BC+ Handbook Release 14-02

Table Of Contents

Program Overview 1
1.1 BC+ Introduction 1
1.1.1 Organization of the BC+ Handbook 2
1.1.2 BadgerCare Plus Health Plans 2
1.1.4 How to Apply 4
Non-Financial Requirements (Chapters 2-15) 7
2 BC+ Group 7
2.1 BC+ Non-Financial Program Requirements 7
2.2 Coverage group definitions 8
2.2.1 Parents 8
2.2.1.1 Paternity 9
2.2.1.2 Joint Placement 10
2.2.1.3 Dependent 18 Year Old 11
2.2.2 Caretaker Relative 12
2.2.3 Child Welfare Parents/Caretakers 13
2.2.4 Pregnant woman 13
2.2.5 Former Foster Care Youth (formerly known as Youth Exiting out of Home Care) 13
2.2.6 Child 14
2.2.7 Childless Adults 14
2.3 BC+ Test Group 14
2.3.1 The non-MAGI Test Group 15
2.3.1.1 Parents and Caretaker Relatives 15
2.3.1.2 Essential Person 16
2.3.1.3 Pregnant Women 17
2.3.1.4 Children 18
2.3.1.5 Childless Adults 18
2.3.2 MAGI Test Group 18
2.3.2.1 Forming the Test Group using MAGI Tax Filing Rules 19
2.3.2.2 Forming the Test Group Using MAGI Relationship Rules 20
2.3.2.3 MAGI Flowchart 20
2.3.3 Applying non-MAGI Rules vs. MAGI Rules 21
2.3.4 Former Foster Care Youth Eligibility 22
2.4 The BC+ Household 23
2.4.1 Not Living in the Household 23
2.4.2 Temporary Absence 24
2.4.3 Students 24
2.5 BC+ Assistance Groups 25
2.6 Participation Status Codes 27
2.7 BC+ Group Examples 27
2.7.1 BC+ Group Examples using non-MAGI Rules 28
2.7.2 BC+ Group Examples using MAGI Rules 34
2.8 BC+ Test Group Financial Rules 36
2.8.1 Non-MAGI Income Counting Rules 36

2.8.2 MAGI Income Counting Rules 37
3 Residence 39
3.1 Residence 39
3.2 Intent To Reside 40
3.3 Determining State Residency 40
3.3.1 Under Age 21 41
Not in an institution 41
In an institution 41
3.3.2 Age 21 and Over 41
3.4 Special Situations 42
3.4.1 SSP Payment 42
3.4.2 IV-E Children 42
3.4.3 Non IV-E Foster Children 43
3.4.4 Homeless Persons 43
3.5 Absence From Wisconsin 43
3.5.1 Temporary Absence 43
3.6 Inmates 44
3.6.1 Huber Law 45
4 Citizenship and Immigration Status 45
4.1 U.S. Citizens and Nationals 45
4.1.1 Child Citizenship Act 46
4.1.2 Compact of Free Association States 47
4.2 Documenting Citizenship and Identity 47
4.2.1 Covered Programs 49
4.2.1.1 Exempt Populations 49
4.2.2 Reserved 50
4.2.3 Reserved 50
4.2.4 Hierarchy of Documentation 50
4.2.5 Agencies Paying for Documentation 52
4.2.6 Policy For Special Populations 53
4.2.7 Situations which require Special Documentation Processing 55
4.2.7.1 Person Add 55
4.2.7.2 Presumptive Eligibility/Express Enrollment (EE) 56
4.2.7.3 Individuals Without Verification and Affect on Household Eligibility 56
4.2.7.4 Child Citizenship Act 2000 56
4.2.7.5 Non-citizens 56
4.2.7.6 Individuals in Institutional Care Facilities 57
4.3 Immigrants 57
4.3.1 Public Charge 62
4.3.2 INS Reporting 62
4.3.4 Immigration Status Chart 66
4.3.5 Iraqis & Afghans With Special Immigrant Status 68
4.3.5.1 Counting Refugee Related Income 68
4.3.5.2 Refugee Medical Assistance 69
5 Medical Support and Third Party Liability 69
5.1 Medical Support 69

5.1.1 Recovery of Birth Costs 69
5.1.2 Referral to CSA 70
5.2 Medical Support / CSA Cooperation 72
5.2.1 Introduction 72
5.2.2 Failure to Cooperate 73
5.3 Claiming Good Cause 74
5.3.2 Notice 74
5.3.3 Good Clause Claim 74
5.3.4 Circumstances 75
5.3.5 Evidence 75
5.3.6 Investigation 78
5.3.7 Determination 78
5.3.8 Good Cause Found 79
5.3.9 Good Cause Not Found 79
5.4 Cooperation Between IM & CSA 80
5.4.1 Information 81
5.4.2 BC+ Discontinued 81
5.4.3 Failure to Cooperate 81
5.4.4 Fraud 81
5.5 Third Party Liability 81
5.5.1 TPL Cooperation 82
5.5.2 TPL Cooperation Requirements 82
5.5.3 TPL Good Cause Claim 83
5.5.4 Assignment Process 83
5.6 Casualty Claim Process (Subrogation) 83
5.6.1 Reporting Accident or Injury Claims 83
5.7 Other Health Insurance 85
5.7.1 Policies Not to Report 85
6 Social Security Requirements 85
6.1 SSN Requirements 86
7 Health Insurance Access and Coverage Requirements 86
7.1 Health Insurance Conditions of Eligibility 87
7.1.1 Health Insurance Conditions of Eligibility under Non-MAGI rules 87
7.1.2 Health Insurance Conditions of Eligibility under MAGI rules 88
7.2 Past Access to Health Insurance 89
7.2.1.1 The 80 % Past Access Test 89
7.2.1.2 The 9.5% Past Access Test 90
7.2.2 Good Cause for 80% and 9.5% "Past Access Test" under Non-MAGI Rules 91
7.2.3 Good Cause for the 80% "Past Access Test" Under MAGI Rules 92
7.3 Current Access to Health Insurance 93
7.3.1 Introduction 93
7.3.2 The 80% Current Access Test 93
7.3.3.The 9.5 % Current Access Test 94
7.4 Current Health Insurance Coverage 95
7.4.1 Introduction 95
7.4.2 The 80% Coverage Test 95

7.4.3 The 9.5% Current Coverage Test 96
7.4.4 Current Coverage for BC+ Prenatal Program 96
7.5 Dropped Health Insurance Coverage 96
7.5.1 Introduction 97
7.5.2 The 80% Dropped Coverage Test..... 97
7.5.3 The 9.5% Dropped Coverage Test..... 97
Note: Non-pregnant, non-disabled parents and caretaker relatives with state employee health insurance coverage, who have household income between 133% and 150% FPL, are only ineligible for BadgerCare Plus if the employee-only premiums were not more than 9.5% of household income. 98
7.5.4 Dropped Coverage Policy for BadgerCare Plus Prenatal Program 98
7.6 Good Cause Reasons for dropping insurance coverage 99
7.7 Health Insurance Premium Payment (HIPP) 100
7.7.1 Introduction 100
7.7.2 Cost Effectiveness 101
7.7.3 Participation in HIPP 101
7.7.4 Cooperation..... 101
7.8 Access/Coverage Overview 101
7.8.1 Access/Coverage Overview Prior to January 31, 2014 102
7.8.2 Access/Coverage Overview for new applicants on or after February 1, 2014 107
7.8.3 BC+ Prenatal Program Insurance Access/Coverage Overview 110
8 Pregnant Women and Continuously Eligible Newborns..... 112
8.1 Pregnant Women 112
8.2 Continuously Eligible Newborns (CENs) 113
9 Verification..... 114
9.1 Verification 114
9.2 Application 115
9.3 Eligibility Renewals 115
9.4 Changes 116
9.5 Documentation..... 116
9.6 Collateral contacts 117
9.6.1 Documenting Verbal Statements and Collateral Contacts 117
9.7 Release of information..... 118
9.8 General Rules..... 118
9.9 Mandatory Verification Items 119
9.9.1 Social Security Number..... 120
9.9.1.1 Newborns 121
9.9.1.2 BC + Emergency Services..... 121
9.9.1.3 BC+ Prenatal Program 122
9.9.2 Immigrant Status 122
9.9.3 Pregnancy..... 122
9.9.4 Medical Expenses 123
9.9.5 Power of Attorney and Guardianship 123
9.9.6 Access to Employer-Sponsored Health Insurance 123
9.9.6.1 Employer Verification of Health Insurance (EVHI) Database..... 124

9.9.6.2 Other Forms of Health Insurance Access Verification 124
9.9.7 Tribal Membership 125
9.9.8 Pre-Tax Deductions 125
9.9.9 MAGI Tax Deductions 125
9.10 Questionable Items 126
9.10.1 Front End Verification 126
9.11 Processing Timeframe 126
9.11.1 Verification Receipt Date 127
9.11.2 Positive Actions 127
9.11.3 Delay 127
9.11.4 Negative Actions 127
10 Child Welfare Parents 128
10.1 Child Welfare Parent or Caretaker Relative 128
11 Former Foster Care Youth 130
11.1 Out of Home Care (i.e., foster care) and Former foster care youth (ffcy) 130
11.2 former foster care youth 131
12 Migrant Workers 132
12.1 Migrant Workers 132
12.2 Migrant Worker Definition 132
12.3 Simplified Application 133
12.3.1 Renewal dates for simplified application 134
12.4 Regular Application 135
12.4.1 Renewals 135
13 - 15 Reserved 135
Chapters 13-15 (Reserved) 135
Financial Requirements (Chapters 16-24) 137
16 Income 137
16.1 Income 137
16.1.1 Income Limits 137
16.1.2 Income under non-MAGI Rules 138
16.1.3 Income under MAGI Rules 139
16.2 Income Types Not Counted 140
16.3 Income Deductions 152
16.3.1 Support Payments 152
16.3.2 Pre-Tax Deductions 153
16.3.3 Tax Deductions 153
16.4 Earned Income 156
16.4.1 Specially Treated Wages 158
16.4.2 Room and Board Income 159
16.4.3 Self Employment Income 160
16.4.3.1 Income Sources 162
16.4.3.2 Calculating BC+ Self Employment Income 165
16.4.3.2.1 IRS Tax Forms 165
16.4.3.2.2 Worksheets 166
16.4.3.2.3 Disallowed Expenses 167
16.4.3.2.4 Anticipating Earnings 168

16.4.3.3 Losses Offsetting Other Income (MAGI Rules Only) 171
16.4.4 Verification 171
16.4.4.1 Self-Employment Hours 171
16.5 Other Income 171
16.6 Fluctuating Income 176
16.7 Prorating Income 176
16.8 Migrant Worker's Income 177
17 Deductibles 177
17.1 Deductibles 177
17.2 Pregnant Women 178
17.2.1 Introduction 178
17.2.2 Deductible Period 179
17.2.3 Calculating the Deductible Amount 180
17.3 Children Under 19 181
17.3.1 Deductible Period 181
17.3.2 Calculating the Deductible Amount 182
17.4 Meeting The Deductible 183
17.4.1 When expenses can be counted toward a Deductible 183
17.4.2 Countable expenses 186
17.5 Order of Bill Deduction 189
17.5.1 Hospital Bills 189
17.5.2 Pregnancy Fees 189
17.6 Prepaying a Deductible 190
17.6.1 Insufficient Funds 190
17.6.2 Payment of Entire Deductible Amount 190
17.6.3 Combination of Payment and Incurred Expenses 190
17.6.4 Combination of Payment and Outstanding Expenses 191
17.6.5 Calculation Errors 191
17.7 Remaining Deductible 191
17.8 Changes In Income 192
17.9 Non-financial Changes 193
17.9.1 Non-Financial Changes Introduction 194
17.9.2 Group Size Changes 194
17.9.3 Death 194
17.10 Late Reports of Changes 195
18 BC+ Extensions 195
18.1 BC+ Extensions 195
18.1.1 BC+ Extensions Introduction 195
18.1.2 Pregnant Women 196
18.1.3 Children 197
18.2 Increase in Earnings/Decrease in Group Size Extensions 198
18.2.1 Earned Income Extensions under Non-MAGI Rules 198
18.2.2 Earned Income Extensions under MAGI Rules 199
18.2.3 SSI Exception 200
18.3 Increase in Child Support or spousal Income Extensions 200
18.3.1 Support Extensions under Non-MAGI Rules 200

18.3.1.1 Four Month Extensions under Non-MAGI Rules 201
18.3.1.2 Twelve Month Extensions under Non-MAGI Rules 201
18.3.2 Support Extensions under MAGI Rules 201
18.3.2.1 Four Month Extensions under MAGI Rules 202
18.3.2.2 Twelve Month Extensions under MAGI Rules 202
18.4 Income Changes During The Extension 203
18.5 Losing an Extension 203
18.5.1 Introduction 203
18.5.2 Leaving Wisconsin 204
19 Premiums 205
19.1 BC+ Premiums 205
19.2 Premium Calculations 206
19.2.1 Premium Calculations for Non-MAGI Households 207
19.2.2 Premium Calculations for MAGI Households 208
19.2.2.1 Children's Premiums using MAGI Rules 209
19.2.2.2 Adults' Premiums using MAGI Rules 209
19.3 Premium Limits 209
19.4 Premium Payment Methods 211
19.5 Initial Payments 212
19.6 On-going Payment 214
19.7 Advance Payments 214
19.7.1 Refunds 214
19.8 Non-Payment 215
19.8.1 Non-Payment Introduction 215
19.8.2 Insufficient Funds 216
19.8.3 Good Cause for Non-Payment 216
19.9 Late Payments 216
19.10 Premium Changes 217
19.10.1 Decreased premium amount 217
19.10.2 Increased premium amount 217
19.10.2.1 Person adds: 217
19.10.2.2 Effective dates of premium increase (Person Add) 218
19.10.2.3 Effective dates of premium increase (other than person adds) 218
19.11 BadgerCare Plus Restrictive Re-enrollment Period (RRP) 220
19.11.1 Restrictive Re-Enrollment Period (RRP) Introduction 220
19.11.2 Reapplying 223
20 Assets 223
20.1 Assets 223
21 - 24 Reserved 224
Chapter 21-24 (Reserved) 224
Program Administration (Chapters 25-37) 225
25 Application 225
25.1 Application 225
25.2 Application Types/Methods 226
25.3 Where to Apply 226
25.3.1 Where to Apply Introduction 226

25.3.2 Intercounty Placements 226
25.3.3 Applications Outside Wisconsin 227
25.3.4 Applications Received from the Federal Marketplace 227
25.4 Valid Application 228
25.5 Valid Signature 229
25.5.1 Witnessing the Signature 231
25.5.2 Telephone Signature Requirements 231
25.6 Filing Date 232
25.7 Timeframes 233
25.7.1 Timeframes Introduction 233
25.7.2 Changes 234
25.8 Begin Dates 234
25.8.1 Backdated Eligibility 235
25.8.1.1 BC+ Family Planning Services 237
25.8.1.2 Pregnant Women 237
25.9 Denials and Terminations 237
25.9.1 Termination 237
25.9.2 Denial 238
26 Renewal 238
26.1 Renewals 238
26.1.1 Renewals Introduction 238
26.1.2 Administrative Renewals 240
26.2 Choice of REnewal 242
26.3 Renewal Processing 242
27 Change Reporting 243
27.1 Changes reported during the application processing period 243
27.2 Non- financial Change Reporting Requirements 243
27.3 Income Change Reporting Requirements 244
27.4 Other reported changes 245
27.5 Change Reporting Requirements for BC+ Family Planning ONLY Services Members: 246
28 Corrective Action 246
28.1 Overpayments 246
28.2 Recoverable Overpayments 247
28.3 Non-Recoverable Overpayments 249
28.4 Overpayment Calculation 250
28.4.1 Overpayment Period 250
28.4.2 Overpayment Amount 250
28.4.3 Overpayments for Individuals Eligible for Family Planning Only Services (FPOS) 251
28.4 4 Determining Liable Individual 252
28.5 Member Notice 252
28.6 Refer to District Attorney 252
28.7 Fair Hearing 253
28.8 Agency Retention 253
28.9 Restoration of Benefits 253

28.9.1 Premiums 253
29 Notices and Fair Hearings 254
29.1 Notices 254
29.2 Fair Hearings 255
30 Affirmative Action 255
30.1 Affirmative Action and Civil Rights 255
31 Interagency Transfer 255
31.1 Interagency Transfer 255
32 Presumptive Eligibility 256
32.1 Presumptive Eligibility (PE) for Children 256
32.2 Presumptive Eligibility (PE) for Pregnant Women 258
32.3 Presumptive Eligibility for Adults 260
32.4 At the IM Agency 261
32.5 Qualified hospitals for presumptive eligibility (PE) 263
33-37 Reserved 264
Reserved 264
Program Coverage (Chapters 38-47) 265
38 Covered Services 265
38.1 Covered Services 265
38.2 Standard Plan 265
38.2.1 Introduction 265
38.2.2 Copayment 268
38.3 Transportation 270
38.3.1 Ambulance 271
38.3.2 Specialized Medical Vehicle (SMV) 271
38.3.3 Common Carrier 271
38.3.4 Transportation Coordination 271
38.4 HMO Enrollment 272
38.4.1 Change of Circumstances 273
38.4.2 Disenrollment 273
38.4.3 Fiscal Agent Ombuds 274
38.5 BC+ Cards 274
38.5.1 BC+ Cards Introduction 274
38.5.1.1 BadgerCare Plus & Medicaid Card Image 275
38.5.1.2 SeniorCare Card Image 275
38.5.1.3 Wisconsin Well Woman Program Card Image 276
38.5.2 Appeals 276
38.5.3 Homeless 277
38.5.4 Pharmacy Services Lock-in Program 277
38.5.5 Temporary Cards 277
38.5.6. Lost-Stolen Cards 277
38.6 Good Faith Claims 278
38.6.1 Definition of Good Faith Claims 278
38.6.2 Denials 278
38.6.3 Causes and Resolutions 279
38.6.4 Process 280

38.6.5 Instructions ... 280
38.7 Impact on Dual Eligible Individuals ... 283
39 Emergency Services ... 284
39.1 Emergency Services Income Limits ... 284
39.2 Determining if an emergency exists ... 286
39.2.1 Determining Eligibility ... 286
39.2.2 Providing Manual Positive Or Negative Notice ... 288
39.3 Emergency Services For Pregnant Women ... 288
39.4 Newborns ... 289
39.5 Eligibility Begin Date for non-qualifying immigrants who lose eligibility for the BC+ Prenatal Program ... 290
39.6 BC+ Deductible ... 290
40 Family Planning Only Services (FPOS) ... 291
40.1 Family Planning Only Services Program ... 291
40.2 FPOS Presumptive Eligibility (PE) ... 291
40.2.1 Introduction ... 292
40.2.2 Qualified Providers ... 292
40.2.3 IM Agency ... 294
40.3 FPOS Application ... 294
40.4 FPOS Non-financial Requirements ... 294
40.5 FPOS FINANCIAL Requirements ... 295
40.5.1 Financial Eligibility Requirements Specific to FPOS ... 295
40.5.2 Income Under MAGI Rules ... 296
40.6 FPOS Group ... 296
40.6.1 Fetus ... 296
40.6.2 Children 18 years of Age ... 297
40.6.3 FPOS Group under MAGI Rules ... 297
40.6.4 Transitioning to MAGI Rules ... 297
40.7 FPOS Program Choice ... 297
40.8 FPOS Changes ... 298
40.9 FPOS BC+ Extension Phase ... 299
40.10 FPOS Reviews and Recertifications ... 299
40.11 FPOS Confidentiality ... 300
41 BC+ Prenatal Program ... 301
41.1 BC+ Prenatal Program ... 301
41.2 BC+ Prenatal Program Eligibility Requirements ... 301
41.2.1 Unique Aspects of BC+ Prenatal Program ... 302
41.3 BC+ Prenatal Policy for Non-qualifying Immigrants ... 302
41.4 BC+ Prenatal Program Policy For Inmates ... 303
41.5 BC+ Prenatal Program Eligibility Begin Date ... 303
41.6 BC+ Prenatal Eligibility End Date ... 304
41.7 Determining BC+ Prenatal Group ... 304
41.7.1 The BC+ Prenatal Group through January 31, 2014 ... 304
41.7.2 The BC+ Prenatal Group After February 1, 2014 ... 305
41.8 BC+PP Benefit Information ... 305
43 BadgerCare Plus Core Plan ... 306

43.1 BadgerCare Plus CORE PLAN 306
44 Reserved 306
ReSERVED 306
45 BC+ Basic Plan 306
45.1 BadgerCare Plus basic plan 306
42, 46-47 Reserved 307
Reserved 307
Tables (Chapters 48-52) 309
48 Premiums 309
48.1 BC+ Premium Tables 309
48.1.1 Premiums for Children 309
48.1.2 Premiums for Adults 310
48.1.3 Premiums for Adult Caretaker Families with Self Employment Income 316
49 Health Care Choice 317
49.1 Health Care Choice 317
50 FPL Table 318
50.1 Federal Poverty Level (FPL) Table 318
51 BC+ Medical Status Codes 320
51.1 BadgerCare Plus Medical Status Codes 320
52 Core Plan Health Insurance 322
52.1 CORE PLAN HEALTH INSURANCE 322

PROGRAM OVERVIEW

1.1 BC+ INTRODUCTION

1.1.1 Organization of the BC+ Handbook
1.1.2 BadgerCare Plus Health Plans
1.1.3 Health Care Choice
1.1.4 How to Apply

BadgerCare Plus (BC+) is a state/federal program that provides health coverage for Wisconsin families and individuals living in poverty. BC+ replaced the former AFDC-Medicaid, Healthy Start and BadgerCare programs.

Potential BC+ members will include:

- Children under 19 years of age,
- Pregnant women,
- Parents and caretakers of children under 18 and dependent 18 year olds,
- Parents and caretaker relatives whose children have been removed from the home and placed in out of home care,
- Former foster care youth under age 26 who were in out-of-home care when they turned 18, and
- Effective April 1, 2014, adults ages 19-64 who are not receiving Medicare and do not have dependent children.

For information on income limits see Chapter 16.1 and Chapter 50.1. A person is eligible for BadgerCare Plus if s/he meets all BC+ non-financial and financial requirements.

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 and men ages 15 years of age or older may be eligible for limited benefits under the BC+ Family Planning Only Services program.

Women ages 35-65 diagnosed with cervical or breast cancer may be eligible for Well Woman Medicaid. See the Medicaid Handbook for more information on Well Woman Medicaid.

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*-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-related Medicaid
- 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 about these sub-programs.

1.1.1 Organization of the BC+ Handbook

This handbook outlines eligibility policy for Wisconsin's BadgerCare Plus program. This version documents multiple policy changes that will affect the BC+ program in 2014 as a result of changes in State law and the federal Affordable Care Act. Accordingly, this handbook contains policy for the BadgerCare Plus program that is currently in effect and policy that will take effect in 2014. Policy that is time-limited or time-dependent will be modified with the appropriate effective date. Policy that is not identified as having an effective or end date is currently in place and will continue to exist in 2014.

Beginning in 2014, the BadgerCare Plus program will use a different set of eligibility rules to determine household size and countable income. This version of the handbook addresses two forms of budgeting rules. More information about these budgeting methodologies is found in Chapter 2. The new budgeting rules that will be applied to applicants and members in 2014 will be referred to as Modified Adjusted Gross Income (MAGI) rules. The rules currently in place for BadgerCare Plus will be referred to as "non-MAGI rules."

1.1.2 BadgerCare Plus Health Plans

Through March 31, 2013, existing BC+ members will have one of two major health care benefit plans: Standard Plan and Benchmark Plan. The Standard Plan is for families with household 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)

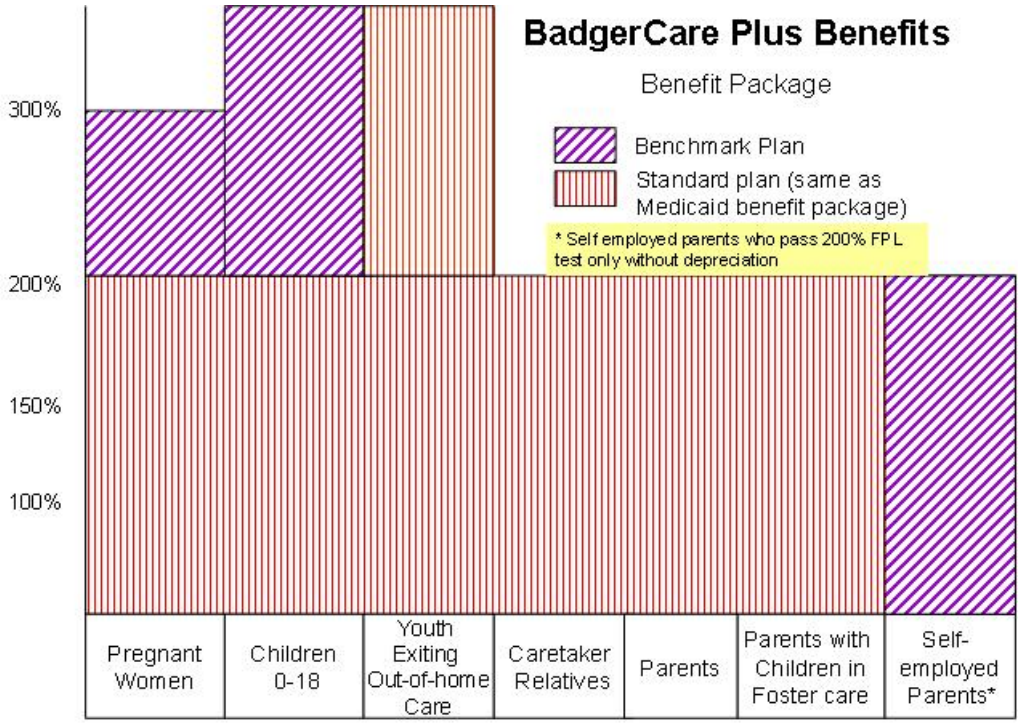
BadgerCare Plus has several limited health plans. These include:

- Family Planning Only Services
- BC+ Prenatal Program, and
- BC+ Emergency Services

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.

See the chart below for BC+ benefit plans for existing BC+ members through March 31, 2013. Beginning February 1, 2014, all new applicants found eligible for BC+ will be covered under the Standard Plan. Beginning April 1, 2014, all BadgerCare Plus members, regardless of when they applied, will receive coverage under the Standard Plan.



1.1.3 Health Care Choice

It is possible for individuals to qualify for both BadgerCare Plus and Elderly, Blind and Disabled Medicaid (EBD MA) based on financial and non-financial eligibility criteria.

When a person is eligible for both BC+ and EBD MA, different rules apply based on whether the BC+ eligibility is determined under non-MAGI or MAGI rules.

When eligibility is determined for such an individual under *non-MAGI* rules, *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 will be 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.

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

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

When eligibility is determined for such an individual under *MAGI* rules, federal law requires that once an individual has been determined eligible for EBD Medicaid, s/he must be enrolled in EBD MA, even if they are also eligible for BC+, unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BC+. In these instances, the pregnant woman will be enrolled in the BadgerCare Plus program.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD Medicaid and can enroll in BadgerCare Plus. Pending for EBD MA includes, but is not limited to, waiting for an official disability determination from DDB. If an individual enrolled in EBD MA is determined ineligible for EBD Medicaid for any reason, including going over the asset limit or failing to pay a MAPP premium, s/he can enroll in BC+ if s/he is still eligible to do so.

1.1.4 How to Apply

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

1. ACCESS online application at https://access.wisconsin.gov/ .
2. Face-to-Face Interview at the local county/tribal office.
3. Paper application
4. Telephone Interview.

5. An application submitted to the *Federally Facilitated Marketplace*.

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 18 years of age or dependent 18 year olds, 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), and
4. Former foster care youth under age 26 who were in out-of-home care when they turned 18, and
5. Effective April 1, 2014, adults ages 19-64, not receiving Medicare, who do not meet any of the conditions listed above.

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 COVERAGE GROUP DEFINITIONS

2.2.1 Parents
2.2.1.1 Paternity
2.2.1.2 Joint Placement
2.2.1.3 Dependent 18 Year Old
2.2.2 Caretaker Relative
2.2.3 Child Welfare/Caretakers
2.2.4 Pregnant woman
2.2.5 Former Foster Care Youth (formerly known as Youth Exiting out of Home Care)
2.2.6 Child
2.2.7 Childless Adults

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

2.2.1 Parents

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

considered a parent of a child under age 19 for BC+ purposes, the child must be under the care of that individual at least 40% of the time. For example, in families where parents are divorced, if the child does not live with Parent B at least 40% of the time, Parent B would have his/her eligibility considered under the Childless Adults coverage group, rather than the Parents/Caretakers coverage group.

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.

If the parents of the child are 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. Legal/Adjudicated 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 parents 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 parents decide that Johnny will be receiving his BadgerCare Plus coverage through 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 Dependent 18 Year Old

Effective February 1, 2014, when an adult is eligible as a parent or caretaker because they are caring for an 18 year old child, and that child is the only child in the home, the child must meet the following conditions in order for the parent or caretaker to be eligible for BC+ as a parent or caretaker of a dependent 18 year old:

- Be enrolled in high school, and
- Be expected to graduate high school before turning 19.

The child does not have to be enrolled full time in high school in order to meet this definition of dependent child.

The 18 year old remains eligible as a child until he or she turns 19, regardless of school enrollment or expected date of graduation.

2.2.2 Caretaker Relative

A caretaker relative is a non-legally responsible relative of 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: 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 Child Welfare Parents/Caretakers

For individuals whose eligibility is being determined under *non-MAGI* rules
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.

For individuals whose eligibility is being determined under *MAGI* rules
Parents and caretakers whose children have been placed in out of home care and who are having their eligibility determined or renewed will still be considered parents or caretakers, as the child will be considered temporarily absent. However, the inclusion of the child in the parent's group will be dependent upon MAGI budgeting rules. If the child has been placed with a caretaker relative, the relative will not be considered the primary caretaker of the child. If there are no other dependent children in the home with this relative would be considered a childless adult for purposes of BC+ eligibility. Inclusion of the child in the caretaker relative's group will also be dependent upon MAGI rules. See Chapter 10 for more information.

