaid.
4. Becomes an inmate of a public institution.

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40.9 FPOS BC+ FPOS EXTENSION PHASE

An *FPOS* member enters into a FPOS extension phase if any of the following occur:

1. A change is reported at any time during the 12-month *certification period* in income or household composition that results in income that exceeds the FPOS income limit.
2. If 60 days after the birth of a BC+ member's baby she is no longer eligible for BC+, she will be placed into a FPOS extension.

The extension continues until the review date that was originally set for the FPOS eligibility.

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40.10 FPOS REVIEWS AND RECERTIFICATIONS

A review/recertification (Chapter 26) is required every 12 months, after an initial eligibility determination. At the time of the *FPOS* review, income and household composition are again tested against the FPOS eligibility criteria.

If a member completes a review for another program of assistance at any time during the 12 month *certification period* and the information collected from that review indicates that she still meets FPOS eligibility requirements, the FPOS review date will be set 12 months from that review date.

If a member completes a review for another program of assistance at any time before the 12th month of FPOS eligibility, and no longer meets the BC+ eligibility requirements, s/he will be entered into a BC+ extension phase. S/he will be required to complete a review at the end of the original12-month certification period. If at this review, s/he is found to still have income in excess of the BC+ limit, eligibility for the FPOS ends.

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40.11 FPOS CONFIDENTIALITY

Members applying for or receiving *FPOS* benefits will have all of the confidentiality protections as other BC+ applicants, as well as the following additional confidentiality protections:

1. If requested, member can have written communication sent to an alternate address instead of the home address.
2. Minors are not referred to child support.
3. Eligibility information regarding minors who apply independently for FPOS is kept confidential from parents or guardians, unless the member gives clear consent for release of the information.

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41 BC+ PRENATAL SERVICES

41.1 BC+ PRENATAL PROGRAM

The BC+ Prenatal Program (*BC+PP*) provides coverage for women who:

- Meet the non-financial and financial eligibility requirements for BC+
- Have verified pregnancies, and
- Are not eligible for BC+ because they are either inmates of a public institution or *non-qualifying immigrants*.

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41.2 BC+ PRENATAL PROGRAM ELIGIBILITY REQUIREMENTS

Pregnant women (or when applicable, her assistance group), must meet the following BC+ eligibility requirements to qualify for the *BC+PP*:

1. The applicant's net countable income must not exceed 300% of the Federal Poverty Level (FPL).

2. The *applicant* must not have current or past access to an employer's health insurance benefit where the employer pays 80% or more of the premium cost.
3. The applicant must provide verification of pregnancy and any other required verification.
4. The applicant must not have health insurance coverage (Chapter 7) now or in the three calendar months prior to the BC+ Prenatal request.

41.2.1 Unique Aspects of BC+ Prenatal Program

1. Providing an *SSN* is not an eligibility requirement for either inmates or *non-qualifying immigrants* applying for the BC+PP.
2. Cooperation with Child Support Enforcement is not an eligibility requirement for this program.
3. Unlike regular BC+ which locks in eligibility throughout the pregnancy, BC+PP eligibility may be terminated with timely notice for these pregnant women for failure to meet any of the BC+ eligibility requirements listed in 41.1.
4. There is no Presumptive Eligibility for the BC+PP. Eligibility for the BC+ Prenatal Program may only be determined by the IM agencies.

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41.3 BC+ PRENATAL POLICY FOR NON-QUALIFYING IMMIGRANTS

1. For immigrants who are legally present in the United States, verify *immigration status* through normal *SAVE* procedures in order to determine eligibility for BC+. If SAVE verifies the pregnant woman is a non-qualifying immigrant, proceed with determining eligibility for the BC+ Prenatal.
2. For immigrants who do not have legal immigration status, do not request SAVE verification and continue with the determination of eligibility for the BC+ Prenatal.
3. A non-qualifying immigrant whose immigration status changes while she is pregnant and receiving BC+ Prenatal must have her eligibility re-determined using the new immigration status. If her new status makes her eligible for BC+, she is no longer eligible for the BC+ Prenatal Program.

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41.4 BC+ PRENATAL PROGRAM POLICY FOR INMATES

1. Inmates will always be considered to be residing in the county where the jail or prison facility is located.

2. An inmate who is released from jail or prison while receiving *BC+PP* must have her eligibility re-determined based on her new circumstances. Once released from an institution, she is no longer eligible for the BC+PP.

NOTE: When a BC+PP member notifies the IM agency that she has become a citizen or qualifying immigrant, or is released from prison or jail, *CARES* will redetermine BC+ eligibility based on the new information.

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41.5 BC+ PRENATAL PROGRAM ELIGIBILITY BEGIN DATE

BC+ Prenatal Program eligibility begins no sooner than the first of the month in which a valid *application* is received and the pregnancy is verified.

Example: An application for *BC+PP* is received on January 20. The agency does not receive a verification of the pregnancy until February 5. BC+PP is denied for January due to lack of pregnancy verification in that month. If the woman is otherwise eligible for BC+PP, eligibility may begin on February 5.

Pregnant *non-qualifying immigrants* who are not eligible for the BC+PP should have Emergency Services eligibility determined according to policy in (Chapter 39).

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41.6 BC+ PRENATAL ELIGIBILITY END DATE

BC+PP eligibility ends when the pregnancy ends. Benefits will continue through the end of the month following timely notice requirements.

Non-qualifying immigrants who lose eligibility for the BC+PP when their pregnancy ends, for any reason other than moving out of state, are eligible for Emergency Services (Chapter 39) from the time they lose BC+PP eligibility.

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41.7 DETERMINING BC+ PRENATAL GROUP

1. If a pregnant woman is in a household where her spouse or her children are eligible, or applying for BC+, she is to be included in the BC+ group with the other non-financially eligible members of her family. Include the number of verified fetuses when determining the BC+ group size. If the number is not verified, always count one fetus.

2. Pregnant inmates must always be considered to be living alone. If the inmate is married while incarcerated, consider her to be separated (ignore the spouse) when determining eligibility. The pregnant inmate's BC+ group size will always include herself and the number of fetuses she is carrying.

NOTE: Women in the Huber program who are eligible for BC+ are not eligible for the BC+ Prenatal Program.

3. Pregnant *non-qualifying immigrants* who have no other born children in the home will have their financial eligibility determined in the same way as pregnant women applying for BC+. The BC+ group size will only include the woman, the fetuses and her spouse. If the pregnant immigrant is a minor living with her parent(s), the parent(s) will be included in the *BC+ test group*.

BC+ Prenatal Program Group Examples

Household	Test Group Size	Participation Status	
Mom and fetus	2	EA	
Mom and fetus, boyfriend/alleged	2	EA	XA

father				
Mom and fetus, spouse	3	EA	CA	
Mom and fetus, father, and child-in-common eligible for BC	4	EA	EA	EC
Minor Mom and fetus and Minor's parents (2)	4	EC	EA	EA

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41.8 BC+PP BENEFIT INFORMATION

Women determined eligible for the *BC+PP* receive a ForwardHealth Card, which can also be used to access emergency services under BC+ Emergency Services only after BC+ ends.

BC+PP and BC+ Emergency Services members will not be enrolled in an HMO. Services will only be provided on a fee-for-service basis.

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42 WELL WOMEN SERVICES

42.1 WISCONSIN WELL WOMAN MEDICAID PLAN

Information about Wisconsin Well Woman Medicaid can be found in the Medicaid Eligibility Handbook; Chapter 36.

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43 BADGERCARE PLUS CORE PLAN

43.1 BADGERCARE PLUS CORE PLAN FOR CHILDLESS ADULTS

43.1 Introduction
43.1.1 Key Program Goals

43.1 Introduction

The BadgerCare Plus Core Plan (for adults without dependent children) expansion of the BadgerCare Plus program is the second step in a comprehensive strategy to ensure access to affordable health insurance for virtually all Wisconsin residents.

The Core Plan provides basic health care coverage to adults who do not otherwise qualify for Medicaid or the BadgerCare Plus Standard or Benchmark Plans.

43.1.1 Key Program Goals

- Expanding BadgerCare Plus to childless adults and together with Medicaid, State Children's Health Insurance Program (SCHIP), Medicare and, and employer-sponsored insurance, Wisconsin will be able to provide access to insurance to 98% of residents in the most cost-effective manner;
- Effectiveness in meeting the health care needs of the uninsured childless adults population through flexible benefit package using evidence-based medicine and advice from the medical community via the Clinical Advisory Committee on Health and Emerging Technology (CACHET);
- Encouraging quality health care outcomes from private health plans utilized by the BadgerCare Plus childless adults population through the use of a new health plan selection tool and the tiering of the health plans (and differing enrolment fee amount) based upon quality measures;
- Reduction in emergency room usage and uncompensated care by encouraging use of preventative primary care for this population; and
- Improved health outcomes for this population in the areas of prevention and successful management of chronic diseases such as diabetes and asthma.

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43.2 BC+ CORE PLAN ELIGIBILITY CRITERIA

In order to enroll in the Core Plan, an individual must meet all of the following criteria:

Income
- Have gross income below 200% of the FPL
- No asset test

Age
- Be at least 19 but no more than 64 years of age

Dependents
- Does not have any children under age 19 under his/her care (2.2).
- Is not pregnant. Exception: a Core Plan member who becomes pregnant remains enrolled in the Core Plan until she has provided pregnancy verification and becomes eligible for the BadgerCare Plus Standard or Benchmark Plan.

Citizenship/Identity
- Must provide verification, including documentation, of US citizenship or qualifying immigrant status (4.2) and social security number (or proof of *application* for a *SSN*) (9.9.1)

Residency
- Must be a Wisconsin resident

Other Programs
- Is ineligible for the BadgerCare Plus Standard or Benchmark plan, or any full benefit Medicaid plan
- Is not entitled to Medicare.
- Is not disabled. Exception: a disabled individual who is not yet entitled to Medicare benefits can be enrolled in the Core Plan if s/he has an unmet EBD Medicaid *deductible* or was determined ineligible for EBD Medicaid due to excess assets.
- Individuals can be dually enrolled in the Core Plan and Family Planning Only Services and Tuberculosis (TB) Medicaid but cannot be entitled to Medicare benefits under any part.

Health Insurance
- Does not have access to health insurance through a current employer in the month of application or subsequent three months, regardless of the amount of employer contribution toward the premium.
- Did not have access to health insurance through a current employer in the past 12 months, regardless of the amount of employer contribution toward the premium, unless there is a *good cause* reason for not signing up.

