WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
P-10030 (03/2021)

Medicaid Eligibility Handbook Release 21-01

The information concerning the Medicaid program provided in this handbook release is published in accordance with: Titles XI and XIX of the Social Security Act; Parts 430 through 481 of Title 42 of the Code of Federal Regulations; Chapters 46 and 49 of the Wisconsin Statutes; and Chapters HA 3, DHS 2, 10 and 101 through 109 of the Wisconsin Administrative Code.

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INTRODUCTION (CH. 1)

1.1 Introduction to Medicaid

1.1.1 Introduction

Wisconsin Medicaid is a state/federal program that provides health coverage for Wisconsin residents who are *elderly*, blind, or disabled or receive *WWWMA*. Medicaid is also known as Medical Assistance, MA, and Title 19.

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

Full-Benefit EBD Medicaid Programs

1. SSI-Related Medicaid
2. Medicaid Purchase Plan (MAPP)
3. Katie Beckett Medicaid
4. Wisconsin Well Woman Medicaid (WWWMA)

Long-Term Care Programs

1. Institutional Medicaid
2. Home and Community-Based Waivers (HCBWLTC), including:

    a. Community Integration Program I (CIP 1A and CIP 1B)
    b. Community Integration Program II (CIP II)
    c. Children's Long Term Support Waiver Programs (CLTS)
    d. Community Options Program Waiver (COP-W)
    e. Include, Respect, I Self-Direct (IRIS)

7. Long-Term Managed Care programs:

    a. Family Care
    b. Family Care Partnership
    c. Program of All-Inclusive Care for the Elderly (PACE)

Limited-Benefit EBD Medicaid Programs

8. Tuberculosis-Related Medicaid (TB MA)
9. Medicare Savings Program:

    a. Qualified Medicare Beneficiary (*QMB*)
    b. Specified Low-Income Medicare Beneficiary (*SLMB*)
    c. Specified Low-Income Medicare Beneficiary Plus (*SLMB+*)
    d. Qualified Disabled and Working Individual (*QDWI*)

10. Emergency Medicaid
11. SeniorCare

A person may qualify for one or more of the subprograms listed above, and will be found eligible if he or she meets all the requirements for a given subprogram. Individuals who do not qualify under a subprogram listed above may be eligible for BadgerCare Plus. See the BadgerCare Plus Handbook for more information.

1.1.3 Financial Introduction

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for *EBD* asset limits. See Section 25.7.2 Financial Tests for TB-related asset limits. See Section 1.1.3.3 Disabled Minors to determine Medicaid eligibility for disabled minors who fail BadgerCare Plus financial tests.

1.1.3.1 Assets

The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups that have assets in excess of the appropriate EBD asset limit are ineligible for Medicaid.

1.1.3.2 Elderly, Blind, or Disabled Fiscal Group

An EBD fiscal group includes the individual who is nonfinancially eligible for Medicaid and anyone who lives with him or her, who is legally responsible for him or her. EBD *FTG*s will always be a group of one or two. Spouses who live together are in each other's fiscal group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled *minor* living with his or her parents would be a one-person fiscal group. Special instructions for deeming parental income and assets to the disabled minor are described in Section 24.1 SSI Related Medicaid Introduction.

Another exception to the fiscal group policy involves SSI recipients. If one *spouse* is applying for EBD Medicaid and the other spouse is an SSI recipient, the spouse who is an SSI recipient is not included in the other spouse's fiscal group. For this situation you would again have a one-person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual applying for LTC Medicaid, including institutional, HCBW, Family Care, PACE, Partnership, or IRIS would be a one-person fiscal group. If the individual is married, refer to Section 18.1 Spousal Impoverishment Introduction for special instructions regarding *spousal impoverishment* procedures.

1.1.3.3 Disabled Minors

A blind or disabled minor (or *Dependent 18-year-old*) must have his or her Medicaid eligibility determined according to special procedures if eligible (see Section 15.1.2 Special Financial Tests for Disabled Minors).

Note: EBD Medicaid testing procedures are different from those used for HCBW Medicaid for the Children's Long-Term Support Waiver Program. (See Section 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program.)

1.1.3.4 Income

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for EBD income limits. See Section 39.5 Federal Poverty Level Table for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income that you compare to the income limits.

See Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances for TB-related income limits.

1.1.4 Health Care Choice

Once an individual has been determined eligible for EBD Medicaid, he or she must be enrolled in EBD Medicaid even if he or she is also eligible for BadgerCare Plus, unless he or she has a change in circumstances that results in ineligibility for EBD Medicaid. The only exception to this policy is pregnant women who are eligible for both EBD Medicaid and BadgerCare Plus. In these instances, the pregnant woman will be enrolled in BadgerCare Plus.

If an individual is pending for EBD Medicaid or has an unmet deductible for EBD Medicaid, the individual is not considered eligible for EBD Medicaid and can enroll in BadgerCare Plus. Pending for EBD Medicaid includes, but is not limited to, waiting for a *disability* determination from *DDB* or not being eligible for Medicare. If an individual enrolled in EBD Medicaid becomes ineligible for EBD Medicaid for any reason, including going over the asset limit or failure to pay a

MAPP premium, he or she can enroll in BadgerCare Plus if he or she is still eligible to do so.

1.1.5 How to Apply

The following application options are available for anyone who is applying for EBD Medicaid:

- ACCESS online application at access.wisconsin.gov/.
- Face-to-face interview at the agency.
- Mail-in.
- Telephone interview.

Click here to view the directory of local *IM* agencies in Wisconsin or call Member Services at (800) 362-3002.

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APPS AND REVIEWS (CHS. 2-3)

2 Applications

2.1 Applications Introduction

Anyone has the right to apply for Medicaid. However, individuals younger than 18 years old must have a parent or a legal guardian apply for Medicaid on their behalf unless they are living independently.

They may be assisted by any person he or she chooses in completing an application.

Encourage anyone who expresses interest in applying to file an application as soon as possible. When an application is requested:

1. Suggest the *applicant* use the ACCESS online application at the following site: access.wisconsin.gov/; or
2. Mail-in using the Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet, F-10101; 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 Notice (DWSP 2018) to each applicant with children applying for Medicaid 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 www.dhs.wisconsin.gov/forms/index.htm.