2.2.4 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+.

2.2.5 Former Foster Care Youth (formerly known as Youth Exiting out of Home Care)

This category was formerly referred to as Youth Exiting Out of Home Care.

BadgerCare Plus benefits are available to certain individuals who were in out- of- home care, including foster care, court ordered kinship care, and subsidized guardianship, as of their 18th birthday. These individuals are categorically eligible for BadgerCare Plus. The individual did not have to be in foster care in Wisconsin when he or she was 18 in order to be eligible for this coverage group. Through December 31, 2013, *FFCY* will only be eligible for BC+ benefits until they are age 21. After January 1, 2014, benefits will be available to all former foster care youth under age 26. See Chapter 11 for additional eligibility criteria for Former Foster Care Youth.

2.2.6 Child

A child under age 19 is non-financially eligible for BC+. Marital status and school enrollment status have 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. Individuals over age 19 must always apply separately from their parents or caretakers, irrespective of their living arrangement or tax dependency.

2.2.7 Childless Adults

A childless adult is an individual aged 19 to 64 who does not have any dependent children under age 19 who reside with them at least 40% of the time. Their marital status has no effect on their BadgerCare Plus eligibility. In 2013, childless adults are covered under BadgerCare Plus through the Core Plan. Enrollment in the Core Plan has been closed since 2009. Beginning April 1, 2014, childless adults who are not eligible for Medicare will be non-financially eligible for regular BC+ under the Standard Plan.

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2.3 BC+ TEST GROUP

2.3.1 The non-MAGI BC+ Test Group
- 2.3.1.1 Parents and Caretaker Relatives
- 2.3.1.2 Essential Person
- 2.3.1.3 Pregnant Women
- 2.3.1.4 Children
- 2.3.1.5 Childless Adults

2.3.2 MAGI Test Group
- 2.3.2.1 Forming the Test Group Using MAGI Tax Filing Rules
- 2.3.2.2 Forming the Test Group Using MAGI Relationship Rules
- 2.3.2.3 MAGI Flowchart

2.3.3 Applying non-MAGI Rules vs. MAGI Rules
2.3.4 Former Foster Care Youth (FFCY) Eligibility

The following sections outline how to form BadgerCare Plus test groups under the *non-MAGI* rules and the new *MAGI* rules. See 2.3.3 for more information about when to apply non-MAGI rules and when to apply MAGI rules to a case.

2.3.1 The non-MAGI Test Group

For BadgerCare Plus members whose eligibility is determined using non-MAGI budgeting rules, workers should use the following methodology to determine who should be included in the member's household and whose income in that household should be counted.

The non-MAGI *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 caretaker relative residing with a child in the home who is under age 19, or an individual residing with a spouse who is a caretaker relative of a child in the home who is under age 19,
3. A pregnant woman, or the spouse of a pregnant woman,
4. A Youth under age 26 who was in out-of-home care (e.g., foster care) at age 18, or
5. A child under age 19.

2.3.1.1 Parents and Caretaker Relatives

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 who is residing with, the primary person, the primary person's spouse or another included adult, and
11. An essential person (2.3.1.2)

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 (2.3.1.2).

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. See Chapter 10 for more information on Child Welfare Parents.

When an eligible child moves from the home of a parent or caretaker relative 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 his or her eligibility ends on the previous case.

Joint Placement

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. See 2.2.1.2

2.3.1.2 Essential Person

Note: This policy ends as of March 31, 2014.

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

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),
   1.
   - Attend HS or GED classes full time (as defined by the school).

a.

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.

2.3.1.3 Pregnant Women

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 fetus the pregnant woman is carrying. Verification of the number of fetuses is not required unless questionable. If the number of fetuses is unknown, add 1 to the group size. If verification is required but there is no verification on the number of fetuses, add 1 to the group size.

2.3.1.4 Children

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.

2.3.1.5 Childless Adults

Prior to April 1, 2014, childless adults will only be eligible for coverage under the BadgerCare Plus Core Plan. The Core Plan assistance group only consists of the childless adult and his or her spouse, if the member was married at the time of application.

2.3.2 MAGI Test Group

Beginning February 1, 2014, BC+ eligibility determinations will use Modified Adjusted Gross Income (MAGI) rules. MAGI rules are based on the concept of an individual's tax household, not necessarily on the physical household or family relationships.

Note: Whether or not someone is a tax filer or is a dependent of a tax filer is based on what the individual plans to do for the current calendar year's taxes, not on what he or she is required to do based on IRS tax law. For example, many individuals file taxes even though they are under the filing threshold because they want to receive their full tax refund or to qualify for the Earned Income Tax Credit. If a member reports that they plan to file taxes, we will treat them as a tax filer in the test group, even if they are below the threshold for being required to file.

All new applicants with a filing date on or after February 1, 2014 will be tested only using MAGI rules. Ongoing beneficiaries will transition to MAGI rules at their next scheduled renewal or April 1, 2014, whichever is later.

An ongoing beneficiary is someone who:

- Applied prior to February 1, 2014,

- Was eligible for March 2014, and
- Remained eligible under the new income limits after April 1, 2014.

Note: Ongoing cases that had a renewal in January or February of 2014 will transition to MAGI rules the next time eligibility is run by the worker for the month of April 2014 or later.

2.3.2.1 Forming the Test Group using MAGI Tax Filing Rules

All MAGI groups are based on a "target" individual. Each person who can become eligible for BC+ on the application will be a target during the eligibility determination for a case.

Tax Filers

If the individual is a tax filer and is NOT being claimed as a dependent by anyone else, then the individual's MAGI group consists of the tax filer, the tax filer's spouse, and any dependents the tax filer is claiming.

Out-of-the-Home Tax Dependents

A tax filer is able to claim individuals who live outside of their home as their tax dependents. Common examples include college students and other adult children, elderly parents, or siblings who do not live with the filer(s). Tax filers can also claim a deceased child as his or her tax dependent in the year that the child has died. In these instances, the deceased child would be included in the tax filer's group size, though the child would not be eligible for benefits on that application.

Deceased Co-Filers

It is possible for an individual to file his or her taxes jointly with a deceased spouse for the taxable year in which the spouse died. However, unlike deceased tax dependents, they will not be included as a household member.

Household Members in the Military

Deployed military members are still considered part of a tax household. Under MAGI rules, the military member's taxable income will count in the household, and he or she will also be included in the household's group size, as appropriate. If a household member is absent due to military activity, he or she may be included in the group size, but will not be eligible for assistance on this case.

Married Couples

Married individuals who are living together are always included in each other's group size, even if they are filing taxes separately. If a married couple is living apart but filing jointly, the couple is included in each other's group size. If the married couple is living apart and filing taxes separately, or are not planning to file taxes, do not include them in each other's group size.

Tax Dependents

In general, a tax dependent's household will be the same as his or her tax filer's household, even if the tax dependent is also a tax filer.

However, if any of the following situations apply, then the tax dependent's eligibility is based on MAGI relationship rules:

1. The individual is being claimed as a dependent by a parent outside of the home (a non-custodial parent is defined as a parent who is living apart from the parent applying for benefits for the child),

2. The individual is being claimed as a dependent by someone who is not their parent; or
3. The individual lives with both parents and his or her parents are not married filing jointly.

2.3.2.2 Forming the Test Group Using MAGI Relationship Rules

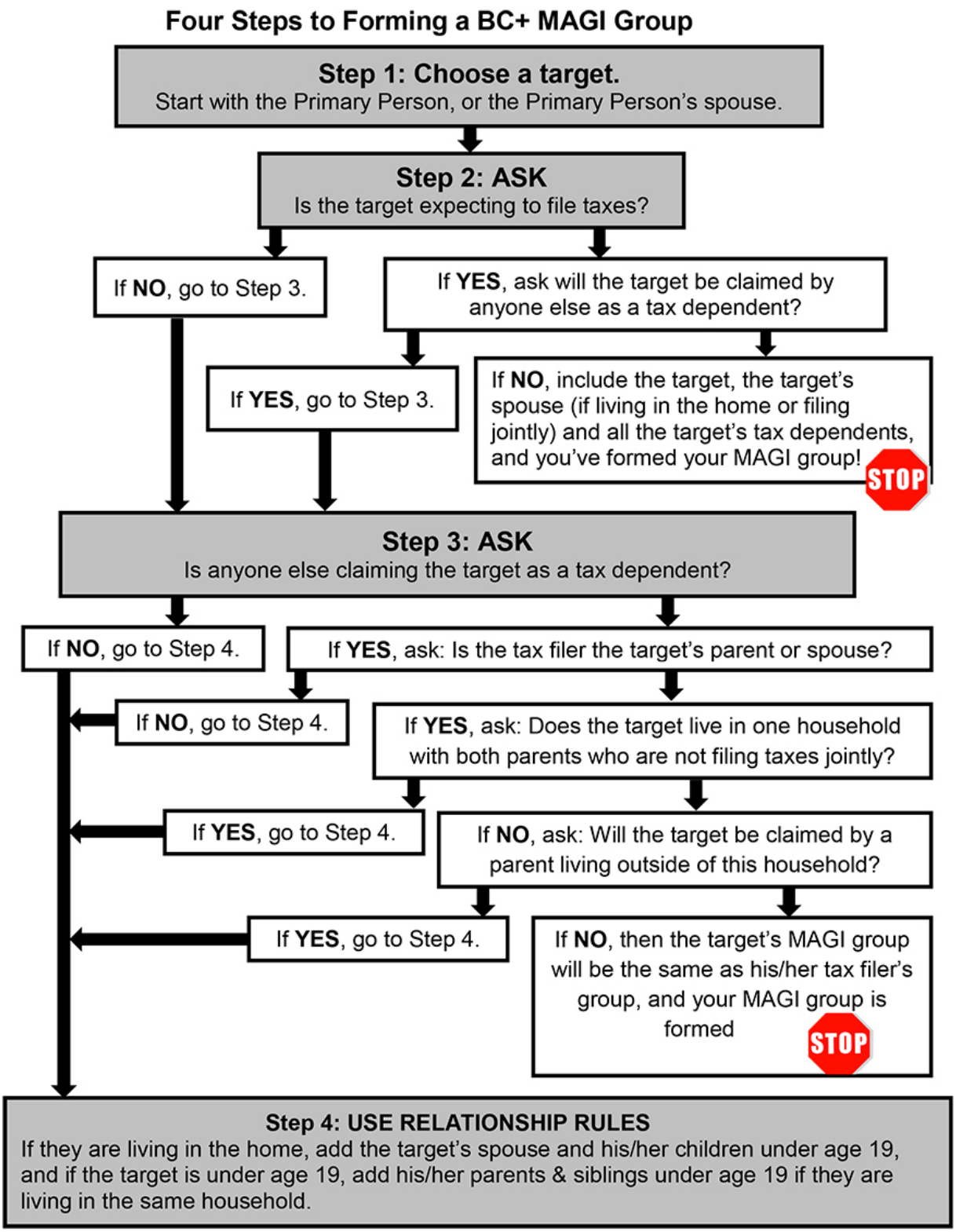
Individuals who meet one of the exceptions to the MAGI tax filing rules or who are not tax filers or tax dependents will have their eligibility determined using MAGI relationship rules.

Under relationship rules, only include individuals who are living in the home with the target. If the target individual is under 19, then the target's group includes the target's parents, the target's spouse, the target's siblings under age 19 (including step and half siblings), and the target's children.

If the target individual is over age 19, the target's group includes the target's spouse and the target's children under age 19.

2.3.2.3 MAGI Flowchart

The following flowchart may assist workers in forming groups under MAGI rules.



2.3.3 Applying non-MAGI Rules vs. MAGI Rules

Applications Submitted to the Department of Health Services

Individuals who apply for BadgerCare Plus prior to February 1, 2014 will have their eligibility determined using *non-MAGI* rules. These individuals will continue to be subject to non-MAGI rules until March 31, 2014 or their next regularly scheduled 2014 renewal, whichever comes later.

If an individual with eligibility under non-MAGI rules reports a change that makes them ineligible for BadgerCare Plus, MAGI information will be collected and their eligibility re-run under MAGI rules in order to determine if the individual may still be eligible for BadgerCare Plus.

Individuals who apply for BadgerCare Plus coverage on or after February 1, 2014 will have their eligibility determined under MAGI rules. If they request backdated eligibility for a month prior to February 2014, we will use non-MAGI rules for those months.

Applications Submitted to the Federally-facilitated Marketplace
Beginning October 1, 2013, individuals can submit applications for Medicaid or CHIP coverage to the federally-facilitated marketplace (the Marketplace). If the Marketplace determines or assesses individuals as eligible for coverage through BadgerCare Plus or EBD Medicaid, the account will be transferred to Wisconsin.

The filing date for applications received from the Marketplace is the date the application was submitted to the Marketplace. The 30 day processing time frame begins on the date the application is submitted to the IM agency's inbox.

Effective February 1, 2014, DHS will send accounts of applicants and members found ineligible for BadgerCare Plus to the *Marketplace* for a determination of advanced premium tax credits and cost-sharing reductions.

2.3.4 Former Foster Care Youth Eligibility

Former Foster Care Youth are categorically eligible for BadgerCare Plus.

Through December 31, 2013, if the primary person is:

- A former foster care youth,
- under 21 years old,

then the BC+ test group will include the youth and his/her spouse if the spouse is also a former foster care youth.

Beginning January 1, 2014, if the primary person is:

- a former foster care youth,

- under age 26,
-

then the BC+ group will include the youth and his/her spouse if the spouse is also a former foster care youth.

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2.4 THE BC+ HOUSEHOLD

2.4.1 Not Living in the Household
2.4.2 Temporary Absence
2.4.3 Students

"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 of 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.

2.4.1 Not Living in the Household

Do not consider the following to be living in the household regardless of whether *non-MAGI* rules or *MAGI* rules were used to determine a member's BC+ group:

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 Program.
    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.

2.4.2 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. See Chapter 10 for more information about Child Welfare.

The following children are not considered temporarily absent:

- Children who are inmates of public institutions. (3.6)
- Children who are placed in an institution for 30 or more days, unless they were placed there by a child welfare agency.
- Children who are placed in an *IMD*, unless they were placed there by a child welfare agency.

2.4.3 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 on his/her own case, or a temporarily absent individual included in his/her parent’s case.

Students over age 19 will need to apply for BadgerCare Plus with their own application.

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2.5 BC+ ASSISTANCE GROUPS

Because of different BC+ group requirements, 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, other individuals 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. Some individuals on the application will not considered at all when determining eligibility. Placement in the BC+ AG is dependent on age, and relationships to the individual(s) whose eligibility is being determined.

The following are the BC+ Assistance Groups for individuals whose eligibility is being determined using *non-MAGI* rules:

AG	Description
BCPY:	Former Foster Care Youth
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
BCPM	Non-pregnant, non-disabled adults in extensions who owe a premium.
BCPN	Persons who are caretakers relatives, or the spouses of caretakers relatives in the home including 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 who do not owe a premium

The following are the BC+ Assistance Groups for individuals whose eligibility is being determined using the *MAGI* rules. These AGs will not be effective until February 1, 2014.

AG	Description
MAGY	Former Foster Care Youth
MAGP	Pregnant women, including those who are eligible for the BC+ Prenatal Program and those who become eligible after meeting a deductible.
MAGB	Continuously Eligible Newborns
MAGM	Adults in extensions who owe a premium.
MAGN	Persons who are caretakers relatives, or the spouses of caretakers relatives in the home, including Child Welfare caretakers
MAGL	Children living with non-legally responsible relatives
MAGC	Children under age 19, living alone or with a parent or parents
MAGA	Persons age 19 or older who are parents, or stepparents of a child in the home, including Child Welfare parents
MAGD	Children who are eligible through meeting a deductible
MAGE	Children and Adults in Earned Income and Spousal Support Extensions who do not owe a premium
MAGS	Childless adults

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2.6 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		Budgeting Rules (non-MAGI/ MAGI)	Description	Include in the Group Size?
CA	Counted Adult	non-MAGI and MAGI	Ineligible for BC+ in this AG	Yes
CC	Counted Child	non-MAGI and MAGI	Ineligible for BC+ in this AG	Yes
EA	Eligible Adult	non-MAGI and MAGI	Non-financially eligible in this BC+ AG	Yes
EC	Eligible Child	non-MAGI and MAGI	Non-financially eligible in this BC+ AG	Yes
TC	Test Child	non-MAGI	Ineligible for BC+ solely because receives SSI or Adoption Assistance	Yes
TA	Test Adult	non-MAGI	Ineligible for BC+ solely because receives SSI or 1619b	Yes
XA	Excluded Adult	non-MAGI and MAGI	Ineligible for BC+ in this AG	No
XC	Excluded Child	non-MAGI and MAGI	Ineligible for BC+ in this AG	No

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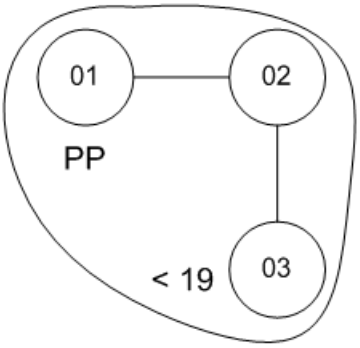
2.7 BC+ GROUP EXAMPLES

2.7.1 BC+ Group Examples using non-MAGI Rules

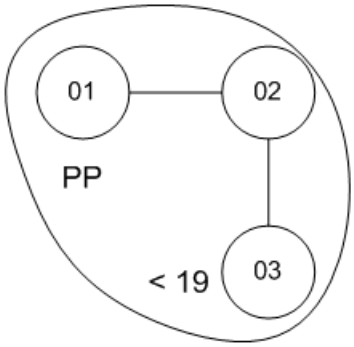
2.7.2 BC+ Group Examples using MAGI Rules

2.7.1 BC+ Group Examples using non-MAGI Rules

Example1

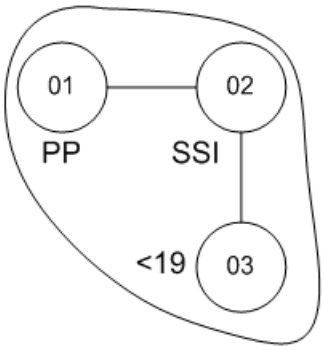


Individuals	01	02	03
Health Care Request	Y	Y	Y
Assistance Group	Individual Part status		
BCPA	EA	EA	CC
BCPC	CA	CA	EC

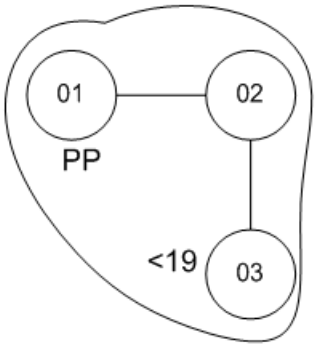


Individuals	01	02	03
Health Care Request	Y	N	Y
Assistance Group	Individual Part status		
BCPA	EA	CA	CC
BCPC	CA	CA	EC

Example 2

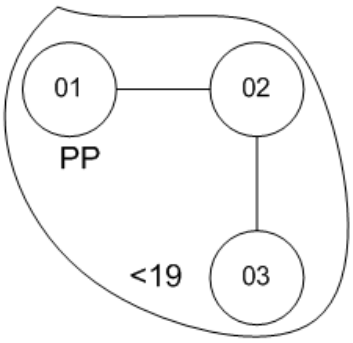


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPA	EA	TA	CC

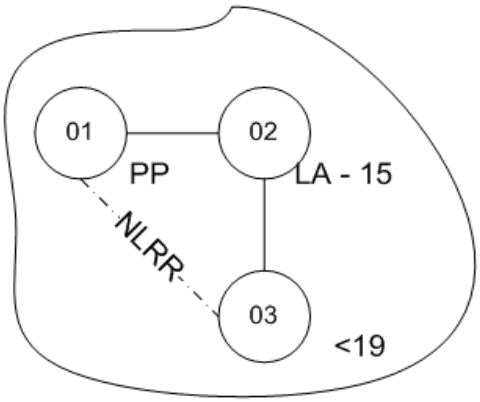


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPA	EA	EA	CC

Example 3

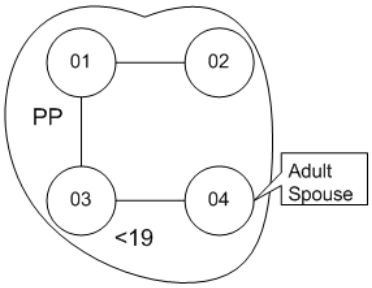


Individuals	01	02	03
Health Care Request	Y	N	N
Assistance Group	Individual Part status		
BCPA 01	EA	CA	CC

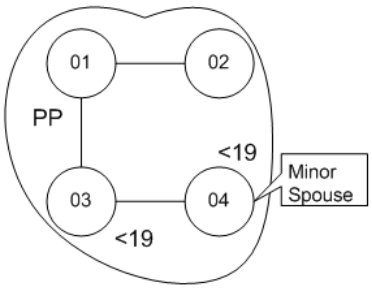


Individuals	01	02	03
Health Care Request	Y	Y	N
Assistance Group	Individual Part status		
BCPN 01	EA	XA	XC

Example 4

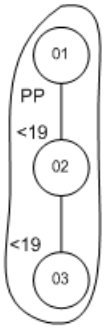


Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA 01	EA	EA	CC	CA
BCPC 01	CA	CA	EC	CA

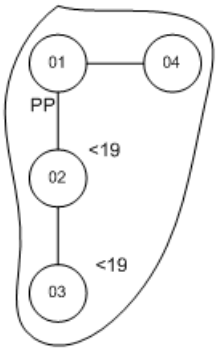


Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA 01	EA	EA	CC	CC
BCPC 01	CA	CA	EC	EC

Example 5



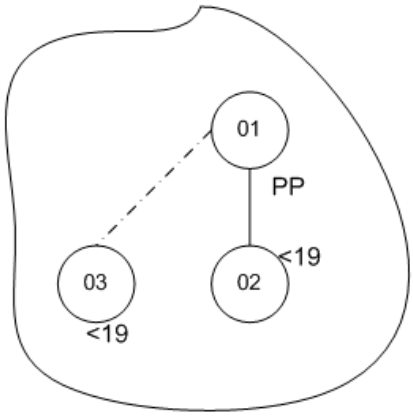
Individuals	01	02	03	
Health Care Request	Y	Y	Y	
Assistance Group	Individual Part status			
BCPA	EA	CC	CC	
BCPC	CA	EC	EC	



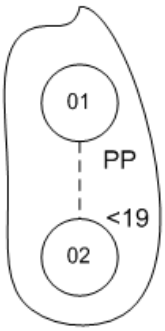
Individuals	01	02	03	04
Health Care Request	Y	Y	Y	Y
Assistance Group	Individual Part status			
BCPA	EA	CC	CC	EA
BCPC	CA	EC	EC	CA

Example 6

Example 7

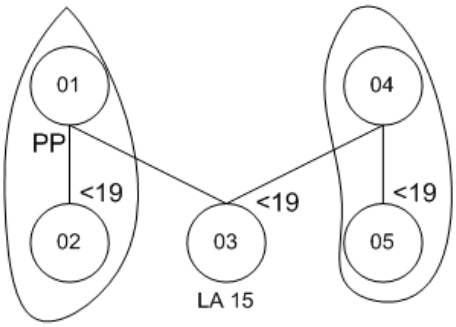


Individuals	01	02	03		
Health Care Request	Y	Y	Y		
Assistance Group	Individual Part status				
BCPA 01	EA	CC	XC		
BCPC 01	CA	EC	XC		
BCPL 01	XA	XC	EC		

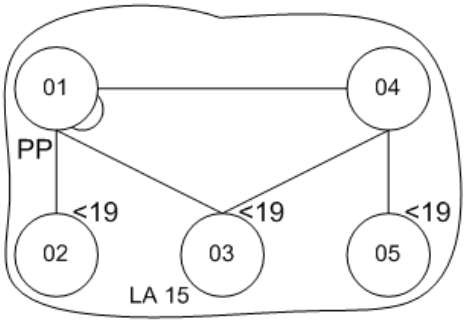


Individuals	01	02			
Health Care Request	Y	Y			
Assistance Group	Individual Part status				
BCPN 01	EA	XC			
BCPL 01	XA	EC			

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

2.7.2 BC+ Group Examples using MAGI Rules

Example 1
Temperance (36) and Seeley (40) are married parents and are not filing taxes. They have one daughter, Christine (1).

Person	BC+ Category	Temperance	Seeley	Christine
Temperance	MAGA	EA	CA	CC
Seeley	MAGA	CA	EA	CC
Christine	MAGC	CA	CA	EC

Example 2
Mr. and Mrs. Bennett are married parents filing taxes separately but living together. They have two daughters, Jane (18) and Elizabeth (17). Jane's husband, Charles (20) also lives with them. Mr. Bennett is claiming Jane, Elizabeth, and Charles as his tax dependents.

Person	BC+ Category	Mr. Bennett	Mrs. Bennett	Jane	Elizabeth	Charles
Mr. Bennett	MAGA	EA	CA	CC	CC	CA
Mrs. Bennett	MAGA	CA	EA	XC	XC	XA
Jane	MAGC	CA	CA	EC	CC	CA
Elizabeth	MAGC	CA	CA	CC	EC	XA
Charles	MAGS	XA	XA	CC	XC	EA

Example 3
Evie (29) and Derrick (32) are divorced parents. Their son, Neal (8), lives with Evie 80% of the time and 20% of the time with Derrick. Per their divorce agreement, this is Derrick's year to claim Neal as his tax dependent. Evie also files taxes. Evie is pregnant with her second child. Evie, Derrick, and Neal are all applying for health care. Evie and Neal will be on their own application. Derrick will have to apply on a separate application.

Person	BC+ Category	Evie	Derrick	Neal
Evie	MAGA	EA (+1)	-	XC
Derrick	MAGS	-	EA	CC
Neal	MAGC	CA (+1)	-	EC

Example 4

Same as above, except Neal lives 60% of the time with Evie and 40% of the time with Derrick, and neither Evie nor Derrick file taxes.

Person	BC+ Category	Evie	Derrick	Neal
Evie	MAGA	EA (+1)	-	CC
Derrick	MAGA	-	EA	CC
Neal	MAGC	CA (+1)	-	EC

Example 5
George (50) and Lucille (40) are married tax filers and are filing jointly. They have three tax dependents: Michael (14), Lindsay (14), and Buster (6). Buster is Lucille's nephew who George and Lucille care for. Michael and Lindsay are George and Lucille's children. George and Lucille also care for George's nephew Tobias (17) but will not claim him as a tax dependent. All six individuals are requesting health care.

Person	BC+ Category	George	Lucille	Michael	Lindsay	Buster	Tobias
George	MAGA	EA	CA	CC	CC	CC	XC
Lucille	MAGA	CA	EA	CC	CC	CC	XC
Michael	MAGC	CA	CA	EC	CC	CC	XC
Lindsay	MAGC	CA	CA	CC	EC	CC	XC
Buster	MAGL	XA	XA	XC	XC	EC	XC
Tobias	MAGL	XA	XA	XC	XC	XC	CC

Example 6:
Danny (45) and Vicki (40) are non-married co-parents. They submit a BC+ application for themselves, Danny's daughter DJ (22), Vicki's daughter Stephanie (13) Danny and Vicki's daughter, Michelle (10) and Danny's brother, Uncle Jesse (40). Danny claims DJ and Jesse as his tax dependents, while Vicki claims Stephanie and Michelle as her tax dependents.

Person	BC+ Category	Danny	Vicki	DJ	Stephanie	Michelle	Jesse
Danny	MAGA	EA	XA	CA	XC	XC	CA
Vicki	MAGA	XA	EA	XA	CC	CC	XA
DJ	MAGS	CA	XA	EA	XC	XC	CA
Stephanie	MAGC	XA	CA	XA	EC	CC	XA
Michelle	MAGC	CA	CA	XA	CC	EC	XA
Jesse	MAGS	XA	XA	XA	XC	XC	EA

Note: Uncle Jesse and DJ will need to file their own applications.

Example 7
Emily is a 52 year old grandmother who cares for her daughter, Lorelai (18) and her granddaughter, Rory (2). Emily is the primary caretaker of Rory. Lorelai has graduated high school. Nobody files taxes.

Person	BC+ Category	Emily	Lorelai	Rory
Emily	MAGN	EA	XC	XC
Lorelai	MAGC	CA	EC	CC
Rory	MAGC	XA	CC	EC

Example 8
Same example as example 7, except Emily is claiming Lorelai and Rory as her tax dependents.

Person	BC+ Category	Emily	Lorelai	Rory
Emily	MAGN	EA	CC	CC
Lorelai	MAGC	CA	EC	CC
Rory	MAGC	XA	CC	EC

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2.8 BC+ TEST GROUP FINANCIAL RULES

2.8.1 Non-MAGI Income Counting Rules
2.8.2 MAGI Income Counting Rules

2.8.1 Non-MAGI Income Counting Rules

Under *non-MAGI* BadgerCare Plus 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.

2.8.2 MAGI Income Counting Rules

Within each *MAGI* assistance group, all counted and eligible individuals' income is counted with one exception: if a group member is a child or tax dependent of a counted or eligible member within the same assistance group, his or her income is only counted if he/she is "expected to be required" to file a tax return for the current year. If the tax dependent or child chooses to file a tax return when they are not required to, we will not count their income. Tax dependents' and children's income is only counted when they are "expected to be required" to file a tax return.

Note: If a child or tax dependent is the only individual in the MAGI group, he or she would not have a parent or tax filer eligible or counted in that group. As a result, his or her income will always be counted, regardless of whether or not she or he is expected to be required to file taxes. *NLRR* children are an example of a child who is the only counted or eligible individual in a MAGI group.