- Is not currently covered by a health insurance policy (through employer or individual policy).
- Has not been covered by a health insurance policy for the past 12 months, unless individual has a good cause reason for losing the coverage.

Application requirements

- Must complete a health needs assessment at application and annual renewal;
- Must pay a non-refundable, annual application fee. The fee is waived for homeless individuals. ”Homeless” is defined according to HUD standards (43.4.2.1).
- To remain enrolled in the Core Plan, individuals must obtain a comprehensive physical exam within the first 12 month certification period, unless there is a good cause reason for not doing so.

Married couples apply with one application and pay one annual non-refundable renewal fee.

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43.3 BC+ CORE PLAN ADMINISTRATION

The Core Plan will be administered by the state’s Enrollment Services Center (ESC). All applications, renewals, and case management for households with a Core Plan member will be assigned to the ESC. In addition, applications for other programs (Food Share and Family Planning Only Services) for the ""adults without dependent children" population will be processed by the ESC.

The adults without dependent children population consists of individuals and married couples who are:

- Between the ages of 19 and 64
- Not pregnant, disabled, or qualified for any other Medicaid, Medicare or SCHIP program
- May have children, but either their minor children are not currently living with them (40 percent of the time) or those children living with them are 19 years of age or older.

If a Core Plan member has a spouse applying for another health care program (Medicaid or BC+ for families), ESC *application* processing will include that health care program. The ESC will also handle all Family Planning Only

Services only cases - regardless of age of the member - unless other members of the household are eligible for BadgerCare Plus or Medicaid.

Companion Cases will occur when there is/are:

- A core plan individual with spouse requesting LTC (Family Care or Community Waivers), or
- Unrelated individuals with a non-qualifying relationship for BC+ or Medicaid in a FS case that includes the core plan.

Shared Cases will occur when there is a core plan individual:

- Living with a child less than 40% of the time requesting for CC
- With pregnant spouse requesting W2
- Requesting W2 as a non-*custodial parent*

See Process Help (6.1), for instructions on when and how to transfer cases between the *local agency* and the ESC.

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43.4 BC+ CORE PLAN APPLICATION

43.4.1 How to Apply
43.4.2 Application Processing Fee
43.4.2.1 Waiver of Application Fee
43.4.2.2 Medicaid Certified Provider Application Fee Policy
43.4.2.3 Community Based Organization Payment Options for the Application Processing Fee
43.4.2.4 Screening
43.4.2.5 Processing Fee as a Medical Expense
43.4.2.6 Methods of Payment

43.4.1 How to Apply

Applicants will be able to request BadgerCare Plus Core Plan online or by phone.

To enroll in the BadgerCare Plus Core Plan, applicants will be asked to complete these steps:

1. Complete the request online at access.wi.gov or by phone at 1-800-291-2002,
2. Take a short survey about their health,

3. Pay a $60 non-refundable *application* processing fee, and
4. Mail or fax proof of income and other information provided to:

Enrollment Services Center
P.O. Box 7190
Madison, WI 53707-7190

Fax number: (888) 409-1982 (toll free)

NOTE: THIS PO BOX IS ONLY FOR VERIFICATION AND OTHER CORRESPONDENCE. APPLICATION FEES SHOULD BE SENT TO:

Enrollment Services Center
PO Box 93735
Milwaukee, WI 53293-0735

There are no mail-in or face-to-face application options for Core Plan applicants.

43.4.2 Application Processing Fee

A non-refundable, application processing fee is required before an application for the Core Plan can be processed, unless the fee is waived because the *applicant*/member is homeless. The applicant/member has 30 calendar days from the day the initial or renewal request for Core Plan is submitted to pay the fee. If the fee is not paid within 30 calendar days, the application will be withdrawn and will not be processed.

Unmarried individuals residing together will each have their own application (1 fee per application required), married couples should apply on the same application (1 fee required).

If a partial payment is submitted, the remaining amount must be paid by the 30th calendar day after the application was submitted or the application will be withdrawn. The partial fee payment will not be refunded.

The current fee amount for all Core Plan applications is $60. In the future, the amount of the application processing fee will be based on the performance rating of the HMO selected by the applicant during the application process. HMOs that have a higher performance rating will be in the Tier One group and have a lower fee. HMOs that have a lower performance rating will be in the Tier Two group and have a higher fee.

43.4.2.1 Waiver of Application Fee

The application processing fee is waived for applicants who meet the federal Housing and Urban Development (HUD) definition of homeless:

> A homeless individual lacks a fixed, regular, and adequate nighttime residence; and s/he has a primary nighttime residence that is:
>
> - A publicly supervised or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter and transitional housing for the mentally ill);
> - An institution that provides a temporary residence for individuals intended to be institutionalized or an inpatient facility for mental health and/or substance abuse; **or**
> - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

The application processing fee is waived for applicants who are eligible for Indian Health Services.

43.4.2.2 Medicaid Certified Provider Application Fee Policy

Medicaid certified providers cannot pay enrollment fees on behalf of individual BadgerCare Plus Core Plan members. An offer by a Medicaid certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States Department of Justice and the Department of Health and Human Services; Office of Inspector General. Organizations that are not Medicaid-certified providers may pay an enrollment fee on behalf of prospective Medicaid members according to the following procedures.

43.4.2.3 Community Based Organization Payment Options for the BC+ Core Plan Application Processing Fee

Community based organizations may pay the annual, non-refundable $60 application processing fee for BC+ Plus Core Plan on behalf of one or more applicants. **Medicaid certified providers cannot pay the application processing fee on behalf of their members.**

The following payment options are available:

1. Pay online using credit/debit card or electronic check using ACCESS and the ePayment system
    - If a community based organization is assisting the individual complete their ACCESS application for BC+ Core Plan and wished to pay the application processing fee immediately following the electronic signature and completion of the HNA, the organization

could use their credit card, debit card or electronic check using the ePayment system.
- If they wish to pay using a credit/debit card or electronic check and the applicant is no longer at the organization, they would use Option 2 below.

2. Pay by phone using credit/debit card or electronic check
   - If a community based organization would like to pay the application processing fee for one or more BC+ Core Plan applicants using a credit/debit card or electronic check and are paying at a different time than the ACCESS application was submitted, they will need to call the Enrollment Services Center (ESC) to make the payment(s).
   - The community based organization will need to provide the following information:
     - First and Last Name of each Applicant
     - ACCESS Tracking Number for each Applicant
     - Credit/Debit Card or Electronic Check Information
   - The ESC will need to process each transaction separately. The ePayment System will currently not allow an amount greater than $60.00.
   - **Note**: The payment cannot be processed unless the applicant has electronically signed and submitted their ACCESS BC+ Core Plan application.
3. Pay by mail via check or money order
   - If the community based organization wishes to pay the processing fee for one or more BC+ Core Plan applicants via the mail, they will complete these steps:
     - Retrieve and complete the Payment Form which will be available on the BadgerCare Plus.org website. The form will require the organization to type in the first and last name and the ACCESS Tracking Number for each applicant.
     - If they cannot print the form, they can also call the ESC and request a form to be mailed to them.
     - **Note**: Handwritten forms are not searchable in the US Bank tracking system.
   - Send one check or money order for the entire amount along with the completed form to the lock box for entry.
     - The form will have instructions for making out the check or money order and the address of the lock box.
     - The lock box has instructions to deposit the check or money order and split the payment evenly to each applicant. If the amount is not enough, each applicant will be short and a partial fee letter will be mailed to each applicant.

43.4.2.4 Screening

All applicants will receive a pre-screening to determine potential eligibility for the Core Plan before the application processing fee is collected. If an applicant does not appear to meet all eligibility requirements, s/he will be notified of that fact and discouraged from paying the application processing fee. Written documentation of the reason why s/he does not qualify based on information provided will be made available if requested to access charitable care and community programs.

43.4.2.5 Processing Fee as a Medical Expense

The application processing fee is considered a medical expense for FoodShare and can also be used toward meeting a Medicaid *deductible*.

43.4.2.6 Methods of Payment

The application processing fee may be paid by:

1. Credit card via ACCESS
2. Electronic check via ACCESS
3. Sending, check, credit card information, or money order to the ESC lockbox with an appropriate payment slip.

Checks and money orders should be mailed to the ESC lockbox at:

Enrollment Services Center
P.O. Box 93735
Milwaukee, WI 53293-0735

NOTE: THIS P.O. BOX IS ACTUALLY A LOCKBOX. IT IS ONLY FOR APPLICATION FEES. VERIFICATION AND OTHER CORRESPONDENCE SHOULD BE SENT TO:

P.O. Box 7190
Madison, WI 53707-7190

Or faxed to (608) 261-9310 or 1-888-415-2115 (toll free)

If a fee is returned for any reason (NSF, unsigned, foreign currency) prior to the time the application has been processed, the application will not be processed until the full fee is paid.

If a fee is returned for any reason after enrollment, the member will be contacted and given another chance to pay the fee. If the fee is still not paid, the enrollment will be terminated with timely notice and any benefits received during the enrollment period are considered a recoverable overpayment.

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43.5 BC+ CORE PLAN ENROLLMENT BEGIN DATES

43.5.1 Filing Date
43.5.2 Enrollment Date
43.5.2.1 Retroactive Eligibility/Backdating
43.5.2.2 Late Processing
43.5.3 Certification Period
43.5.4 Re-enrollment
43.5.4.1 Processing Re-enrollments

43.5.1 Filing Date

The *filing date* for a Core Plan *application* is established only when an application with a name, address and valid signature is submitted and the application processing fee is paid (whichever is later).

The signature can be provided electronically through the phone or by using the online ACCESS Apply for Benefits tool. See Chapter 25.5 for the policy regarding valid signatures.

For all applications and renewals, a notice of decision must be issued within 30 calendar days after the filing date. If an application is not processed with sufficient time to allow the *applicant* 10 calendar days to provide verification, the processing timeframe must be extended. An extension can be granted, in 10 day increments, to allow the applicant additional time to provide requested verification.

Notification must be provided for any delays that extend the application processing beyond the 30-day processing period.

Note: The EBD Medicaid application filing date can be used as the Core Plan filing date, if:

- A Core Plan application is received and the application fee is paid within 30 days after the EBD Medicaid denial notice is issued; and
- All required verification is submitted prior to the deadline.

Any EBD applicant with a file date prior to October 10th, who meet the above criteria, will be able to enroll in the Core Plan without being put on the waitlist.