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, he or she is not eligible.

2.1.1 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.

Notify members during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the ForwardHealth Enrollment and Benefits Handbook (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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2.2 Application Types/Methods

Medicaid applicants have the choice of one of the four following methods:

- ACCESS: access.wisconsin.gov/access/.
- Mail-in using the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet (F-10101).
- Telephone interview. When a request for assistance is made by phone, the filing date is not set until a signed application and/or registration form is received by the agency.
- Face-to-face interview.

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2.3 Where To Apply

2.3.1 Where to Apply Introduction

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

An individual who resides in a nursing home/hospital for 30 days or more is considered a resident of the county in which the nursing home/hospital is located.

The applicant's county of residence at the time of admission must receive and process applications for persons living in these state institutions:

- Northern, Central, and Southern Centers.
- Winnebago and Mendota Mental Health Institutes.
- The University of Wisconsin Hospital.

When an applicant contacts the wrong consortium or tribal agency, redirect him or 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 redirected to the agency responsible for processing that application no later than the next business day. A paper application must be date stamped before it is redirected. The filing date remains the date originally received by the wrong consortium or tribal agency.

2.3.2 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 Medicaid eligibility. This does not include situations where a guardian or the *member* elects to move the member to another county.

A congregate care facility is a:

- Child care institution
- Group home
- Foster home.
- Nursing home
- *AFH*

- *CBRF*
- 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 Medicaid and reviews for Medicaid 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:

- The applicant's name, age, and *SSN*.
- The date of placement.
- The applicant's current Medicaid status.
- The name and address of the congregate care facility in which the applicant has been placed.
- The name of the county and agency making the placement.

When there is a dispute about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health Services' Area Administration office for resolution. Pending a decision, the county where the person is physically present must process the application, any changes, and reviews.

2.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when he or she 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 (see Section 2.2 Application Types/Methods), by the public assistance agency in the other state. The forms should be forwarded to the IM agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.

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2.4 Valid Application

A valid application for Medicaid must include the applicant's:

1. Name,
2. Address, and
3. Signature:
    - In the Signature Section of the Medicaid application (F-10101),
    - On the Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (F-10129),
    - In the Signature Section of the BadgerCare Plus Application Packet (F-10182),
    - An electronic signature in ACCESS, **or**
    - Telephonically.

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2.5 Valid Signature

2.5.1 Valid Signature Introduction

The *applicant* or his or her representative (see below) must sign **one** of the following:

- The paper application form
- The signature page of the Application Summary, either over the telephone or face to face
- The ACCESS application with an electronic signature
- The online or paper Application for Health Coverage & Help Paying Costs from the *FFM*

2.5.1.1 Signatures From Representatives

An applicant's representative can be one of the following:

- Guardian: 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 person claiming to be the applicant's guardian can file an application on his or her behalf. Only the person designated as one of the following may sign the application:
    - Guardian of the estate
    - Guardian of the person and the estate
    - Guardian in general

  When someone has been designated as the guardian of the estate, guardian of the person and the estate, or guardian in general, only the guardian, not the applicant, may sign the application or appoint another representative.

  If the applicant only has a legal **guardian of the person**, the applicant must sign the application unless the applicant has appointed his or her guardian of the person to be the authorized representative.

- *Authorized Representative*: The applicant may authorize someone to represent him or her. An authorized representative can be an individual or an organization. See Section 22.5 Representatives for more information.

If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or Organization F-10126B).

An authorized representative is responsible for submitting a completed, signed application 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.

- Durable power of attorney (Wis. Stat. ch. 244): 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. An individual's durable power of attorney may appoint an authorized representative for purposes of making a Medicaid application if authorized on the Durable 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 applicant from filing his or her own Medicaid application nor does it prevent the applicant from granting authority to someone else to apply for public assistance on his or her behalf.

- Someone acting responsibly for an incompetent or incapacitated person.

Example 1: Carl is in a coma in the hospital. Sherry, a nurse who works at the

hospital, can apply for Medicaid on Carl's behalf.

- A superintendent of a state mental health institute or center for the developmentally disabled.

- A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.

- The superintendent of a county psychiatric institution, who has been designated by the county social or human services director, for residents of the institution. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.5.2 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 paper, online, or telephonic application.

Note: This does not affect the state of Wisconsin's ability to prosecute for fraud nor does it prevent the Medicaid program from recovering benefits provided incorrectly due to an applicant's or member's misstatement or omission of fact.

2.5.3 Spousal Impoverishment Medicaid Signatures

All *spousal impoverishment* Medicaid applications, renewals, or changes in marital status that cause someone to be subject to spousal impoverishment rules, require the signatures of **both** the institutionalized person and the *community spouse* or of a person authorized to sign for them as described in Section 2.5.1.1 Signatures From Representatives.

If the benefits are denied or terminated because the community spouse refuses to sign, disclose the value of assets, or provide required information on income or resources, the applicant or member must be sent information on the Undue Hardship Waiver process. For more information on this policy, see Section 22.4 Undue Hardship and Process Help Section 11.7.

2.5.4 Telephone Signature Requirements

Telephonic signatures are valid forms of signatures for Medicaid. To collect a valid telephonic signature:

1. Create an audio recording of the following:

    - Key information provided by the household during the telephone interview
    - Signature statement that includes:

        a. Rights and responsibilities
        b. Attestation to the accuracy and completeness of information provided
        c. Attestation to the identity of individual signing the application
        d. Release of information

2. Store the audio recording in the ECF.
3. Send the applicant or member 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 10 calendar days if any errors are noted.
4. Store a copy of the written summary and cover letter in the ECF.

Note: Applications that are submitted through ACCESS or transferred from the Federally-Facilitated Marketplace are signed electronically, so an additional signature (telephone or physical) is not needed.