Tax dependents are only required to file a tax return if they have more income than the filing thresholds set by the IRS each year. If the child or tax dependent of another member in the same AG expects to have less annual taxable income than the amounts below, his/her income is not included in the eligible determination for the AG.

- $1,000 per year in taxable unearned income, or
- $6,200 per year in taxable earned income.

For expected unearned income, do not count Child Support, Social Security, Supplemental Security Income (SSI), Workers Compensation, Veteran's Benefits, Money from Another Person or Educational Aid.

These income counting rules apply regardless of whether the assistance group was formed based on MAGI Tax Filing Rules or MAGI Relationship Rules.

The income of household members who are currently out of the home due to military activity will still be counted according to MAGI rules, meaning it may be counted, even though the individual will not be eligible on the case.

Example 1: Jack and Jill are married and will be filing a joint tax return. They have two children, Mickey (16) and Minnie (12), whom they will claim as tax dependents. Minnie has no income, but Mickey works at McDonald's earning approximately $100 per month. Mickey's annual earned income is expected to be $1200; he is not expected to be required to file a tax return at the end of the year. Mickey's income is not counted.

Example 2: Daisy plans to file taxes this year. She has one tax dependent, her son Donald (16), who works part-time at a grocery store. He earns $550 per month; with an annual income of $6,600. Based on this income, Donald will be expected to be required to file a tax return. Donald's income is counted.

Example 3: Kelly and Zack are non-married co-parents and have two children, Jessie (17) and Albert (14). Albert mows lawns in the summer and makes around $300 for the year. The only other income in the household is Zack's unemployment payment in the amount of $400 per month ($4800 per year). Kelly and Zack do not plan to file taxes. Albert is not expected to be required to file taxes. The AGs for this case will be based on non-MAGI relationship rules since there is no tax filer in the household. Zack's UI payment will be counted, but Albert's self-employment income is not counted because he is not expected to be required to file.

Example 4: Michael (16) and his sister Janet (17) live with their aunt Barb and her two children. Barb applies for BC+ for herself, her two children and her niece and nephew. Barb states she plans to file taxes and will be claiming Michael, Janet, and her two children as tax dependents. Barb is self-employed earning about $800/mo. Michael is working part-time at Dairy Queen earning approximately $150/month. Michael is not expected to be required to files taxes. Janet works part-time at Copp's and makes $600/mo. She will be expected be required to file taxes.

<u>Outcome for Barb</u>
Barb's assistance group will consist of herself and all four children since she will be claiming them as tax dependents. Michael's income will not be counted in Barb's AG because he is not expected to be required to file taxes, but Janet's income will be counted in Barb's group because Janet is expected to be required to file taxes. Barb's children's AGs will be the same as Barb's AG.

<u>Outcome for Michael and Janet</u>
Michael and Janet will both have an assistance group of two (MAGL) since they are siblings being claimed as tax dependents by someone living in the home who is not their parent. Michael and Janet's groups are built using MAGI relationship rules. All of Michael's and Janet's earned income will be countable when determining their eligibility because they are not the children or tax dependents of someone in their group.

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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. Wisconsin residents who are temporarily out of state (see 3.5 Absence from Wisconsin), including students going to school in another state, do not have to be physically present to apply. However, individuals who are not Wisconsin residents and intend to move to Wisconsin must be physically present in Wisconsin to apply.

   and
2. Express intent to reside in Wisconsin. (see 3.2 Intent to Reside.). Effective January 1, 2014, an individual can also be considered a resident of Wisconsin if they are physically present in the State and have entered Wisconsin with a job commitment or seeking employment, whether or not they are employed at the time of application.

Example 1: John, a student from Wisconsin who is attending college in Minnesota, can apply for BC+ as a Wisconsin resident.

Example 2: Margie lives in Florida. She is planning to move to Wisconsin in the next few months. Margie would not be considered a resident of Wisconsin until she is physically present in Wisconsin.

Example 3: 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.

“Intent to reside” does not mean an intent to stay permanently or indefinitely in the State, nor does it require an intent to reside at a fixed address.

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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:

- Age 18 or under age 18 and emancipated from his or her parents, or married, and is:
    1. Living in Wisconsin with the intent to remain living in Wisconsin, or
    2. Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

- Under age 18 and not emancipated from his or her parents and not married, and is living in Wisconsin.

  Note: For individuals received Medicaid based on receipt of Title IV-E assistance or if the individual receives State SSI, see section 3.4.

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

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

In an institution

The residence of a person under age 21 living in a Wisconsin institution 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

Not in an Institution

The residence of an individual over age 21 who is not institutionalized is Wisconsin if s/he is:

- Living in Wisconsin with the intent to remain living in Wisconsin, or

- Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

If s/he is incapable of expressing intent, an individual is a resident if s/he is living in Wisconsin.

In an institution

The residence of a person who became incapable of indicating intent before age 21 is determined in the same way as the residence of an institutionalized person under age 21.

The residence of a person who became incapable of indicating intent at age 21 or older is Wisconsin, unless the placement was arranged by another state.

For all others, the person is a Wisconsin resident if s/he intends to reside in Wisconsin

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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.

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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

3.6.1 Huber Law

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. An individual who is legally confined to his/her home by a monitoring device, such as an ankle bracelet, is not considered in inmate for purposes of BC+. Individuals who are inmates of a public institution are not eligible for BC+ unless they meet the Huber criteria or the following two exceptions:

- **Prenatal Exception:** Pregnant women may apply for and enroll in the BC+ Prenatal Program (Chapter 41) while they are inmates.
- **Inpatient Exception:** 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 of a public institution is admitted as an inpatient to a medical institution for 24 hours or more and is otherwise eligible, manually certify him/her for BC+ from the admission date through the discharge date.

Use the following process for inmates of state correctional institutions:

1. Department of Corrections (DOC) staff submits an ACCESS application, which will be systematically routed to EM CAPO. Superintendents of state correctional facilities (Wardens) or their designee may sign the application for the inmate. Refer to MEH 6.9.4 State Correctional Institutions for the list of state correctional facilities at which the Warden may sign the application.
2. Process the inmate as a one-person household with a living arrangement of "01-Independent (Home/Apt/Trlr)" on the demographics page.
3. If the individual is eligible, close the case in CARES by changing the Healthcare Request page to "N". Suppress CARES generated notices for Medicaid and any program the Individual has not requested. Manually certify the Individual with the appropriate medical status code (see below), from the hospital admission date through the date of discharge. If the individual has not yet been discharged, certify the individual from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility.

Also if the individual had not been discharged when you sent the initial positive notice, send a manual negative notice with the eligibility end date as soon as that is known. If you issue the notice after the discharge date, the effective date of the termination and the notice should be the date you mail out the notice. The reason for the termination should be shown as, “Individual is incarcerated”. The legal citation should read, “DHS 103.03(6)”.

Note: It is not necessary to provide a ten-day notice of termination for Medicaid when the reason for termination is the return of the individual to prison. The notice is considered timely if it is mailed no later than the termination effective date.

4. If the individual is ineligible, confirm the denial on CARES, and allow CARES generated notices to be sent to the designated DOC staff person.

For a list of Med Stat Codes, see Process Help 81.5.

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 Reserved
- 4.2.3 Reserved
- 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 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.

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 95 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 95 days, the

eligibility will be terminated with Adverse Action notice, unless the eligibility worker believes a good-faith effort is being made by the applicant/member and the worker chooses to extend the good-faith period. This 95 day period applies to applications, reviews and person adds. An individual can only receive one 95 day good-faith effort period in his or her lifetime.

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 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 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 SOLQ or DXSA.

Note: Qualified providers who conduct BC+ express enrollment determinations must not apply the 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 Reserved

4.2.3 Reserved

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 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 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 verification requirement at the time of his/her application. Inform the applicant of the documentation requirement and give him/her the

"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 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 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.)	8 CFR 103.12(a)(4)(iv)
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	K-1

marriage contract.	
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 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	8 U.S.C. 1101(a)(15)(S)(i)
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 "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	Arrived Before 08/22/96	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 law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible

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 207(c)	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	Ineligible	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	Eligible	Eligible	Eligible	Eligible	Eligible

	Native American					
19	Victims of Trafficking	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	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

5.1.1 Recovery of Birth Costs
5.1.2 Referral to CSA

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* .

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 parent or caretaker relative requests child support services for the child. Do not sanction this parent or caretaker relative if s/he does not cooperate with the CSA.

3. **Non Marital coparents** 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. Former Foster Care Youths, 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

5.2.1 Introduction
5.2.2 Failure to Cooperate

5.2.1 Introduction

Unless the person is exempt or 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 19 or is eligible for the Medicaid expansion category of the Children's Health Insurance Program (CHIP). If the child's BC+ benefit is funded through any other source such as Title 21 Separate CHIP or GPR (i.e., state funds) the *caretaker relative* is not required to cooperate and can not be sanctioned for non cooperation. Check the Medical Status codes (See 51.1) to determine funding source. The CSA will monitor the child's BC+ funding source.

5.2.2 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, and
3. Parents or 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
5.3.4 Circumstances
5.3.5 Evidence
5.3.6 Investigation
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 satisfies the worker 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.

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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. on the date of the accident or injury, lived in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, La Crosse, Lincoln, Marinette, Milwaukee, Rock, Sheboygan, Trempealeau, Vilas, Walworth, Waushara or Winnebago County,

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

WI Casualty Recovery - HMS
5615 Highpoint Dr., Suite 100
Irving, TX 75038-9984

Telephone: (877)391-7471
Fax: (469)359-4319
e-mail: wicasualty@hms.com
Website: http://www.wicasualty.com/wi/index.htm

If the member is enrolled in an HMO or MCO they must also report the accident or injury to that organization.

2. All other Medicaid members should report in person or phone their local agency and any HMO or MCO that may have provided services, before the case is settled. Members should include the date of the accident and any insurance/attorney information.

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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. 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 .
5. Policies that pay benefits only for treatment of accidental injury.
6. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
7. 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.
8. Life Insurance.
9. 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. Non-qualifying immigrants receiving emergency services.
d. Someone without an SSN and may only be issued one for a valid non-work reason.
e. Someone who refuses to obtain an SSN because of well-established religious objections*.
f. Tax dependents or tax filers living outside of the home.

“Well-established religious objections” means that the applicant/member:

1. Is a member of a recognized religious sect or division of the sect, and
2. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

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

7.1.1 Health Insurance Conditions of Eligibility for under Non-MAGI Rules
7.7.2 Health Insurance Conditions of Eligibility Under MAGI Rules

7.1.1 Health Insurance Conditions of Eligibility under Non-MAGI rules

To prevent the crowd out of private insurance, BadgerCare Plus (BC+) benefits may be denied or terminated for individuals who have eligibility determined under *non-MAGI* rules and have access to certain employer sponsored health insurance policies when those individuals:

1. Are adult parents and caretaker relatives with household income above 133% of the FPL (through March 31, 2014).
2. Are infants under age 1 with household incomes over 300% of the FPL, children ages 1 through 5 with household incomes over 185% of the FPL and children ages 6 through 18 with household incomes over 150% of the FPL,
3. Are pregnant women eligible under the BC+ Prenatal Program at any income level,
4. Are not in an exempt category (see list below) **and**,
5. 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. Infants less than 1 year old with household income at or below 300% of the FPL,
4. Children ages 1 through 5 (up to age 6) with household income at or below 185% of the FPL,
5. Children ages 6 to 18 with household income at or below 150% of the FPL,
6. Former Foster Care Youth (*FFCY*),
7. Pregnant women, other than those in the BC+ Prenatal Program,
8. Parents and caretakers who are blind or disabled (including MAPP Disabled), as determined by the DDB, or through the Presumptive Disability process (MEH 5.9), and
9. Parents, caretaker relatives, and children who are in an Extension.

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.

7.1.2 Health Insurance Conditions of Eligibility under MAGI rules

To prevent the crowd out of private insurance, BC+ benefits may be denied or terminated for individuals who have eligibility determined under *MAGI* rules and have access to certain employer sponsored health insurance policies when those individuals:

1. Are children ages 1 through 5 with household incomes over 191% of the FPL and children ages 6 through 18 with household incomes over 156% of the FPL,
2. Are pregnant women eligible under the BC+ Prenatal Program at any income level,
3. Are not in an exempt category (see list below) and,
4. 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. Infants less than 1 year old with household income at or below 306% of the FPL,
4. Children ages 1 through 5 (up to age 6) with household income at or below 191% of the FPL,
5. Children ages 6 to 18 with household income at or below 156% of the FPL,
6. Former Foster Care Youth,
7. Pregnant women, other than those in the BC+ Prenatal Program,
8. Parents and caretaker relatives, including those who are blind or disabled (including MAPP Disabled), as determined by the DDB, or through the Presumptive Disability process (MEH 5.9),
9. Childless adults, and
10. Parents, caretaker relatives, and children who are in an Extension.

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

7.2.1 Introduction
7.2.1.1 The 80% Past Access Test
7.2.1.2 The 9.5% Past Access Test
7.2.2 Good Cause for "Past Access Test" under Non-MAGI Rules
7.2.3 Good Cause for "Past Access Test" under MAGI Rules

Beginning July 1, 2012, there are two Past Access policies in effect:

- The 80% Past Access Test.
- The 9.5% Past Access Test.

The 80% Past Access Test policies applies to non-exempt children (See 7.1). The 9.5% test applies to adult parents and caretakers until March 31, 2014. After April 1, 2014, parents and caretakers are no longer subject to a Past Access Test.

7.2.1.1 The 80 % Past Access Test

Children and any BC+ Prenatal Program members who had access to health insurance, including access due to a *qualifying event*, in the twelve months prior to the application or renewal 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 child under age 19 and child is not exempt; **and**

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

The child or BC+ Prenatal Program member is ineligible for BC+ for twelve calendar months from the date the health insurance would have begun.

Example 1: Marilyn applied for BC+ in April 2014 for herself and her children, ages 10 and 8; they have family income that exceeds 156% of the FPL. She could have enrolled in a family health insurance plan through her current employer in October 2013, and her employer pays 80% of the premium for that plan. 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 December 2013.

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. Her children are ineligible for BC + through November 2014, 12 months from the date the coverage would have begun, unless they become exempt during that time. Marilyn is not eligible because her income is over the 100% FPL limit for the parent and caretaker coverage group.

7.2.1.2 The 9.5% Past Access Test

Note: The 9.5% Past Access Test will no longer be effective beginning April 1, 2014.

Non-exempt parents and caretakers over age 18 with household incomes over 133% of the FPL who had access to health insurance, including access due to a qualifying event, in the twelve months prior to the application or renewal 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,

- The individual could have enrolled in the employer's plan under the current coverage period at any time in the past 12 months prior to the application or renewal date,
- The cost of coverage for an employee-only plan does not exceed 9.5% of the monthly household income, and
- There is no good cause reason for not signing up for the coverage.

When an employed parent or caretaker has been determined to have had past access, the individual's spouse will also be considered to have past access if the employer

offers a plan that would provide coverage to the spouse, such as employee + spouse or employee + family coverage.

Non-pregnant, non-disabled parents and caretaker relatives with household income above 150% of the FPL will not be eligible for BadgerCare Plus benefits if they had past access to a State Employee's health care plan, regardless of the amount of the premium. Non-pregnant, non-disabled parents and caretakers with access to state employee health insurance, who have household income between 133% and 150% FPL, are only ineligible for BadgerCare Plus if the employee-only premiums are not more than 9.5% of household income.

Example 2: Joe and his wife, Mary, apply for BadgerCare Plus for themselves and their 3 children on July 2, 2012. Their income is 145% of the FPL. Joe works for ABC Company. ABC Company offers an employee-only plan as well as a family plan. Joe's cost for the employee-only plan is less than 9.5% of the household's countable income. The last open enrollment period to sign up for the employer sponsored insurance was October 1, 2011 through October 31, 2011. The plan coverage period is January 1, 2012 through December 31, 2012.

Since Joe could have enrolled in the past 12 months and could have had coverage under the current coverage period, and the premiums would have been less than 9.5% of the family's income, he is ineligible. Since the employer offers a family plan that would cover Mary, she is also ineligible. Children under age 19 are not subject to the 9.5% access tests so the children's eligibility is not affected.

7.2.2 Good Cause for 80% and 9.5% "Past Access Test" under Non-MAGI Rules

Good cause reasons for failure to enroll in an employer sponsored health insurance plan in the 12 months prior to application or renewal 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,
- BC+ with a household income above 150% of the FPL,

- If the failure to enroll occurred on or after July 1, 2012, BC+ with household income above 133% of the FPL,
- BC+ Extension, **or**
- BC+ as a Pregnant Woman (not including the BC+ Prenatal Program).

3. The employment ended, **or**

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

Example 3: Olivia applied for BC+ in January 2012 for herself and her children. Although it was determined that she had access to employer sponsored health insurance in August of 2011 (past access), she has a good cause exemption because she and her children were enrolled in BadgerCare Plus from July 2011 through November 2011 and the family income at that time was only 120% of the FPL.

7.2.3 Good Cause for the 80% "Past Access Test" Under MAGI Rules

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

- BC+ with an assistance group income above 156% of the FPL,
- BC+ Extension, **or**
- BC+ as a Pregnant Woman (not including the BC+ Prenatal Program).

3. The employment through which the child is insured ended, **or**

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

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7.3 CURRENT ACCESS TO HEALTH INSURANCE

7.3.1 Introduction
7.3.2 The 80% Current Access Test
7.3.3.The 9.5% Current Access Test

7.3.1 Introduction

Beginning July 1, 2012, there are two Current Access policies in effect:

- The 80% Current Access Test.
- The 9.5% Current Access Test.

The 80% Current Access Test policies applies to non-exempt children (See 7.1). The 9.5% test applies to adult parents and caretakers until March 31, 2014.

7.3.2 The 80% Current Access Test

Children and BC+ Prenatal Program members 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 child under age 19 and the child is not exempt; **and**
3. The coverage would begin within three calendar months following:
    a. The BC+ application *filing date*; **or**
    b. Annual review month; **or**
    c. Employment start date

The child or BC+ Prenatal Program member 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*. (See Ch. 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 her child is eligible for BC + until the next eligibility renewal (assuming there are no other changes that resulted in ineligibility). If Janelle's circumstances remain unchanged, her child will be disenrolled at his/her next review because she had "past access". Janelle is not eligible because her income is over the limit for the parent and caretaker coverage group.

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+. His children are not eligible for BC+ because Bill can sign up in this month and coverage would begin within the next three calendar months. Bill is not eligible because his income is over the limit for the parent and caretaker coverage group.

7.3.3.The 9.5 % Current Access Test

The 9.5% test applies to adult parents and caretakers until March 31, 2014.

For parents and caretakers who are not exempt (See 7.1), an individual with current access to employer sponsored health insurance is not eligible for BadgerCare Plus. An individual has current access to employer sponsored insurance if:

- the individual could enroll in and be covered under the plan in the month for which eligibility is being determined, **and**
- the cost of coverage for the employee-only plan does not exceed 9.5% of the monthly household income.

When an employed parent or caretaker has been determined to have current access, the individual's spouse will also be considered to have current access if the employer offers a plan that provides coverage to the spouse, such as employee + spouse or employee + family coverage.

Non-pregnant, non-disabled parents and caretaker relatives with household income above 150% of the FPL will not be eligible for BadgerCare Plus benefits if they have current access or will have access in the next three months to a State Employee's health care plan, regardless of the amount of the premium. Non-pregnant, non-disabled parents and caretaker relatives with access to state employee health insurance, who have income between 133% and 150% FPL, are only ineligible for BadgerCare Plus if the employee-only premiums are not more than 9.5% of household income.

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

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7.4 CURRENT HEALTH INSURANCE COVERAGE

7.4.1 Introduction
7.4.2 The 80% Coverage Test
7.4.3 The 9.5% Current Coverage Test
7.4.4 Current Coverage for BC+ Prenatal Program

7.4.1 Introduction

Beginning July 1, 2012, there are two Current Coverage policies in effect:

- The 80% Current Coverage Test.
- The 9.5% Current Coverage Test.

The 80% Current Access Test policies applies to non-exempt children (See 7.1). The 9.5% test applies to adult parents and caretakers until March 31, 2014.

7.4.2 The 80% Coverage Test

Certain children who currently have individual or family health insurance coverage through an employed family member currently living in the household AND who meets the following criteria are not eligible for BadgerCare Plus:

1. The child is not exempt from access and coverage policies (See 7.1); 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).

Example 1: 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. His children are not eligible for BC+ because they are currently covered. Dave is not eligible because his income is over the income limit for the parent and caretaker coverage group.

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

7.4.3 The 9.5% Current Coverage Test

Note: This policy will only be effective until March 31, 2014.

For parents and caretakers who are not exempt (See 7.1), an individual with current coverage to employer sponsored health insurance is not eligible for BadgerCare Plus.

An individual has current coverage to employer sponsored insurance if:

- The individual is covered under the plan in the month for which eligibility is being determined, **and**
- The cost of coverage for the employee-only plan does not exceed 9.5% of the monthly household income,

or

- Household income is above 150% of the FPL and the coverage is under a State Employee's health care plan, regardless of the amount of the premium.

Note: Non-pregnant, non-disabled parents and caretaker relatives with state employee health insurance coverage, who have household income between 133% and 150% FPL, are only ineligible for BadgerCare Plus if the employee-only premiums are not more than 9.5% of household income.

7.4.4 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 they are 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

7.5.1 Introduction
7.5.2 The 80% Dropped Coverage Test
7.5.3 The 9.5% Dropped Coverage Test
7.5.4 Dropped coverage policy for BadgerCare Plus Prenatal Program

7.5.1 Introduction

Beginning July 1, 2012, there are two Dropped Health Insurance Coverage policies in effect:

- The 80% Dropped Coverage Test.
- The 9.5% Dropped Coverage Test.

The 80% Dropped Coverage policies will continue to apply to non-exempt children (See 7.1). The 9.5% Dropped Coverage Test applies to non-pregnant, non-disabled adult parents and caretakers until March 31, 2014.

7.5.2 The 80% Dropped Coverage Test

Children 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:

1. The employer paid 80% or more of the premium or the insurance was part of the Wisconsin state employees' health insurance plan; and,
2. The *applicant*/member is child under age 19 and the child is not exempt; **and**
3. The individual did not have *good cause* for dropping the coverage (See 7.6).

Example 1: Joanne is employed and has access to employer sponsored health insurance in which the employer pays 80% of the premium. The children are not exempt from the health insurance access and coverage tests. In May 2013, she dropped their family health insurance coverage through her employer. In June, Joanne applies for BC+ for herself and her family. Because Joanne dropped her health insurance in which the employer pays at least 80% of the family plan premium, her children are not eligible for BC+ for 3 months after the coverage ended.

Example 2: Joanne was employed and had family coverage under employer sponsored health insurance in which the employer paid 80% of the premium. The children are not exempt from the health insurance access and coverage tests. In May 2013, 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 family plan premium, and she voluntarily quit her job, her children are not eligible for BC+ in June, July and August because Joanne 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.

7.5.3 The 9.5% Dropped Coverage Test

Note: The 9.5% Dropped Coverage Test will no longer be in effect beginning April 1.

Parents and caretakers are ineligible for BadgerCare Plus (BC+) benefits for three calendar months following the month in which coverage through an employer-sponsored health insurance plan, which meets the standards of a HIPAA standard plan, ended if:

1. The cost of premiums for the health plan was less than 9.5% of their countable household income, or if the individual was covered by a Wisconsin state employee's health insurance plan, regardless of the cost of the premiums, and their income is at least 150 % of the FPL, and
2. The person is not exempt from access and coverage policies (See 7.1), **and**
3. The individual did not have good cause for dropping the coverage (See 7.6).

Note: Non-pregnant, non-disabled parents and caretaker relatives with state employee health insurance coverage, who have household income between 133% and 150% FPL, are only ineligible for BadgerCare Plus if the employee-only premiums were not more than 9.5% of household income.

Example 1: Joanne is employed and has access to employer-sponsored health insurance through which her premiums are less than 9.5% of her income for her health insurance. Joanne's family income is 160% of the federal poverty level. In July, Joanne voluntarily quit her job. In August, Joanne applies for BC+. Since Joanne had health insurance coverage that met the access requirements for herself and she voluntarily quit her job, Joanne is not eligible for BC+ in August, September and October.

7.5.4 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,
- 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 BC+ Prenatal Program applicants or members 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)

7.7.1 Introduction
7.7.2 Cost Effectiveness
7.7.3 Participation in HIPP
7.7.4 Cooperation

7.7.1 Introduction

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 BadgerCare Plus members when it is cost effective to do so.

In addition to families with employer sponsored health insurance plans, the following BC+ families 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.

7.7.2 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+.

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.

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+.

7.7.3 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 that BC+ covers, BC+ will cover the cost.

7.7.4 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.

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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7.8 ACCESS/COVERAGE OVERVIEW

7.8.1 Access/Coverage Overview prior to January 1, 2014
7.8.2 Access/Coverage Overview for new applicants on or after February 1, 2014
7.8.3 BC+ Prenatal Program Access/Coverage Overview

These overviews are intended to be a guide to help determine whether a BC+ member or *applicant* is subject to the BC+ insurance access/coverage requirements.

7.8.1 Access/Coverage Overview Prior to January 31, 2014

To determine whether an individual passes BC+ insurance access/coverage requirements through December 31, 2013, answer the following questions for each individual within a BC+ group.

1. Is the applicant /member pregnant, disabled, 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. Is the member in a BadgerCare Plus Extension?

    - If yes, the applicant/member is not subject to the access/coverage requirements.
    - If no, continue to question #4.

4. Is the applicant/member either:
    a. An infant under age 1 with household income at or below 300% FPL,
    b. A child age 1 through 5 with household income at or below 185% FPL, or
    c. A child age 6 through 18 with household income at or below 150% FPL?
    - If yes, the applicant/member is not subject to the access/coverage requirements.
    - If no, continue to question #5.

5. Is this member a child under age 19?

- If yes, continue to question #6.
- If no, continue to question #20.

6. 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 #7.
   - If no, continue to question #10.

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

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

8. 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 #9.
   - If no, continue to question #10.

9. 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 #10.

10. 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 #11.
    - If no, continue to question #14.

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

    - If yes, continue to question #13.
    - If no, continue to question #12.

12. 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 #13.
    - If no, continue to question #14.

13. 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 (See 7.2.1)?

    - If yes, continue to question #14.
    - If no, the applicant is ineligible for BC+ for 12 months from the date the coverage would have begun, unless s/he becomes exempt from health insurance/access coverage requirements during that time.

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

    - If yes, continue to question #15.
    - If no, the applicant/member passes the BC+ insurance/access coverage requirements.

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

    - If yes, continue to question #17.
    - If no, continue to question #16.

16. 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 #17.
    - If no, the applicant/member passes the BC+ insurance access/coverage requirements.

17. Did the applicant/member have "good cause" for dropping the health insurance (See 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.

18. Is this member's income greater than 133% of the FPL?

    - If yes, continue to question #19.
    - If no, the applicant/member is not subject to the access/coverage requirements.

19. 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 #20.
    - If no, continue to question #24.

20. Is the cost of the premium for an employee-only plan offered by the employer more than 9.5% of the household income in the month for which you are determining eligibility?

    - If yes, continue to question #21.
    - If no, continue to question #23.

21. Is the employer provided insurance the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government) and is household income over 150% of the FPL?

    - If yes, continue to question #22.
    - If no, continue to question #24.

22. 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 #24.

23. Would the coverage begin in any of the months for which you are determining eligibility and are those months immediately following:
    a. The BC+ application *filing date*; or
    b. The annual review; or
    c. The employment start date?
    - If yes, the applicant is not eligible for BC+ benefits.
    - If no, continue to question #24.

24. 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 #25.
    - If no, continue to question #28.

25. Was the cost of the premium for an employee-only plan offered by the employer more than 9.5% of the household income in the month for which you are determining eligibility?

    - If yes, continue to question #26.
    - If no, continue to question #27.

26. Was the employer provided insurance under the WI State employee health plan (regardless of plan type, or premium amount contributed by state or local government) and is the household income over 150% of the FPL?

    - If yes, continue to question #27.
    - If no, continue to question #28.

27. 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 (See 7.2.1)?

    - If yes, continue to question #28.
    - 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.

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

- If yes, continue to question #29.
- If no, the applicant/member passes the BC+ insurance/access coverage requirements.

29. Was the cost of the premium for an employee-only plan offered by the employer more than 9.5% of the household income in the month for which you are determining eligibility?

    - If yes, continue to question #30.
    - If no, continue to question #31.

30. 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) and is the household income over 150% of the FPL?

    - If yes, continue to question #31.
    - If no, the applicant/member passes the BC+ insurance access/coverage requirements.

31. Did the applicant/member have "good cause" for dropping the health insurance (See 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.

7.8.2 Access/Coverage Overview for new applicants on or after February 1, 2014

To determine whether an individual passes BC+ insurance access/coverage requirements beginning January 1, 2014, answer the following questions for each individual within a BC+ group.

1. Is the applicant /member pregnant, disabled, 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. Is the member in a BadgerCare Plus Extension?

    - If yes, the applicant/member is not subject to the access/coverage requirements.
    - If no, continue to question #4.

4. Is the applicant/member either:
    a. An infant under age 1 with household income at or below 300% FPL,
    b. A child age 1 through 5 with household income at or below 185% FPL, or
    c. A child age 6 through 18 with household income at or below 150% FPL?
    - If yes, the applicant/member is not subject to the access/coverage requirements.
    - If no, continue to question #5.

5. Is this member a child under age 19?

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

6. Does the employer pay 80% or more of the premium?
    - If yes, continue to question #8.
    - If no, continue to question # 7.

7. 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 #8.
    - If no, continue to question #9.

8. 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 #9.

9. 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 #10.
    - If no, continue to question #13.

10. Would the employer have paid 80% or more of the premium (at any time in the last 12 months)?
    - If yes, continue to question #12.
    - If no, continue to question #11.

11. 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 #12.
    - If no, continue to question #13.