If the applicant is eligible to enroll in the Core Plan, s/he can also choose a later coverage begin date. This option affords a longer certification period for individuals who did not incur any medical expenses while the EBD Medicaid application was being processed.

Example 1: Virginia applies for EBD Medicaid on September 1st. On September 30th, her EBD Medicaid application is processed and it is determined that her income is over the program limits for EBD Medicaid. A six month *deductible* (September through February) is established. She contacts the ESC to apply for the BadgerCare Plus Core Plan on October 15th and pays her application fee on October 25th. She submitted all required verification timely.
When Virginia's Core Plan application is approved on November 20th, her enrollment in the

Core Plan is approved to begin on October 15th, since that is the date her Core Plan enrollment would have begun if she had applied for the Core Plan and paid the application fee on September 1st. The October 15th enrollment date takes into consideration the 30 days allowed for processing the application had the ESC received the application and the fee on September 1st.

Example 2: Bill applies for EBD Medicaid on September 25th. On November 30th, DDB issued a decision that he is not disabled. He decides to appeal the decision. He seeks Core Plan coverage by calling the ESC and pays the application fee on December 23rd. Bill meets the Core Plan eligibility criteria and is eligible to enroll effective November 1st since that is the date his Core Plan enrollment would have begun if he had applied for the Core Plan and paid the application fee on September 25th. The November 1st enrollment date takes into consideration the 30 days allowed for processing the application had the ESC received the application and the fee on September 25th.

However, Bill can choose to enroll in the Core Plan effective November 15th, December 1st, December 15th, or January 1st. The choice will depend on whether medical expenses were incurred during that time versus a longer certification period.

43.5.2 Enrollment Date

Enrollment in the Core Plan begins on the next available enrollment period (always the 1st or the 15th of the month) after:

- All eligibility requirements have been met; and
- Eligibility has been confirmed and transmitted.

Eligibility must be confirmed at least two business days prior to the next enrollment period in order for enrollment in the Core Plan to occur on that date. If eligibility is timely confirmed after the ”r;cut-off date”, enrollment begins on the next available 1st or 15th enrollment date.

Example 3: Phil applied for Core Plan on June 15th and his eligibility was timely confirmed on July 14th. Enrollment begins on August 1st because enrollment was confirmed after the cutoff date and there are not two business days before the next enrollment period.

43.5.2.1 Retroactive Eligibility/Backdating

There is no retroactive eligibility or backdating allowed in the Core Plan, unless an agency delay in application processing would otherwise result in a loss of coverage.

43.5.2.2 Late Processing

Core Plan enrollment will never occur retroactively. Coverage will be granted retroactively when:

- Solely due to agency delay, enrollment in the Core Plan is confirmed after the 30 day application processing period; and
- The enrollment date was actually impacted by the agency delay.

Example 4: Phil applied for Core Plan on June 15th and his eligibility was confirmed on July 28th. Enrollment begins August 1st. Although there was an agency delay, enrollment would have begun on August 1st even if enrollment had been confirmed timely. Retroactive coverage is not granted.

Example 5: Dawn applied for Core Plan on June 10th and due to agency delay, her eligibility was confirmed on July 28th. Enrollment begins August 1st. If the application had been processed timely, her enrollment would have begun on July 15th. Retroactive coverage will be granted from July 15th through July 31st.

Reapplication

Upon request from the applicant/member, a reapplication will be processed without an additional application fee if the request is made within:

- Thirty days of the date after an initial application was denied; or
- One calendar month after an early disenrollment date.

The request establishes a new filing date and a new 30-day processing period. If the individual is determined eligible through the reapplication process, the enrollment start date is determined according to the next available enrollment period after eligibility is confirmed.

This policy does not apply to annual renewals or subsequent applications.

43.5.3 Certification Period

Once enrollment has been confirmed, the *certification period* is continuous for 12 calendar months unless the individual:

- Turns age 65;
- Moves out of the state of Wisconsin;
- Is admitted to an Institution for Mental Disease (*IMD*);
- Becomes incarcerated;
- Becomes eligible for Medicare;
- Meets the non-financial criteria for BadgerCare Plus or Medicaid (pregnancy, children in the home, disability, etc.)
- Attains health insurance coverage

Changes in income and/or marital status do not affect a member's eligibility during the 12 month certification period.

New Spouse
If a member gets married during the 12 month certification period and the new spouse applies for the Core Plan, an application fee (43.4.2) and Health Needs Assessment (43.6.3) is not required for the new spouse. The new spouse's application for Core Plan is treated as a "r;person add" (Process Help 3.2) and a separate eligibility determination is done for the new spouse.

The financial eligibility for the new spouse is based on both spouses' income as of the new spouse's application date. If eligible, the new spouse is enrolled in the same HMO (if applicable) as the current member throughout the duration of the certification period for the current member. The review date for the new spouse is aligned with the current member's review date.

If the new spouse is not eligible, the current member remains enrolled until the end of the 12 month certification period. At that time a review must be completed to determine if the couple is eligible taking into account all the income in the household.

43.5.4 Re-enrollment

MEMBERS ELIGIBLE FOR MEDICAID OR BADGERCARE PLUS

If a member is disenrolled from the Core Plan because s/he becomes eligible for Medicaid or BadgerCare Plus Standard or Benchmark plan and the eligibility for that program ends during the 12 months for which the Core Plan had been certified, s/he can re-enroll in the Core Plan for the remainder of that 12 month period without paying a $60 application processing fee as long as s/he continues to meet the non-financial requirements for the Core Plan (not pregnant, not caring for children under 19 living in the household, not entitled to Medicare, etc).

Example 6: John Smith is enrolled in the Core Plan and renewed his coverage in March 2010. His certification period is 4/1/10 - 3/31/11. In early June 2010, he is found presumptively disabled and enrolled in Medicaid. His Core Plan coverage ends July 1, 2010. In September 2010, the Social Security Administration denies his disability claim and his Medicaid eligibility ends October 1, 2010. John Smith can re-enroll for 10/1/10 - 3/31/11 without having to pay a $60 application processing fee.

Example 7: June Smith enrolled in the Core Plan on September 15, 2009. Her Core plan coverage ends September 30, 2010. In April 2009 Jane is determined disabled and eligible for Medicaid. In July 2009 Jane turns 65, begins receiving her Social Security Retirement benefit and becomes entitled to Medicare. Her increased income puts her over the income limit for Medicaid and she is on an unmet deductible. Jane can't re-enroll for the Core Plan even though she lost her Medicaid eligibility within the 12 months of the Core Plan certification because she no longer meets the non-financial requirements for the Core Plan.

Example 8: Mary Smith's Core Plan certification period is October 1, 2009 through September 30, 2010. In May 2010, Mary's children moved back to her household and she became eligible for BadgerCare Plus Standard Plan with a premium. Because she failed to pay her July 2010 premium, her BadgerCare Plus Standard Plan closed effective July 31, 2010 and a six month *RRP* was imposed. Because Mary's children are still living in her household she does not meet the non-financial requirements for the Core Plan and can't re-enroll.

If the disenrolled Core Plan member's eligibility for Medicaid or BadgerCare Plus (for families or pregnant women) ends within 12 months after the Core Plan certification period ended, s/he can reapply for the Core Plan and bypass the waitlist as long as all the steps (including payment of the $60 fee) are completed and s/he continues to meet the non-financial requirements for the Core Plan.

Example 9: Jane Smith is enrolled in the Core Plan. Her current certification period is for 7/1/09 - 6/30/10. In May, Jane Smith reports a pregnancy, the pregnancy is verified and BadgerCare Plus for pregnant women opens 6/1/10 and her Core Plan coverage ends. In August, she reports she is no longer pregnant due to a miscarriage. Because this is past the end of her 12-month Core Plan certification period (7/1/09 - 6/30/10), she can reapply for the Core

Plan (including paying the $60 application processing fee) and bypass the waitlist.

Example 10: Julie Smith's Core Plan certification period is 8/1/09 - 7/31/10. She is determined disabled in June, 2010 and is enrolled in Medicaid and disenrolled from the Core Plan. In August 2011, she received an increase in her SSDI payment and her income now exceeded the income limit for SSI Medicaid. She is on an unmet deductible and not yet eligible for Medicare. Because her Medicaid eligibility was terminated more than 12 months after her Core Plan 12-month certification period would have ended, she must reapply to get back on the Core Plan and cannot bypass the waitlist.

MEMBERS WITH PRIVATE INSURANCE

If a Core member is disenrolled because s/he gains private health insurance coverage or access and then loses the coverage or access for a "r;*good cause*" reason during the 12 months for which Core had been certified, s/he can re-enroll in the Core Plan for the remainder of that 12 month period without paying a $60 application processing fee.

If the disenrolled Core member's coverage or access ends for a "good cause" reason within 12 months after the Core certification period ended, s/he can reapply for Core and bypass the waitlist as long as all the steps (including payment of the $60 fee) are completed.

43.5.4.1 Processing Re-enrollments

WITHIN THE 12 MONTH CERTIFICATION PERIOD

Go to the "Potential Eligibility' page and determine if the member still meets the eligibility requirements for the Core Plan. Increases in income do not affect the member's re-enrollment. If s/he was below the income limit when the 12 month certification was determined, continue to use that income until the end of the certification period.

Once you determine the member still meets the Core Plan requirements, go to the "BC+ Core Plan for Childless Adults Details' page and enter a new request using the date the person is requesting to re-enroll. Indicate the fee is Waived using the new '"WR-Waived-Re-Enroll'r; reason code. Once the Core Plan has been confirmed open on AGEC, go to AGOR and change the Core Plan renewal date back to the original renewal date for the 12 month certification.

Do not require the customer to complete the HNA.

PAST THE 12 MONTH CERTIFICATION PERIOD

These applications must be processed directly to *CWW* in order to bypass the waitlist. Follow the same process as any other application processed in CWW.

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43.6 BC+ CORE PLAN NON-FINANCIAL

43.6.1 BC+ Non-Financial
43.6.2 Age
43.6.3 Health Needs Assessment
43.6.4 Physical Exam
43.6.5 Health Insurance Coverage
43.6.6 Health Insurance Access

43.6.1 BC+ Non-Financial

The Core Plan member must meet the existing BadgerCare Plus requirements including:

- Providing an *SSN* (6.1),
- State residency (3.1),
- US Citizenship (4.1;.4.2) or Qualifying Immigrant Status (4.3)
- Subrogation settlements or payouts (5.6).