2.5.5 Valid Signature on the Federally-Facilitated Marketplace Application

Agencies should accept the signature on the *FFM* application for all individuals on that application and create companion cases for adult children without obtaining a separate signature or application. Workers should reference the original FFM ACCESS application in case comments on the companion case. This policy is for FFM applications only. Current policies for non-FFM applications requiring an adult child to apply separately are still valid.

Because the Medicaid-specific rights and responsibilities information is not provided when a person applies for health care through the FFM, a summary must be sent to the applicant once the application is processed. No additional signature is required.

Note: Referrals from the FFM may include households with individuals whose eligibility may not be able to be determined on one case.

2.6 Filing Date

2.6.1 In Person/Mail/Fax

The filing date is the day a signed, valid application/registration form (F-10101 or F-10182) or registration form (F-10129) is received by the *IM* agency or the next business day if it is received after the agency's regularly scheduled business hours.

2.6.2 By Telephone

When a request for assistance is made by telephone, the filing date is set when a telephonic signature or signed application/registration form is received by the agency.

2.6.3 By ACCESS

The filing date on an ACCESS application is the date the application is electronically submitted.

2.6.4 Low Income Subsidy Program of Medicare Savings Programs

LIS data sent electronically to CARES from the *SSA* is considered a request for *MSP* and must be processed using the same processing guidelines that would be followed if a request for MSP was submitted directly by the *applicant*.

Because the data sent by SSA is not sufficient to determine Medicaid or MSP eligibility, the data from the LIS application will be used to establish an *RFA* in CARES. The contact date on the RFA is the date the LIS data was received by *DHS* from SSA. The filing date for the MSP request is the filing date set by SSA for the LIS application.

A completed, timely application will have to be submitted by the applicant to the local agency in order to determine Medicaid and MSP eligibility for the person. If an application is not submitted within 30 days of the RFA contact date, the RFA will be automatically withdrawn and a notice generated.

2.6.5 Federally-Facilitated Marketplace

The filing date for applications received from the *FFM* is the date the application was submitted to the FFM.

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2.7 Time Frames

2.7.1 Time Frames Introduction

All applications received by an agency (except those submitted from the *FFM*) must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from when the agency receives the application. This includes issuing a Notice of Decision.

The 30-day time frame for processing applications submitted through the FFM begins the date the FFM application is submitted to the agency inbox.

The 30-day processing time frame must be extended to allow the *applicant* at least 10 days to provide requested verification.

Workers may also extend the 30-day processing time up to 10 days to allow the applicant additional time to provide the information. CARES will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due page.

For more information on application denials for failure to provide verification, see Section 20.7 When to Verify.

Example 1: A signed application was received on March 15. The worker processed the application on April 7 and requested verification. Verification was due April 17, but was not received by that date. Even though the end of the 30-day application processing period was April 14, the application should not be denied until April 17 to allow at least 10 days to provide verification.

If an agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, as a result of his or her most recent Medicaid application, redetermine eligibility using the filing date associated with that most recent application.

Example 2: A signed application was received on May 15. The first day of the 30-day period was May 16. The end of the 30-day period would have been June 14. The application was approved on June 20, and the applicant is determined eligible beginning May 1.

2.7.2 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 Income Maintenance Manual Section 3.2 Adverse Action and Appeal Rights.

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2.8 Begin Dates

2.8.1 Begin Dates Introduction

Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. Those begin dates are the date a valid application is submitted, all program requirements are met, and:

1. Deductible – The date the deductible was met.
2. Inmates – The date the *member* is no longer an inmate of a *public institution*.
3. Person Adds – The date the person moved into the household.
4. Recent Moves – The date the member moved to Wisconsin.

   Exception: The begin date for an *SSI* recipient who moves to Wisconsin is the 1st of the month of the move.

Example 1: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April 2009. He becomes eligible 04-01-09 in Wisconsin.

5. Home and Community-Based Waivers – The program start date provided by the care manager.
6. Family Care and *PACE* or Partnership – The date the individual is enrolled in the *MCO*.
7. Institutionalized – His or her entry into the nursing home or hospital.
8. *QMB* – The first of the month following the eligibility confirmation.
9. SeniorCare – The first of the month following the month in which all program requirements have been met.

2.8.2 Backdated Eligibility

Medicaid eligibility can be backdated up to three months prior to the month of application.

The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month.

A backdate request can be made at any time except when 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 Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example 2: Mary who is 66 years old, applied for Medicaid on April 6, 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 Medicaid for both months.

See Section 15.6.8 Backdated Months for information on counting self-employment income for backdated months.

For backdating rules for Medicare Beneficiaries, see Section 32.8 Medicare Savings Programs Backdating.

Assets
A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.

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2.9 Denials and Terminations

2.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, Medicaid can be reopened without requiring a new application. The person may need to provide required verification.

If the person re-requests Medicaid after eligibility was terminated and the case is open for another program of assistance, do not require him or her to re-sign his or her application or sign 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 or her Medicaid.

If *EBD* Medicaid, *HCBW*, Institutional Medicaid, *MAPP*, or *MSP* eligibility closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the person may be reopened without filing a new application if he or she provides the necessary information within three months of the renewal date (see Section 3.1.6 Late Renewals).

2.9.2 Denial

If the person re-requests health care after the application was denied and the case is open for another program of assistance, do not require him or her to re-sign his or her application or sign a new application.

If the applicant is not open for any other program of assistance and less than 30 days has passed since the applicant's eligibility was denied, allow the applicant or his or her representative to do one of the following:

- Re-sign and date the original application
- Sign Section 22 - Signature of the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet
- Sign the signature page of the application summary
- Call the agency to submit a telephonic signature to set a new filing date

Note: Individuals eligible for an un-met Medicaid Deductible only are not considered open for a program of assistance and must file a new application to reopen Medicaid.

If the applicant is not open for any other programs of assistance and more than 30 days has passed since an applicant's eligibility was denied or was only determined eligible for an unmet deductible, the person must file a new application to reopen his or her Medicaid.

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3 Renewals

3.1 Renewals

3.1.1 Renewals Introduction

A renewal is the process during which all eligibility factors subject to change are reexamined and a decision is made if eligibility should continue. 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 Medicaid case is 12 months from the certification month except for cases open with a deductible. A renewal is not scheduled for a case that did not meet its deductible unless someone in the case was open for Medicaid. For cases that did meet the deductible, the renewal date is six months from the start of the deductible period.