12. 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 (See 7.2.1)?
    - If yes, continue to question #13.
    - If no, the applicant is ineligible for BC+ for 12 months from the date the coverage would have begun, unless s/he becomes exempt from health insurance/access coverage requirements during that time.

13. Did the applicant/member lose employer provided health insurance coverage provided through an employer or an employer of an adult BC+ test group member in the three calendar months prior to the application?
    - If yes, continue to question #14.
    - If no, the applicant/member is not subject to the BC+ insurance/access coverage requirements.

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

    - If yes, continue to question #16.
    - If no, continue to question #15.

15. 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 #16.
    - If no, the applicant/member passes the BC+ insurance access/coverage requirements.

16. Did the applicant/member have "good cause" for dropping the health insurance (See 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.

7.8.3 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 HIPAA 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 HIPAA 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 HIPAA 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 CONTINUOUSLY ELIGIBLE NEWBORNS

8.1 PREGNANT WOMEN

Note: This chapter does not apply to pregnant women in the BC+ Prenatal Program.

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 to 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, regardless of changes in income or other eligibility factors. As of April 1, 2014, every pregnant woman in BC+ will be enrolled in the Standard Plan, including someone who has become eligible by meeting a deductible. After February 1, 2014 pregnant women will be enrolled in the Standard Plan once she has been found eligible for Badgercare Plus. Pregnant women who are enrolled in the Benchmark Plan prior to

February 1, 2014 will transition to the Standard Plan on April 1, 2014 if they are still in their certification period.

A pregnant woman with income over 300% FPL (under *non-MAGI* rules) or 306% FPL (under *MAGI* rules) at the time of application can become eligible for BC+ by meeting a *deductible*. (See section 17.2)

There are no premiums for pregnant women. (See section 19.1)

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 months prior to the month of application.

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8.2 CONTINUOUSLY ELIGIBLE NEWBORNS (CENS)

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

Note: Children born to incarcerated mothers will not be eligible as a CEN. In addition, children born to pregnant minors with family income over 300% FPL who were eligible for BC+ are not eligible as CENs. This policy only applies through March 31, 2014 because children will no longer be eligible above 300% FPL as of April 1, 2014. 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: Sasha. gave birth on April 15. On June 15 she applied for BC+. Her

eligibility was backdated to March 15. Her infant son is eligible as a CEN 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 as a CEN if the mother's BC+ enrollment is a temporary enrollment through the Express Enrollment program.

A newborn is not 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.

Through March 31, 2014, 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. Effective April 1, 2014, all infants eligible for BadgerCare Plus as a CEN will be covered under the Standard Plan. If the child is enrolled in BadgerCare Plus on or after February 1, 2014, the child will be covered under the Standard Plan upon enrollment. If the child is covered by the Benchmark plan prior to February 1, 2014, the child will transition to the Standard plan effective April 1, 2014.

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 requirements.

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 (9.10) items must be verified at *application* , renewal, 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* or from the date the local agency receives the application from the *Federally Facilitated Marketplace*. 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:

- 10th day after requesting verification, or
- 30th 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 RENEWALS

The group's eligibility should not be denied for failure to provide the required verification until the 10th day after requesting verification or the end of the renewal month whichever is later.

Example 1: Fred's eligibility renewal is due in April. He submits a mail-in renewal

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 renewal 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 renewal. 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 10th, her eligibility beginning July 1st was denied.

Note: After an individual transitions to MAGI rules, requested verification turned in within 90 days of the renewal due date should be processed as timely. See Process Help 4.6.

his page last updated in Release Number: 13-02
Release Date: 10/25/13
Effective Date: 10/01/13

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.

This page last updated in Release Number: 07-01
Release Date: 10/29/07
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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, benefit level, and coverage group 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.

This page last updated in Release Number: 13-02
Release Date: 10/25/13
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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.

This page last updated in Release Number: 07-01
Release Date: 10/29/07

Effective Date: 02/01/08

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.

This page last updated in Release Number: 07-01
Release Date: 10/29/07
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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-Sponsored Health Insurance
9.9.6.1 Employer Verification of Health Insurance (EVHI) database
9.9.6.2 Other Forms of Health Insurance Access Verification
9.9.7 Tribal Membership
9.9.8 Pre-Tax Deductions
9.9.9 MAGI Tax Deductions

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)

   Note: Effective January 1, 2014, pregnancy is no longer required to be verified.

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 (9.9.6)
10. Health Insurance Coverage (Chapter 7)
11. Family Re-unification plan for Child Welfare Parents (Chapter 10)
12. The placement status of a FFCY (Chapter 11) on his/her 18th birthday
13. Tribal membership or Native American Descent (9.9.7)
14. Pre-tax Deductions* (9.9.8)
15. MAGI Tax Deductions* (9.9.9)

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

*These mandatory verification requirements apply only to whose members eligibility is determined under MAGI rules.

9.9.1 Social Security Number

Social Security Numbers (SSNs) need to be furnished for household members requesting BC+ unless they are exempt from the SSN requirement (see 6.1). SSNs are

not required from non-applicants, including outside of the home tax dependents and co-filers.

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 renewal, 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

Verification of pregnancy is only required until December 31, 2013. Beginning January 1, 2014, verification is no longer required for pregnancy unless the worker has information that contradicts the applicant or member's statement.

Through December 31, 2013, if a woman wants to be considered pregnant for the BC+ pregnant women group or the 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.

When pregnancy must be verified, acceptable 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:

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

5. A valid BC+ Temporary Enrollment card.

Note: After January 2014, if pregnancy must be verified, the IM worker will no longer be able to use a BC+ Temporary Enrollment card as a source of verification, as pregnancy will not be verified for Temporary Enrollment for Pregnant Women.

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-Sponsored 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 Renewal.
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 household income to exceed the following FPL thresholds:
    - Infants less than 1 year old, 300% of the FPL,
    1.
    - Children ages 1 through 5 (up to age 6), 185% of the FPL,
    - Children ages 6 to 18, 150% of the FPL,
    - Parents and caretakers, 133% of the FPL, **and**
    - Parents and caretakers with access to a Wisconsin state employee's health insurance plan, 150 % of the FPL

Note: Because of changes in income limits, the reporting requirements listed above for parents and caretakers are only effective until March 31, 2014.

Note: Verification of access to insurance when parents' and caretakers' household income exceeds 133% is applied beginning July 1, 2012, when one of the following occurs:

- A new application or program request is submitted,
- New employment is reported,
- The next review/renewal is completed, or
- A parent or caretaker with employment is added to the 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

9.9.7 Tribal Membership

Tribal members are exempt from paying BC+ premiums and may be exempt for certain benefit co-payments. Effective January 1, 2014, tribal members eligible for BC+ will also be exempt from co-pays.

To receive these exemptions, verification of tribal membership or descent from a tribal member is required. Verification may be done with a:

- Tribal Enrollment Card
- Written verification or a document issued by the tribe indicating tribal affiliation
- Certificate of degree of Indian blood issue by BIA
- Tribal census document
- Medical record card or similar documentation that specifies an individual is an Indian that is issued by an Indian Health Care provider.

9.9.8 Pre-Tax Deductions

Individuals whose eligibility is determined using MAGI rules can claim pre-tax deductions in order to determine their MAGI taxable income. In order to claim a pre-tax deduction, verification of the amount is required. Verification sources such as pay stubs or other documentation from the individual's employer can serve as acceptable documentation. See 16.3.2 for list of pre-tax deductions.

9.9.9 MAGI Tax Deductions

Individuals whose eligibility is determined using *MAGI* rules can claim certain tax deductions from the IRS 1040 Form, regardless of whether or not the individual files taxes. Individuals who claim such deductions must provide proof that the expense is or was incurred. See 16.3.3 for a list of tax deductions.

Forms of verification for MAGI tax deductions could include:

- receipts,
- bank statements,

- check stubs, or
- previous years' tax forms.

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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. The information provided is unclear or vague.

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
9.11.2 Positive Actions

9.11.3 Delay
9.11.4 Negative Actions

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. The member/*applicant* 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 living with them at the time the child welfare agency removed the child and placed him/her in:

    a. Foster care, (both IV-E and non IV-E).
    b. Court Ordered Kinship Care.
    c. Other living arrangement.
    Note: If child welfare is involved and the child welfare agency has established a permanency plan for the child under authority of *ss.* 48.38 or 938.38 of the statutes, other living arrangements for the children meet this criteria. For example, a child may be placed with grandparents who are not eligible for Kinship Care or a child may be placed with the other parent.

2. The parent/*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.

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.

The parents/caretaker relative who meet the above requirements are considered caring for a child who has been temporarily removed from the home. The parent/caretaker relative did not have to be enrolled in BadgerCare Plus at the time of removal, but the child did have to live with the parent/caretaker. 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 under *non-MAGI* rules.
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.

The parents/caretaker relative who meet the above requirements are considered caring for a child who is temporarily absent. The parent/caretaker relative did not have to be enrolled in BC+ at the time of removal, but the child did have to live with the parent/caretaker. The parent will continue to be considered a parent or caretaker for purposes of BC+ eligibility under *MAGI* rules. However, the child may not always be included in the parent's MAGI group. Please refer to Chapter 2 on the MAGI methodology.

If the Child Welfare System places a child with a Kinship Care relative, the Kinship Care relative is no longer considered as a caretaker relative. Instead, he or she may qualify for BC+ as a childless adult.

Example 1: Stacy's child, Jared, was placed in Kinship Care with Stacy's mom, Laura (55). Stacy files taxes but will not be claiming Jared as her tax dependent. Laura will claim Jared as her tax dependent. There are no other children, tax filers, or tax dependents in either Stacy's or Laura's households. Assuming they meet all financial and non-financial requirements, Stacy will be eligible for BC+ as a parent with a group size of 1 and Laura as a childless adult with a group size of 2.

Example 2: Ben's daughter, Megan, was placed in Kinship Care with her grandfather, James

(60). Ben does not file taxes. James does file taxes and will claim Megan as his dependent that year. There are no other children, tax filers, or tax dependents in either Ben's or James's households. Assuming they meet all financial and non-financial requirements, Ben will be eligible for BC+ as a parent with a group size of 2 and James as a childless adult with a group size of 2.

Example 3: Same as example 2, except James is 66. Under this example, James would not be eligible for BC+ because he is a childless adult over age 65. He may be eligible for EBD Medicaid.

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11 FORMER FOSTER CARE YOUTH

11.1 OUT OF HOME CARE (I.E., FOSTER CARE) AND FORMER FOSTER CARE YOUTH (FFCY)

BadgerCare Plus Benefits are available for all youths placed in:

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

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

IM agencies must develop a procedure with their local Child Welfare agencies to ensure that whenever a child is losing Foster Care MA eligibility, a separate re-determination of MA eligibility is completed by the IM agency before Foster Care MA is terminated. The only exception to this requirement is when a child dies or leaves Wisconsin.

As part of the plan, it is expected that the Child Welfare agency will extend MA eligibility, using the Foster Care medical status code, until a re-determination of MA eligibility is done by the IM agency. A formal communication process must be established to assure

IM agencies are made aware of all children leaving the Foster Care system, and provided with information necessary to re-determine eligibility.

If the IM agency does not have sufficient information to re-determine MA eligibility, the agency must request needed information from the individual or family. If the individual or family does not comply with a request for information after 30 days, MA can be terminated with *adverse action* notice, since the family has a responsibility to cooperate during a re-determination.

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11.2 FORMER FOSTER CARE YOUTH

Until December 31, 2013 the age limit for the FFCY coverage group is 21 years. Effective January 1, 2014, the age limit is 26 years.

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 is:
    - Under age 21 prior to December 31, 2013, OR
    - Under age 26 on or after January 1, 2014.
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 requi(rements
    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 policies and they are not required to pay any premiums for themselves. Regardless of income, they are eligible for the BC+ Standard Plan unless they are found otherwise ineligible or until the end of the month in which they:

- Turn age 21 (prior to December 31, 2013),

  OR

- Turn age 26 (on or after January 1, 2014)

A 12 month recertification renewal 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+ use the appropriate rules as outlined in Chapter 2, depending on whether budgeting using *non-MAGI* rules or *MAGI* rules.

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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 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 renewal 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 come 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 Renewal dates for simplified application

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

See example 1 above. The renewal 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.

Renewal dates for regular applications

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

12.4.1 Renewals

Offer the following three renewal choices for migrant families:

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

See Chapter 26 for information on renewals.

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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

16.1.1 Income Limits
16.1.2 Income under non-MAGI Rules
16.1.3 Income under MAGI Rules

16.1.1 Income Limits

Population	Income Limit for Existing members through March 31, 2014	Income Limit for New Applications as of February 1, 2014	Income Limits for all Members effective April 1, 2014
Pregnant Women	300% FPL* (*non-MAGI* rules)	306% FPL (*MAGI* rules)	300% FPL (*non-MAGI* rules) 306% FPL (*MAGI* rules)
Children under 19*	No Limit	No Limit	300% FPL (*non-MAGI* rules) 306% FPL (*MAGI* rules)
Parents/Caretaker Relatives	200% FPL	100% FPL	100% FPL
Childless Adults	200% FPL	N/A	100% FPL
Family Planning Only Services	300% FPL (*non-MAGI* rules)	306% FPL (*MAGI* rules)	300% FPL (*non-MAGI* rules) 306% FPL (*MAGI* rules)

*Children and pregnant women with income above the limit can become eligible by meeting a deductible.

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

The income limits under MAGI rules listed above include the following income disregards.

- Children, pregnant women and individuals eligible under Family Planning Only Services will be allowed an income disregard equal to 5% of the FPL in addition to a conversion factor adjustment equal to 1% of the FPL. While the income limit remains 300% FPL, CWW will actually test against an income limit of 306% FPL once the income disregard and conversion factor are included.
- Parents, caretakers and childless adults already have the income disregard included in the income limit of 100% FPL. CWW will test against an income limit of 100% FPL.

Note: Other effective income limits for children under *MAGI* rules will also reflect the addition of the 6% disregard with the exception that the income thresholds for children's premiums will only be increased by 1%.

16.1.2 Income under non-MAGI Rules

In general, all available gross income is counted when determining BC+ eligibility under non-MAGI rules for existing BC+ members with a filing date prior to February 1, 2014. See unavailable income below for exceptions to this rule.

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.
   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.
All taxable income is counted when determining BC+ eligibility under *MAGI* rules. Social Security income is also counted under MAGI rules. See 16.2 for the list of income that is not counted. These rules apply to families that are filing taxes and those who are not.

16.1.3 Income under MAGI Rules

All taxable income is counted when determining BC+ eligibility under MAGI rules. Social Security income is also counted under MAGI rules. See 16.2 for the list of income that is not counted. These rules apply to families that are filing taxes and those who are not.

Within a MAGI group, income will be counted as detailed in Chapter 2. For any member whose income is budgeted for their assistance group, income under the countable income types listed in 16.4 and 16.5 will be counted and deductions under the types listed in 16.3 will be allowed. See Chapter 2 for determining the assistance group size.

All MAGI group members' income is counted with one exception: If a group member is the child or tax dependent of another group member, his or her income is only counted if s/he is "expected to be required" to file a tax return for the current year. See section 2.8.2 for more information.

If a member's income is budgeted for his or her assistance group, his or her deductions will be counted for that group. In situations where an individual is planning to file a joint tax return with his or her spouse, the individual's deductions may offset the spouse's income even if the individual has no income.

Note: The availability of income does not affect whether or not the income is counted under MAGI rules.

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 Unemployment compensation benefits of $430. However, she declined a $100 increase offered by unemployment compensation, and the amount of her check remains at $430. Since the full entitlement amount is known, the available income is $530.

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16.2 INCOME TYPES NOT COUNTED

1. Adoption Assistance
2. Agent Orange Settlement Fund
3. Combat Pay
4. Other Military Pay
5. Crime Victim Restitution Program
6. Disaster and Emergency Assistance
7. Earned Income *(non-MAGI only)*
8. Foster Care
9. IDA
10. Jury Duty Payments *(non-MAGI only)*
11. Kinship Care
12. Life Insurance policy dividends
13. Nutrition Benefits
14. Payments to Native Americans
15. Payments to Nazi Victims
16. Radiation Exposure Compensation Act (PL 101-426)
17. Refugee Cash Assistance (RCA)
18. Refugee "Reception and Placement"
19. Reimbursements
20. Relocation Payments
21. Repayments
22. Special Programs
23. Spinal Bifida Child
24. Susan Walker Payments
25. Student Financial Aids
26. Stipends from the UW Upward Bound Program
27. Tax Refunds (Income and EITC)
28. Unpredictable Income
29. Veterans Benefits
30. Wartime Relocation of Citizens
31. Workforce Investment Act Unearned Income
32. W2 Payments
33. General Relief and Charity
34. SSI/Supplemental Security Income
35. Interest and Dividend income *(non-MAGI only)*
36. Lump Sum Payments *(non-MAGI only)*
37. Property Settlements

38. Subsidized Guardianship
39. The American Recovery and Reinvestment Act (ARRA) of 2009
40. Child Support

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. **Other Military Pay** Do not count income received for the following purposes:
   - Living allowances
     - Basic Allowance for Housing (BAH)
     - Basic Allowance for Subsistence (BAS)
     - Housing and cost-of-living allowances abroad paid by the U.S. Government or by a foreign government
     - Overseas Housing Allowance (OHA)
   - Death allowances

- Family allowances
- Moving allowances
- Travel allowances
- Professional education allowances
- ROTC educational and subsistence closure benefit allowances
- Uniform allowances

Note: Military pay can be verified using the Leave and Earnings Statement (LES) received by active duty personel.

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

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

7. **Earned Income** of individuals under 18 years of age.

   For cases under *non-MAGI* rules, disregard the income until the month following the month in which the person turns 18 years of age.

   For cases under *MAGI* rules, see section 2.8.2 about counting income.

8. **Foster Care**

9. **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.

10. **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.

    For cases under *non-MAGI* rules, count any portion of a jury payment that is over and above expenses as earned income for the month in which it is received.

    For cases under *MAGI* rules, count all jury duty payments as earned income for the month in which it is received if the payments are not turned over to the individual's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

11. **Kinship Care**

12. **Life Insurance policy dividends**.

13. **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.

14. **Payments to Native Americans from**:

    a. Distributions from Alaska Native Corporations and Settlement Trusts, including:

        - Menominee Indian Bond interest payments.
        - All judgment payments to tribes through the Indian Claims Commission or Court of Claims.
        - Payments under the Alaskan Native Claims Settlement Act.
        - Payments under the Maine Indian Claims Settlement Fund.
        - Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except under *non-MAGI*rules, individual shares over $2,000.
        - 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 under non-MAGI rules, individual shares over $2,000.

- 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.
- Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.
- Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.
- 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.
- Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan.
- Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, MN, reservations.
- Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.
- Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.
- Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000.

b. Other Exempt Tribal Payments

Disregard non-gaming tribal income from the following sources:

- Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from -
    - Rights of ownership or possession in any lands held in trust, subject to Federal restrictions, located within the most recent

boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; or
- Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

- Distributions resulting from real property ownership interests related to natural resources and improvements –
  - Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
  - Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

c. Payments to tribal members from gaming revenue:
- Under *non-MAGI* rules, 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.
- Under *MAGI* rules, all of the income form Tribal Per Capita payments from gaming revenue are counted income.

15. **Payments to Nazi Victims** made under PL 103-286 to victims of Nazi persecution.

16. **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.

17. **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.

18. **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.

19. **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.

20. **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.

21. **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.

22. **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. Under *non-MAGI* rules, income from Volunteers in Service to America (VISTA) is not counted. Under *MAGI* rules, earnings and cash benefits from VISTA are counted.
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.

23. **Spinal Bifida Child** (PL 104-204) payments to any child of a Vietnam veteran for any disability resulting from the child's spinal bifida.

24. **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.

25. **Student Financial Aids**

Under non-MAGI Rules, student financial aids are not counted as income 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 as earned income. 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.

Under MAGI Rules, work study income and any income from an internship or assistantship should be counted as earned income. Grants, scholarships, fellowships and any additional financial assistance provided by public or private organizations that exceed the cost of tuition, books and mandatory fees are counted as unearned income and should be pro-rated over the period of time they are intended to cover. Student loans are not counted as income irrespective of what the loan is used to pay for.

Example: Mary was awarded a scholarship for $3,500 in July that is intended to cover her fall semester (September through December). Her tuition and course related expenses are $3,250 for the semester. The $250 that exceeds the amount of tuition and course-related expenses will be pro-rated over the four month period from September through December at $62.50 in unearned income each month ($250/4 months = $62.50/month).

Types of grants, scholarships and fellowships counted as income include:

- Pell Grants,

- Robert Byrd Honors scholarships,
- Any grants, scholarships or fellowships received from the college or university as part of a financial aid package,
- Any grants, scholarships or fellowships provided by public or private organizations.

The following educational aid types are not counted as income:

- Loans, including Stafford Loans and Perkins Loans,
- AmeriCorps or HealthCorps grant,
- Bureau of Indian Affairs grant,
- GI Bill / Veterans benefits,
- ROTC benefits.

Note: These income types will not be considered when determining if grants, scholarships and fellowships exceed the cost of tuition, books and mandatory feeds.

The following expense types will be used to offset income from grants, scholarships, fellowships and other financial aid:

- Tuition,
- Required books, supplies or equipment,
- Mandatory fees

The following expense types will not be allowed to offset income from grants, scholarships or other financial aid:

- Room,
- Board (meals or meal plans),
- Personal expenses,
- Transportation and parking,
- Loan fees,
- Health insurance costs.

26. **Stipends from the UW Upward Bound Program** paid to high school students to encourage low income students to further their education.

27. **Tax Refunds (Income and EITC)**

28. **Unpredictable Income** which is unpredictable, irregular, and has no appreciable effect on ongoing need.

29. **Veterans Benefits**

Under *non-MAGI* rules, count veterans benefits as unearned income. Do not count 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.

Under *MAGI* rules, do not count any veterans' benefits paid under any law, regulation, or administrative practice administered by the Department of Veterans Affairs (VA). The following amounts paid to veterans or their families are not countable.

- Education, training, and subsistence allowances. (i.e., GI Bill benefits)
- Disability compensation and pension payments for disabilities paid either to veterans or their families.
- Grants for homes designed for wheelchair living.
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs.
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.
- Interest on insurance dividends left on deposit with the VA.
- Benefits under a dependent care assistance program.
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.
- Payments made under the compensated work therapy program.
- Any bonus payment by a state or political subdivision because of service in a combat zone.

Do not count 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.

30. **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.

31. **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).

32. **W2 Payments** for W-2 Transition (W-2 T), Custodial Parent of an Infant (CMC), At Risk Pregnancy (ARP), and Community Service Jobs (CSJ). Do not disregard payments for Trial Employment Match Program or Transform Milwaukee Jobs.

33. **General Relief and Charity**

34. 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

35. **Interest and Dividend Income**

Under *non-MAGI* rules, interest and dividend income is not counted income for BC+.

Under *MAGI* rules, interest and dividend income is counted as unearned income.

36. **Lump Sums Payments**

Under *non-MAGI* rules, 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.

Under *MAGI* rules, count lump sum payments (if the payment is otherwise a countable income type) in the month received.

37. **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.

38. **Subsidized Guardianship Payments**

Subsidized guardianship payments are not counted for BadgerCare Plus (BC+).

39. **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).

40. **Child Support**

Under *non-MAGI* rules, count child support income as unearned income.

Under *MAGI* rules, do not count child support income. If a household is receiving family support, divide the payment by the number of members in the household. The amount of the payment allocated to the child(ren) is considered child support and is disregarded. Count the amount of the payment allocated to the adult(s) as alimony/spousal support. See Process Help 62.2.6.

Example: Morgan receives $500.00/month in family support for herself and her three children, Kyra (age 15), Kevin (age 9), and Katie (age 7). $500/4 people = $125/person. Disregard the amount allocated to the children ($125 x 3 children = $375). Count $125/month as income for Morgan.

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16.3 INCOME DEDUCTIONS

16.3.1 Support Payments

Under *non-MAGI* rules, 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. Under *MAGI* rules, child support payments will not be allowed as an income deduction.

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.

16.3.2 Pre-Tax Deductions

Under MAGI rules, pre-tax deductions will be allowed if the payments are taken out of the individual's paycheck on a pre-tax basis. Examples include but are not limited to:

1. Health Insurance premium payments, including pre-tax premium payments for medical, dental or vision plans
2. Health Savings Account (including flexible spending accounts) contributions
3. Retirement contributions
4. Parking & Transit costs
5. Child Care Savings Account contributions
6. Group Life Insurance premium payments

16.3.3 Tax Deductions

Under MAGI rules, monthly expenses related to the following tax deductions from page one of the IRS Form 1040 will be allowed as income deductions for the current year, even if the individual does not plan on filing taxes. If the expense is not incurred on a monthly basis, it will be prorated and counted as a monthly expense.

Most of these deductions are not common, and they do not include itemized tax deductions, like charitable contributions or mortgage interest.

In addition, a few deductions have caps, as noted in detail below. If an individual reports and verifies a monthly expense that is more than the monthly cap, the deduction will be the amount of the cap.

1. **Student Loan Interest**
   Interest on a loan taken to pay for school expenses for the following persons at the time the loan was taken out:

   - His or her spouse;
   - His or her child under age 19; or
   - His or her child under age 24 who was a student, lived with the individual for more than half a year, did not provide more than half of his or her own support for that year, and did not earn more than $3,900 during that year.

   Do not count interest on a loan used for anything besides paying for education or if a relative or employer gave the loan.

   This deduction is capped at a monthly amount of $208.

2. **Higher Education Expenses** Includes tuition and amounts paid for books or fees, but only if those amounts are required to be paid to the institution as a condition of enrollment or attendance. This deduction may not be claimed for expenses that were paid with tax-free educational assistance. Grants and scholarships used for tuition and fees are generally non-taxable, therefore this deduction cannot be claimed for the portion of tuition and fees that were paid for with grants and scholarships. This is capped at a monthly amount of $333.

3. **Self-employment Tax Deduction** Applies to individuals who are self-employed, who owe self-employment tax, and who are able to deduct a portion of the self-employment tax they pay. Only deduct the portion that the person can deduct on their tax return (as calculated on Schedule SE), not the entire amount of self-employment tax that is paid.

4. **Spousal Support, Alimony or Maintenance** The amount paid for court ordered spousal support, alimony or maintenance or payments under Section 73 for a current or prior spouse as a result of a legal separation or divorce. Do not deduct more than the court ordered amount.

5. **Teachers' Tax-Deductible Expenses** Applies to K-12 teachers who have up to $250 in out-of-pocket work expenses (expenses not paid for by the employer). This is capped at a monthly amount of $21.

6. **Self-employed SEP, Simple or Qualified Plan Contributions**
   Examples of these plans include:
   - Simplified Employee Pension (SEP) Plan

- Savings Incentive Match Plan For Employees (SIMPLE)
- Qualified Plan Contributions

7. **Penalties for Early Withdrawal of Funds** Penalties to a bank or financial institution for withdrawing funds early from a savings account where money must be left in the account for a fixed period of time, such as a time saving account, certificate of deposit (CD) or an annunity.

8. **Performing Artists Tax-deductible Expenses** Applies to performing artists who have out-of-pocket business expenses not paid by the employer and meet the following criteria:
   - Worked for at least two employers who each paid at least $200;
   - Did not earn more than $16,000 for his or her work in the current year; and
   - Out-of-pocket expenses were more than 10% of his or her earnings.
9. **Military Reserve Members' Tax-deductible Expenses** Applies to travel expenses for members of the Armed Forces Reserve who travel more than 100 miles away from home to perform work for the Armed Forces Reserve.

10. **Out-of-pocket Costs for a Job-related Move** Applies to individuals who paid out-of-pocket expenses for a job-related move and meets the following criteria:
    - The move must be for a job-related reason, such as starting a new job, and
    - The new job must be at least 50 miles farther from the individual's old home than the old home was from the individual's old job or must be at least 50 miles from the old home if the individual did not have a job before.

11. **Loss from Sale of Business Property** Applies to self-employed individuals that had a loss from the sale or exchange of property that they owned for their business.

12. **Individual Retirement Account (IRA) Contributions** Applies to individuals who had income from a job and made contributions to an individual retirement account (IRA). Also applies to self-employed individuals who made contributions to an IRA they set up themselves.

13. **Fee-based Official Tax-deductible Expenses** Applies to individuals who are fee-based officials and have out-of-pocket business expenses. Examples of fee-based officials include chaplains, county commissioners, judges, justices of the peace, sheriffs, constables, registrars of deeds or building inspectors.

14. **Domestic Production Activities Deduction** Applies to self-employed individuals who led the production of things like property, electricity, natural gas, or potable water, as long as these things were produced in the United States. This also applies to individuals who invented or created software, recordings, or films in the United States.

Note: This deduction is not common.

15. **Allowable Write-in Expenses** These deductions include:
    - Contributions to Archer MSAs
    - Deductions attributable to rents and royalties
    - Certain deductions of life tenants and income beneficiaries of property
    - Jury duty pay given to the employer because the juror was paid a salary during duty
    - Reforestation expenses
    - Costs involving discrimination suits
    - Attorney fees relating to awards to whistleblowers
    - Contributions to section 501(c)(18)(D) pension plans.
    - Contributions by certain chaplains to section 403(b) plans

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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
16.4.3.3 Losses Offsetting Other Income (MAGI Rules Only)
16.4.4 Verification
16.4.4.1 Self-Employment Hours

Earned income is income from gainful employment.

Under *non-MAGI* rules, earned income for individuals under 18 years of age is not counted. The gross earned income before any deductions are taken out is counted.

Under *MAGI* rules, earned income after pre-tax deductions will be counted. See 16.3.2 for more information on pre-tax deductions.

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**
   Under *non-MAGI* rules, count Worker's Compensation as earned income.

Under *MAGI* rules, do not count Worker's Compensation as earned income.

16.4.1 Specially Treated Wages

1. **Income Received by Members of a Religious Order**
   Under *non-MAGI* rules, 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. 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.