Cooperation with child support requirement does not apply to Core Plan members.

Note: The Emergency Services Plan is not available under the Core Plan.

In addition, the Core Plan member must also meet the following non-financial criteria.

43.6.2 Age

The member must be at least 19 but no more than 64 years of age.

43.6.3 Health Needs Assessment

At *application* and renewal, the member must complete a Health Needs Assessment (HNA) as a condition of enrollment. The HNA is completed online through ACCESS Apply for Benefits or by telephone with ESC staff.

Answers from the survey will be used to help the *applicant* choose a Health Maintenance Organization (HMO) that best meets his/her health needs. It will provide the applicant with information about the HMOs his/her doctor, clinic or hospital may belong to. It will also be used to provide HMOs with information about members' health needs. It is not be used to screen individuals out of the Core Plan for any health status reasons.

43.6.4 Physical Exam

All members must complete a physical exam within the first 12 months enrollment period, unless they have a *good cause* reason. The completion of the exam is a requirement for re-certification at renewal. If our records show that an exam has not been completed, members will receive a reminder letter about the physical exam requirement. Failure to complete the physical exam will result in a six-month restrictive re-enrollment period (*RRP*) before the member can re-enroll in the Core Plan.

This is a one time requirement. Once the member has completed the physical exam, s/he will not be required to complete another exam even if there are gaps in enrollment.

There are good cause reasons for not completing the physical exam. These include the following:

- The health plan or health care provider certifies that they were unable to schedule a physical exam appointment within the required time frame;
- The member is a migrant worker;
- The member completed a physical exam while enrolled in BadgerCare Plus or Medicaid within one year prior to enrollment in the Core Plan;
- Transportation issues prevented the member from getting to the provider.

43.6.5 Health Insurance Coverage

Health insurance coverage is defined as medical care (provided directly, through insurance or reimbursement or otherwise) under any hospital or medical service policy or certificate, hospital or medical services plan contract, or HMO contract offered by a health insurance issuer.

Health insurance coverage includes group health insurance coverage, individual health insurance coverage and short-term, limited duration insurance. For the purposes of this policy, health insurance does not include County General Assistance Medical Programs, Health Insurance Risk Sharing Plan (HIRSP),

Medicaid, BadgerCare Plus, Indian Health Program or other public health care programs for the uninsured.

Current Coverage
An individual is ineligible for the Core Plan if s/he is currently covered by a health insurance plan.

Past Coverage
An individual is ineligible for the Core Plan if s/he has been covered by a health insurance plan in the previous 12 months, unless a good cause reason exists.

Good cause reasons for losing past coverage:

The 12-month waiting period does not apply if the applicant/member has good cause for losing the insurance. Good cause reasons for losing coverage in the 12 months prior to the application date are:

- Health insurance was lost during the 12 month period for employment related reasons, including:
  - Involuntary termination of employment;
  - Voluntary termination due to the incapacitation or health condition of the individual or that of an immediate family member. An immediate family member is defined as a spouse, child or parent;
  - Employer discontinued health plan coverage for all employees.
- Coverage was lost due to the death or change in marital status of the policy holder;
- The Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage continuation period expired during the 12 month period.

43.6.6 Health Insurance Access

Current or past access to employer sponsored insurance through a current employer of the applicant/member, the applicant/member's spouse or the applicant/member's parent can affect eligibility for the Core Plan.

Insurance is considered "employer sponsored" only if the employer contributes some amount to the cost of the insurance. If the employer pays no portion of the premium it is not considered employer sponsored.

Current Access
An individual with access to employer sponsored health insurance through a current employer or his/her spouse's or parent's employer is ineligible, regardless of the amount of the employer contribution. Current access means the coverage would begin:

- Within the month of application, or

- In the three months following the month of application.

There is no good cause for not signing up when the applicant or member has current access to insurance.

Past Access
An individual who had access to employer sponsored insurance through his/her current employer (or his/her spouse's or parent's current employer) in the past 12 months is ineligible, regardless of the amount of the employer contribution, unless there is a good cause reason for not signing up for the insurance. The good cause reason only applies at the time of application. There will be no good cause reasons granted at renewal if the member did not sign up for the employer sponsored insurance while he/she was enrolled in the Core Plan.

Good cause reasons for past access at application
The good cause reasons for not signing up for employer insurance in the past 12 months are:

- The individual was enrolled in a public health care benefit at the time s/he could have signed up for the employer sponsored plan. Public health care benefit includes the Health Insurance Risk Sharing Plan (HIRSP) (the temporary high risk pool is also considered HIRSP for purposes of the waiting period), BadgerCare Plus Standard or Benchmark Plan, Medicaid, the Veteran's Administration (VA) or other public health care program for the uninsured.
- The individual tried to sign up for an employer sponsored plan but was denied coverage for pre-existing conditions.

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43.7 BC+ CORE PLAN FINANCIAL

43.7.1 Core Plan Group
43.7.2 Income and Resources

43.7.1 Core Plan Group

The "r;Fiscal Test Group" (FTG) for Core Plan applicants and members includes only the *applicant*/member and his or her spouse. The Core Plan FTG is never more than two. If both spouses are applying, each is tested in his or her own Core Plan assistance group (2.4), with the other spouse as a counted or test adult or child in the group. (2.5)

Eligibility for two adults who are living together, but not married, is determined on separate cases with each case a FTG of 1.

43.7.2 Income and Resources

In order to qualify for the Core Plan, an applicant or member's gross monthly income must not exceed 200% of the FPL for the FTG size (1 or 2). See Chapter 16 for types of income that are counted or not counted and instructions on how to budget income.

Spenddown
An applicant cannot 'r;spend down' or meet a *deductible* to become eligible.

Deductions
There are no income deductions allowed for the Core Plan.

Unlike the BadgerCare Plus Benchmark Plan, *depreciation* is not an allowed expense when calculating income for self-employed Core Plan applicants and members.

Resource/Asset limit
There is no asset limit for the Core Plan.

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43.8 BC+ CORE PLAN DISENROLLMENT

43.8.1 Change Reporting Requirements
43.8.1.1 Income Changes
43.8.2 Redetermination of Eligibility

43.8.1 Change Reporting Requirements

There are changes that result in the termination of enrollment in the Core Plan. If these items are not reported within ten calendar days, the member is liable for payments that are made on his/her behalf for any months during which s/he was ineligible.

Members must report within ten calendar days if s/he:

1. Moves out of the state of Wisconsin;
2. Becomes institutionalized or incarcerated;
3. Has a child under 19 under his/her care who moves into the home for more than 40% of the time;
4. Becomes pregnant; or
5. Attains health insurance coverage.

In addition, members are strongly encouraged to report any change in address. While address changes within the state of Wisconsin do not impact eligibility, a current address is important to facilitate member communication and access to care.

Members may report changes to the ESC by phone, or online through the ACCESS Report My Changes (RMC) tool.

43.8.1.1 Income Changes

Changes in income that occur after enrollment do not impact Core Plan eligibility and do not have to be reported until the annual renewal.

43.8.2 Redetermination of Eligibility

A redetermination of eligibility must be done when a change in non-financial circumstance is reported, in order to assess the individual's eligibility for BadgerCare Plus or Medicaid programs.

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43.9 BC+ CORE PLAN RENEWALS

All Core Plan members must complete a renewal by the last day of the 12-month *certification period* in order to stay enrolled without any lapse in coverage. In order to avoid any lapse in enrollment, a complete renewal must be submitted by the 5th of the month.

A complete renewal consists of:

- Providing updated information by phone or through ACCESS
- *Application* processing fee
- Health needs assessment

If the renewal request is not received by the 5th of the renewal month there may be a delay and/or loss of coverage. If the request is received after the 5th but before the last day of the renewal month, the request is processed and all eligibility actions completed by the agency timely (within 10 calendar days), enrollment resumes on the first day of the next available enrollment period after confirmation.

Example 1: Angie's request for renewal was due July 5th. She submitted her request on July 25th. The agency processed the request on July 30th and requested verification of income. The verification was turned in on August 2nd. The agency processed the verification and confirmed the Core Plan eligibility on August 10th. Angie's enrollment in the Core Plan began August 15th. She had a gap in coverage from August 1st through August 14th.

Example 2: Alyssa's request for renewal was due August 5th. She submitted her request on August 31st. The agency processed the request on September 8th and requested verification of income. Alyssa returned the verification on September 17th. The ESC updated the verification information and confirmed the Core Plan eligibility on October 3rd. Because the ESC did not process her verification timely, eligibility for the Core Plan will go back to October 1st. She will have a gap in coverage from September 1 through September 30.

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43.10 BC+ CORE PLAN VERIFICATION

See the Verification Chapter 9.1 for general rules and definitions for verification.

The following verification is required for the Core Plan:

1. Earned and Unearned Income (16.1)
2. Social Security Number and date of birth (9.9.1)
3. US citizenship and identity (4.2) or *immigration status* (9.9.2)
4. Health Insurance Access (43.6.6)
5. Health Insurance Coverage (43.6.5)
6. *Good Cause* for not signing up for insurance (access) and for losing insurance coverage (43.6.6)
7. Eligibility in another state (migrant workers) (12.3)

8. Documentation of Power of Attorney and Guardianship (9.9.5) (if applicable)

Verification Methods
Verification will be obtained using data exchange resources to the fullest extent possible as follows:

Earned and Unearned Income
Verification of current wages needs to be provided by the *applicant*/member.

Information about income from the following sources can generally be obtained systematically:

-
- Child Support income (court ordered and received in WI)
- Social Security Disability Insurance
- Unemployment Insurance
- Veterans Administration

Social Security Number and Date of Birth
Proof from the applicant is requested only if the information s/he provided does not match records available through the Social Security Administration

US citizenship or Immigration Status
Proof from the applicant is requested only if the required documentation cannot be obtained through the Wisconsin DHS Vital Records (Birth Query), the Social Security Administration (SSA) and Department of Transportation/Division of Motor Vehicles

Health Insurance Access
Employer Verification of Health Insurance (EVHI) system

Health Insurance Coverage
Information will be self-declared at *application*, but will be verified through the *Third Party Liability (TPL)* process within several months after enrollment.

Good Cause for Losing Health Insurance
- Employer dropped coverage: EVHI
- Health condition of self/famiy: Provided by the applicant
- Life changing event: Provided by the applicant
- Involuntary Termination: UC Date Exchange or provided by the applicant

Good Cause for Access to Health Insurance
- Enrollment in BC+/Medicaid: *CARES*, *CWW* or iC
- Pre-existing Condition: Provided by the applicant

Eligibility in another state (migrant workers)

See chapter 9.9.