Note: For manually certified Medicaid cases, send a manual renewal notice 45 days prior to the end of the renewal month.

Agency Option

The agency may renew any case at any other time when the agency can justify the need. Examples include:

1. Loss of contact, **or**
2. *Member* request

Note: Shortening certification periods in an attempt to balance agency workload is not permissible.

3.1.2 Choice of Renewal

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

1. Face-to-face Interview,
2. Telephone Interview.
3. Mail in: Mail in renewals can be submitted using the paper application (F-10101) or the pre-printed renewal packet generated through *CWW*. Cases requesting to complete a Mail-in renewal must be sent the pre-printed renewal packet if the case includes a blind or disabled child, **or**
4. ACCESS

3.1.3 Renewal Processing

A Medicaid eligibility renewal notice is generated on the first Friday of the 11th month of the certification period. The notice states that "some or all of your benefits will end" if a

renewal is not completed by the end of the following month. Do not process a renewal until after *adverse action* in the month prior to the month of renewal.

Example 1: CARES sends out the renewal letter on July 7 for a renewal due in August, do not process the renewal prior to July 18.

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.

3.1.4 Signature at Renewal

The member must include a valid signature at the time of renewal. This includes either signing telephonically or signing one of the following:

- The paper application form
- The signature page of the Application Summary
- The ACCESS or *FFM* application form with an electronic signature

The signature requirements for renewals are the same as those for applications (see Section 2.5 Valid Signature). The signature requirements do not apply to people whose renewal is completed through the administrative renewal process.

3.1.5 Administrative Renewals

3.1.5.1 Administrative Renewals Introduction

Based on federal requirements, health care eligibility must be redetermined once every 12 months based on information available to an agency. Agencies cannot require information from health care members during an annual renewal unless the information cannot be obtained through an electronic data exchange or the information from the electronic data exchange is not reasonably compatible with the information on file. The process of using electronic data exchanges for renewals is referred to as an administrative renewal.

If information from electronic data exchanges validated information about the member's income as currently recorded in *CARES*, additional information about income cannot be requested from the member at renewal. This includes earned income information that is found to be reasonably compatible with member-reported information, as well as any information about unearned income verified through *SSA* or *UIB* data exchanges. Unless reported otherwise, it is assumed during the administrative renewal process that household composition has not changed.

3.1.5.2 Administrative Renewal Selection Criteria and Exclusions

To be considered for an administrative renewal, a case must be due for renewal in the following month and have one or more qualifying BadgerCare Plus, FPOS, or *EBD* Medicaid assistance groups open, including health care assistance groups open with a suspended status.

The following Medicaid subprograms **can be** administratively renewed:

- SSI-related Medicaid
- MAPP without premiums (income up to and including 100 percent of the FPL)
- MSP
- Group A Community Waivers with eligibility based on SSI

The following Medicaid subprograms **cannot be** administratively renewed:

- SSI-related Medically Needy Medicaid with met or unmet deductibles
- MAPP with premiums (income over 100 percent of the FPL)
- Institutional Medicaid
- Group B and B+ Community Waivers
- Group A Community Waivers with eligibility based on 1619(b), BadgerCare Plus, EBD Medicaid, or Adoption Assistance

SSI-related Medicaid, MAPP, and MSP **can be** administratively renewed if all members on the case have:

- Only income that can be verified through a data exchange (for example, income with a SWICA match or Equifax match through the FDSH), or only Social Security or Unemployment income
- Countable assets at or below 50% of the asset limit

SSI-related Medicaid, MAPP, and MSP **cannot be** administratively renewed if any members on the case have or are:

- Income or deductions that cannot be verified through a data exchange (for example, self-employment, in-kind income, child support/maintenance, or *IRWE*s)
- An unverified or missing *SSN*
- An unresolved Prisoner, UIB, or *SOLQ-I* discrepancy
- An expired immigration status
- An expired disability diary date
- MAPP benefits with a work requirement waiver or Health and Employment Counseling enrollment
- A presumptive disability
- Persons turning 19 or 65 years old

> **Note:** Members who receive SSI and SSI MA but are open in CARES for Group A Community Waivers and/or QMB **will go through** administrative renewal unless the case is in review mode. The criteria listed above do not apply to and will not exclude these types of cases from the Admin Renewal process.
>
> Medicaid also cannot be administratively renewed if anyone on the case is receiving BadgerCare Plus or Family Planning Only Services benefits and is excluded from administrative renewal for a reason listed in BadgerCare Plus Eligibility Handbook 26.1.3.2.

Health care will not be successfully administratively renewed if any of the following occur during the administrative renewal process:

- A new Error Prone Profile (EPP) is generated
- A new discrepancy if found through a data exchange
- A new or increased premium is required
- Health care or FPOS benefits would pend or terminate for any person on the case
- Related unprocessed items are found, such as applications, change reports, renewals, or FoodShare Six Month Report forms

3.1.5.3 Administrative Renewal Process

The administrative renewal process begins in the 11th month of a member's certification period. CARES determines who qualifies for an administrative renewal, verifies and updates information based on data exchanges, tests employment income and SWICA and FDSH results for reasonable compatibility, and runs through batch eligibility. See Process Help 4.7 Administrative Renewals.

3.1.5.3.1 Successful Administrative Renewals

Cases that have a successful administrative renewal will have health care eligibility redetermined and will be certified for a new 12- month certification period. The member will be sent a letter notifying them that their eligibility has been renewed, along with a case summary (except for cases open only for Group A Community Waivers and/or QMB based on SSI eligibility). The member must review the information on the case summary and report if any of the information is incorrect within 30 days of the mailing date. The member can make the changes on the summary and mail or fax it to their agency, or they can report their changes through ACCESS or by phone. If all of the information on the case summary is correct, the member does not need to take any other action. Members who have their health care administratively renewed will be sent a Notice of Decision.