   Under *MAGI* rules,if a person is a member of a religious order and has taken a vow of poverty, do not count any compensation that a member of a religious order receives if the compensation is turned back over to the order.

2. **Housing Allowances for Members of the Clergy**
   Under MAGI rules, do not count any housing or housing utility allowances that are received as compensation for services as an ordained, licensed, or commissioned minister as income.
3. **Jury Duty Payments**

   Under *non-MAGI* rules, count any portion of a jury payment that is over and above expenses as earned income.

   Under *MAGI* rules, count all jury duty payments as earned income for the month in which it is received if the payments are not turned over to the individual's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

4. **AmeriCorps**

   Under *non-MAGI* rules, disregard any benefit whether cash or in-kind, including but not limited to living allowance payments, stipends, food and shelter, clothing allowance, and educational awards or payments in lieu of educational awards. 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.

Under *MAGI* rules, earnings or cash benefits received through AmeriCorps, including VISTA, will be counted as earned income. Educational awards received from AmeriCorps are not counted as income.

5. **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

Under *non-MAGI* rules, 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.

Under *MAGI* rules, these deductions are no longer used if this income is reported as room and board income. If room and board income is reported as self-employment income, see section 16.4.3 for more information on counting self-employment income.

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.

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. Under *non-MAGI*

rules, personal capital gains are not counted as income. Under *MAGI* rules, personal capital gains and ordinary gains or losses are counted as income. See section 16.5 for more information.

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. See section 16.5 for more information on counting royalty income.

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, F-16037 and F-16037A).

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. Under *non-MAGI* rules, losses from self-employment can't be used to offset other earned or unearned income. Under *MAGI* rules, losses from self-employment can be used to offset other income types.

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, under *non-MAGI* rules, some specific expenses allowed in the calculation of Self Employment Income on the IRS tax forms but are not allowed for BadgerCare Plus. Under *MAGI* rules, countable self-employment income will be the same as the net self-employment taxable income.

Depreciation and Depletion

Through March 31, 2014, depreciation expenses will continue to be handled using the follow process for applicants tested under non-MAGI rules:

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)

Effective February 1, 2014 for new BC+ applicants and effective April 1, 2014 for existing BC+ members, depreciation and depletion expenses will be allowable expenses.

Under *non-MAGI* rules the following expenses are not allowed for BadgerCare Plus:

1. Net loss carryover from previous periods (long term capital loss)
2. Federal, State, and local income taxes
3. Charitable donations
4. Work-related personal expenses, such as transportation to and from work
5. 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).
6. 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.
7. Guaranteed payments to partners

Under *MAGI* rules, the following expenses will continue to not be allowed for BadgerCare Plus:

1. Charitable donations
2. Work-related personal expenses, such as transportation to and from work
3. 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).

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.

16.4.3.3 Losses Offsetting Other Income (MAGI Rules Only)

Under *MAGI* rules, losses from self-employment can be used to offset the individual's other income types. In situations where an individual is planning to file a joint tax return with his or her spouse, losses from self-employment may offset the spouse's income.

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
13. Royalties
14. Capital and Ordinary Gains and Losses

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**
   Under *non-MAGI* rules, count child support income as unearned income.

   Under *MAGI* rules, do not count child support income. If a household is receiving family support, divide the payment by the number of members in the household. The amount of the payment allocated to the child(ren) is considered child support and is disregarded. Count the amount of the payment allocated to the adult(s) as alimony/spousal support.
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)

   Under *MAGI* rules, although Social Security Benefits are not taxable, they must be counted as unearned income. However, Social Security Benefits are not considered when determining if an individual is "expected to be required" to file a tax return for the current year. See section 2.7.2 for more information.
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. Under *non-MAGI* rules, count these payments as unearned income. Under *MAGI* rules, do not count this 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).

   Under *non-MAGI* rules, count Monetary gifts over $30 a calendar quarter. A Calendar quarter is three consecutive months beginning with January, April, July or October.

   Under *MAGI* rules, do not count the value of property received as a gift as income. Count a gift as income in the month received if it meets either of the following criteria:
   - Income from a bequest, devise or inheritance
   - Income generated from property given to a trust if the income is paid, credited or distributed to the individual

Example 1: Keisha is the beneficiary of a trust. Land was given to the trust, and it generates interest that is distributed to Keisha as the beneficiary. Count this interest as unearned income.

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 in the month received. Tax-deferred contributions made to a profit-sharing plan are not taxable and are not counted as 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.

Under *non-MAGI* rules, 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.

Under *MAGI* rules, count the taxable portion of any retirement distribution as unearned income.

10. **Sick Benefits** -
Under *non-MAGI* rules, count Sick benefits received from an insurance policy such as an income continuation policy as unearned income.
Under *MAGI* rules, count sick benefits received from an insurance policy if the individual's employer contributed or paid for the benefit. Do not count the following:
    - Reimbursement for medical care;
    - Payments for loss of a member or bodily function, or permanent disfigurement; or

- Amounts computed with reference to the injury but not with respect to the individual's absence from work.

11. **Trusts** - A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention 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**
Under *non-MAGI* rules, gambling winnings are counted as unearned income in the month of receipt. Gambling losses cannot be used to offset the winnings.

Under *MAGI* rules, count gambling winnings that are regular and predictable as income. Gambling losses cannot be used to offset other types of income.

13. **Royalties** - Count Royalty income is as unearned income. Royalties are payments 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.

14. **Capital and Ordinary Gains and Losses**
Under *non-MAGI* rules, do not count personal capital and ordinary gains or losses.

Under *MAGI* rules, if personal capital gains are regular and predictable, count as

unearned income. Personal capital losses can be used to offset the individual's other income types. In situations where an individual is planning to file a joint tax return with his or her spouse, personal capital losses may offset the spouse's income.

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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

Through March 31, 2014 children (under age 19) with income above 150% of the FPL who have access to insurance can qualify for BC+ by meeting a deductible.

Effective April 1, 2014, children (under age 19) with income over 300% FPL (*non-MAGI* rules) or 306% (*MAGI* rules) may become eligible for BC+ by meeting a deductible. Children with income over 150% FPL (*non-MAGI* rules) or 156% FPL (*MAGI* rules) who are denied BC+ solely due to access to health insurance may also become eligible for BC+ by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150% FPL.

Pregnant women with incomes above 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules) 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 300% FPL for pregnant women. The deductible is met by incurring medical expenses that equal the deductible amount.

Note: When determining the deductible amount under MAGI rules, only the income of the member, the member's spouse, and if the member is under age 19, the member's parents should be considered. If a sibling's or tax dependent's income has been counted as part of the applicant's regular MAGI assistance group, it should be excluded

for purposes of calculating the deductible. Do not change the group size for the MAGI assistance group.

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17.2 PREGNANT WOMEN

17.2.1 Introduction
17.2.2 Deductible Period
17.2.3 Calculating the Deductible Amount

17.2.1 Introduction

The *deductible* amount for a pregnant woman is the amount of countable income above 300% 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. If she applied prior to February 1, 2014, when the deductible is met she will be covered under the Benchmark plan through March 31, 2014 with no premium until two months after giving birth. Effective February 1, 2014, all pregnant women who are applying for BC+, including those eligible through deductibles, will be covered under the Standard Plan.

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.

Through March 31, 2014, a self-employed pregnant woman with assistance group 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+. Beginning April 1. 2014, she will be eligible for coverage under the Standard Plan once she meets the deductible.

Effective January 1, 2014, a pregnant minor with family income over 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules) has the option to either prepay the pregnancy deductible or to wait to meet the deductible.

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.

Note: Effective April 1, 2014, if Janet has no children living with her, she can also be tested for BC+ eligibility as a childless adult.

17.2.2 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.

17.2.3 Calculating the Deductible Amount

To calculate the dollar amount of the BC+ deductible for a pregnant woman under *non-MAGI* rules:

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 income of each month with 300% FPL. If a month's income is less than or equal to 300% FPL, ignore it. If a month's income is more than the income limit, find the excess income by subtracting the income limit from the 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.

To calculate the dollar amount of the BC+ deductible for a pregnant woman under *MAGI* rules:

1. Determine the BC+ deductible period
2. Find the BC+ group's total countable income for each month in the deductible period.
3. If the assistance group's total countable income include the income of someone other than the pregnant woman, her spouse, or if she under age 19, her parents, subtract the income of that person, but do not change the group size of the AG.
4. Compare the total income of each month with 300% FPL. If a month's income is less than or equal to 300% FPL, ignore it. If a month's income is more than the income limit, find the excess income by subtracting the income limit from the income of that month.
5. 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

17.3.1 Deductible Period
17.3.2 Calculating the Deductible Amount

The *deductible* amount for a child under 19 is the amount of countable income above 150% FPL for a 6 month period.

Under *MAGI* rules, to meet the deductible, the child or his/her parents included in the child's BC+ group must incur medical bills equal to the deductible amount. Deductible-based eligibility is **not** extended to other children or members of the original assistance group. The parents' medical expenses may be used for meeting the deductible of more than one child are a time.

Under *non-MAGI* rules, 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 child under 19 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*.

Example 1: On November 1, 2014 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 are eligible for BC+ with a premium. Because the health insurance does not cover all of John's medical expenses, in December John's mother requests a deductible for John. The deductible period is December through May. John has medical bills that will meet the deductible as of January 1st. John will be covered under the standard plan with no premium from January through May.

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 under *non-MAGI* rules.

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 income of each month with 150% FPL. 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 income of that month. The child could choose to drop the deductible for months his/her income decreases and the child is eligible to enroll in BC+. If the child chooses to drop the deductible, the 6-month deductible period is interrupted and the deductible lapses. If the income later increases to above 150%, the child would need to start a new deductible period.

4. Add together the excess income of the months in the deductible period. The result is the child's BC+ deductible amount.

To calculate the dollar amount of the BC+ deductible for a child under *MAGI* rules:

1. Determine the BC+ deductible period.
2. Find the child's assistance group's total countable income for each month in the deductible period.
3. If the assistance group's total countable income includes the income of someone other than the child, the child's parents, or, if married, the child's spouse, subtract the income of that person, but do not change the group size of the AG.
4. Compare the total income of each month with 150% FPL. 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 income of that month. The child could choose to drop the deductible for months his/her income decreases so that the child is eligible to enroll in BC+.

5. Add together the excess income of the months in the deductible period. The result is the child's BC+ deductible amount.

Example 1: John, age 14, is ineligible for BC+ because his assistance group's 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 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. (366.25*6=2197.50)

Example 2: Mark, age 5, is ineligible for BC+ because his assistance group's income is over 306% of the FPL. The household is made up of Mark's mother, who earns $4,000/month and his brother, age 17, who earns $1,500/month and whose income is counted because he is expected to be required to file taxes. Mark's assistance group's income is $5,500 per month, which is $3,026 over the 150% FPL for a group size of 3. However, because Mark's brother is not his parent or spouse, we must exclude his income from the deductible calculation. This reduces the excess income to $1,526. John's six month deductible amount is $9,156 ($1,526*6=$9,126).

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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.

Note: Under *MAGI* rules, the deductible is built on an individual basis. To meet the deductible, the member and his/her parents in the BC+ group must incur medical bills equal to the deductible amount. The parent's medical expenses may be used for meeting the deductible of more than one child at a time, but deductible-based eligibility is not extended to other children or members of the original assistance group.

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 '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. 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.

3. 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 agency 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

17.9.1 Non-Financial Changes Introduction
17.9.2 Group Size Changes
17.9.3 Death

17.9.1 Non-Financial Changes Introduction

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.

17.9.2 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 FPL limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes.

17.9.3 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

18.1.1 BC+ Extensions Introduction
18.1.2 Pregnant Women
18.1.3 Children

18.1.1 BC+ Extensions Introduction

A BC+ Extension is a period of eligibility given to a person when the assistance group's income increases above 100% FPL either due to an increase in earned income, child support income, and/or spousal support; and otherwise meets the BC+ eligibility criteria for persons with incomes below 100% FPL.

- *Non-MAGI* BC+ individuals (parents/caretakers, pregnant women, and children) can enter an extension when the assistance group's earned income, child support, or both increases above 100% FPL.
- A parent/caretaker relative or pregnant woman whose eligibility is determined using *MAGI* rules can enter an Extension due to an increase above 100% FPL in the assistance group's earned income, spousal support, or both. The children, stepchildren, and NLRR children of the parent/caretaker will also enter the Extension at this time, provided they are under age 19, living with the parent/caretakers, and meet the income requirements outlined in section 18.1.3.

BC+ members eligible as childless adults are not eligible for an Extension.

If a family is also moving out of the State of Wisconsin at the time of the income increase, or if a case closes for lack of review or verification and then later reapplies, they would not be eligible for the Extension. While on the Extension, the member is covered under the Standard Plan and is not subject to the insurance access and coverage requirements. 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.

Non-exempt adults are subject to premiums while in an Extension (see 19.1) with the exception of adults whose income is at or below 133% FPL during the first 6 calendar months of their Extension. Starting April 1, 2014, the restrictive re-enrollment period for adults who fail to pay a premium will be 3 months (See 19.11). For RRPs that being prior to April 1, 2014, if the adult member has served at least 3 months in an RRP, the RRP may be ended.

Former Foster Care Youth under *non-MAGI* rules 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. If the FFCY is tested under *MAGI* rules, the FFCY will no longer qualify for Extensions.

The BC+ Extension lasts 4 months when the income goes above 100% FPL solely due to an increase in child support or spousal support. Child support Extensions can occur for anyone under non-MAGI rules. Because child support is not a counted income type under MAGI rules, such Extensions for members tested under MAGI rules can only occur based on an increase in spousal support.

Note: Extensions will not be granted to anyone in the household if the household fails to verify the income that would trigger the extension unless all the parents/caretakers in the Extension are exempt from paying premiums because they are disabled, a tribal member or pregnant.

18.1.2 Pregnant Women

A pregnant woman tested under *non-MAGI* rules 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 pregnant woman, 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.

Beginning January 1, 2014, a pregnant woman whose eligibility is tested under MAGI rules will be able to enter an Extension if she was eligible for BC+ as a pregnant woman or a parent or caretaker relative at any time during the pregnancy with income at or below 100% FPL in 3 of the past 6 months. In most cases, her continuous eligibility as a pregnant woman will take precedence over the Extension, but the Extension will be maintained and will result in eligibility if the pregnancy and postpartum period end prior to the end of the Extension.

18.1.3 Children

Under *non-MAGI* rules, Extensions apply to all the parents and children in the home who are eligible as part of the same BC+ Test Group (2.3.1). When the Test Group's income exceeds 100% FPL due to increased earnings or child support, all members of the affected BC+ group go into the Extension, as long as at least one member of the group was eligible with income below 100% FPL for 3 of the previous 6 months. Likewise, under most circumstances, the end of an Extension will apply to all of the members of the BC+ Test group. For example, when the household income decreases to 100% FPL or less, the Extension will end for both parents and children. Only when an Extension ends for a parent for failure to pay a required premium will we continue the Extension for the child.

All dependent children, stepchildren and *NLRR* children who are eligible under MAGI rules and whose parent or caretaker becomes eligible for an Extension under MAGI rules will be eligible for the same Extension provided that they are eligible for BC+ in the month prior to the start of the Extension and:

- Have AG income under 306% FPL and are under age 1
- Have AG income under 191% FPL and are age 1 through age 5
- Have AG income under 156% FPL and are age 6 through age 18

Conditions:

1. Children do not have to be eligible for BC+ for 3 of the past 6 months.

2. The child's AG income does not have to be below 100% FPL at the time the Extension starts.
3. CENs are not eligible for Extensions.
4. A child who is currently in an Extension is not eligible for a new extension.
5. If a parent's income decreases below 100% FPL the child's extension continues.
6. Once a child is in an Extension, the child does not lose the extension for any reason except for death, moving out of Wisconsin, or turning 19 while in an earned income Extension.

Note: If a child is in an unexpired Extension and a parent qualifies for a new Extension, the child's Extension will continue to stay in the original Extension eligibility category until it expires. The child is not eligible for the new Extension.

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18.2 INCREASE IN EARNINGS/DECREASE IN GROUP SIZE EXTENSIONS

18.2.1 Earned Income Extensions Under Non-MAGI Rules
18.2.1.1 SSI Exception
18.2.2 Earned Income Extensions under MAGI Rules

18.2.1 Earned Income Extensions under Non-MAGI Rules

To receive a BC+ Extension due to an increase in earnings a person whose eligibility is determined under *non-MAGI* rules 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. The parent, caretaker or pregnant woman 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.

4. S/he must otherwise meet the BC+ eligibility criteria for persons with income below 100% FPL, and

5. S/he verified his or her income, unless s/he is exempt from paying a premium.

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.

18.2.2 Earned Income Extensions under MAGI Rules

To receive a BC+ Extension due to an increase in earnings, a parent, caretaker or pregnant woman under *MAGI* rules must meet the following requirements:

1. The income increase which caused the countable income for his or her BC+ assistance group to exceed 100% FPL must be due solely to:

    a. Increased earnings (of anyone in the same AG) 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. The parent, caretaker or pregnant woman 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.

4. S/he must otherwise meet the BC+ eligibility criteria for persons with income below 100% FPL, and

5. S/he verified his or her income, unless s/he is exempt from paying a premium because s/he and any co-parent/spouse in the assistance group are disabled, a tribal member or pregnant. (This policy applies to all adults in the assistance group; unless they are all exempt from paying a premium, income must be verified.)

Note: These requirements do not apply to children eligible under MAGI Rules. See 18.1.3.

Example 2: Jane lives with her two teenage children and Dave, the non-marital co-parent of the two children. Jane is claiming both children on her taxes and her income for her MAGA assistance group of 3 is 90% FPL. Dave's MAGA AG consists only of himself, and he is eligible for BC+ with income of 95% FPL. The children-in-common are eligible in a MAGC AG group of 4, with both parents as counted adults in their AG and their group's income is 121% FPL. Jane was enrolled in BC+ with income below 100% FPL for three of the prior six months. In June, her earned income increased to 120% FPL. She is eligible for a 12-month BC+ Extension. Dave is not included in the Extension, because he was not a counted member of Jane's AG. The children are eligible for a 12-month Extension because they were eligible in June when Jane's income rose above 100% and their own AG's income was below 156% FPL at the time.

18.2.3 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 3: 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

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18.3 INCREASE IN CHILD SUPPORT OR SPOUSAL INCOME EXTENSIONS

18.3.1 Support Extensions Under Non-MAGI Rules
- 18.3.1.1 Four Month Extension under Non-MAGI Rules
- 18.3.1.2 Twelve Month Extension under Non-MAGI Rules

18.3.2 Support Extensions Under MAGI Rules
- 18.3.2.1 Four Month Extensions under MAGI Rules
- 18.3.2.2 Twelve Month Extensions under MAGI Rules

18.3.1 Support Extensions under Non-MAGI Rules

For assistance groups (AG) under non-MAGI rules, 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 4 or 12 months depending on the case circumstances.

18.3.1.1 Four Month Extensions under Non-MAGI Rules

The 4 month Extension applies only if:

1. The income increase which caused the countable income to exceed 100% FPL must be due solely to:

    a. Increased child support income or,
    b. Increased child support income along with other unearned income (changed or unchanged).

2. There has been no increase in earned income.

3. S/he must be a BC+ member with income at or below 100% FPL, at the time the income increased to over 100% FPL.

4. 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.

5. S/he must otherwise meet the BC+ eligibility criteria for persons with income below 100% FPL, and

6. S/he verified his or her income, unless s/he is exempt from paying a premium.

18.3.1.2 Twelve Month Extensions under Non-MAGI Rules

The 12 month BC+ Extension applies only if:

1. Earned income increased but child support income remained the same or both earned income and child support income increased.
2. S/he is 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 has 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 otherwise meets the BC+ eligibility criteria for persons with income below 100% FPL.
5. S/he verified his or her income, unless s/he is exempt from paying a premium.

18.3.2 Support Extensions under MAGI Rules

For AGs using *MAGI* rules, if a parent, caretaker, or pregnant woman's countable income increases above 100% FPL and all or part of the excess income consists of spousal support income, grant an Extension of either 4 months or 12 months depending on the case circumstances.

18.3.2.1 Four Month Extensions under MAGI Rules

The 4 month Extension only applies if:

1. The income increase which caused the countable income to exceed 100% FPL must be due solely to:

    a. Increased spousal support income, or
    b. Increased spousal support income along with other unearned income (changed or unchanged).

2. There has been no increase in earned income.

3. S/he is an eligible BC+ member with income at or below 100% FPL, at the time the income increased to over 100% FPL.
4. S/he 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.
5. S/he otherwise meets the BC+ eligibility criteria for persons with income below 100% FPL
6. S/he verified his or her income, unless s/he is exempt from paying a premium.

18.3.2.2 Twelve Month Extensions under MAGI Rules

The 12 month BC+ Extension applies only if:

1. Earned income increased but child support income remained the same or both earned income and child support income increased.
2. S/he is a BC+ member with income at or below 100% FPL, at the time the income increased to over 100% FPL.
3. S/he 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 otherwise meets the BC+ eligibility criteria for persons with income below 100% FPL.
5. S/he verified his or her income, unless s/he is exempt from paying a premium.

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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

18.5.1 Introduction
18.5.2 Leaving Wisconsin

18.5.1 Introduction

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. All children under the parent's or caretaker relative's care have either left the household or turned 19 and the Extension was based on an increase in earned income.

3. A child in an earned income Extension turns 19.
4. S/he fails to provide verification of income and at least one parent/caretaker in the extension AG is not disabled, a tribal member, or pregnant. Only the non-disabled, non-tribal, non-pregnant parents/caretakers are ineligible for failure to provide verification. The other members of the family in the extension remain eligible for the duration of the Extension.

5. S/he fails to pay a premium or quits BC+ (See 19.11.3). Only the parents/caretakers that owed the premium (those in the BCPM AG) are put into a restrictive re-enrollment period. The other members of the family in the Extension remain eligible for the duration of the Extension.

Note: Under *MAGI* rules, children in a support Extension who turn 19 do not lose the extension just for turning 19. Similarly a parent or caretaker relative in a support Extension just because all of the children under his or her care either left the home or turned 19.

Note: An assistance group does not need to maintain employment in order to maintain an earned income Extension, irrespective of whether the assistance group is tested under *MAGI* or *non-MAGI* rules.

If a condition necessary for an Extension is lost, the Extension is not regained solely by recovering the lost condition.

Example 1: A group has an Extension and the parent fails to provide verification of earnings. The parent loses eligibility for BadgerCare Plus. The children in the Extension remain eligible for the duration of the Extension. The parent does not regain the Extension if she later provides verification of income.

18.5.2 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 3: 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 4: 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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19 PREMIUMS

19.1 BC+ PREMIUMS

Note: Premium policies for BadgerCare Plus Core members are found in Chapter 43.

The following individuals must pay a premium to become or remain eligible for BC+ unless exempt:

1. Children in families with income over 200% FPL (under non-MAGI rules) or 201% (under MAGI rules),
2. Parents, stepparents and caretaker relatives with income over 100% FPL in a BC+ Extension that starts on or after April 1, 2014,
3. Through March 31, 2014, parents, stepparents and caretaker relatives with income over 133% through 200% of the FPL,
4. Through March 31, 2014, self-employed parents, stepparents and caretaker relatives with income above 200% of the FPL before subtracting the *depreciation* but below 200% of the FPL after subtracting the depreciation.

Note: Effective with BC+ Extensions that begin on or after April 1, 2014, parents, stepparents and caretaker relatives with income between 100% and 133% FPL in a BC+ Extension will be subject to premiums starting in the seventh calendar month of their Extension.

If a member's income changes during their Extension, s/he will only be exempt from premiums if s/he is in the first six calendar months of that Extension, and if his/her income is at or below 133% FPL.

- If the member has an increase in income that puts his/her income above 133% FPL, s/he will be subject to premiums, even if s/he is still in the first six calendar months of the Extension.
- If the member's income subsequently decreases to below 133% FPL, s/he will be exempt from premiums as long as s/he is in the first six months of the Extension.

If the member's income drops below 100% FPL, then later increases and the member qualifies for a new Extension, the six-month premium exemption will begin with the new Extension. If the member does not qualify for a new Extension, the member will be re-enrolled in the previous Extension and the original six-month time frame for exempting premiums will apply.

The following individuals are exempt from the requirement to pay a premium:

1. All pregnant women and pregnant minors,
2. Pregnant women under age 19 with income at or below 300% of the FPL,
3. Former Foster Care Youth. (Chapter 11),
4. Children who have met a BC+ *deductible*, during the remainder of the deductible period,
5. Children in a BC+ Extension,
6. Children who are not in an Extension but whose parents are in an Extension and paying a premium,
7. Adult parents and caretakers who are blind or disabled or MAPP Disabled, as determined by the Disability Determination Bureau (DDB) or through the presumptive disability process (MEH, 5.9),
8. Adults with assistance group income at or below 100% FPL,
9. All children under age 1 including Continuously Eligible Newborns (Chapter 8.2) ,
10. American Indian or Alaskan Native Tribal members, the son or daughter of a tribal member, the grandson or granddaughter of a tribal member, or anyone otherwise eligible to receive Indian Health Services. The following table outlines which populations of adults and children are exempt from premiums due to their Tribal status:

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

19.2.1 Premium Calculations for Non-MAGI Households
19.2.2 Premium Calculations Effective January 1, 2014
19.2.2.1 Children's Premiums Using MAGI Rules
19.2.2.3 Adults' Premiums Using MAGI Rules

19.2.1 Premium Calculations for Non-MAGI Households

Note: The following policy applies to all BC+ members whose eligibility is determined under non-MAGI rules.

Under BC+, premiums for children are initially calculated on an individual basis and then a total for the case is determined. Premiums for adults are based on a percentage of the household income and the amount is the same regardless of the number of adults covered by the premium *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 for children 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 non-pregnant, non-disabled parents and caretaker relatives, including those in BadgerCare Plus Extensions with a family income above 133% of the FPL, premiums will be calculated based on a sliding scale, ranging from 3% of countable household income for individuals above 133% of the FPL to 9.5% of household countable income for individuals at or above 300% of the FPL. Premiums for adults will be calculated based on actual household income and rounded to the nearest dollar. See 48.1 for premium ranges based on family size and income.

4. Through March 31, 2014, 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. Through March 31, 2014, 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.

6. Through March 31, 2014, for families with income below 300% of the FPL, where only children owe a premium or self-employed parents/caretakers owe the 5% premiums, the combined total of all family members' premiums will be rounded down to the nearest whole dollar amount.

7. Through March 31, 2014, For families with income at or above 300% of the FPL, premium amounts for cases where only children owe a premium and the 5% premiums for self-employed parents/caretakers will not be rounded.
8. 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.

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 133% 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*.

The premium for the BC+ group is the total of the individually calculated premiums for the children 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.

Premiums for adults with household income less than or equal to 200% of FPL or in an extension are based on a percentage of the household income and the amount is the same regardless of the number of adults covered by the premium.

19.2.2 Premium Calculations for MAGI Households

The basic approach for determining premiums remains the same for MAGI households: premiums for children are initially calculated on an individual basis and then a total for the case is determined, while premiums for adults in Extensions are based on a percentage of the adult's assistance group income.However, there are some significant differences to premium amount calculations under MAGI rules. CARES will calculate the premium for each case, but the general rules for calculating the premium amounts are explained below for children and adults.

19.2.2.1 Children's Premiums using MAGI Rules

1. The minimum monthly premium amount for children is $10 per person.
2. The maximum monthly premium for a child with income above 301% up to 306% FPL is $97.53.
3. Each child's premium amount will be based on their AG's size and income. Under MAGI rules, it is possible for different children within the same household to have different amounts of income counted and to have a different AG sizes. For this reason, each child's AG is evaluated separately to determine that AG's income and group size, which is the basis for determining the FPL percentage of that child's income. That FPL percentage, in turn, will determine whether a child potentially owes a premium and the amount of the premium.
4. The premium for the BC+ group is the total of the individually calculated premiums combined, not to exceed 5% cap.
5. The cap will be 5% of the income of the assistance group with the highest income (in terms of dollar amount) in the case. (See 19.3.)

19.2.2.2 Adults' Premiums using MAGI Rules

1. For non-pregnant, non-disabled parents and caretaker relatives in BadgerCare Plus Extensions with a family income above 133% of the FPL, premiums will be calculated based on a sliding scale, ranging from 3% of countable income for individuals above 133% of the FPL to 9.5% of countable income for individuals at or above 300% of the FPL.
2. Premiums for adults in extensions will be calculated based on actual income and rounded to the nearest dollar. See 48.1 for premium ranges based on family size and income. When a child is pulled into an adult's extension, the child does not owe a premium.
3. Adults in an extension who are married filing jointly, or who are married but not filing taxes, will have a combined premium. Adults in an extension who are married filing separately or are non-marital co-parents will have premiums calculated on an individual basis.

Note: Pregnant minors are not charged a premium.

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19.3 PREMIUM LIMITS

For all BC+ members whose eligibility is determined under non-MAGI rules, 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 211% of the FPL as it would be for a family with an income at 218% of the FPL.

Exceptions to this policy are:

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. Adults with incomes over 180% of the FPL in a BC+ Extension.

4. Adults with incomes over 180% of the FPL up to 200% of the FPL.

For all BC+ members whose eligibility is determined under MAGI rules, children with assistance group income above 201.00% of the FPL will be required to pay premiums. The total premium amount for the household is the total of the individually calculated premiums, not to exceed a 5% cap. The cap will be 5% of the income of the assistance group with the highest income (in terms of dollar amount) in the case.)

The 5% cap methodology for children with premiums will be effective as soon as one child on the case who is subject to premiums has his or her eligibility determined using MAGI rules.

Example: Susan and Alan are non-marital co-parents caring for four children: Susan's son, Aaron (15); Alan's daughters Rachel (12) and Hannah (11); and Susan and Alan's son Jacob (9). Alan claims Rachel and Hannah as his two tax dependents, while Susan claims Aaron and Jacob. Susan earns $2500/month as a waitress, and Alan earns $4500/month as a computer analyst.