Documentation of Power of Attorney and Guardianship (if applicable)
Verification needs to be provided by the applicant/member

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43.11 BC+ CORE PLAN COVERED SERVICES

Co-payments are the only cost sharing requirement for services covered under the Core Plan. There are no premiums in the Core Plan. There are two income tiers for the purposes of co-payment charges.

Co-payments are waived for everyone for preventive services. For other services, the copayment amount varies according to FPL level (below or above 100% FPL).

Co-payments and covered services can be found at badgercareplus.org/core/coveredservices.htm.

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43.12 BC+ CORE PLAN ENROLLMENT CAP (WAITLIST)

Core Plan applications received after 5:00 P.M. on October 9, 2009, will not be processed. A Waitlist was established on October 9, 2009 because the total number of applications received is greater than the amount of funding available.

Any person who is enrolled in the BadgerCare Plus Basic Plan and is confirmed by a physician to have a diagnosis of any cancer type, excluding non-melanoma skin cancers, will not be subject to the Core Plan enrollment cap. These individuals are eligible to be removed from the waitlist and apply for the Core Plan. If the member is eligible for the Core Plan, s/he will be enrolled on the next first or fifteen of the month. The member must be currently enrolled in the Basic Plan before s/he can be approved to bypass the waitlist and apply for the Core Plan. See chapter 45.2.

Members Removed From The Core Plan Waitlist Due To Eligibility For Medicaid/BadgerCare Plus or Health Insurance Access or Coverage

If a person is removed from the Core Plan Waitlist because he or she:

- became eligible for Medicaid or BadgerCare Plus Standard or Benchmark Plan,
- gained coverage under a private health insurance plan, **or**
- gained access to private health insurance,

he or she can be added back to the waitlist, in the same position he or she was in prior to being removed, if the eligibility for Medicaid or BadgerCare Plus is terminated or the insurance access/coverage is lost due to a *good cause* reason.

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43.13 BC+ CORE PLAN RE-ENROLLMENT

43.13.1 Members Eligible for Medicaid or BadgerCare Plus
43.13.2 Members With Private Insurance

43.13.1 Members Eligible for Medicaid or BadgerCare Plus

If a member is disenrolled from the Core Plan because s/he becomes eligible for Medicaid or BadgerCare Plus Standard or Benchmark plan and the eligibility for that program ends during the 12 months for which the Core Plan had been certified, s/he can re-enroll in the Core Plan for the remainder of that 12 month period without paying a $60 *application* processing fee as long as s/he continues to meet the non-financial requirements for the Core Plan (not pregnant, not caring for children under 19 living in the household, not entitled to Medicare, etc).

Example 1: John Smith is enrolled in the Core Plan and renewed his coverage in March 2010. His *certification period* is 4/1/10 - 3/31/11. In early June 2010, he is found presumptively disabled and enrolled in Medicaid. His Core Plan coverage ends July 1, 2010. In September 2010, the Social Security Administration denies his disability claim and his Medicaid eligibility ends October 1, 2010. John Smith can re-enroll for 10/1/10 - 3/31/11 without having to pay a $60 application processing fee.

Example 2: June Smith enrolled in the Core Plan on September 15, 2009. Her Core plan coverage ends September 30, 2010. In April 2009 Jane is

determined disabled and eligible for Medicaid. In July 2009 Jane turns 65, begins receiving her Social Security Retirement benefit and becomes entitled to Medicare. Her increased income puts her over the income limit for Medicaid and she is on an unmet *deductible*. Jane can't re-enroll for the Core Plan even though she lost her Medicaid eligibility within the 12 months of the Core Plan certification because she no longer meets the non-financial requirements for the Core Plan.

Example 3: Mary Smith's Core Plan certification period is October 1, 2009 through September 30, 2010. In May 2010, Mary's children moved back to her household and she became eligible for BadgerCare Plus Standard Plan with a premium. Because she failed to pay her July 2010 premium, her BadgerCare Plus Standard Plan closed effective July 31, 2010 and a six month *RRP* was imposed. Because Mary's children are still living in her household she does not meet the non-financial requirements for the Core Plan and can't re-enroll.

If the disenrolled Core Plan member's eligibility for Medicaid or BadgerCare Plus (for families or pregnant women) ends within 12 months after the Core Plan certification period ended, s/he can reapply for the Core Plan and bypass the waitlist as long as all the steps (including payment of the $60 fee) are completed and s/he continues to meet the non-financial requirements for the Core Plan.

Example 4: Jane Smith is enrolled in the Core Plan. Her current certification period is for 7/1/09 - 6/30/10. In May, Jane Smith reports a pregnancy, the pregnancy is verified and BadgerCare Plus for pregnant women opens 6/1/10 and her Core Plan coverage ends. In August, she reports she is no longer pregnant due to a miscarriage. Because this is past the end of her 12-month Core Plan certification period (7/1/09 - 6/30/10), she can reapply for the Core Plan (including paying the $60 application processing fee) and bypass the waitlist.

Example 5: Julie Smith's Core Plan certification period is 8/1/09 - 7/31/10. She is determined disabled in June, 2010 and is enrolled in Medicaid and disenrolled from the Core Plan. In August 2011, she received an increase in her SSDI payment and her income now exceeded the income limit for SSI Medicaid. She is on an unmet deductible and not yet eligible for Medicare. Because her Medicaid eligibility was terminated more than 12 months after her Core Plan 12- month certification period would have ended, she must reapply to get back on the Core Plan and cannot bypass the waitlist.

43.13.2 Members With Private Insurance

If a Core member is disenrolled because s/he gains private health insurance coverage or access and then loses the coverage or access for a "*good cause*"

reason during the 12 months for which Core had been certified, s/he can re-enroll in the Core Plan for the remainder of that 12 month period without paying a $60 application processing fee. If the disenrolled Core member's coverage or access ends for a "good cause" reason within 12 months after the Core certification period ended, s/he can reapply for Core and bypass the waitlist as long as all the steps (including payment of the $60 fee) are completed.

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44 BC+ CORE PLAN TRANSITIONAL CHILDLESS ADULTS (TCLA)

CHAPTER 44.1 CORE PLAN FOR TRANSITIONAL CHILDLESS ADULTS (TCLA)

44.1 Introduction
44.1.1 Certification Periods for TCLA
44.1.2 Covered Services
44.1.2.1 Prescription Drug Coverage

44.1 INTRODUCTION

BadgerCare Plus Core Plan for Childless Adults (Core Plan) is an expansion of the BadgerCare Plus program to allow health care coverage to adults who do not meet the non-financial criteria for BadgerCare Plus or Medicaid.

Individuals enrolled in the Milwaukee General Assistance Medical Program (GAMP) and other participating county/tribal agency general assistance (GA) medical programs as of

12/26/08, will automatically be enrolled in the BadgerCare Plus Core Plan effective January 1, 2009, and will be referred to as Transitional Childless Adults (TCLA).

TCLA member's enrollment and benefits will be managed by state and other staff.

44.1.1 Certification periods for TCLA

The TCLA enrollment period will be from 12-14 months. The certification end dates will be staggered between December 2009 and February 2010, and will be based on the birth month of the member. If the member's birth date falls between:

- January and April, the certification end date will be 12/31/09.
- May and August, the certification end date will be 1/31/2010
- September and December, the certification end date will be 2/28/10

TCLA certification will be 'frozen' until the certification end date unless the member:

- Becomes eligible for Medicare, Medicaid, or BadgerCare Plus Standard or Benchmark Plans;
- Turns age 65. The certification will end at the end of the month in which they turn 65;
- Dies;
- Becomes incarcerated;
- Obtains health insurance coverage;
- Moves to an *IMD* or other medical institution or
- No longer resides in the state of Wisconsin

Note: If otherwise eligible, a TCLA member who moves to a county that did not have a GA/GR medical program, will continue to receive TCLA benefits.

Members must renew their benefits and enroll into the BC+ Core plan at the end of their TCLA *certification period*. In addition, the TCLA member must complete a physical exam prior to the end of the certification period in order to renew enrollment. A six month Restrictive Re-enrollment Period will be imposed if the physical exam requirement is not met.

44.1.2 Covered Services

The BadgerCare Plus Core Plan for Childless Adults covers basic health care services including primary care and preventive care, generic and a limited number of brand name prescription drugs.

All members will receive TCLA benefits under the BadgerCare Plus Core Plan on a fee-for-service basis from January 1, 2009 through March 31, 2009. Effective April 1, 2009,

TCLA members in Milwaukee County will be enrolled in the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population. Members will be sent enrollment choice materials beginning in January and will enroll through the State's enrollment broker as they currently do with the BadgerCare Plus population. The date of HMO enrollment for TCLA members in other counties has not yet been determined.

The covered services offered to TCLA members are as follows:

COVERED SERVICES	CO-PAYMENT
Visits to the doctor • Includes office visits and surgical procedures. • Mental health visits are only covered when they are with a psychiatrist. • For substance abuse, physician services are covered. • Routine eye exams are not covered.	$0.50 to $3 per service, limited to $30 per provider per calendar year. No co-payments for emergency services, preventive care, anesthesia, or clozapine management.
Hospital services • This includes inpatient and outpatient visits. • Inpatient mental health and substance abuse services are not covered.	For outpatient visits, $3 per visit. For inpatient visits, $3 per day. For each stay, you will not have to pay more than $75 in co-payments. You will not have to pay more than $300 per year in co-payments for all of your hospital services.
Emergency room visits and ambulance rides for emergencies.	$0
Emergency dental services.	$0
Prescription drugs - See 44.1.2.1.	See 44.1.2.1.
Physical therapy, occupational therapy, and speech therapy • There is a limit of 20 visits per year for each type of therapy. Cardiac rehabilitation is included under physical therapy.	$0.50 to $3 per service. Co-payments will not be charged after the first 30 hours or $1,500 of each type of therapy, whichever occurs first, each calendar year.
Durable Medical Equipment • This has a benefit limit of	$0.50 to $3 per priced unit.

$2,500 per year. Rental items count towards the limit.	
Disposable Medical Supplies • This is limited to syringes, diabetic pens, and items used with durable medical equipment.	$0.50 to $3 per priced unit.
Dialysis and other kidney-related services for people with end-stage renal disease, who do not qualify for Medicare end-stage renal disease services.	$0

44.1.2.1 Prescription Drug Coverage

To ensure continuity of care for GA Medical Program members who are transitioned to the TCLA program, the following additions to Core Plan covered services have been made for this population.