If a successfully administratively renewed case is open only for Group A Community Waivers and/or QMB based on SSI eligibility, the member will be sent a different administrative renewal letter that does not include a case summary. Because these

members are categorically eligible based on their SSI eligibility, the letter informs them that their benefits have been renewed because they continue to receive SSI. These members will not need to review a case summary and do not need to take any other action.

3.1.5.3.2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the case will be excluded from the administrative renewal process, and the member will be sent a 45-day renewal letter and a Pre-Printed Renewal Form (PPRF). The member will have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS.

3.1.5.3.3 Change Reporting After Administrative Renewal

Cases that have a successful administrative renewal remain subject to their applicable change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the attached case summary and informs him or her of the potential consequences for not reporting those changes. If a member does not correct information that is wrong and gets benefits that he or she should not get, the member would be liable for any resulting overpayments. In addition, administrative renewal cases will receive a Notice of Decision that 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.

Changes reported as part of a renewal for another program should also be applied to health care.

3.1.6 Late Renewals

Late renewals are only permitted for individuals whose eligibility ended because of lack of renewal and not for any other reasons for the following *EBD* programs:

- EBD Medicaid
- *HCBW*s
- Institutional Medicaid
- *MAPP*
- *MSP* (*QMB*/*SLMB*/*SLMB+*/*QDWI*).

Late renewals and related-renewal verifications should be accepted for up to three calendar months after the renewal date. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

Consider late submissions of an online or paper renewal form or a late renewal request by phone or in person as a valid request for health care. The new health care certification date should be set based on receipt of the signed renewal. If verification is required to complete the renewal, the member will have 10 days to provide it.

If the health care renewal was completed timely but the requested verifications were not provided as part of the renewal, the health care program can be reopened without a new application if these verifications are submitted within three months of the renewal month. The verifications must include information for the current month of eligibility. If verification was submitted for a past month, a new Verification Checklist must be generated to request current verification. The member will have 10 days to provide it.

If a gap in coverage occurs because of a late renewal, the member may request coverage of the past month in which the gap occurred. The member must provide all necessary information and verification for those months and must pay any required premiums to be covered for those months. For EBD Medicaid renewals, the member must provide the missing verification and verify assets for the current month if there was a gap in coverage.

Note: QMB coverage is not retroactive. Members cannot request backdated eligibility for this program.

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NONFINANCIAL (CHS. 4 - 14)

4 Who is Nonfinancially Eligible for Medicaid?

4.1 Who is Nonfinancially Eligible for Medicaid?

To be eligible for Medicaid, an individual must meet the following criteria:

- Be *elderly*, blind, or disabled (Section 5.2 Determination of Disability, or Section 37.1.2 Children's Long-term Support (CLTS) Waiver Program Introduction)
- Be a resident of the state of Wisconsin (see Section 6.1 Residency Eligibility)
- Be a U.S. citizen or Qualifying Immigrant (see Section 7.1 US Citizens and Nationals)
- Cooperate with medical support liability (see Section 8.1 Medical Support)
- Cooperate with *TPL* (see Section 9.1 Third Party Liability)
- Provide *SSN* or apply (see Section 10.1 SSN Requirements)
- Pay a premium if required (see Section 11.1 Premium or Cost Share)
- Pay a community waiver/FamilyCare cost share if required (see Section 11.1 Premium or Cost Share)

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5 Elderly, Blind, or Disabled

5.1 Elderly

Elderly is defined as an individual 65 years of age or older. See Section 4.1 Who is Nonfinancially Eligible for Medicaid?.

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5.2 Determination of Disability

5.2.1 Definition of Disability

The law defines *disability* for Medicaid as: "The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." See Section 39.4.1 Elderly, Blind, or Disabled Assets and Income Table for the current SGA limits.

One exception to this is that a MAPP disability determination does not involve the SGA test. See Section 26.1 Medicaid Purchase Plan Introduction for the *MAPP* disability definition.

Disability and blindness determinations are made by the *DDB*. The *IM* agency should submit an application for a disability determination even if the applicant/*member* has already applied for *SSI* or *SSDI* (see Section 5.3 Disability Application Process), except for children applying for home and community-based waivers. An application for a disability determination should only be submitted for these children at the parent's request.

Note that for some long-term care programs, eligibility is based on level of care determinations rather than on a disability determination. For example, there is no disability determination required for children to be eligible for home and community based waivers. The appropriate level-of-care determination as established by the functional screen is used as an indicator of the child's need for services. This is also true for some adults. See Section 28.1 Adult Home and Community-Based Waivers Long-term Care Introduction and Chapter 37 Home and Community-Based Services: The Children's Long-Term Support Waiver Program.

5.2.2 Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits

An EBD Medicaid applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. The member is not required to provide verification of the disability unless the worker is not able to use data exchanges or other information from SSA to confirm that the individual received disability payments immediately prior to receiving SSRE.

Example 1: Ed is an EBD Medicaid member who was determined disabled ten years ago and has been receiving SSDI since that time. Upon turning 63, his SSDI payments change to SSRE payments. The IM worker can see this change by

querying SOLQ-I. By policy, Ed is considered disabled and will not be required to provide any further verification or go through a re-determination.

Example 2: Nancy was determined disabled fifteen years ago and began receiving SSDI. Two years ago, her SSDI payments converted to SSRE payments. Nancy came into the agency this year to apply for MAPP. Although she was previously unknown to CARES, the IM worker was able to research her payments through SOLQ-I and see that prior to receiving her SSRE payment, she was receiving SSDI. Nancy is considered disabled and is not required to provide any further disability verification.

Example 3: Fred was determined disabled twenty years ago. His SSDI payments recently converted to SSRE. Fred moved to Wisconsin and applied for MAPP. The worker was unable to find evidence of this conversion through SOLQ-I. Fred provided a statement from his “My Social Security” account that shows his SSDI payment stopped and SSRE payments began. This verification is sufficient to consider Fred disabled. He does not need to provide any further verification or go through a re-determination.

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5.3 Disability Application Process

5.3.1 Application Form

Give a *MADA* Medicaid Disability Application form, F-10112 to each person applying for Medicaid Disability. The MADA must be completed by the Medicaid *applicant* or his or her representative.