None of the children have income. All four children are eligible for BC+.

Child	MAGI Group Formation	AG Income Amount	FPL	Premium Amount
Aaron	Susan, Aaron, and Jacob	$2500	122%	$0
Rachel	Alan, Rachel, and Hannah	$4500	276%	$55
Hannah	Alan, Rachel, and Hannah	$4500	276%	$55
Jacob	Susan, Alan, Aaron, Rachel, Hannah, and Jacob	$7000	265%	$44

Aaron does not have a premium, Rachel and Hannah have $55 premiums, and Jacob has a premium of $44. In this example, 5% of the income of the assistance group with the highest income is 5% of Jacob's MAGI group, or 5% of $7000/month, or $350. Altogether, the household's monthly premiums are $154. The household will pay $154 in premiums for their children's coverage.

Parents and caretakers in Extensions will pay premiums based on the sliding scale discussed above, without a 5% cap applied. Non-exempt children with incomes above 201% of the FPL will not be required to pay premiums when the adults in the household are paying premiums in an Extension. If the parents enter a restrictive re-enrollment period (RRP) for failure to pay a premium or are otherwise ineligible, non-exempt children with income above 201% will be required to pay a premium.

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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 or go to the CARES mainframe manual standard letter CNSL NCBP009901. 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 Services
Box 93187
Milwaukee, WI 53293-0187

The eligibility policy and time frame 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.

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

Through December 31, 2013, 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.

Effective January 1, 2014, premium payments can no longer be made in advance.

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

19.8.1 Non-Payment Introduction
19.8.2 Insufficient Funds
19.8.3 Good Cause for Non-Payment

19.8.1 Non-Payment Introduction

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.

- Children under age 19
  - Effective with RRPs beginning January 1, 2014 (for failure to pay December 2013 premiums), children under age 19 who do not pay their premiums will not be eligible for BC+ for 3 calendar months, unless there is good cause (see 19.8.3). See 19.11 for more information.
  - Through December 31, 2013, children were not eligible for 6 calendar months following the date on which their coverage terminated for failure to pay premiums, unless there was *good cause*. However, effective April 1, 2014, any RRPs that began prior to January 1, 2014 were updated in CARES to set the RRP end date to no later than 3 months after the RRP started.
- Adults age and older
  - Beginning April 1, 2014, adults who fail to pay a premium will not be eligible for BC+ for 3 calendar months following the date on which their coverage terminated, unless there was good cause. See 19.11 for more information.
  - Through March 31, 2014, adults are not eligible for BC+ for 12 calendar months following the date on which their coverage terminated, unless there was good cause. However, if the adult member has served at least 3 months in an RRP as of April 1, 2014, the RRP may be lifted and the member may re-enroll at their request.

For more information on how RRPs can be lifted and BC+ eligibility reinstated, see 19.11.

The total family premium for a case must be paid to avoid being considered late or unpaid. No partial premium payments will be accepted.

19.8.2 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.

19.8.3 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

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: 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.

Note: An individual's BC+ eligibility can be reinstated during an RRP if the individual pays the owed premiums. For information about payments made during the RRP, see 19.11.

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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)
19.10.2.3 Effective dates of premium increase (other than person adds)

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 1: 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

through the FowardHealth Portal. If unable to certify through the ForwardHealth Portal, complete and return the F-10110 (formerly DES 3070) for the days that cannot be confirmed in CARES. See Process Help 81.

- Mail:

  ForwardHealth iChange
  P.O. Box 7636
  Madison, WI 53707-7636
  Fax: (608) 221-8815

- 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 2: 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 3: 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.

19.10.2.3 Effective dates of premium increase (other than person adds)

A delay in the effective date of premium increases must also be done in certain ongoing cases that may or may not include a person add. These are cases where a change results in an assistance group opening up and has new or increased premiums for a month (or months) that cannot be confirmed in CARES. In these situations, the member

is not responsible for a premium payment (or a premium increase) for the month or months that cannot be confirmed in CARES. The first premium (or increased premium) for which the family must pay is the one for the month for which eligibility can be confirmed.

The following situations qualify for this treatment:

- Through March 31, 2014, a case reports a decrease in income from above 200% to below 200% FPL and the parents are now eligible with a premium.
- A person is added to a case that has not paid the premium for another member.
- A person becomes eligible for BC+ for any non-financial reason except late payment of the previous month's premium, failure to verify a reported change that resulted in the premium increase, or failure to complete a renewal.
- Cases where the Call Center is unable to get premiums adjusted on the interChange system.
- Effective April 1, 2014, a case reports a decrease in income from above 300% to below 300% and the child(ren) are now eligible with a premium.

In a situation where other members in the AG or in another BC+ AG may owe a premium, treat their premium separately from the newly eligible members and/or AG. Through March 31, 2014, a family that owes a small premium for the children but then has an income decrease to below 200% of the Federal Poverty Level (FPL) that causes the parents to be eligible for a larger premium. With the income change, the children no longer owe a premium. If the premium was already paid for the children, that amount must be refunded. If the premium was not paid, the children should not be sanctioned for non-payment since they no longer owe a premium.

Example 4: June and Ward Cleaver are receiving BC+ for their two sons, Wally and Theodore. The family income is 205% of the Federal Poverty Level (FPL), and they are paying $20 in monthly premiums for the boys. On March 25, Ward reports a decrease in wages and the family's income is now 191% of the FPL. This makes June and Ward eligible for BC+ with a premium. When the IM worker runs eligibility for May, the new BC+ premium amount is $213. CARES will not allow the worker to confirm eligibility for March or April because their premium is higher than the $20 amount that had already been confirmed for the children. The worker needs to:

1. Confirm BC+ eligibility in CARES for May,
2. Do an online or manual certification of BC+ eligibility for Mr. and Mrs. Cleaver for the months of March and April. No premium is owed for the parents for those months, **and**
3. Issue a manual Positive Notice of Decision to the family for those two months.

In addition, since the sons are no longer required to pay a premium and are now eligible for the Standard Plan, the worker must also update their medical status code

using the online or manual F-10110. Once the medical status is updated in iC to a non-premium status, HP will automatically refund the $20.00 premium that was paid.

Example 5: Mary and Tom apply for BC+ on May 1, 2014 for their son, Sam, and Mary's daughter, Sara. Mary and Tom are not married and both plan to file taxes. Mary claims Sara as a dependent and Tom claims Sam. Sara's AG income is 208%, so she has a $10 premium. Sam's AG income is at 310%, so he is not eligible for BC+. The case is confirmed on May 15, 2014 with Sara's eligibility beginning May 1, 2014. On June 1st, Tom reports his income decreased in late March, resulting in Sam's AG income to decrease to 265%. Sam would now be eligible with a $44 premium. Because CARES will not allow the worker to confirm the increase in premium for June, Sam will not be required to pay a premium until July 1, 2014, although he will be eligible as of June 1, 2014. Sara is still required to pay her $10 June premium, and the combined premium of $54 will be effective July 1, 2014.

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19.11 BADGERCARE PLUS RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

(This section was rewritten with this release.)

19.11.1 Restrictive Re-Enrollment Period (RRP) Introduction
19.11.2 Reapplying

19.11.1 Restrictive Re-Enrollment Period (RRP) Introduction

A member for whom a premium is owed for the current month who leaves BC+ by 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 a certain number of months from the termination date while their income remains high enough to owe a premium, unless they pay the premiums owed, meet a good cause exemption or the RRP is lifted. Effective January 1, 2014, children can make late premium payments at any time during their 3 month RRP. Effective April 1, 2014, adults can make late premium payments at any time during their 3 month RRP.

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 November, the premiums for September, October and November must be paid in order for eligibility to be restored for those months.

If the member owes a premium for a month during the RRP, s/he must pay all owed premiums before CARES will restore eligibility for BC+. The member must pay the IM agency directly (not the *Fiscal Agent*). You can check with the Fiscal Agent to see if a premium has already been collected for that month.

Example 2: 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.

Members whose income decreases to an amount that would not require a premium will be removed from the RRP and re-enrolled in BC+.

Children under age 19

- *RRPs* beginning on or after January 1, 2014, are set for 3 months.
- RRPs beginning prior to January 1, 2014, lasted for 6 months.
- However, any RRPs that began prior to January 1, 2014 were updated in CARES to set the RRP end date to March 31, 2014, as children are no longer required to be in a 6 month RRP.

Note: The RRPs impacted by the update to set the RRP end to March 31, 2014, are limited to RRPs that began in November 2013 or December 2013.

The child can become eligible for BC+ again at any time during the three month RRP if s/he pays all owed premiums. The child's eligibility will be restored back to the beginning of the RRP. If the individual serves the full three month penalty period, s/he will become eligible for BC+ again (without paying any owed premiums) on the first of the following month after the RRP ends, if s/he continues to meet the program eligibility criteria.

Example 3: Kayla (age 10) had a premium of $10 and failed to pay her May premium. Her BadgerCare Plus benefits ended May 31 and she was put into a three month RRP from June 1 to August 31. Eligibility can be re-determined in September OR Kayla could re-enroll prior to September if she pays all owed premiums.

Effective April 1, 2014, any RRPs for children that began prior to January 1, 2014 were updated in CARES to set the RRP end date to no later than 3 months after the RRP started. If eligibility is subsequently re-run for an open case, the child's eligibility will re-open. However, if the case has been closed for more than 30 days, the household must reapply in order to regain BC+ benefits for the child.

Adults age 19 and older

- RRPs beginning on or after April 1, 2014, are set for 3 months.
- RRPs beginning prior to April 1, 2014, lasted for 12 months. However, effective April 1, 2014, if the adult member has served at least three months in an RRP as of April 1, 2014, the RRP may be ended at the member's request.

An adult can become eligible for the remainder of the Extension again at any time during the three month RRP if s/he pays all owed premiums. The adult's eligibility will be restored back to the beginning of the RRP. If the individual serves the full three month penalty period, s/he can become eligible for the remainder of the Extension (without paying any owed premiums) if s/he requests to re-enroll for the remainder of his/her Extension and if s/he continues to meet the program eligibility criteria.

After the RRP has been served, eligibility can be reinstated as of any month after the end of the RRP until the end of the Extension. For example, if an RRP ends June 30 for an Extension that runs through December, a member could request in November to be reinstated starting July 1. However, members must pay owed premiums for any months of coverage, and the months of eligibility must be consecutive. So using the same example, the member could not request to be reinstated for July, September, October and November, but not August.

Example 4: Joyce (age 29) is an adult in an Extension. She fails to pay the June premium, so she is in a 3 month RRP for July, August and September. In August, Joyce pays her owed premiums for June, July and August. Joyce's eligibility is restored back to the beginning of the RRP.

Example 5: Tina (age 45) did not pay the September premium while in an Extension. Tina will be in a 3 month RRP for October, November and December. Tina contacted the IM agency in January, after she served the full 3 month RRP and requested to re-enroll in BC+. As long as there are still months left in the Extension and she continues to meet the program eligibility criteria, Tina can re-enroll starting January without paying any owed premiums from the RRP. Tina would not be able to re-enroll for October, November and December. If Tina had contacted the agency in April, she would be able to choose whether to reinstate her enrollment starting in January, February or March, but she would not be able to choose to be covered only in February and then start coverage again in April.

Effective April 1, 2014, the 3 month RRP length will also apply to RRPs that started prior to April 1, 2014. If the adult member has served at least three months in an RRP as of April 1, 2014, the member can be re-enrolled in the remainder of the extension at his or her request.

Example 6: Chelsey fails to pay her October 2013 BCPA premium and is put in a 12 month RRP from November 1, 2013 to October 31, 2014. As of April 1, 2014, she has already served at least three months of her RRP. Chelsey contacts her IM agency to request that the RRP be ended and that she be reenrolled in BC+. The

agency may reenroll Chelsey effective April 1.

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.

19.11.2 Reapplying

An individual who applies for BC+ before the end of the RRP and whose assistance group's income is above the premium limit may be eligible for BC+ for the remainder of the existing extension if s/he pays owed premiums. If the individual's assistance group's income is below the premium threshold, s/he can become eligible for BC+ without paying owed premiums.

Example 7: Jackie, John and their three children are open for BC+. Jackie and John are in an Extension and have a premium. The children are eligible without a premium. They fail to pay the June premium so Jackie and John are in a RRP from July through September. The children are still eligible. In August, Jackie and John reapply for BC+ and report a decrease in income to 95% FPL. Beginning August 1, Jackie and John are again eligible for BC+ without a premium. In addition, because their income is below the premium threshold, they are not required to pay their owed premiums first.

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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 https://access.wisconsin.gov/access/ ; 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://www.dhs.wisconsin.gov/em/customerhelp/

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.

25.2 APPLICATION TYPES/METHODS

BC+ applicants have the choice of one of the following *application* methods:

1. ACCESS https://access.wisconsin.gov/.
2. Mail-In using the BadgerCare Plus Application Packet (F-10182).
3. Telephone Interview.
4. Face-to-Face Interview.
5. Use of the paper or online application available through the *Marketplace*
6. Telephone application with the *Marketplace*

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25.3 WHERE TO APPLY

25.3.1 Where to Apply Introduction
25.3.2 Intercounty Placements
25.3.3 Applications Outside Wisconsin
25.3.4 Applications Received from the Federal Marketplace

25.3.1 Where to Apply Introduction

The *applicant* must apply in the county in which s/he resides.

The agency (county/tribe or consortia) of the applicant's county of residence should process the individual's application.

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 consortium or tribal agency responsible for processing the *application* immediately. Anytime an application is received in the wrong consortium or tribal 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 consortium or tribal agency.

25.3.2 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 renewals 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 renewals.

25.3.3 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.

25.3.4 Applications Received from the Federal Marketplace

The Federally-faciliated *Marketplace* (the Marketplace or the Exchange) will begin sending applications to DHS through an account transfer process for individuals the

Markeplace assesses as potentially eligible for BadgerCare Plus or Medicaid. Such applications are considered full applications for all "insurance affordability programs" including BadgerCare Plus and should be appropriately processed. The 30 day processing requirement begins on the day that the account is received by the local agency or the next business day if received after normal operating hours or on weekends or holidays. If eligible, the individual's benefits will begin on the first day of the month the application was filed at the Marketplace, not the date that the application was received by the agency. If the individual requests backdating, their eligibility will be backdated for up to three months from the first day of the month the application was filed at the Marketplace.

If a paper application from the Marketplace is mailed to a consortium or tribal agency, the IM worker should consider that application as an application for BadgerCare Plus and/or Medicaid and process it.

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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 one of the following forms:
    - Wisconsin Medicaid for the Elderly, Blind and Disabled Application / Review Packet (F-10101),
    - Medicaid, BadgerCare Plus and Family Planning Services Registration Application (F-10129),
    - BadgerCare Plus Application Packet (F-10182),
    - BadgerCare Plus Supplement to FoodShare Wisconsin Application (F-10138) or an electronic signature in ACCESS,
    - Health Coverage & Help Paying Costs Application from the Federally-facilitated *Marketplace*
    - Telephonic signature in CARES
    - Electronic signature in CARES
    - Electronic signature in an account transfer from the Marketplace.

The date the BC+ paper or ACCESS application 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)

For applications assessed as Medicaid eligible that were filed at the Marketplace and subsequently determined eligible for BC+ or the Medicaid, the filing date for the BC+ or MA coverage will be the date the application was submitted to the Marketplace. Marketplace-referred applications must be processed within 30 days of the date the Marketplace application was received by the consortium or agency. For additional information about the filing date, see 25.6.

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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.
4. The online or paper Health Coverage & Help Paying Costs Application from the Federally-facilitated Marketplace.

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.

   When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.

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 or transferred from the Marketplace are signed electronically, so an additional signature (telephone or pen-and-paper) is not needed.

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25.6 FILING DATE

For applications submitted to the local agency, 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 or an application submitted to the Marketplace 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 valid signature is received by the agency.

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25.7 TIMEFRAMES

25.7.1 Timeframes Introduction
25.7.2 Changes

25.7.1 Timeframes Introduction

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 for applications submitted directly to the local tribal or consortium agency,

  OR

- The date the local agency received the application(s) from the Marketplace.

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.

Example 3: A signed application was submitted to the Marketplace on March 2nd. The Marketplace assessed the individual as potentially eligible for BC+ and transferred the individual's account to the agency on March 5th. The first day of the 30-day period for processing requirements was March 6th. The end of the 30-day period would have been April 4th. The application was approved on March 31st, and the applicant is determined eligible beginning March 1st.

25.7.2 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. See Section 3.6 for more information on exceptions.
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.

   Note: As of January 1, 2014, pregnancy for the BC+ Prenatal Program will only be verified if the worker has information that contradicts the individual's self-declaration.

1. Recent Moves - The date the member moved to Wisconsin.
2. 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 former foster care youth 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.

All disabled adults may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application.

Children determined eligible for BadgerCare Plus are eligible for the following periods of backdated eligibility:

- Infants less than 1 year old 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 300% FPL (under *non-MAGI* rules) **OR** at or below 306% FPL (under *MAGI* rules),
- Children ages 1 through 5 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 185% FPL (under *non-MAGI* rules) **OR** at or below 191% FPL (under *MAGI* rules), and

- Children ages 6 through 18 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% FPL prior to December 31, 2013 (under *non-MAGI* rules) **OR** at or below 156% FPL (under *MAGI* rules).

All non-pregnant, non-disabled 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 133% FPL, for new applications submitted prior to February 1, 2014

  OR
- At or below 100% FPL, for new applications submitted after February 1, 2014.

Childless adults with assistance group income under 100% FPL will be eligible for backdating beginning in 2014. However, retroactive coverage cannot begin prior to April 1, 2014. As a result, a childless adult could not be eligible for the full three calendar months period of backdating until July 1, 2014.

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, certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month and in which their assistance group income was at or below the appropriate FPL level for their age group.

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 1: 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.

Example 2: Jess applied for BC+ on May 2, 2014 and was found eligible as a childless adult, with coverage beginning May 1, 2014. At the time of application, Jess requested three months of backdated coverage, through February 1, 2014. Because Jess is eligible as a childless adult and coverage cannot be backdated for childless adults prior to April 1, 2014, Jess will only receive backdated coverage in April 2014.

25.8.1.1 BC+ Family Planning Services

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.

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+.

Starting with renewals due March 31, 2014, if a case is determined under *MAGI* rules and is closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the individual can be reopened for BC+ without filing a new application if s/he provides the necessary information within 90 days of the renewal date.

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 RENEWAL

26.1 RENEWALS

26.1.1 Renewals Introduction
26.1.2 Administrative Renewals

26.1.1 Renewals Introduction

A renewal 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 renewal. Each renewal results in a determination to continue or discontinue eligibility.

The first required eligibility renewal for a BC+ case is 12 months from the certification month, except for:

1. **CENS** - The renewal date is 12 months from the date of birth.

2. **Pregnant women** -The renewal date is two calendar months after the date the pregnancy ends.

   Note: Women in the BC+ Prenatal Program lose eligibility on the date the pregnancy ends. However, they are automatically eligible for emergency services for two months after eligibility for BC+ Prenatal Program ends. (Chapter 41.6)

3. **Deductibles** - A renewal 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 renewal 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 renewal is due.

Agency Option

For individuals whose eligibility is determined under *non-MAGI* rules, 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.

BC+ members whose eligibility is determined using *MAGI* rules are required to complete a renewal no earlier or no later than 12 months from their certification period. Individuals whose benefits are time-limited, such as CENs or pregnant women, will not be required to do a renewal at the end of their time limited benefit if the individual is on a case with other open BC+ assistance groups.

Once individuals' BC+ eligibility is determined under *MAGI* rules, workers can complete an early renewal only if the member requests an early renewal. Once the member requests an early renewal, the renewal must be completed.

For MAGI based AGs, renewals received within 90 days of the renewal month can be processed as a late renewal instead of requiring a new application. The income that was required to have been reported had the renewal been timely is the income that is required to be budgeted unless the income has changed. If the income has significantly changed, use the actual income or the best available income for the previous months and prospective budgeting for the current and future months.

26.1.2 Administrative Renewals

Administrative Renewals through December 31, 2013

An administrative renewal is an extension of program eligibility for certain low-risk cases based on the information in *CARES* as of the month prior to the renewal month. Cases selected for administrative renewal are cases that are highly unlikely to lose eligibility at renewal due to increases in income or assets.

The extension of program eligibility under an administrative renewal is based on the information in *CWW* as of the month prior to the month a full renewal would otherwise have been due. An administrative renewal case will not receive an eligibility renewal notice and is not required to provide the IM agency with any additional information in order to have program eligibility continued.

Administrative renewal cases remain subject to change reporting requirements. The administrative renewal notice identifies program specific change reporting requirements, as well as the potential consequences for not reporting changes timely. Changes reported for a case that has undergone an administrative renewal should be processed under existing policy.

BadgerCare Plus (BCP) cases selected for administrative renewal must meet all the following criteria:

- No child in household turning 18 in current or next month
- Countable income at or below 75% FPL
- No premium
- No open FoodShare, Child Care or W-2

Through December 31, 2013, Family Planning Only Services (*FPOS*) cases selected for administrative renewal must meet all the following criteria:

- No child in household turning 18 in current or next month
- Countable income of individuals age 18 and older at or below 275% FPL

Open for Multiple Programs
If the case is open for MSP and BadgerCare Plus or FPOS, the case may be selected for administrative renewal if the BCP/FPOS renewal is due and the case meets all the selection criteria listed above. If the MSP renewal is due but not the BCP/FPOS renewal, or the case does not meet all the selection criteria listed above, the case will not be selected for administrative renewal.

Continuous Eligibility
To be selected for an administrative renewal, the case must be open and currently eligible with continuous program eligibility for at least the twelve month period prior to the month in which the case is being considered for an administrative renewal. Additionally, the case must have had at least one full regular renewal.

Alternate Years
Cases will not be selected for administrative renewal if the last renewal requirement was met through an administrative renewal. Administrative renewals will be done every other year. The exceptions to this rule are:

- HCBW or MLTC members who are Group A due to their eligibility for SSI or 1619b
- Family Planning Only Services cases where the only eligible case member is under 18 and will not turn age 18 in the current or next month.

Persons meeting these criteria may be selected for administrative renewal annually as long as the detailed selection criteria are met.

Schedule
Administrative renewal case selection will occur prior to sending the regular renewal notices. Any cases not selected for an administrative renewal will be sent the regular renewal notice.

Renewal Mode
Cases in renewal mode will not be selected for administrative renewal.

CARES
CWW will automatically:

- Select cases subject to administrative renewal,
- Determine the continued eligibility, **and**
- Notify the member of the administrative renewal and eligibility determination.

Worker intervention is not necessary to complete the administrative renewal process.
Cases selected for Administrative Renewal will run through a batch eligibility process. Cases

that have a pending or fail status after running through the batch eligibility process will not continue through the Administrative Renewal process and will be set for regular renewal.

Cases that are passing after eligibility batch run will go through the administrative renewal confirmation process.

During the confirmation process:

- Case level renewal dates are set.
- A case comment is added indicating that the case has gone through an Administrative Renewal.
- The Application/Review Interview Details page will display 'Admin Renewal'.
- The Notice of Decision process is triggered and will generate an administrative renewal letter. The letter will be stored in the ECF.
- The Enrollment and Benefit brochure is sent to the customer.

Administrative Renewals Effective January 1, 2014
Effective January 1, 2014, administrative renewals will be suspended for BC+ and FPOS cases.

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26.2 CHOICE OF RENEWAL

The member has the choice of the following methods for any BC + renewal:

1. Face-to-Face Interview.
2. Mail-In (paper application or pre-printed renewal packet).
3. Telephone Interview.
4. ACCESS (https://access.wisconsin.gov/access/)

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26.3 RENEWAL PROCESSING

A BC+ eligibility renewal notice is generated in the 2nd week of the 11th month of the *certification period*. Do not schedule a renewal until after *adverse action* in the month prior to the month of renewal.

Example 1: CARES sends out the renewal letter the 2nd week of July for a review due in August. Do not schedule the renewal for a date prior to adverse action in July.

Do not require a new *Authorized Representative* form at renewal, if the person signing the renewal is the Authorized Representative on file. If the renewal 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 renewal 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 Plus members whose eligibility is determined under *non-MAGI* rules 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.)
- Change in marital status

BadgerCare Plus members whose eligibility is determined under *MAGI* rules 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.)
- Change in marital status
- Change in insurance coverage
- Change in expected tax filing status
- Change in tax dependents
- No longer receiving a tax-related deduction

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27.3 INCOME CHANGE REPORTING REQUIREMENTS

BadgerCare Plus members whose eligibility is determined under *non-MAGI* rules must report income changes when their total monthly gross income exceeds the following percentages of the Federal Poverty Level (FPL) for their group size.

- 100% FPL
- 133% FPL
- 150% FPL
- 185% FPL
- 200% FPL
- 250% FPL
- 300% FPL
- 350% FPL
- 400% FPL

BC+ members whose eligibility is determined under *MAGI* rules, income changes must be reported when the total monthly income of the assistance group with the highest monthly income amount exceeds the following FPL percentages for their assistance group size:

- 100% FPL
- 133% FPL
- 156% FPL
- 191% FPL

- 200% FPL
- 250% FPL
- 306% FPL
- 350% FPL
- 400% FPL

The income change must be reported by the 10th of the month following the month in which the total income exceeded its previous threshold.

Adults in a BadgerCare Plus Extension who are required to pay a premium must also report and verify income changes during the extension *certification period*. Eligibility for adult members who would be required to pay premiums will be terminated for failure to submit requested verification. Effective April 1, 2014, all non-exempt parents and caretakers in BC+ Extensions will be required to pay a premium. However, parents and caretakers with income between 100 and 133% FPL will not be subject to premiums until the seventh calendar month of their extension.

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 ONLY SERVICES MEMBERS:

There are only two changes that BC+ Family Planning Only Services members need to report during the *certification period* :

- Address or
- Living arrangement (e.g. incarceration, institutionalization)

These changes must be reported within ten days of 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.

Note: Overpayments can only be recovered if the member failed to report a change for which they were notified they were required to report.

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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.

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: 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. Fee-For-Service claims and/or HMO capitation payments for September, October, November and December are recoverable.

Example 4: 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” 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 Department of Health Services (DHS) Office of the Inspector General (OIG) 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, corporation counsel for investigation, or OIG. 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 prior to a negative action such as a termination of benefits, a change from the Standard plan to the Benchmark plan (only until March 31, 2014), 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 3 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-00079).

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).

The renewal date will remain the same after case transfer.

Do not require a renewal 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 PRESUMPTIVE ELIGIBILITY

32.1 PRESUMPTIVE ELIGIBILITY (PE) FOR CHILDREN

Note: Wisconsin's presumptive eligibility programs are known by multiple terms: express enrollment, temporary enrollment, and presumptive eligibility. All such policy will be collectively referred to as presumptive eligibility.

Children can be presumptively eligible (PE) for the BC+ Standard Plan, 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 or lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the US) and
3. Through January 31, 2014:

    1.

- 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.

4. Effective February 1, 2014
   - If the child is younger than age 1, the child's assistance group's income must be at or below 306% of the Federal Poverty Level.
   - If the child is age 1 through 5, the child's assistance group's income must be at or below 191 % of the Federal Poverty Level.
   - If the child is age 6 through 18, the child's assistance group's income must be at or below 156% of the Federal Poverty Level

Note: See section 16.1.2 for additional information on *MAGI* income disregards.

Presumptive eligibility can begin on the day on which a qualified provider determines that the child meets the criteria listed above by completing an application for a presumptive eligibility determination through ACCESS APP.

A child is allowed to have only one period of presumptive eligibility 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. Qualified Hospitals
10. Any other entity the state so deems as approved by the Secretary.

Once certified by *fiscal agent* to enroll children through the presumptive eligibility category, the PE certifying agencies will:

1. Complete an online PE application through the ACCESS Partners/Providers portal designed for PE determinations.

2. Provide a temporary BC+ card for the child if s/he meets the non-financial and financial criteria for PE.

3. Provide a denial notice to the child if s/he does not meet the requirements for PE.

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 presumptively eligible, the child will remain enrolled until the last day of the calendar month after the month in which the presumptive eligibility is granted.

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 determined presumptively eligible, the enrollment period ends the day on which the agency completes processing the BC+ application, regardless of the result of the eligibility determination.

If a BC+ application is not submitted by the end of the month following the month in which the child was temporarily enrolled, the PE period ends the last day of the month following the month in which the child was enrolled.

Example: Joe Green applied for BC+ PE for his son Jim on February 4th at the Center Street Boys Club. Jim was found presumptively eligible for BC+ from February 4th through March 31st. Joe submits a BC+ ACCESS application to the local IM agency on February 10th. The agency completes processing the application on March 1st. Jim is found ineligible for BC+ for February and March and the application is denied. A notice is sent to Joe informing him Jim is not eligible for BC+ and his BC+ presumptive

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32.2 PRESUMPTIVE ELIGIBILITY (PE) 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 are presumptively eligible for BC+ by meeting the following financial and non-financial criteria:

1. Currently pregnant,

2. A U.S. Citizen or lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the U.S.), and
3. Through January 31, 2014,
    - Family income at or below 300% of FPL

4. Effective February 1, 2014,

    - Has assistance group income at or below 306% of the FPL, and
    - Has not been found presumptively eligible for BC+ through EE for Pregnant Women at any time during her current pregnancy.

Through January 31, 2014, if the pregnant woman's income is at or below 200% of the FPL, she will be eligible for prenatal services under the Standard Plan, if it is between 201% and 300% of the FPL, she will be eligible for prenatal services under the Benchmark Plan. Beginning February 1, 2014, she will be eligible for out-patient services under the Standard Plan, regardless of her income at or below 306% of the FPL.

The provider will:

1. Medically verify the pregnancy.

    Note: Pregnancy will no longer be required to be verified for PE effective February 1, 2014.