Mental Health Drugs

- From January 1, 2009 through March 31, 2009, the TCLA Core Plan will cover any mental health drug the member was taking in December 2008 to treat depression, Alzheimer's disease, Parkinson's disease, epilepsy and other seizure disorders, bipolar disease and schizophrenia, and drugs used to treat attention deficit disorder.
- Beginning April 1, 2009, the Core Plan will cover mental health drugs. If the member is taking drugs for Alzheimer's disease, bipolar disease or schizophrenia, s/he will continue on any drug used to treat these conditions as long as s/he remains enrolled in the TCLA Core Plan.
- Beginning April 1, 2009, the TCLA Core Plan will continue to cover the specific drug the member is currently taking to treat depression, Parkinson's disease, epilepsy and other seizure disorders, and attention deficit disorder, as long as s/he remains enrolled in the Core Plan. If the member needs to change to a different drug for these conditions, it may not be covered under the BadgerCare Plus Core Plan.

Asthma and Diabetes Drugs

From January 1, 2009 through March 31, 2009, the Core Plan will cover any insulin the member was taking in December 2008 to treat diabetes and some inhalers s/he was taking to treat asthma.

- Beginning April 1, 2009, the only insulins that will be covered under the Core Plan are Humalog and Lantus.
- Beginning April 1, 2009, the only asthma inhalers that will be covered under the Core Plan are Flovent, Serevent and Proventil HFA.
- Other asthma and diabetes medications may be covered under the Badger Rx Gold program.

All Other Medications

- Beginning January 1, 2009, generic drugs and a limited number of over the counter (OTC) drugs will be covered under the TCLA Core Plan.
- Beginning January 1, 2009, brand name drugs and other drugs not covered under the TCLA Core Plan will be available through the Badger Rx Gold program.

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45 BC+ BASIC PLAN

45.1 BADGERCARE PLUS BASIC PLAN INTRODUCTION

Wisconsin's new BadgerCare Plus Basic Plan (Basic Plan) is a self-funded plan which will provide BadgerCare Plus Core Plan (Core Plan) Waitlist members with access to vital, cost-effective primary and preventive care until space becomes available in the Core Plan. This new program builds upon Wisconsin's goal to ensure access to affordable health insurance for virtually all Wisconsin residents.

As a self-funded plan, premium payments and member cost-sharing are required. Efforts have been made to design a broad-based benefit package while keeping premium costs as low as possible. Premiums have been established that will be sufficient to fund the health care costs of the population served.

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45.2 BADGERCARE PLUS BASIC ELIGIBILITY CRITERIA

45.2.1 Core Plan Waitlist Bypass for Basic Members Diagnosed with Cancer
45.2.1.1 Processing Core Plan Waitlist Bypass Cases

Eligibility to enroll in the Basic Plan is limited to individuals who are on the Core Plan Waitlist (Waitlist). Individuals are placed on the Waitlist once s/he applies for the Core Plan and, based on information provided, is determined to be potentially eligible for Core Plan coverage. Individuals must meet the following Core Plan financial and non-financial eligibility criteria to qualify for the Core Plan Waitlist and BadgerCare Plus Basic Plan:

- Wisconsin residency;
- Age 19-64;
- U.S. citizenship or qualifying *immigration status*;
- Income at or below 200% of the FPL ($1,805 for a single person and $2,428.33 for a married couple);
- Not pregnant and no dependent minor children under age 19 living in the home;
- Not disabled;
- Not entitled to Medicare, Medicaid or BadgerCare Plus for families;
- Does not have access to health insurance through a current employer in the month of *application* or subsequent three months;
- Did not have access to health insurance through a current employer in the 12 months prior to application, unless there is a good cause reason for not signing up;
- Is not currently covered by a health insurance policy (through employer or individual policy); and
- Has not been covered by a health insurance policy in the 12 months prior to application, unless there is a *good cause* reason for losing the coverage, such as a recent layoff.

Basic Plan coverage does not count as health insurance coverage for the purposes of the Core Plan rules, once an individual is invited to enroll in the Core Plan.

Participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan Waitlist.

45.2.1 Core Plan Waitlist Bypass for Basic Members Diagnosed with Cancer

Any person who is enrolled in the BadgerCare Plus Basic Plan and is confirmed by a physician to have a diagnosis of any cancer type, excluding non-melanoma skin cancers, will not be subject to the Core Plan enrollment cap. These individuals are eligible to be removed from the waitlist and apply for the Core Plan. If the member is eligible for the Core Plan, s/he will be enrolled on the next first or fifteen of the month. The member must be currently enrolled in the Basic

Plan before s/he can be approved to bypass the waitlist and apply for the Core Plan.

EXAMPLE 1: Joe is on the Core Plan Waitlist. On July 7th he submitted his $130 premium payment to enroll in the Basic Plan. His enrollment will begin on August 1st. On July 10th his physician submitted the Core Plan Medical Bypass form to the ESC. Since Joe's Basic Plan enrollment will not begin until August 1st he is not allowed to apply for Core Plan before August 1st. Joe applies for the Core Plan on August 4th and is determined eligible, so his Core Plan enrollment begins August 15th.

EXAMPLE 2: Mary is on the Core Plan Waitlist and submitted her $130 premium to enroll in the Basic Plan on June 6th. She was enrolled in the Basic Plan beginning July 1st. On July 8th, her physician submitted the Core Plan Medical Bypass form to the ESC. Mary applied for the Core Plan and was determined eligible on July 10th. Her Core Plan enrollment date will be July 15th.

Basic members who bypass the Core Plan waitlist are not required to pay the Core Plan processing fee. If it is determined that the member does not meet the Core Plan enrollment criteria, including providing all required verification, enrollment for the Core Plan is denied and enrollment in the Basic Plan is terminated.

45.2.1.1 Processing Core Plan Waitlist Bypass Cases

Wisconsin Basic Plan providers will be notified to fax the completed Core Plan Medical Bypass form (F-00292) for newly diagnosed members to the Enrollment Services Center (ESC).

Note: Any applications received in local IM or tribal agencies should be faxed to the ESC at 1-888-409-1982 immediately upon receipt to prevent any delay in eligibility determination or treatment for the *applicant*.

Upon receipt of the completed form, the ESC will check for completeness and accuracy as follows.

1. Confirm in interChange that member is currently enrolled in the BadgerCare Plus Basic Plan. If the member is enrolled in any other health care plan except Family Planning Only Services (*FPOS*), Well Woman Program (WWP) or TB MA, or if the member is inactive in BC+ Basic and has no other BC+ or Medicaid Plan coverage, send written notification (NOTICE OF DENIAL) to the member explaining why they are not eligible to enroll in the BadgerCare Plus Core Plan.
2. Ensure all required information is present and that the diagnosis is cancer. Allow all cancer diagnoses excluding non-melanoma skin cancers (just

”r;melanoma” is acceptable). Do not allow conditions that appear not to be cancer (e.g. multiple sclerosis, epilepsy).

3. Review physician’s signature and credentials. Only Doctors of Medicine (MD) and osteopaths (DO) are acceptable.
4. Review the date of physician’s signature to ensure the physician’s confirmation of the cancer diagnosis was made while the member was enrolled in the Basic Plan.

If a waitlist bypass is approved, the ESC will attempt to contact the member to complete the Core Plan application process by phone. If member cannot be reached by phone within two business days, send the F-00287 to notify the member s/he can bypass the waitlist and to contact the ESC by phone to complete the Core Plan application.

Process the application following the normal procedures, including the HNA, and obtain all required verification. A processing fee is not required.

During the application process, determine if the member meets eligibility criteria for Medicaid or the BadgerCare Plus Standard or Benchmark Plans. Eligibility for any of these programs would preclude enrollment into Core.

If it is determined that the member meets all eligibility criteria for the Core Plan, s/he will be enrolled in the Core Plan on the next first or fifteenth of the month. If it is determined that the member does not meet all eligibility criteria for the Core Plan, Core Plan eligibility will be denied and enrollment in the Basic plan will be terminated at the end of the current month. Any Basic Plan premiums paid for future months should be refunded.

A copy of the completed waitlist bypass form should be shared with the DHS Nurse Consultant by fax at: (608) 250-6563.

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45.3 BADGERCARE PLUS BASIC ENROLLMENT PROCESS

The Enrollment Services Center (ESC) will be responsible for the administration of the Basic Plan. There is no *application* for the Basic Plan. Anyone who applies for the Core Plan and is put on the Waitlist will receive instructions on how to enroll in the Basic Plan with an initial premium payment slip (See Notification to Waitlist Members). Once the $130 initial premium is paid, s/he will be enrolled in the Basic Plan. Initial premium payments can be made by credit

card, debit card, electronic check, personal check, cashier check, certified check or money order via:

1. Using ACCESS to pay online with a credit card, debit card or electronic check;
2. Calling the ESC to pay online with a credit card, debit card or electronic check; or
3. Mailing their $130 premium payment with the payment slip to the address on the payment slip. (Please note: credit card or debit card information can also be provided on the payment slip. These payments will be made by the ESC fiscal staff using the ePayment Administrative Site.)

There is no other application process for the Basic Plan. No paper applications designed as applications for other BadgerCare Plus or Medicaid programs will be accepted and processed as a Basic Plan application. There is no signature required to enroll in the Basic Plan. An *SSN* is required before a Basic Plan enrollment request can be processed. If an individual on the Waitlist makes the initial premium payment online, s/he will not be able to complete the process without entering an SSN if one was not provided when the individual applied for the Core Plan.

45.3.1 Ongoing Coverage

In order to stay enrolled in the Basic Plan, members must submit a $130 monthly premium payment by the 5th of each month for the next month's coverage. A payment slip will be mailed to the member on or around the 20th of the month before their next premium payment is due. The member can make their ongoing premium payment using the same methods as making their initial premium payment. If using ACCESS, the member will be able to pay from the 20th of the current month to the 10th of the next month. The payment must be received before *Adverse Action* in order to remain eligible for the next month. More details of ongoing premium processing will be released in a future Operations Memo.