The applicant must send the following to the local/county/tribal human or social service agency:

1. The completed MADA Medicaid Disability Application form, F-10112. Applicants must list information about all of their medical problems and contact information for all medical providers that have treated them;
2. One copy of the Authorization to Disclose Information to Disability Determination Bureau (DDB) form, F-14014; **and, if applicable,**
3. The Medicaid/FoodShare Wisconsin Appoint, Change, or Remove an Authorized Representative form, F-10126.

5.3.1.1 Claims Filed on Behalf of Deceased Applicants

Even when the applicant is deceased DDB needs medical and other information upon which to base the disability decision. If available, the *IM* worker should send copies of the following to DDB, along with all other application materials:

1. Medical reports (if available from the person filing the Medicaid disability application on the decedent's behalf.)
2. Death Certificate.
3. Medical releases Authorization to Disclose Information to Disability Determination Bureau (DDB) form, F-14014. If the claim was initiated prior to the applicant's death and the applicant signed medical releases, those should be sent to DDB. If the applicant was able to sign the releases only with an "X" or other mark, two witness signatures are needed on the release form.
4. Documentation of guardianship or power of attorney should be included if medical releases are signed by a guardian or person with power of attorney.

The IM worker should complete the MADA form as thoroughly as possible, including:

1. Name, address, and phone number of next of kin, friend, or other person initiating the Medicaid application on the decedent's behalf (Section I).
2. The date on which the applicant became unable to work (Section I, number 2).
3. Contact information for medical sources treating the applicant prior to and at time of death (Section III).

If Medicaid coverage is needed for less than three full months prior to application the IM worker should include a statement regarding the necessary coverage dates in Part VI of

the MADA. For example, when the applicant died shortly after an accident or start of illness and coverage is needed only for brief medical care and/or burial expenses.

5.3.2 Agency Form Processing

See Process Help Section 9.4 Automated Medicaid/BadgerCare Plus Disability Determination.
When completed MADA forms are received by the local agency, the IM worker must:

Determine if the applicant meets all other Medicaid eligibility requirements, with the exception of the disability determination and income. Do not send the MADA to DDB if the applicant does not meet all other Medicaid eligibility requirements aside from disability and income, with one exception:

If a non-qualifying immigrant would qualify for Emergency Services Medicaid only if he or she was disabled, send the MADA to DDB.

5.3.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization to Disclose Information to Disability Determination Bureau (DDB) form, F-14014. This is the only form DDB can accept. See Process Help Section 9.4 Automated Medicaid/BadgerCare Plus Disability Determination.

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative's signature on the release is not acceptable unless he or she has a court order.

5.3.4 Medical Report

If the applicant has copies of any medical records, school records, etc., include them with the application.

A medical report of disability does not need to be submitted with the application. DDB will obtain all of the medical reports necessary for the disability determination. However, if the applicant or the representative has already provided medical records/reports to the IM agency, this evidence must be scanned into the *ECF* along with the completed MADA form.

DDB will contact the IM agency for applications that are not fully completed with names and addresses and work information. See Process Help Section 9.4.5 How to Resend an Application to DDB.

5.3.5 SSI Application Date

Occasionally a person applies for *SSI* and is determined ineligible for SSI payments. In these cases, determine Medicaid eligibility from the SSI application date, if it is earlier than the Medicaid application date.

An application for SSI is also an application for Medicaid.

He or she must still meet all Medicaid eligibility requirements. You must request the SSI application date by using the state on line query (SOLQ).

Use the SSI application date as the filing date if the *member* contacts the IM agency within the calendar month following the month of the SSI denial. If the contact to the IM agency is later than the above, the filing date is the regular date he or she applied at the IM agency.

5.3.6 Routine SSI Medicaid Extension

An SSI Medicaid member is eligible for a redetermination of Medicaid eligibility and Medicare Savings Program (MSP) when SSI is terminated. Members that are eligible for Medicare should also be tested for the Medicare Savings Program unless the member requests not to be tested for the Medicare Savings Program. The person is allowed an extra month of SSI Medicaid eligibility and MSP to allow the IM agency to redetermine eligibility. The IM agency must fill the gap by ensuring continued Medicaid and MSP eligibility between the last date of SSI Medicaid and the date an eligibility determination for continuing Medicaid and MSP on another basis is completed (see Process Help Section 26.2 Routine SSI Medicaid Extension). Determining Medicaid and MSP eligibility should usually occur within the month after the person loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps.” The exception to this is in Section 5.3.5 SSI Application Date.

There is no fill the gap provision for those who lose their SSI eligibility because of:

- Death
- Leaving Wisconsin
- Incarceration
- Fleeing drug felon

Reminder: For all cases (CARES and non-CARES), even if the member does not meet Medicaid eligibility requirements for the months between when he or she lost SSI and when you are re-determining eligibility, he or she is still eligible. Do not require the member to come into the office. Ineligibility starts, following timely notice, when he or she:

a. Does not return the application (the fiscal agent takes care of this), or

b. Fails to respond to an information request, or
c. No longer meets eligibility requirements (as of when the review or application is done).

5.3.7 Other SSI Medicaid Extensions

Fill the gap between the loss of SSI Medicaid and an eligibility determination by the IM agency when:

1. Retroactive SSI approval and termination occurs. A person applies for SSI and is approved. The approval is retroactive and the SSI also is terminated retroactively.
2. Eligibility for Medicaid is not determined timely by the IM agency through no fault of the member.

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5.4 Disability Determination Bureau Action

5.4.1 Disability Determination Bureau Action Introduction

DDB will attempt to process the *disability* determination within 90 days of the date it receives the signed application. If the DDB determines that the application needs to be medically deferred because the extent of an impairment will not be known until several months after its onset, DDB will notify the *applicant* in writing that additional evaluation time is necessary.

A DDB disability decision on a *SSDI* or *SSI* case generally has binding authority. A Medicare, SSDI, or SSI disability certification notice is acceptable verification of disability.

To check on the status of a disability case, call 608-266-1565, and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to Heather Pearson at 608-266-6664.