2. Complete a BC+ PE for Pregnant Women application .
3. Provide a temporary BC+ card if she meets the non-financial and financial criteria for PE.
4. Provide a denial notice if she does not meet the requirements for PE.
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 https://access.wisconsin.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 PE 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 found presumptively eligible, the enrollment period ends the day on which the agency determines her eligibility, regardless of the result of the determination.

Example: Sandra's was enrolled in BC+ through the EE for Pregnant Women Program from January 10th through February 28th. She applied for regular BC+ eligibility through the IM agency on January 15th and was found eligible effective January 1st. Her PE 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 PE for pregnant women, the PE period ends the last day of the month following the month in which she was determined eligible for PE for pregnant women. If she is found ineligible for BC+, her enrollment will end following *adverse action* notice.

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32.3 PRESUMPTIVE ELIGIBILITY FOR ADULTS

Effective April 1, 2014, qualified hospitals can make presumptive eligibility determinations for parents, caretakers and childless adults for the BC+ Standard Plan if they meet the following financial and non-financial criteria:

1. Has assistance group income at or below 100% of the FPL, and
2. Is one of the following:
    - U.S. Citizen,
    - Lawfully residing in the United States for at least 5 years,
    - Lawfully residing in the United States and a refugee or is seeking asylum,
    - From Cuba or Haiti and is lawfully residing in the United States, or
    - Lawfully residing in the United States under one of the eligible immigration statuses listed in section 4.3.4.

Parents, caretakers and childless adults will be limited to one PE period within a rolling 12-month period, starting with the effective date of the initial PE period. Hospitals are required to assist applicants with the completion of the full Medicaid and BadgerCare Plus application.

Note: Please see the Medicaid Eligibility Handbook Chapter 36.2.2.1 for information on presumptive eligibility under the Wisconsin Well Women Medicaid program for women under age 65 with breast or cervical cancer.

Qualified hospitals will be allowed to make PE determinations for patients who are inmates of public correctional institutions that are not state correctional facilities (e.g., county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The PE determination process for these patients will be the same as for other patients. Patients who are inmates of a state correctional facility are not eligible for Medicaid or BadgerCare Plus through the hospital PE process.

Once a qualified hospital determines the parent, caretaker or childless adult presumptively eligible, the individual will remain enrolled until the last day of the calendar month after the month in which the presumptive eligibility is granted.

If an application is made for BC+ at the local agency by the end of the month following the month in which the individual was determined presumptively eligible, the enrollment period ends the day on which the agency completes processing the BC+ application, regardless of the result of the eligibility determination.

If a BC+ application is not submitted by the end of the month following the month in which the individual was temporarily enrolled, the PE period ends the last day of the month following the month in which the individual was enrolled.

This page last updated in Release Number: 14-01
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32.4 AT THE IM AGENCY

If an individual who has been determined presumptively eligible for BC+ applies for full BC+ at the IM agency on or before the last day of the PE period:

- Verify the individual is temporarily enrolled by checking his or her temporary BC+ ID card or MMIS.
- Assist him or 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 the application by the end of her PE period, extend the enrollment period for an additional calendar month. Prior to the last date of the presumptive eligibility period, complete a paper Medicaid/BadgerCare Plus Certification form (F-10110, former DES 3070) and send to the fiscal agent or extend the PE eligibility through the manual certification process in the ForwardHealth portal. Enter the extended date for the presumptive eligibility enrollment for the individual and use the following medical status codes:

For enrollment period extensions to a date up through January 31, 2014:

Med Stat	Population
BU	Children
BV	Pregnant women eligible under the Standard Plan
BW	Pregnant women eligible under the Benchmark Plan

Note: Beginning February 1, 2014, all eligible PE women at or below 306% of the FPL will be eligible under the Standard Plan. Presumptive eligibility for parents, caretakers and childless adults is not effective until April 1, 2014, so no enrollment period extension is available to these individuals prior to this date.

For enrollment period extensions to a date after February 1, 2014:

Med Stat	Population
9J	Children under age 1 with assistance group income above 200% FPL and at or below 306% FPL
7Q	Children under age 1 with assistance group income above 133% FPL and at or below 200% FPL
EC	Children under age 1 with assistance group income at or below 133% FPL
7S	Children age 1 through 5 with assistance group income above 156% FPL and at or below 191% FPL
BU	Children age 1 through 18 with assistance group income at or below 156% FPL
9E	Pregnant women with assistance group income above 200% FPL and at or below 306% FPL
BV	Pregnant women with assistance group income at or below 200% FPL
PP	Parents and caretakers*
PN	Childless adults*

* The medical status codes PP and PN are not effective until April 1, 2014.

Once the full BC+ application is processed, if the individual is found ineligible for BC+, complete a negative notice (F-16001) to end the PE period. 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 PE end date is the day the woman is found ineligible for BC+.

If the individual does not apply for BC+, or applies after the end of the month following the month in which he or she was determined presumptively eligible, his or her PE period ends with no extension. Sending a negative notice is not necessary. If the individual applies after the end of the month following the month he or she was determined eligible, process the application as you would a standard BC+ application.

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32.5 QUALIFIED HOSPITALS FOR PRESUMPTIVE ELIGIBILITY (PE)

(This section is new with this release.)

Qualified hospitals can make PE determinations for the following populations:

- Children
- Pregnant women
- Individuals applying for FPOS
- Parents and caretakers
- Childless adults
- Women under age 65 with breast or cervical cancer

Only qualified hospitals are allowed to make presumptive eligibility determinations for parents, caretakers and childless adults. Other types of providers or partners are not allowed to made presumptive eligibility determinations for these populations.

Qualified hospitals will be allowed to make PE determinations for patients who are inmates of public correctional institutions that are not state correctional facilities (e.g., county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The PE determination process for these patients will be the same as for other patients. Patients who are inmates of a state correctional facility are not eligible for Medicaid or BadgerCare Plus through the hospital PE process.

For the purposes of PE, a “hospital” is defined as an inpatient hospital facility or an outpatient hospital facility located within the four walls of an inpatient hospital facility, consistent with the definition of “hospital” for the purpose of billing Medicaid. These facilities are enrolled in Wisconsin Medicaid as Provider Type 01 or Provider Type 58.

Becoming a qualified hospital for PE is a straightforward process and there is no cost for this designation. Hospitals will be required to notify ForwardHealth of their interest in becoming a qualified hospital for PE via the ForwardHealth Portal: forwardhealth.wi.gov.

Qualified hospitals engaging in the PE process are subject to standards on assisting the patient with also submitting a BadgerCare Plus application for ongoing coverage after the PE period ends. For patients determined eligible for PE for FPOS, qualified hospitals are subject to standards on assisting the patient with submitting a BadgerCare Plus application or a FPOS application.

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33-37 RESERVED

RESERVED

PROGRAM COVERAGE (CHAPTERS 38-47)

38 COVERED SERVICES

38.1 COVERED SERVICES

A covered service is any health care service that BC+ will pay for an eligible member, if billed. The Division of Health Care Access and Accountability (DHCAA) enrolls qualified health care providers and reimburses them for providing BC+ covered services to eligible BC+ members. Members may receive BC+ services only from enrolled 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-enrolled provider.

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38.2 STANDARD PLAN

38.2.1 Introduction
38.2.2 Copayment

38.2.1 Introduction

Effective April 1, 2014, all BC+ members are covered under the Standard Plan. The following chart shows some of the covered services and co-payments under the Standard Plan.

Services	BadgerCare Plus Standard Plan
Chiropractic Services	Full coverage. Co-payment $.50 to $3 per service (varies by service provided).
Dental	Full coverage of preventive, restorative and palliative services. Co-payment $.50 to $3 per service (varies by service provided).
Disposable Medical	Full coverage.

Supplies (DMS)	Co-payment $0.50 to $3.00 per service.
Drugs (See also 38.7 Impact on Dual Eligible Individuals)	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to 5 prescriptions per month for opioid drugs. Co-payments: $0.50 for OTC Drugs $1.00 for Generic Drugs $3.00 for Brand Name Drugs Co-payments are limited to $12.00 per member, per provider, per month. OTCs are excluded from this $12.00 maximum.
Durable Medical Equipment (DME)	Full coverage. Co-payment $0.50 to $3.00 per item (varies by item provided). Rental items are not subject to a co-payment.
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.
Hearing Services	Full coverage. Co-payment $.50 to $3 per procedure. No co-payments for hearing aid batteries.
Home Care Services (home health, private duty nursing and personal care)	Full coverage. No co-payment.
Hospice	Full coverage. No co-payment.
Hospital - Inpatient	Full coverage. Co-payment $3 per day with a $75 cap per stay.
Hospital - Outpatient	Full coverage.

	Co-payment $3 per visit.
Hospital - Outpatient Emergency Room	Full coverage. No co-payment.
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.
Nursing Home	Full coverage. 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.)
Physician Visits	Full coverage, including laboratory and radiology. Co-payment $.50 to $3 co-payment per service (varies by service provided). Llimited to $30 per provider per calendar year. No co-payment for emergency services, anesthesia or clozapine management.
Podiatric Services	Full coverage. Co-payment $.50 to $3 per service.
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.
Reproductive Health	Full coverage, excluding infertility treatments,

Services	surrogate parenting and related services, including but not limited to artificial insemination, and subsequent obstetrical care as a non covered service, 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).
Smoking Cessation Services	Coverage includes prescription and over-the-counter tobacco cessation products. 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.

If you or the member has additional questions, contact Member Services at 1-800-362-3002.

38.2.2 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".

Through March 31, 2014, the co-payment policy is as follows:

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.

<u>Effective April 1, 2014, the co-payment policy is as follows:</u>

Providers are prohibited from collecting co-payment from the following members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
    - Children in foster care, regardless of age.
    - Children in adoption assistance, regardless of age.
    - Children under age one with income up to 150 percent of the FPL.
    - Children ages 1 through 5 with income up to 185 percent of the FPL.

  - Children ages 6 through 18 years of age with incomes at or below 133 percent of the FPL.

- Children in the Katie Beckett program, regardless of age.
- Children under 19 eligible through Express Enrollment.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP.
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.
- Women enrolled in Wisconsin Well Woman Medicaid.

The following services do not require co-payment:

- Case management services.
- Crisis intervention services.
- Community support program services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck.
- HealthCheck "Other Services."
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- Pregnancy related services.
- Preventive services with an A or B rating from the U.S. Preventive Services Task Force.
- School-based services.
- Substance abuse day treatment services.
- Surgical assistance.

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38.3 TRANSPORTATION

38.3.1 Ambulance

38.3.2 Specialized Medical Vehicle (SMV)
38.3.3 Common Carrier
38.3.4 Transportation Coordination

Federal regulations require the Medicaid program provide transportation for members who have no other way to receive a ride to their Medicaid health care appointments. Transportation can be by ambulance, specialized medical vehicle (SMV) or common carrier.

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 transportation when use of any other method of transportation is contraindicated and is authorized in writing by a physician, physician assistant, nurse midwife, nurse practitioner, or registered nurse.

38.3.2 Specialized Medical Vehicle (SMV)

An SMV is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of an SMV must meet driver requirements in accordance with DHS 105.39 Wis. Admin Code.

SMV transportation is a covered service if provided by a BC+ SMV enrolled provider and a health care provider has documented why the member's condition prevents him/her from using a common carrier or private vehicle

38.3.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

38.3.4 Transportation Coordination

Non-emergency Medical Transportation (NEMT) is coordinated by Department of Health Services' NEMT manager, Medical Transportation Management, Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include ambulance, SMV

or common carrier transportation depending on a member's medical and transportation needs.

The NEMT manager does not coordinate transportation for the following members:

- Members who are residing in a nursing home.
  - Members residing in a nursing home have their NEMT services coordinated by the nursing home.

- Members who are enrolled in Family Care.
  - Members enrolled in Family Care receive NEMT services from the Family Care Managed Care Organization (MCO).

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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 lives in an area covered by two or more HMOs, enrollment is mandatory. In areas with only one available HMO, enrollment is voluntary and the process stops here.

3. If the member lives in a mandatory area and does not choose and HMO, 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 can be disenrolled by the HMO's request in the following situations:

1. They become inmates of a public institution.
2. They need an experimental transplant.

Note: HMO disenrollment is not automatic in these situations.

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 BC+ Cards Introduction
38.5.1.1 BadgerCare Plus & Medicaid Card Image
38.5.1.2 BadgerCare Basic Plan Card Image
38.5.1.3 BadgerCare Core Plan Card Image
38.5.1.4 SeniorCare Card Image
38.5.1.5 Wisconsin Well Woman Program Card Image
38.5.2 Appeals
38.5.3 Homeless
38.5.4 Pharmacy Services Lock-in Program
38.5.5 Temporary Cards
38.5.6. Lost-Stolen Cards

38.5.1 BC+ Cards Introduction

All BC+ members are issued ForwardHealth cards. These cards are plastic and display the words: **ForwardHealth**.

Note: Members who were previously enrolled in the BadgerCare Core Plan or the BadgerCare Plus Basic Plan received cards with the program names listed. These programs ended on March 31, 2014.

Members use the same ForwardHealth card each month to receive services on a fee for service basis and/or through a managed care organization, if enrolled. Monthly cards are not issued.

Each person in the family who is eligible receives his/her own card for the Benefit Plan for which they are eligible. Members may have multiple ID cards if they have been in one or more of the plans listed above.

The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Members will know if they are eligible, and for which Benefit Plan, based on positive and negative notices sent from the IM agency. They will also receive separate notices if enrolled in a Managed Care Organization. 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 log into ACCESS> Change My Benefits or call Member Services at 1-800-362-3002.

38.5.1.1 BadgerCare Plus & Medicaid Card Image

38.5.1.2 SeniorCare Card Image

38.5.1.3 Wisconsin Well Woman Program Card Image

38.5.2 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.

38.5.3 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.

38.5.4 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:

Wisconsin Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

38.5.5 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering from HP.

38.5.6. Lost-Stolen Cards

If a member needs a replacement card, s/he or an *authorized representative* , can request a replacement card by:

1. Going to ACCESS
    - Create a MyACCESS Account, then
    - Go to your MyACCESS Page and select a new ForwardHealth Card, or

2. Contacting Member Services at 1-800-362-3002.

Workers may also log into the Partner Portal and select "Replacement ID Card Request" under the Quick Links on the right side of the page.

If the member has multiple benefit ID cards, there will be a choice of which ID card to request. A new ForwardHealth card will be created the evening of the request and will be sent out the following business day.

Replacement cards are issued automatically when the card has been returned as undeliverable and the member's address changes.

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:

Forward Health iChange
P.O. Box 7636
Madison, WI 53707-7636
Fax: (608) 221-8815

Send completed 3070 forms by:

1. Mail: HP Enterprise Services
P.O. Box 7636
Madison, WI 53707

2. 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 interChange 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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38.7 IMPACT ON DUAL ELIGIBLE INDIVIDUALS

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for BadgerCare Plus under a Title 19 (Medicaid) funded Med Stat Code (51.1), are referred to as Dual Eligible individuals. Since January 1, 2006, Medicaid does not provide prescription drug coverage for these individuals. Instead these individuals receive prescription drug coverage through Medicare Part D.

These Dual Eligible individuals are deemed eligible for "Extra Help" from CMS to help pay for their Medicare Part D drug costs.

A Medicare Part D Preferred Drug Plan (PDP) card will be issued to them and it must be used for prescription drugs instead of their Forward Card.

For more information on Medicare Part D, see:
http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx

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39 EMERGENCY SERVICES

39.1 EMERGENCY SERVICES INCOME LIMITS

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. Immigrants who meet the criteria for BadgerCare Plus under

the childless adults' coverage group under *MAGI* rules will also be ineligible 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 Through January 31, 2014

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
Former Foster Care Youth	Any FPL Level
Parents and Caretakers	Up to 200% FPL

BC+ Emergency Services Income Limit Effective February 1, 2014

A 5% income disregard and 1% conversion factor will be applied to the Emergency Services income limit for pregnant women and children effective January 1, 2014.

Group	Income
Pregnant Women	Up to 306% FPL
Newborns to age 1	Up to 306% FPL
Children ages 1 - 5	Up to 191% FPL
Children ages 6 - 18	Up to 156% FPL
Former Foster Care Youth	Any FPL Level
Parents and Caretakers	Up to 100% 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

39.2.1 Determining Eligibility
39.2.2 Providing Manual Positive Or Negative Notice

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 (F-10110 or DES 3070). See Process Help 81.3. 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.

Note: The *Federally Facilitated Marketplace* will send accounts to State consortia and tribal agencies for individuals who have been assessed as potentially eligible for BC+ Emergency Services.

The F-10110 may be submitted to the fiscal agent in the following ways:

1. Mail: Forward Health iChange

   P.O. Box 7636
   Madison, WI 53707-7636

2. 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 the BC+ Prenatal Program will be issued a ForwardHealth Card, which can also be used to access emergency services under the Emergency Services coverage group after the BC+ Prenatal Program coverage 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. 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.

Note: As of January 1, 2014, pregnancy is no longer required to be verified.

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 18th. On March 15th, Guadeloupe applied for BC+ Emergency Services for both the February hospital stay and her pregnancy, with a verified due date of April 15th. Certify Guadalupe for BC+ Emergency Services from February 18th 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 10th. 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 on January 15th. Her expected due date is May 10th. 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 10th. 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 FPL (under *non-MAGI* rules) or 306% FPL (under *MAGI* rules) and who are:

1. Of child bearing age (defined as 15 years or older), and
2. Not enrolled in BC+ or receiving other full benefit Medicaid.

For more information about income disregards under MAGI rules, see 16.1.2.

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 Wisconsin Well Woman Medicaid plan. (See MEH chapter 36)"

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40.2 FPOS PRESUMPTIVE ELIGIBILITY (PE)

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 306% FPL, and is:

1. Of child bearing age (defined as 15 years or older), and
2. A Wisconsin resident, and
3. Not enrolled in BC+ or receiving full benefit Medicaid,
4. One of the following:

   For individuals under 19:
   - U.S. Citizen, or
   - Lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).

   For individuals age 19 and older:
   - U.S. Citizen;
   - Lawfully residing in the United Status under one of the eligible immigration statuses/situations listed in section 4.3.4.

For more information about income disregards under MAGI rules, see 16.1.2.

The qualified provider should refer non-citizens to the Income Maintenance Agency (IM) for a BC+ eligibility determination.

FPOS PE 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 found presumptively eligible, the enrollment period ends the day on which the agency determines his/her eligibility.

FPOS PE 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 determines if an individual is temporarily enrolled for FPOS. If the member is eligible, the qualified provider will:

1. Complete and sign the Presumptive Eligibility 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 PE 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 presumptive eligibility period depends on when the member applies for BC+ and ongoing FPOS benefits through the 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 PE, the ongoing FPOS period begins the first of the month in which the member applied and is found eligible. The FPOS presumptive eligibility period ends the day before the members ongoing FPOS period begins.

Example 1: Amber applied for FPOS PE 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 PE, the FPOS presumptive eligibility period ends the last day of the second month following the month in which the member was determined eligible for FPOS PE.

Example 2: Brenda applied for FPOS PE on April 3, 2011. Her FPOS PE continues through May 31, 2011. Brenda does not apply for ongoing FPOS until August 15, 2011 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 presumptive eligibility period:

1. Verify the member is presumptively 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 presumptive eligibility period, submit an F-10110 to extend the FPOS presumptive eligibility period 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. Of child bearing age (defined as 15 years or older),
2. A Wisconsin resident, and
3. Not be enrolled in BC+ or receiving other full benefit Medicaid.
4. One of the following:

For individuals under age 19:

- Lawfully residing in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).

For non-pregnant individuals age 19 and older:

- U.S. Citizen; or
- Lawfully residing in the United States under one of the eligible immigration statuses/situations listed in section 4.3.4.

5. Meet all BC+ non-financial criteria (See Section 2.1) 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 REQUIREMENTS

40.5.1 Financial Eligibility Requirements Specific to FPOS
40.5.2 Income Under MAGI Rules

40.5.1 Financial Eligibility Requirements Specific to FPOS

The following specific financial eligibility requirements apply to *FPOS* members, regardless of the methodology used to determine his or her *FPOS* income:

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.
4. All changes in income will be applied at the 12-month *FPOS* eligibility renewal.

40.5.2 Income Under MAGI Rules

Because FPOS eligibility is determined based on a group size of one, the applicant's taxable earned and unearned income is the only income that should be used when calculating their income for purposes of FPOS eligibility under MAGI rules. When a child under 19 is applying, their parents' income is not included in his or her eligibility determination. If a married individual is applying for FPOS coverage, do not include the income of the spouse, even if he or she is living with his or her spouse.

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40.6 FPOS GROUP

40.6.1 Fetus
40.6.2 Children 18 Years of Age
40.6.3 FPOS Group under MAGI Rules
40.6.4 Transitioning to MAGI Rules

40.6.1 Fetus

For *non-MAGI* based FPOS groups, 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

For *non-MAGI* based FPOS groups, 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.

40.6.3 FPOS Group under MAGI Rules

For all individuals, including children under 19, whose eligibility for *FPOS* is determined under *MAGI* rules, the group size of the applicant will always be one, regardless of his/her marital status, pregnancy status, and whether or not s/he has children or tax dependents.

40.6.4 Transitioning to MAGI Rules

Current *FPOS* members whose eligibility for the program is based on *non-MAGI* rules will transition to *MAGI* rules in the same manner as BC+ members: on March 31, 2014 or their regularly scheduled 2014 renewal, whichever is later.

All applicants to the *FPOS* program who apply on or after February 1, 2014 will have his or her eligibility determined under *MAGI* rules.

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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. S/he will be enrolled in BC+.

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. However, s/he will continue to receive the same family planning services through BC+/MA.

Example: Theresa is an 18-year-old woman applying for MA, BC+ and FPOS for herself and for BC+ for her daughter Sara (age three). 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

Members 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 moving out of state, incarceration, etc. within 10 days of the change.

Changes reported in household composition or income 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.

Note: Household composition changes will not affect eligibility when the member's eligibility is determined using *MAGI* rules in 2014, as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

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+ or becomes eligible for other full benefit Medicaid.
4. Becomes an inmate of a public institution.

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40.9 FPOS BC+ EXTENSION PHASE

An *FPOS* member enters into a FPOS extension phase if 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.

The extension continues until the renewal date that was originally set for the FPOS eligibility.

Note: Household composition changes will not affect eligibility when the member's eligibility is determined using *MAGI* rules in 2014, as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

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40.10 FPOS REVIEWS AND RECERTIFICATIONS

A renewal/recertification (Chapter 26) is required every 12 months, after an initial eligibility determination. At the time of the *FPOS* renewal, income and household composition are again tested against the FPOS eligibility criteria.

If a member completes a renewal for another program of assistance at any time during the 12 month FPOS *certification period* and the information collected from that renewal indicates that she still meets FPOS eligibility requirements, the FPOS renewal date will be set 12 months from that renewal date.

If a member completes a renewal for another program of assistance at any time before the 12th month of FPOS eligibility ends, and no longer meets the FPOS eligibility requirements, s/he will enter into an FPOS extension phase. S/he will be required to complete a renewal at the end of the original 12-month certification period. If at this renewal, s/he is found to still have income in excess of the FPOS limit, eligibility for FPOS ends.

Through December 31, 2013, FPOS cases can be selected for administrative renewal (26.1.2). These cases must meet all the following criteria to be selected for this process:

- No child in household turning 18 in current or next month
- Countable income of individuals age 18 and above at or below 275% of the FPL.

Administrative renewals for FPOS case will not be allowed in 2014.

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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 PROGRAM

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+ outside of incarceration or immigration status
- Have verified pregnancies, and
- Are not eligible for BC+ because they are either inmates of a public institution or *Non-qualifying immigrants*.

Note: Pregnancy will no longer be verified for the BC+ Prenatal Program beginning on January 1, 2014. Only verify pregnancy if the worker has information that contradicts the member or *applicant*'s self-declared information.

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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 FPL (under *non-MAGI* rules) or 306% of the FPL (under *MAGI* rules).
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 or to any State of Wisconsin health insurance plan.
3. The applicant must provide any required verifications.

Note: For eligibility beginning on or after January 1, 2014, pregnancy will only be verified if the worker has information that contradicts the applicant's self-declared information.

4. The applicant must not have health insurance coverage (Chapter 7) through any HIPAA standard plan 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 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.
5. There is no 3-month backdating option available for Prenatal Program members.
6. Unlike BC+ for Pregnant Women, Prenatal Program members are not eligible for the 60-day pregnancy extension, but are eligible for Emergency Services during that time.

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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 Program.
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 Program.
3. A non-qualifying immigrant whose immigration status changes while she is pregnant and receiving BC+ Prenatal benefits must have her eligibility re-determined using the new immigration status. If her new status makes her

eligible for BC+ for Pregnant Women, 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. For *applicants* whose eligibility is beginning prior to December 31, 2013, the pregnancy must be verified before eligibility can begin.

Example: An application for *BC+PP* is received on October 20, 2013. The agency does not receive a verification of the pregnancy until November 5th. BC+PP is denied for October due to lack of pregnancy verification in that month. If the woman is otherwise eligible for BC+PP, eligibility may begin on November 1st.

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

41.7.1 The BC+ Prenatal Group through January, 31, 2014
41.7.2 The BC+ Prenatal Group after February 1, 2014

41.7.1 The BC+ Prenatal Group through January 31, 2014

For individuals who applied prior to January 31, 2014, continue to form the BC+ Prenatal group according to the following rules:

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 father	2	EA	XA	
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

41.7.2 The BC+ Prenatal Group After February 1, 2014

Effective February 1, 2014, all new applicants for the BC+ Prenatal Program will have their eligibility determined under MAGI rules. Follow the rules outlined in Chapter 2 in order to form group size.

Beginning January 1, 2014, pregnancy, the number of fetuses, and the due date are not required to be verified unless the worker has information that contradicts the applicant's self-declared information. The effective begin date for the BC+ Prenatal Program is the first of the month in which they apply and are otherwise eligible.

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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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43 BADGERCARE PLUS CORE PLAN

43.1 BADGERCARE PLUS CORE PLAN

The BadgerCare Plus Core Plan ended on March 31, 2014. This entire chapter has been removed. To see policy history about the BadgerCare Plus Core Plan, refer to Chapter 43 in the previous PDF versions of the BadgerCare Plus Handbook prior to Release 14-02.

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44 RESERVED

RESERVED

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45 BC+ BASIC PLAN

45.1 BADGERCARE PLUS BASIC PLAN

The BadgerCare Plus Basic Plan ended on March 31, 2014. This entire chapter has been removed. To see policy history about the BadgerCare Plus Basic Plan, refer to Chapter 45 in the previous PDF versions of the BadgerCare Plus Handbook prior to Release 14-02.

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42, 46-47 RESERVED

RESERVED

TABLES (CHAPTERS 48-52)

48 PREMIUMS

48.1 BC+ PREMIUM TABLES

48.1.1 Premiums for Children
48.1.2 Premiums for Adults
48.1.3 Premiums for Adult Caretaker Families with Self Employment Income

48.1.1 Premiums for Children

Under *non-MAGI* rules, group premiums (the total of the premiums of the children 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.

The below table outlines the premium amounts for children whose income is determined under non-MAGI rules.

FPL Income Range	Above 200% to 209.99%	210% to 219.99%	220% to 229.99%	230% to 239.99%	240% to 249.99%	250% to 259.99%	260% to 269.99%	270% to 279.99%	280% to 289.99%	290% to 299.99%	300% and above
Premium Amounts	$10	$10	$10	$15	$23	$34	$44	$55	$68	$82	$97.53

Under *MAGI* rules, non-exempt children whose BadgerCare Plus eligibility is determined under MAGI rules and with an assistance group income above 201% of the FPL will be required to pay premiums. Each child's premium will be based on their own assistance group's size and income. The 5% cap for the cost of total household premiums for children will continue to apply. The cap will be 5% of the income of the premium paying assistance group with the highest countable income amount. The total household's premiums will be determined based on the combined amount of all children's premiums or the 5% cap, whichever amount is less. See sections 19.2 and 19.3 for more information on premium caps.

The below table outlines the premium amounts for children whose income is determined under MAGI rules.

FPL Income Range	Above 201% to 210.99%	211% to 220.99%	221% to 230.99%	231% to 240.99%	241% to 250.99%	251% to 260.99%	261% to 270.99%	271% to 280.99%	281% to 290.99%	291% to 300.99%	301% to 306.00%
Premium Amounts	$10	$10	$10	$15	$23	$34	$44	$55	$68	$82	$97.53

Note: Children in extensions are not required to pay premiums (see section 19.1). If a parent in the household is in an extension, the children are exempt from paying premiums regardless of their income.

48.1.2 Premiums for Adults

The tables below provide the range of premiums for adults in BadgerCare Plus and the Core Plan based on family size and income level. The amounts listed for households with incomes over 200% of the FPL apply to families in a BadgerCare Plus Extension and to Core Plan members whose income increases after their renewal approval.

Note: The BC+ Core Plan ends March 31, 2014. (see Chapter 43).

BC+ parents, caretakers and childless adults with income at or below 100% FPL are not required to pay premiums. Non-exempt parents and caretakers in an extension with income above 133% FPL are required to pay premiums. Effective with extensions that begin on or after April 1, 2014, non-exempt parents and caretakers in an extension with income between 100 and 133% FPL are required to pay premiums starting in the seventh calendar month of their extension.

Click the link below to find the premiums for different family sizes.