45.3.2 Restrictive Re-Enrollment Period (RRP)

An individual will be placed on a 12 month restrictive re-enrollment period if his/her enrollment in the Basic Plan ends for a reason that is not *good cause*, including if the premium payment is not received timely, or is received timely but is later rejected by the financial institution (e.g. bounced check). This means that the member will not be able to re-enroll in the Basic Plan for the 12 calendar month period after enrollment ends. Imposition of an *RRP* does not affect the member's status on the Waitlist, unless it is determined that the member no longer meets the Core Plan eligibility criteria.

Example: Jill signed up for the Basic Plan and paid her first premium on June 10th so her enrollment began July 1st. On July 16th (Adverse Action), her

premium payment for August still had not been received. Her coverage was terminated effective July 31st and a restrictive re-enrollment period was imposed effective August 1st. Jill will be unable to re-enroll in the Basic Plan from August 2010 through July 2011. However, she will remain on the Waitlist and will be able to enroll in the Core Plan during that time if funding becomes available.

If the member is disenrolled from the Basic Plan for a good cause reason the 12 month restrictive re-enrollment period will not be imposed. Good cause reasons include the individual:

- Becoming eligible for BC+ (Core, Benchmark or Standard), Medicaid, or Medicare;
- Obtaining health insurance through an employer or HIRSP;
- Moving out of state before coverage began; or
- Other reasons as determined by the Department.

If an RRP is imposed because a premium payment was returned from the financial institution, the RRP can be lifted if the member makes another payment through an immediately negotiable method within 30 calendar days. This is only allowed once.

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45.4 BADGERCARE PLUS BASIC NOTIFICATION

45.4.1 Notification to Waitlist Members

In May 2010, a letter was be sent to all individuals currently on the Core Plan Waitlist. The letter detailed information about:

- How to enroll in the plan,
- The cost of the plan,
- A list of covered services, and
- An initial premium payment slip.

Beginning May 27, 2010, as an individual is added to the Core Plan Waitlist, s/he will receive similar information about the Basic Plan, along with their Core Plan waitlist confirmation letter. The individual will also be able to pay the initial

premium through ACCESS and enroll immediately after being placed on the Waitlist.

45.4.2 Notification to New Enrollees

Once an individual enrolls, s/he will receive a letter confirming the enrollment and the Basic Plan Enrollment and Benefits information. 45.4.2 Subtopic Three

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45.5 BADGERCARE PLUS BASIC ENROLLMENT BEGIN DATES

45.5.1 Termination of Enrollment

Enrollment in the Basic Plan is triggered by the initial premium payment. The date the initial premium payment is received determines when coverage will begin. Enrollment always begins on the first of the month.

If payment is made between the 1st of the month and 4:30 p.m. on the 15th of the month, coverage starts on the first of the next month.

If payment is made after 4:30 p.m. on the 15th and by the last day of the month, coverage is delayed by one month.

Example: If the Basic Plan initial premium payment is received between June 1st and June 15th at 4:30 p.m., coverage will begin on July 1st. If the initial premium is received between June 15th at 4:30 p.m. and June 30th at 4:30 p.m., coverage will begin on August 1st.

45.5.1 Termination of Enrollment

Enrollment in the Basic Plan will be terminated if an individual:

- Fails to pay his/her monthly premium;
- Obtains health insurance;
- Has income that exceeds 200% FPL
- Becomes eligible for BC+ (Core, Benchmark or Standard), Medicaid, or Medicare;
- Turns 65 years of age;
- Dies; or
- Moves out of state.

If it is determined that a Basic Plan enrollee no longer meets the Core Plan criteria (e.g. income is verified to be over 200% of the FPL) eligibility for the Basic Plan will be terminated and s/he will also be removed from the Core Plan Waitlist.

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45.6 BADGERCARE PLUS BASIC VERIFICATION REQUIREMENTS

Verification of income and health insurance coverage will be required for the Basic Plan. The Bureau of Enrollment Policy and Systems will use automated data exchanges to verify income and identify discrepancies or inconsistencies between the information provided by the enrollee and the third party source which could impact eligibility. A discrepancy report will be generated on a regular basis and provided to the Enrollment Services Center. Customers will be required to provide verification of income or health insurance coverage when a discrepancy that may impact eligibility exists.

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45.7 BADGERCARE PLUS BASIC PREMIUM PAYMENTS

45.7.1 Online Payments
45.7.2 Phone Payments
45.7.3 Payments By Mail

45.7.1 Online Payments

The ACCESS online payment tool can be used to make the initial and ongoing monthly premium payments. The online payment tool cannot be used to set up

automatic withdrawals or payments for multiple months. See ACCESS handbook chapter 10.7.

45.7.2 Phone Payments

Waitlist members can pay their premium over the phone by calling the ESC at 1-800-291-2002. Designated ESC staff will assist Waitlist member's who call the ESC to pay a Basic premium.

45.7.3 Payments by Mail

If the person wishes to make their premium payment by mail, they will send the payment slip along with their payment to the PO Box address on the payment slip. The person can use the payment slip to pay by check, money order, cashier's check, certified check, cash (not mentioned or encouraged but needs to be accepted if sent) or credit/debit card information can be entered.

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45.8 BADGERCARE PLUS BASIC BASIC PLAN COVERED SERVICES

Copayments and covered services can be found in the Basic Plan Enrollment and Benefits (P-00148) at: http://dhs.wisconsin.gov/badgercareplus/basic/pdf/p-00148.pdf.

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46-47 RESERVED

RESERVED

TABLES (CHAPTERS 48-52)

48.1 BC+ PREMIUM TABLES

48.1.1 Children
48.1.2 Adult Caretakers
48.1.3 Premiums for groups with Self Employment Income

The tables below are for the individual premium amounts. Group premiums (the total of the premiums of the individuals in the group) will be capped at 5% of the group's countable household income for families with incomes at or below 300% of the FPL. This table also includes premium amounts for self employed families who meet the 200% income limit before deducting *depreciation*.

48.1.1 Children

FPL Income Range	Above 200% up to 210%	210% to 220%	220% to 230%	230% to 240%	240% to 250%	250% to 260%
Premium Amounts	$10	$10	$10	$15	$23	$34

FPL Income Range	260% to 270%	270% to 280%	280% to 290%	290% to 300%	300%	Above 300%
Premium Amounts	$44	$55	$68	$82	$97.53	$97.53

48.1.2 Adult Caretakers

FPL Income Range	Above 150% to 160%	160% to 170%	170% to 180%	180% to 190%	190% to 200%	200%
Premium Amounts	$10	$27	$68	$122	$188	$268

48.1.3 Premiums for groups with Self Employment Income

The table below includes premium amounts set at 5% of the countable household income for groups with self employment income at or below 200%

after subtracting depreciation but above 200% and below 300% when the depreciation is included.

Families with self-employment income below 200% after subtracting depreciation but above 300% when including depreciation will pay either the 5% premium amount or the combined premiums for the children, whichever is greater.

Self-Employed Premiums

Family Size	Above 200% to 210%	210% to 220%	220% to 230%	230% to 240%	240% to 250%	250% to 260%	260% to 270%	270% to 280%	280% to 290%	290% to 300%
1	$90.00	$94.00	$99.00	$103.00	$108.00	$112.00	$117.00	$121.00	$126.00	$130.00
2	$121.00	$127.00	$133.00	$139.00	$145.00	$151.00	$157.00	$163.00	$168.00	$176.00
3	$152.00	$160.00	$167.00	$175.00	$183.00	$190.00	$198.00	$205.00	$213.00	$221.00
4	$183.00	$192.00	$202.00	$211.00	$220.00	$229.00	$238.00	$248.00	$257.00	$266.00
5	$214.00	$225.00	$236.00	$247.00	$257.00	$268.00	$279.00	$290.00	$300.00	$311.00
6	$246.00	$258.00	$270.00	$282.00	$295.00	$307.00	$319.00	$332.00	$344.00	$356.00
7	$277.00	$291.00	$304.00	$318.00	$332.00	$346.00	$360.00	$374.00	$388.00	$402.00
8	$308.00	$323.00	$339.00	$354.00	$370.00	$358.00	$400.00	$416.00	$431.00	$447.00
9	$339.00	$356.00	$373.00	$390.00	$407.00	$424.00	$441.00	$458.00	$475.00	$492.00
10	$370.00	$389.00	$407.00	$426.00	$444.00	$463.00	$481.00	$500.00	$519.00	$537.00

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49.1 HEALTH CARE CHOICE

EBD Eligibility	BC+ Eligibility	System

		Choice
MS/NS/MAPP w/no premium	No premium	EBD
MS/NS/MAPP w/no premium	Premium	EBD
MS/NS/MAPP w/o premium	BC+ *Deductible*	EBD
MAPP w/premium	No premium	BC+
NS Deductible	No premium	BC+
MAPP w/premium	Standard Plan with Premium	The program with the lesser premium
MAPP w/premium	Benchmark Plan with Premium	EBD
NS Deductible	Premium	Member Choice
MAPP Premium	Deductible	Member Choice
NS Deductible	Deductible	Member Choice

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50.1 2009 FEDERAL POVERTY LEVEL (FPL) TABLE

Current numbers can be found at dhfs.wisconsin.gov/medicaid/fpl/fpl.htm.

A Federal Poverty Level Calculator can be found at http://www.coalitionclinics.org/fpl.html.