5.4.2 Allowances

The DDB does not notify the claimant of allowance determination made by DDB.

Claims in CARES: For claimants found disabled, DDB will send all the evidence and a completed SSA-831 (Determination of Disability form) to CARES. The paper file at DDB will be destroyed after it is confirmed that the information is in CARES.

Claims NOT in CARES (paper claims): For claimants found disabled, DDB will send the paper file with all the evidence and SSA-831 to the *IM* agency for storage for future use in the redetermination process.

5.4.3 Diary Date

Item 17 on the SSA-831 form indicates whether or not medical re-examination is required for recipients not on SSI or SSDI. A re-examination is required on all allowance cases. A date on the box to the right of item 17, "Diary Type," tells you when DDB wants to review the case again. You may also find it in CARES on the Disability page under Disability Dates. When the Diary Date is earlier than the current date, refer to the instructions that follow under Section 5.7 Redetermination.

5.4.4 Denials

Persons found not disabled will be sent a notice by DDB along with forms to apply for a Reconsideration/Hearing. The paper files on denied cases will be kept at DDB waiting for the appeal application.

Claims in CARES: DDB will send all the evidence and a completed SSA-831 electronically to CARES. The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.

Claims NOT in CARES (paper claims): The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.

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5.5 Reconsideration/Hearing

5.5.1 Reconsideration/Hearing Introduction

Send reconsideration/hearing requests to the following address:

Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886

Reconsideration/hearing requests must be received by the *DDB* within 45 days of the date of the Denial Notice. Late requests cannot be honored. If a claimant's request was received by DDB after the 45-day deadline, DDB will notify the claimant that his or her reconsideration/hearing request has been denied.

DDB will conduct a reconsideration of the denial when the appeal application is received within the 45-day deadline.

If DDB reverses the decision to an allowance:

Claims in CARES: For claimants found disabled, DDB will send all the evidence and a completed *SSA*-831 (Disability Determination and Transmittal form) to CARES. The paper file at DDB will be destroyed after it is confirmed that the information is in CARES.

Claims NOT in CARES (paper claims): For claimants found disabled, DDB will send the paper file with all the evidence and a completed SSA-831 to the *IM* agency for storage for future use in the redetermination process.

If DDB affirms the denial, the paper file will be sent directly to the *DHA*, which will then schedule a hearing.

Claims in CARES: DDB will electronically send all the evidence, a completed SSA-831, worksheet notes, and a flag sheet to CARES. The flag sheet, the first page of the worksheet notes, indicates that the paper folder was sent to DHA for a hearing.

Claims NOT in CARES (paper claims): DDB does not send any notification to the IM agency.

If, in a fair hearing, a person is found to be disabled, and the *ALJ* does not specify a diary date for review, contact DDB and request a diary date to review the disability.

When a DDB disability denial decision is overturned by the DHA, the disability determination is valid as of the disability approval and disability onset dates established by DHA.

5.5.2 Reversed Disability Denial Decision

When DDB or DHA notifies the IM agency that a disability denial decision has been reversed (approved) as a result of a reconsideration/hearing request or SSI or SSDI appeal, the IM agency must redetermine the individual's Medicaid eligibility.

1. Use the original Medicaid application filing date that was associated with the *MADA* decision that has now been reversed (approved).
2. Re-evaluate the member's Medicaid eligibility for all months between the Medicaid application filing date (and three-month backdate period if appropriate) and the date of the DDB, SSI, or SSDI approval. For this retroactive period, certify the member only for those months for which he or she met all Medicaid eligibility requirements.
3. Send the member a positive notice, advising him or her of the months of retroactive eligibility and current ongoing eligibility, if appropriate. If the member was ineligible for Medicaid for some of the prior months, send the member a negative notice, advising him or her of his or her retroactive ineligibility for those specific months.

For these types of cases, the IM worker is simply doing what ordinarily would have been done if the original DDB, SSI, or SSDI decision had been approved rather than denied.

Note: If an SSI or SSDI disability determination is changed, the new determination is binding for Medicaid. The Medicaid filing date should be preserved as if DDB or DHA had reversed the MADA denial.

5.5.3 CARES Processing

Based on the assumption that the Medicaid CARES case has been closed for more than 30 days since the original denial decision date, you will now have to enter a new application in CARES using the application function. Do not require the member to file a new application. Use the recent DDB, SSI, or SSDI disability approval date as the Medicaid application filing date. You should now be able to use CARES to determine and certify the current month's Medicaid eligibility and up to three backdate months. If you need to go back any further than this, do the eligibility determination and certification manually.

When the disability denial decision is overturned by DHA, enter the disability approval and disability onset date established by DHA on the Disability page in *CWW* as if it was approved by DDB. Document in the case comments that this disability approval decision was actually made by DHA and not DDB and record the fair hearing case number. Run eligibility to determine Medicaid eligibility for current and future months and also for any past months in which the person was determined disabled.

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5.6 Medical Exam Cost

If the person's Medicaid application is approved, Medicaid will pay the cost of any medical examination necessary for the completion of a current medical report. If it is denied, you may claim the cost of the examination as an administrative expense. Reimbursement is from the Medicaid administrative account.

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5.7 Redetermination

5.7.1 Redetermination Introduction

Review a *disability* determination when any of the following are true:

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form and the person is not currently receiving SSDI or SSI Disability Benefits.
2. The person is younger than 65 years old and no longer receives *OASDI* (Social Security) disability benefits.This does not include members who have converted from OASDI benefits to Social Security Retirement benefits (see Section 5.10.2 Medicaid Members Who Convert from Social Security Disability to Social Security Retirement).
3. The medical circumstances have significantly improved (see Section 5.7.2 Members Exceeding the Substantial Gainful Activity Level).
4. The person has returned to work.

Complete and/or forward the following **paper** forms to *DDB* at

Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886

- Medicaid Disability Redetermination Report (F-10114).
- Signed Confidential Information Release forms.
- The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-832).

Item 9 (SSA-832) indicates the decision of (A) continuing or (B) ceased.

Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If the member's disability is found to continue, the DDB will send the paper folder, which includes the SSA-832, to the IM agency to be kept until the next redetermination is made.