Family Size 1 Family Size 6
Family Size 2 Family Size 7
Family Size 3 Family Size 8
Family Size 4 Family Size 9
Family Size 5 Family Size 10

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
1	133.01 - 139.99%	$1,293.43 - 1,361.49	3.0%	$39 - 41
	140% - 149.99%	$1,361.50 - 1,458.74	3.5%	$48 - 51
	150% - 159.99%	$1,458.75 - 1,555.99	4.0%	$58 - 62
	160% - 169.99%	$1,556.00 - 1,653.24	4.5%	$70 - 74
	170% - 179.99%	$1,653.25 - 1,750.49	4.9%	$81 - 86
	180% - 189.99%	$1,750.50 - 1,847.74	5.4%	$95 - 100
	190% - 199.99%	$1,847.75 - 1,944.99	5.8%	$107 - 113
	200% - 209.99%	$1,945.00 - 2,042.24	6.3%	$123 - 129
	210% - 219.99%	$2,042.25 - 2,139.49	6.7%	$137 - 143
	220% - 229.99%	$2,139.50 - 2,236.74	7.0%	$150 - 157
	230% - 239.99%	$2,236.75 - 2,333.99	7.4%	$166 - 173
	240% - 249.99%	$2,334.00 - 2,431.24	7.7%	$180 - 187
	250% - 259.99%	$2,431.25 - 2,528.49	8.1%	$197 - 205
	260% - 269.99%	$2,528.50 - 2,625.74	8.3%	$210 - 218
	270% - 279.99%	$2,625.75 - 2,722.99	8.6%	$226 - 234
	280% - 289.99%	$2,723.00 - 2,820.24	8.9%	$242 - 251
	290% - 299.99%	$2,820.25 - 2,917.49	9.2%	$259 - 268
	300%+	$2,917.50+	9.5%	$277+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
2	133.01 - 139.99%	$1,743.41 - 1,835.16	3.0%	$52 - 55
	140% - 149.99%	$1,835.17 - 1,966.24	3.5%	$64 - 69
	150% - 159.99%	$1,966.25 - 2,097.32	4.0%	$79 - 84
	160% - 169.99%	$2,097.33 - 2,228.41	4.5%	$94 - 100
	170% - 179.99%	$2,228.42 - 2,359.49	4.9%	$109 - 116
	180% - 189.99%	$2,359.50 - 2,490.57	5.4%	$127 - 134
	190% - 199.99%	$2,490.58 - 2,621.66	5.8%	$144 - 152
	200% - 209.99%	$2,621.67 - 2,752.74	6.3%	$165 - 173
	210% - 219.99%	$2,752.75 - 2,883.82	6.7%	$184 - 193
	220% - 229.99%	$2,883.83 - 3,014.91	7.0%	$202 - 211
	230% - 239.99%	$3,014.92 - 3,145.99	7.4%	$223 - 233
	240% - 249.99%	$3,146.00 - 3,277.07	7.7%	$242 - 252
	250% - 259.99%	$3,277.08 - 3,408.16	8.1%	$265 - 276
	260% - 269.99%	$3,408.17 - 3,539.24	8.3%	$283 - 294
	270% - 279.99%	$3,539.25 - 3,670.32	8.6%	$304 - 316
	280% - 289.99%	$3,670.33 - 3,801.41	8.9%	$327 - 338
	290% - 299.99%	$3,801.42 - 3,932.49	9.2%	$350 - 362
	300%+	$3,932.50+	9.5%	$374+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
3	133.01 - 139.99%	$2,193.39 - 2,308.82	3.0%	$66 - 69
	140% - 149.99%	$2,308.83 - 2,473.74	3.5%	$81 - 87
	150% - 159.99%	$2,473.75 - 2,638.66	4.0%	$99 - 106
	160% - 169.99%	$2,638.67 - 2,803.57	4.5%	$119 - 126
	170% - 179.99%	$2,803.58 - 2,968.49	4.9%	$137 - 145
	180% - 189.99%	$2,968.50 - 3,133.41	5.4%	$160 - 169
	190% - 199.99%	$3,133.42 - 3,298.32	5.8%	$182 - 191
	200% - 209.99%	$3,298.33 - 3,463.24	6.3%	$208 - 218
	210% - 219.99%	$3,463.25 - 3,628.16	6.7%	$232 - 243
	220% - 229.99%	$3,628.17 - 3,793.07	7.0%	$254 - 266
	230% - 239.99%	$3,793.08 - 3,957.99	7.4%	$281 - 293
	240% - 249.99%	$3,958.00 - 4,122.91	7.7%	$305 - 317
	250% - 259.99%	$4,122.92 - 4,287.82	8.1%	$334 - 347
	260% - 269.99%	$4,287.83 - 4,452.74	8.3%	$356 - 370
	270% - 279.99%	$4,452.75 - 4,617.66	8.6%	$383 - 397
	280% - 289.99%	$4,617.67 - 4,782.57	8.9%	$411 - 426
	290% - 299.99%	$4,782.58 - 4,947.49	9.2%	$440 - 455
	300%+	$4,947.50+	9.5%	$470+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
4	133.01 - 139.99%	$2,643.38 - 2,782.49	3.0%	$79 - 83
	140% - 149.99%	$2,782.50 - 2,981.24	3.5%	$97 - 104
	150% - 159.99%	$2,981.25 - 3,179.99	4.0%	$119 - 127
	160% - 169.99%	$3,180.00 - 3,378.74	4.5%	$143 - 152
	170% - 179.99%	$3,378.75 - 3,577.49	4.9%	$166 - 175
	180% - 189.99%	$3,577.50 - 3,776.24	5.4%	$193 - 204
	190% - 199.99%	$3,776.25 - 3,974.99	5.8%	$219 - 231
	200% - 209.99%	$3,975.00 - 4,173.74	6.3%	$250 - 263
	210% - 219.99%	$4,173.75 - 4,372.49	6.7%	$280 - 293
	220% - 229.99%	$4,372.50 - 4,571.24	7.0%	$306 - 320
	230% - 239.99%	$4,571.25 - 4,769.99	7.4%	$338 - 353
	240% - 249.99%	$4,770.00 - 4,968.74	7.7%	$367 - 383
	250% - 259.99%	$4,968.75 - 5,167.49	8.1%	$402 - 419
	260% - 269.99%	$5,167.50 - 5,366.24	8.3%	$429 - 445
	270% - 279.99%	$5,366.25 - 5,564.99	8.6%	$461 - 479
	280% - 289.99%	$5,565.00 - 5,763.74	8.9%	$495 - 513
	290% - 299.99%	$5,763.75 - 5,962.49	9.2%	$530 - 549
	300%+	$5,962.50+	9.5%	$566+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
5	133.01 - 139.99%	$3,093.36 - 3,256.16	3.0%	$93 - 98
	140% - 149.99%	$3,256.17 - 3,488.74	3.5%	$114 - 122
	150% - 159.99%	$3,488.75 - 3,721.32	4.0%	$140 - 149
	160% - 169.99%	$3,721.33 - 3,953.91	4.5%	$167 - 178
	170% - 179.99%	$3,953.92 - 4,186.49	4.9%	$194 - 205
	180% - 189.99%	$4,186.50 - 4,419.07	5.4%	$226 - 239
	190% - 199.99%	$4,419.08 - 4,651.66	5.8%	$256 - 270
	200% - 209.99%	$4,651.67 - 4,884.24	6.3%	$293 - 308
	210% - 219.99%	$4,884.25 - 5,116.82	6.7%	$327 - 343
	220% - 229.99%	$5,116.83 - 5,349.41	7.0%	$358 - 374
	230% - 239.99%	$5,349.42 - 5,581.99	7.4%	$396 - 413
	240% - 249.99%	$5,582.00 - 5,814.57	7.7%	$430 - 448
	250% - 259.99%	$5,814.58 - 6,047.16	8.1%	$471 - 490
	260% - 269.99%	$6,047.17 - 6,279.74	8.3%	$502 - 521
	270% - 279.99%	$6,279.75 - 6,512.32	8.6%	$540 - 560
	280% - 289.99%	$6,512.33 - 6,744.91	8.9%	$580 - 600
	290% - 299.99%	$6,744.92 - 6,977.49	9.2%	$621 - 642
	300%+	$6,977.50+	9.5%	$663+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
6	133.01 - 139.99%	$3,543.34 - 3,729.82	3.0%	$106 - 112
	140% - 149.99%	$3,729.83 - 3,996.24	3.5%	$131 - 140
	150% - 159.99%	$3,996.25 - 4,262.66	4.0%	$160 - 171
	160% - 169.99%	$4,262.67 - 4,529.07	4.5%	$192 - 204
	170% - 179.99%	$4,529.08 - 4,795.49	4.9%	$222 - 235
	180% - 189.99%	$4,795.50 - 5,061.91	5.4%	$259 - 273
	190% - 199.99%	$5,061.92 - 5,328.32	5.8%	$294 - 309
	200% - 209.99%	$5,328.33 - 5,594.74	6.3%	$336 - 352
	210% - 219.99%	$5,594.75 - 5,861.16	6.7%	$375 - 393
	220% - 229.99%	$5,861.17 - 6,127.57	7.0%	$410 - 429
	230% - 239.99%	$6,127.58 - 6,393.99	7.4%	$453 - 473
	240% - 249.99%	$6,394.00 - 6,660.41	7.7%	$492 - 513
	250% - 259.99%	$6,660.42 - 6,926.82	8.1%	$539 - 561
	260% - 269.99%	$6,926.83 - 7,193.24	8.3%	$575 - 597
	270% - 279.99%	$7,193.25 - 7,459.66	8.6%	$619 - 642
	280% - 289.99%	$7,459.67 - 7,726.07	8.9%	$664 - 688
	290% - 299.99%	$7,726.08 - 7,992.49	9.2%	$711 - 735
	300%+	$7,992.50+	9.5%	$759+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
7	133.01 - 139.99%	$3,993.33 - 4,203.49	3.0%	$120 - 126
	140% - 149.99%	$4,203.50 - 4,503.74	3.5%	$147 - 158
	150% - 159.99%	$4,503.75 - 4,803.99	4.0%	$180 - 192
	160% - 169.99%	$4,804.00 - 5,104.24	4.5%	$216 - 230
	170% - 179.99%	$5,104.25 - 5,404.49	4.9%	$250 - 265
	180% - 189.99%	$5,404.50 - 5,704.74	5.4%	$292 - 308
	190% - 199.99%	$5,704.75 - 6,004.99	5.8%	$331 - 348
	200% - 209.99%	$6,005.00 - 6,305.24	6.3%	$378 - 397
	210% - 219.99%	$6,305.25 - 6,605.49	6.7%	$422 - 443
	220% - 229.99%	$6,605.50 - 6,905.74	7.0%	$462 - 483
	230% - 239.99%	$6,905.75 - 7,205.99	7.4%	$511 - 533
	240% - 249.99%	$7,206.00 - 7,506.24	7.7%	$555 - 578
	250% - 259.99%	$7,506.25 - 7,806.49	8.1%	$608 - 632
	260% - 269.99%	$7,806.50 - 8,106.74	8.3%	$648 - 673
	270% - 279.99%	$8,106.75 - 8,406.99	8.6%	$697 - 723
	280% - 289.99%	$8,407.00 - 8,707.24	8.9%	$748 - 775
	290% - 299.99%	$8,707.25 - 9,007.49	9.2%	$801 - 829
	300%+	$9,007.50+	9.5%	$856+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
8	133.01 - 139.99%	$4,443.31 - 4,677.16	3.0%	$133 - 140
	140% - 149.99%	$4,677.17 - 5,011.24	3.5%	$164 - 175
	150% - 159.99%	$5,011.25 - 5,345.32	4.0%	$200 - 214
	160% - 169.99%	$5,345.33 - 5,679.41	4.5%	$241 - 256
	170% - 179.99%	$5,679.42 - 6,013.49	4.9%	$278 - 295
	180% - 189.99%	$6,013.50 - 6,347.57	5.4%	$325 - 343
	190% - 199.99%	$6,347.58 - 6,681.66	5.8%	$368 - 388
	200% - 209.99%	$6,681.67 - 7,015.74	6.3%	$421 - 442
	210% - 219.99%	$7,015.75 - 7,349.82	6.7%	$470 - 492
	220% - 229.99%	$7,349.83 - 7,683.91	7.0%	$514 - 538
	230% - 239.99%	$7,683.92 - 8,017.99	7.4%	$569 - 593
	240% - 249.99%	$8,018.00 - 8,352.07	7.7%	$617 - 643
	250% - 259.99%	$8,352.08 - 8,686.16	8.1%	$677 - 704
	260% - 269.99%	$8,686.17 - 9,020.24	8.3%	$721 - 749
	270% - 279.99%	$9,020.25 - 9,354.32	8.6%	$776 - 804
	280% - 289.99%	$9,354.33 - 9,688.41	8.9%	$833 - 862
	290% - 299.99%	$9,688.42 - 10,022.49	9.2%	$891 - 922
	300%+	$10,022.50+	9.5%	$952+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
9	133.01 - 139.99%	$4,893.29 - 5,150.82	3.0%	$147 - 155
	140% - 149.99%	$5,150.83 - 5,518.74	3.5%	$180 - 193
	150% - 159.99%	$5,518.75 - 5,886.66	4.0%	$221 - 235
	160% - 169.99%	$5,886.67 - 6,254.57	4.5%	$265 - 281
	170% - 179.99%	$6,254.58 - 6,622.49	4.9%	$306 - 325
	180% - 189.99%	$6,622.50 - 6,990.41	5.4%	$358 - 377
	190% - 199.99%	$6,990.42 - 7,358.32	5.8%	$405 - 427
	200% - 209.99%	$7,358.33 - 7,726.24	6.3%	$464 - 487
	210% - 219.99%	$7,726.25 - 8,094.16	6.7%	$518 - 542
	220% - 229.99%	$8,094.17 - 8,462.07	7.0%	$567 - 592
	230% - 239.99%	$8,462.08 - 8,829.99	7.4%	$626 - 653
	240% - 249.99%	$8,830.00 - 9,197.91	7.7%	$680 - 708
	250% - 259.99%	$9,197.92 - 9,565.82	8.1%	$745 - 775
	260% - 269.99%	$9,565.83 - 9,933.74	8.3%	$794 - 825
	270% - 279.99%	$9,933.75 - 10,301.66	8.6%	$854 - 886
	280% - 289.99%	$10,301.67 - 10,669.57	8.9%	$917 - 950
	290% - 299.99%	$10,669.58 - 11,037.49	9.2%	$982 - 1,015
	300%+	$11,037.50+	9.5%	$1,049+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

Family Size	FPL %	Monthly Income	Premium Rate	Monthly Premium Range
10	133.01 - 139.99%	$5,343.28 - 5,624.49	3.0%	$160 - 169
	140% - 149.99%	$5,624.50 - 6,026.24	3.5%	$197 - 211
	150% - 159.99%	$6,026.25 - 6,427.99	4.0%	$241 - 257
	160% - 169.99%	$6,428.00 - 6,829.74	4.5%	$289 - 307
	170% - 179.99%	$6,829.75 - 7,231.49	4.9%	$335 - 354
	180% - 189.99%	$7,231.50 - 7,633.24	5.4%	$391 - 412
	190% - 199.99%	$7,633.25 - 8,034.99	5.8%	$443 - 466
	200% - 209.99%	$8,035.00 - 8,436.74	6.3%	$506 - 532
	210% - 219.99%	$8,436.75 - 8,838.49	6.7%	$565 - 592
	220% - 229.99%	$8,838.50 - 9,240.24	7.0%	$619 - 647
	230% - 239.99%	$9,240.25 - 9,641.99	7.4%	$684 - 714
	240% - 249.99%	$9,642.00 - 10,043.74	7.7%	$742 - 773
	250% - 259.99%	$10,043.75 - 10,445.49	8.1%	$814 - 846
	260% - 269.99%	$10,445.50 - 10,847.24	8.3%	$867 - 900
	270% - 279.99%	$10,847.25 - 11,248.99	8.6%	$933 - 967
	280% - 289.99%	$11,249.00 - 11,650.74	8.9%	$1,001 - 1,037
	290% - 299.99%	$11,650.75 - 12,052.49	9.2%	$1,072 - 1,109
	300%+	$12,052.50+	9.5%	$1,145+

For incomes over 300% FPL, multiply the net income times .095 and round to the nearest dollar to get the premium amount.

48.1.3 Premiums for Adult Caretaker Families with Self Employment Income

The table 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.

Note: These amounts only apply to self-employed parents and caretakers who applied prior to February 1, 2014 and have their eligibility determined under non-MAGI rules. Self-employment parents and caretakers who apply on or after February 1, 2014 will have their eligibility determined under MAGI rules, which considers depreciation to be an allowable expense. Eligibility ends March 31, 2014, for self-employed parents and caretakers with incomes over 100% of the FPL.

Group Size	200-210%	210-220%	220-230%	230-240%	240-250%	250-260%	260-270%	270-280%	280-290%	290-300%	300%
1	97.00	102.00	106.00	111.00	116.00	121.00	126.00	131.00	136.00	141.00	145.00
2	131.00	137.00	144.00	150.00	157.00	163.00	170.00	176.00	183.00	190.00	196.00
3	164.00	173.00	181.00	189.00	197.00	206.00	214.00	222.00	230.00	239.00	247.00
4	198.00	208.00	218.00	228.00	238.00	248.00	258.00	268.00	278.00	288.00	298.00
5	232.00	244.00	255.00	267.00	279.00	290.00	302.00	313.00	325.00	337.00	348.00
6	266.00	279.00	293.00	306.00	319.00	333.00	346.00	359.00	372.00	386.00	399.00
7	300.00	315.00	330.00	345.00	360.00	375.00	390.00	405.00	420.00	435.00	450.00
8	334.00	350.00	367.00	384.00	400.00	417.00	434.00	451.00	467.00	484.00	501.00
9	367.00	386.00	404.00	423.00	441.00	459.00	478.00	496.00	515.00	533.00	551.00
10	401.00	421.00	441.00	462.00	482.00	502.00	522.00	542.00	562.00	582.00	602.00
11	435.00	457.00	479.00	500.00	522.00	544.00	566.00	588.00	609.00	631.00	653.00
12	469.00	492.00	516.00	539.00	563.00	586.00	610.00	633.00	657.00	680.00	704.00
13	503.00	528.00	553.00	578.00	603.00	629.00	654.00	679.00	704.00	729.00	754.00
14	537.00	563.00	590.00	617.00	644.00	671.00	698.00	725.00	751.00	778.00	805.00

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49 HEALTH CARE CHOICE

49.1 HEALTH CARE CHOICE

For individuals whose eligibility is determined under *non-MAGI* rules:

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

Note: The BadgerCare Benchmark plan ends on March 31, 2014.

For individuals whose eligibility is determined under *MAGI* rules:

Once an individual has been determined eligible for EBD MA, s/he must be enrolled in EBD MA, even if they are also eligible for BC+, unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BC+. In these instances, the pregnant woman will be enrolled in BC+.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD MA and can enroll in BC+. Pending for EBD MA includes, but is not limited to, waiting for a disability determination from DDB or not eligible for Medicare. If an individual enrolled in EBD MA becomes ineligible for EBD MA for any reason, including going over the asset limit or failure to pay a MAPP premium, s/he can enroll in BC+ if s/he is still eligible to do so.

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50 FPL TABLE

50.1 FEDERAL POVERTY LEVEL (FPL) TABLE

group size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL	160% FPL
1	$11,670	$972.50	$1,167.00	$1,293.43	$1,312.88	$1,458.75	$1,517.10	$1,556.00
2	15,730	$1,310.83	$1,573.00	$1,743.41	$1,769.63	$1,966.25	$2,044.90	$2,097.33
3	19,790	$1,649.17	$1,979.00	$2,193.39	$2,226.38	$2,473.75	$2,572.70	$2,638.67
4	23,850	$1,987.50	$2,385.00	$2,643.38	$2,683.13	$2,981.25	$3,100.50	$3,180.00
5	27,910	$2,325.83	$2,791.00	$3,093.36	$3,139.88	$3,488.75	$3,628.30	$3,721.33
6	31,970	$2,664.17	$3,197.00	$3,543.34	$3,596.63	$3,996.25	$4,156.10	$4,262.67
7	36,030	$3,002.50	$3,603.00	$3,993.33	$4,053.38	$4,503.75	$4,683.90	$4,804.00
8	40,090	$3,340.83	$4,009.00	$4,443.31	$4,510.13	$5,011.25	$5,211.70	$5,345.33
9	44,150	$3,679.17	$4,415.00	$4,893.29	$4,966.88	$5,518.75	$5,739.50	$5,886.67
10	48,210	$4,017.50	$4,821.00	$5,343.28	$5,423.63	$6,026.25	$6,267.30	$6,428.00
11	52,270	$4,355.83	$5,227.00	$5,793.26	$5,880.38	$6,533.75	$6,795.10	$6,969.33
12	56,330	$4,694.17	$5,633.00	$6,243.24	$6,337.13	$7,041.25	$7,322.90	$7,510.67
13	60,390	$5,032.50	$6,039.00	$6,693.23	$6,793.88	$7,548.75	$7,850.70	$8,052.00
14	64,450	$5,370.83	$6,445.00	$7,143.21	$7,250.63	$8,056.25	$8,378.50	$8,593.33
15	68,510	$5,709.17	$6,851.00	$7,593.19	$7,707.38	$8,563.75	$8,906.30	$9,134.67
16	72,570	$6,047.50	$7,257.00	$8,043.18	$8,164.13	$9,071.25	$9,434.10	$9,676.00
17	76,630	$6,385.83	$7,663.00	$8,493.16	$8,620.88	$9,578.75	$9,961.90	$10,217.33
18	80,690	$6,724.17	$8,069.00	$8,943.14	$9,077.63	$10,086.25	$10,489.70	$10,758.67
19	84,750	$7,062.50	$8,475.00	$9,393.13	$9,534.38	$10,593.75	$11,017.50	$11,300.00
20	88,810	$7,400.83	$8,881.00	$9,843.11	$9,991.13	$11,101.25	$11,545.30	$11,841.33
21	92,870	$7,739.17	$9,287.00	$10,293.09	$10,447.88	$11,608.75	$12,073.10	$12,382.67
22	96,930	$8,077.50	$9,693.00	$10,743.08	$10,904.63	$12,116.25	$12,600.90	$12,924.00
23	100,990	$8,415.83	$10,099.00	$11,193.06	$11,361.38	$12,623.75	$13,128.70	$13,465.33
24	105,050	$8,754.17	$10,505.00	$11,643.04	$11,818.13	$13,131.25	$13,656.50	$14,006.67
each additional person	$4,060	$338.33	$406.00	$449.98	$456.75	$507.50	$527.80	$541.33

group size	185% FPL	191% FPL	200% FPL	201% FPL	240% FPL	250% FPL	300% FPL	306% FPL
1	$1,799.13	$1,857.48	$1,945.00	$1,954.73	$2,334.00	$2,431.25	$2,917.50	$2,975.8
2	$2,425.04	$2,503.69	$2,621.67	$2,634.78	$3,146.00	$3,277.08	$3,932.50	$4,011.1
3	$3,050.96	$3,149.91	$3,298.33	$3,314.83	$3,958.00	$4,122.92	$4,947.50	$5,046.4
4	$3,676.88	$3,796.13	$3,975.00	$3,994.88	$4,770.00	$4,968.75	$5,962.50	$6,081.7
5	$4,302.79	$4,442.34	$4,651.67	$4,674.93	$5,582.00	$5,814.58	$6,977.50	$7,117.0
6	$4,928.71	$5,088.56	$5,328.33	$5,354.98	$6,394.00	$6,660.42	$7,992.50	$8,152.3
7	$5,554.63	$5,734.78	$6,005.00	$6,035.03	$7,206.00	$7,506.25	$9,007.50	$9,187.6
8	$6,180.54	$6,380.99	$6,681.67	$6,715.08	$8,018.00	$8,352.08	$10,022.50	$10,222.9
9	$6,806.46	$7,027.21	$7,358.33	$7,395.13	$8,830.00	$9,197.92	$11,037.50	$11,258.2
10	$7,432.38	$7,673.43	$8,035.00	$8,075.18	$9,642.00	$10,043.75	$12,052.50	$12,293.5
11	$8,058.29	$8,319.64	$8,711.67	$8,755.23	$10,454.00	$10,889.58	$13,067.50	$13,328.8
12	$8,684.21	$8,965.86	$9,388.33	$9,435.28	$11,266.00	$11,735.42	$14,082.50	$14,364.1
13	$9,310.13	$9,612.08	$10,065.00	$10,115.33	$12,078.00	$12,581.25	$15,097.50	$15,399.4
14	$9,936.04	$10,258.29	$10,741.67	$10,795.38	$12,890.00	$13,427.08	$16,112.50	$16,434.7
15	$10,561.96	$10,904.51	$11,418.33	$11,475.43	$13,702.00	$14,272.92	$17,127.50	$17,470.0
16	$11,187.88	$11,550.73	$12,095.00	$12,155.48	$14,514.00	$15,118.75	$18,142.50	$18,505.3
17	$11,813.79	$12,196.94	$12,771.67	$12,835.53	$15,326.00	$15,964.58	$19,157.50	$19,540.6
18	$12,439.71	$12,843.16	$13,448.33	$13,515.58	$16,138.00	$16,810.42	$20,172.50	$20,575.9
19	$13,065.63	$13,489.38	$14,125.00	$14,195.63	$16,950.00	$17,656.25	$21,187.50	$21,611.2
20	$13,691.54	$14,135.59	$14,801.67	$14,875.68	$17,762.00	$18,502.08	$22,202.50	$22,646.5
21	$14,317.46	$14,781.81	$15,478.33	$15,555.73	$18,574.00	$19,347.92	$23,217.50	$23,681.8
22	$14,943.38	$15,428.03	$16,155.00	$16,235.78	$19,386.00	$20,193.75	$24,232.50	$24,717.1
23	$15,569.29	$16,074.24	$16,831.67	$16,915.83	$20,198.00	$21,039.58	$25,247.50	$25,752.4
24	$16,195.21	$16,720.46	$17,508.33	$17,595.88	$21,010.00	$21,885.42	$26,262.50	$26,787.7
each additional person	$625.92	$646.22	$676.67	$680.05	$812.00	$845.83	$1,015.00	$1,035.3

A Federal Poverty Level Calculator can be found at
http://www.needymeds.org/indices/FPL_Calculator.html.

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51 BC+ MEDICAL STATUS CODES

51.1 BADGERCARE PLUS MEDICAL STATUS CODES

For a complete list of Medical Status Codes see Process Help Chapter 81 Forward Health iChange

The following Medical Status Codes are in effect April 1, 2014 for all BadgerCare Plus members.

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 - 200%	Standard	No	No	T19
9C	Pregnant Woman	>200 - 300%	Standard	No	No	T19
9M	Pregnant Woman *Deductible*	> 300%	Standard	No	No	T19
9D	Pregnant minor under age 19	>200 - 300%	Standard	No	No	T19
BS	Pregnant non-qualifying immigrant	0 - 200%	Standard	No	No	T21 Separate CHIP
9A	Pregnant non-qualifying immigrant	>200 - 300%	Standard	No	No	T21 Separate CHIP
BX	Pregnant Inmate	0 - 200%	Standard	No	No	State Funded
9B	Pregnant Inmate	>200 - 300%	Standard	No	No	State Funded
N1	CEN - Mom on T19 on DOB	0 - 100%	Standard	No	No	T19
N4	CEN - Mom on T19 on DOB	>100 - 133%	Standard	No	No	T19
7V	EN - Mom on T19 on DOB	>133 - 150%	Standard	No	No	T19
7W	EN - Mom on T19 on DOB	>150 - 200%	Standard	Yes	No	T19
9H	CEN - Mom on T19 on DOB	>200%	Standard	Yes	No	T19
BE	Child under age 19	0 - 100%	Standard	No	No	T19
BJ	Child under age 6	>100 - 133%	Standard	No	No	T19
7J	Child under age 6	>133 - 150%	Standard	No	No	T19
7N	Child < age 1	>150 - 200%	Standard	Yes	No	T19
9F	Child < age 1	>200 - 250%	Standard	Yes	No	T19
9G	Child < age 1	>250% - 300%	Standard	Yes	No	T19
7F	Child age 1 through 5	>150 - 185%	Standard	No	No	T19

C3	Child age 1 through 5	>185 - 200%	Standard	Yes	No	T21 Separate CHIP
TF	Child age 1 through 5 who is a tribal member	>185% - 200%	Standard	No	No	T21 Separate CHIP
9U	Child age 6 through 18	>100 - 133%	Standard	No	No	T19
99	Child age 6 through 18	>133 - 150%	Standard	Yes	No	T21
BG	Child age 6 through 18	>150 - 200%	Standard	Yes	No	T21 Separate CHIP
TG	Child age 6 through 18 who is a tribal member	>150% - 200%	Standard	No	No	T21 Separate CHIP
9K	Child age 1 through 18	>200 - 250%	Standard	Yes	Yes	T21 Separate CHIP
T8	Child age 1 through 18 who is a tribal member	>200 - 250%	Standard	No	No	T21 Separate CHIP
9L	Child age 1 through 18	>250 - 300%	Standard	Yes	Yes	T21 Separate CHIP
T9	Child age 1 through 18 who is a tribal member	>250 - 300%	Standard	No	No	T21 Separate CHIP
9N	Child, under age 19 deductible	> 150%	Standard	Yes	No	T19
NC	Child under age 19 Residing in a medical institution.	≤200%	Standard	No	No	T19
9Z	12-month CHIP Extension Child <19	N/A	Standard	Yes	No	T21 Separate CHIP
9Y	Adult (Parent or Caretaker)	0%	Standard	No	No	T19
BL	Parents/Caretakers	>0 - 100%	Standard	Yes	No	T19
BY	Youths exiting out of home care up to age 21	N/A	Standard	Yes	No	T19
9Q	Former Foster Care Youth, up to age 26	N/A	Standard	Yes	No	T19
9W	Childless Adults	0%	Standard	No	No	T19
9X	Transitional Childless Adults	0%	Standard	No	No	T19
9P	Childless Adults	>0 - 100%	Standard	Yes	No	T19
9V	Transitional Childless Adults	>0 - 100%	Standard	Yes	No	T19
X6	Earnings Extension - 12 Mo (Adults)	> 100 - 133% or tribal/disabled	Standard	Yes	No	T19

52 CORE PLAN HEALTH INSURANCE

52.1 CORE PLAN HEALTH INSURANCE

The BadgerCare Plus Core Plan ended on March 31, 2014. To see previously covered services under the BadgerCare Plus Core Plan, select "View History" in the upper right hand corner for more information.

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