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51.1 BADGERCARE PLUS MEDICAL STATUS CODES

For a complete list of Medical Status Codes see Process Help Chapter 81 Forward Health iChange

Med Stat	**Description**	**Income (FPL)**	**BC+ Plan**	**Subject to Co-Pay**	**Premium**	**Funding**
BA	Pregnant Woman	0 - 100%	Standard	No	No	T19
AB	Pregnant Woman	>100 -	Standard	No	No	T19

		200%				
BB	Pregnant Woman	>200 - 250%	Benchmark	No	No	T19
AA	Pregnant Woman	>250 - 300%	Benchmark	No	No	T19
PS	Pregnant Woman *Deductible*	> 300%	Benchmark	No	No	T19
PM	Pregnant minor under age 19	>300%	Benchmark	Yes	Yes	State Funded
TP	Pregnant minor under age 19 who is a tribal member	>200 - 250%	Benchmark	No	No	T19
TB	Pregnant Minor under age 19 who is a tribal member	>250 - 300%	Benchmark	No	No	T19
PA	Non-qualifying pregnant alien	>250 - 300%	Benchmark	No	No	State Funded
BE	Child under age 19	0 - 100%	Standard	No	No	T19
BJ	Child under age 6	>100 - 150%	Standard	No	No	T19
BF	Child age 6 through 18	>100 - 150%	Standard	Yes	No	T21
C1	Child < age 1	>150 - 200%	Standard	Yes	No	T19
C2	Child < age 1	>200 - 250%	Benchmark	Yes	Yes	T19
BC	Child age 1 through 5	>150 - 185%	Standard	Yes	No	T19
C3	Child age 1 through 5	>185 - 200%	Standard	Yes	No	T21 Separate SCHIP
BG	Child age 6 through 18	>150 - 200%	Standard	Yes	No	T21
BH	Child age 1 through 18	>200 - 250%	Benchmark	Yes	Yes	T21
TK	Child age 1 through 18 who is a tribal member	>250 - 300%	Benchmark	No	No	State Funded
TC	Child under age 19 who is a tribal member	>200 - 250%	Benchmark	No	No	T21
TF	Child age 1 through 5 who is a tribal member	>185% - 200%	Standard	No	No	T21
TG	Child age 6 through 18 who is a tribal member	>150% - 200%	Standard	No	No	T21
BI	Child under age 19	> 250%	Benchmark	Yes	Yes	State Funded
BK	Child, under age 19 deductible	> 150%	Standard	Yes	No	T19
BL	Parents/Caretakers	0 - 100%	Standard	Yes	No	T19
BM	Caretakers	>100 - 130%	Standard	Yes	No	T19

5B	Caretakers	>130 - 150%	Standard	Yes	No	T19
BN	Caretakers	>150 - 200%	Standard	Yes	Yes	T19
1B	Parents	>100 - 130%	Standard	Yes	No	T19
2B	Parents	>130 - 150%	Standard	Yes	No	T-19
3B	Parents	>150 - 200%	Standard	Yes	Yes	T-19
B8	Parents/Caretakers/Eligible for Community Waivers	>150 - 200%	Standard	Yes	Yes	T19
BO	Caretakers (Self employed & Farmers)	>200%	Benchmark	Yes	Yes	T19
4B	Parents (Self employed & Farmers)	>200%	Benchmark	Yes	Yes	T-19
BY	Youths exiting out of home care	N/A	Standard	Yes	No	T19
BP	Transitional Grandfathering (Prev. elig. under MA or BC up to 130%)	0 - 130%	Standard	Yes	No	T19
BQ	Transitional Grandfathering (Prev. elig. under BC with income >130 - 150%)	>130 - 150%	Standard	Yes	No	T19
BR	Transitional Grandfathering (Prev. elig. under BC with income >150% - 200%)	>150 - 200%	Standard	Yes	Yes	T19
B9	Transitional Grandfathering (Prev. elig. under BC with income >150% - 200%) Eligible for Community Waivers	>150 - 200%	Standard	Yes	Yes	T19
BS	Nonqualifying Pregnant Alien	0 - 200%	Standard	No	No	T21
BT	Nonqualifying Pregnant Alien	>200 - 250%	Benchmark	No	No	T21
BX	Pregnant Inmate	0 - 200%	Standard	No	No	State Funded
BZ	Pregnant Inmate	>200 - 300%	Benchmark	No	No	State Funded
BU	Temporary Enrollment for a Child	0 - 150%	Standard	No	No	T19
EC	Temporary Enrollment for a Child <age 1	<250%	Standard	No	No	T-19
BV	Temporary Enrollment for a Pregnant Woman	0 - 200%	Standard	No	No	T19
BW	Temporary Enrollment for a Pregnant Woman	>200 - 250%	Benchmark	No	No	T19
EP	Temporary Enrollment for a Pregnant Woman	>250 - 300%	Benchmark	No	No	T19

N1	CEN - Mom in SP or MA on DOB	0 - 100%	Standard	No	No	T19
N4	CEN - Mom in SP or MA on DOB	>100 - 200%	Standard	Yes	No	T19
N3	CEN - mom in BMP on DOB	>200%	Benchmark	Yes	No	T19
NC	Child under age 19 Residing in a medical institution.	<200%	Standard	No	No	T19
X6	Earnings Extension - 12 Mo	> 100%	Standard	Yes	No	T19
X7	Child Support Extension - 4 Mo	> 100%	Standard	Yes	No	T19
X8	Earnings extension - 12 mo, child under 19	>100%	Standard	No	No	T19
X9	Earnings extension - 4 mo, child under 19	>100%	Standard	No	No	T19
AE	IRCA- Alien; Emergency-Services-Only	300%	Emergency-Service-Only	N/A	No	T19
FS	Family Planning Services	>200%	FPS Services Only	N/A	No	T19

For a complete list of Medical Status Codes see Process Help Chapter 81 Forward Health iChange

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52.1 CORE PLAN HEALTH INSURANCE

The following table gives examples of what is, and what is not, considered health insurance for the BadgerCare Plus Core Plan.

Type of Insurance	Other Name	Considered	Description
Major Medical Insurance	*HIPAA Standard Plan*	Yes	These are: • Any group health care plan that provides medical care to covered individuals and/or their dependents. (Medical care means it pays towards diagnosis, cure, mitigation (moderation), treatment or prevention of disease.) and/or • Policies that pay for a doctor's services in either an in-patient or outpatient setting.

			• The amount or type of benefits paid (co-insurance, deductibles, caps, etc) the plan pays do not matter if it meets the above criteria.
		No	If the health care plan is limited to a single type of covered service or only accessible in a very defined circumstance. Plans limited to accident, disability, vision, long term care or dental are no examples of Major Medical Insurance.
AARP		Yes	AARP Essential Premier Health Insurance is major medical insurance for people 50-64. It is advertised as premier-level, major medical health insurance plan similar to plans offered by many companies to their employees. It's the only major medical health insurance program exclusively for AARP members.
		No	AARP vision and dental only plans Also, these plans are currently unavailable for new members, but somebody may have one of them from an earlier time: • AARP Essential Health Insurance • AARP Essential Plus Health Insurance • AARP Hospital Indemnity Insurance
AFLAC Insurance		No	According to www.aflac.com the following options are available: • Accident • Cancer/Specified Disease • Dental • Hospital Confinement Indemnity • Hospital Confinement Sickness Indemnity • Hospital Intensive Care • Life • Long-Term Care • Lump Sum Cancer • Lump Sum Critical Illness • Short-Term Disability • Specified Health Event • Vision These are limited policies that are not major medical insurance.
COBRA	*Consolidated Omnibus Budget*	Yes	When an individual involuntarily loses a job and had insurance through the employer, s/he can take COBRA insurance by paying 100% cost of

	Reconciliation Act		the premium. Individuals with COBRA insurance, are ineligible for Core Plan. There are subsidies available through federal government to help pay COBRA premiums. If COBRA is exhausted (i.e., a person paid for it for 18 months and is no longer able to participate, he or she is eligible for Core Plan without waiting 12 months. If a person drops COBRA, they have to wait 12 months or to the end of 18 months of COBRA expiration, whichever is sooner.
Contract Health Services	*CHS*	No	Indian decent people can get medical services based on their financial and medical needs. Services are prioritized based on available funds and severity of medical needs.
Flexible Spending Account	*FSA*	No	Employee Reimbursement Account Program (State Employees) No Flexible Spending Accounts (FSA) allow employees to set aside pre-taxed income for routine medical expenses. FSA accounts can be used for reimbursement of any medically related cost that is not covered by your health care plan. FSA accounts are owned by employees and have ”r;use it or lose it by the end of the year” rule.
High *Deductible* Health Plan	*HDHP*	Yes	Yes A high deductible plan has a deductible of at least $1,150 for self-only coverage and $2,300 for family coverage. The maximum annual out-of-pocket amount for high deductible individual coverage is $5,800 and $11,600 for family coverage. The maximum annual HSA contribution for an eligible individual with self-only coverage is $3,000 and $5,950 for family coverage in 2009.
Health Reimbursement Arrangements	*HRA*	No	Personal Care Accounts No Health insurance plans that reimburse employees for qualified medical expenses. HRAs allow funds to be placed in a special account to reimburse employees for out-of-

			pocket medical expenses that they may incur. Employer owns the account and money in the account.
Health Savings Accounts	*HSA*	No	An HSA is a tax-advantaged savings and investment plan, similar to an IRA. Funds contributed to the HSA remain in the account from year to year, and are not subject to any "use it or lose it" provisions.
Indemnity Insurance	*Fee-for-Service Traditional Health Insurance plan*	Yes	Under an indemnity health care plan, a plan member can choose any provider and the insurance company will pay a percentage (or se dollar amount) of the medical expenses incurred by the member.
Limited Scope Insurance		No	• Coverage only for accident (including accidental death and dismemberment). • Disability income insurance. • Liability insurance, including general liability insurance and automobile liability insurance. • Coverage issued as a supplement to liability insurance. • Workers' compensation or similar insurance. • Automobile medical payment insurance. • Credit-only insurance (for example, mortgage insurance). • Coverage for on-site medical clinics. • Limited scope dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefits packages.
State/Federal		No	These programs are not considered major medical insurance for Core applicants: • GAMP (General Assistance Medical Program) • HIRSP (Health Insurance Risk Sharing Plan), • Medicaid • BadgerCare+ • Well Woman Program • Well Woman Medicaid • Wisconsin Chronic Disease Program

			• Family Planning Only Services • State or federal veteran benefits (free or low cost care for veterans who do not have insurance)
Student Health Plan available through a college/ university	SHIP	Yes	Many colleges and universities offer insurance plans for students and their dependents. For example, University of Wisconsin in Madison offers Student Health Insurance Plan (http://www.uhs.wisc.edu/home.jsp?cat_id=116) which is a comprehensive, major medical insurance.
		No	If college/university insurance only covers specific check-ups or just family planning services and does not offer hospital or medical service policies or certificates, it is not major medical insurance. Usually student health insurance options can be found on college/university web site.
Tribal Programs	*Indian Health Services*	No	Tribal Health Services
TRICARE	*CHAMPUS*	Yes	TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all.
Other Public Health Care Programs	*Charity Care* *Community Health Clinics* *Affinity Care* *Helping Hands (Aurora Health Care)* *Community Care for the Uninsured (Dean Care)*	No	Programs such as Marshfield plan that allows individuals to pay discounted fees for services. A list of community health clinics (federally qualified health centers) is available at:: dhs.wisconsin.gov/forwardhealth/pdf/clinics.pdf

	Patient Assistance Program (Marshfield)		

Note: If an individual has lost employment and you don't know if it was for "reasons beyond their control", ask if s/he is receiving Unemployment Compensation/Insurance. If yes, s/he should be given *good cause* (chapter 43.6).

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