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the

right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid benefits will continue until a hearing is held and a decision is made. DDB will retain the SSA-832 in these cases.

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a paper folder with a revised SSA-832 will be sent to the IM agency at that time.

If the member appeals the proposed cessation and DDB is unable to reverse this decision, the file will be forwarded directly to the *DHA* for a hearing. DHA will notify the IM agency of its final decision.

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send the paper folder that contains the original SSA-832 to the IM agency following the expiration of the 45-day appeal period. DDB will add a **Medicaid Disability Cessation Case** note to the front of the folder to highlight these cases. See Section 5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text for an example.

Once the IM agency receives final notice of a cessation, then they must follow existing procedures to notify the member of the termination of Medicaid benefits (unless the member qualifies for Medicaid on some other basis). The member will be given another 45 days to appeal that decision.

Note: The process described above provides the Medicaid member with two opportunities to file an appeal regarding whether or not he or she continues to be disabled. This is the result of federal laws that require the DDB to notify a disabled member of Medicaid or Social Security benefits that he or she no longer meets the disability criteria necessary to continue receiving those benefits. These notice requirements for DDB also include an opportunity for the member to appeal the DDB decision within 45 days. Medicaid benefits must be continued during this potential 45-day appeal period, whether or not the client actually files an appeal. DDB cannot notify the IM agency that the client is no longer disabled until this 45-day appeal period has expired, and the client did not file an appeal within that time frame. Once this initial 45-day appeal period expires, with no appeal request from the client, DDB will then notify the IM agency that the Medicaid member is no longer disabled.

Upon receipt of the notification (Medicaid Disability Cessation) from DDB, the IM agency must then redetermine whether or not the member qualifies for some category of Medicaid other than that related to disability. If the member is not eligible for any other Medicaid category, the IM agency would then take the necessary action to discontinue the member's Medicaid eligibility in the normal manner, issuing all required notices. The member would then have another opportunity to appeal the termination of his or her Medicaid eligibility. The fact that this second potential fair hearing essentially involves

the same issue (disability) that was the subject of the first appeal is irrelevant. As stated earlier, this process is required by federal law.

5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text

To: _____
Medicaid Disability Cessation Case

The Disability Determination Bureau has determined that _____
SSN:_____ is no longer disabled. (See the SSA-832 decision in file.)

The member has not appealed this decision within the 45-day appeal period that expired on _____.

Unless this individual qualifies for Medicaid on some basis other than disability, please initiate action to terminate MA coverage. See MA Eligibility Determination Handbook instructions in section 5.7.1.

5.7.2 Members Exceeding the Substantial Gainful Activity Level

A Medicaid member who loses *SSDI* because he or she exceeds the Substantial Gainful Activity level does not lose Medicaid coverage if one of the following is true:

1. He or she is a member with a disability who was receiving non-MAPP full-benefit Medicaid and is currently working.
2. He or she is a current MAPP member.

In these cases, a MAPP disability determination must be done and MAPP continued until the determination is made.

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5.8 Conflicting Claims

Disability determinations for Social Security, *SSI*, and Medicaid are completed under the same regulations. *DDB*'s decisions will be consistent if the person files for any of these programs. If a decision on one program is later changed by appeal or because of new evidence, etc., DDB will notify the other program's to change their determinations to match.

DDB may request return of Medicaid disability files when reviews of conflicting or updated decisions are needed.

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5.9 Presumptive Disability

5.9.1 Presumptive Disability Introduction

Federal *SSI* law and regulations state that the SSI program can find an individual to be presumptively disabled and will be treated as a person with a *disability* until a final disability determination can be completed. To be treated as presumptively disabled by SSI means that the applicant's benefits can begin before SSA, or its contracted agency, has formally determined the individual to be disabled.

Wisconsin's Medicaid program also allows a determination of presumptive disability.

Presumptive *Disability* (PD) is a method for temporarily determining a disability for an individual while a formal disability determination is being done by *DDB*. Presumptive disability is determined either by the DDB, or in some circumstances, by the *IM* worker. The regular disability application process (see Section 5.3 Disability Application Process) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until the DDB makes its final disability determination.

When the regular disability determination is denied by DDB, a new presumptive disability determination cannot be made for that individual unless there has been a change in the person's condition.

5.9.2 PD Determined By the IM Workers

When a *member* has an urgent need for medical services attested to in writing by a medical professional, and is likely to be found disabled by DDB because of an apparent impairment, the member may be certified as presumptively disabled by the IM worker. When the IM worker is making the PD decision, they should do so as quickly as possible. However, the normal 30 day application processing requirements (see Section 2.7.1 Time Frames Introduction) are still applicable even for PD determinations.

In determining that the *applicant* is presumptively disabled, the IM worker will need a "medical professional" to attest in writing that:

1. The individual's circumstances constitutes an urgent need (see Section 5.9.2.1 Definition of Urgent Need) for medical services
2. The individual has one of a certain set of impairments (see Section 5.9.2.2 Impairments)

A "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an 'urgent

need' and the presence of one of the impairments. (A medical professional is a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

5.9.2.1 Definition of Urgent Need

A person must be in one of the following situations to be considered to have an urgent need:

1. The applicant is a patient in a hospital or other medical institution.
2. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment.
3. The applicant is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect.
4. The applicant is unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.

Note: In addition to health conditions of a physical nature, the above criteria may also apply to an urgent need resulting from an individual's serious and persistent mental illness.

Example 1: An individual with schizophrenia who will need to be hospitalized if he or she does not take prescribed medication has an 1; urgent need' if such medication is not available without Medicaid coverage.

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM worker can certify the member as presumptively disabled if the member has one of the following readily apparent impairments, as attested to in writing by a medical professional:

1. Amputation of a leg at the hip
2. Allegation of total deafness
3. Allegation of total blindness
4. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that's expected to last 12 months or longer
5. Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm
6. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms
7. Allegation of Down's syndrome
8. Allegation of severe intellectual disorder made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of an intellectual disability or is

unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities

Note: "Intellectual disorder" means an intellectual disability. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of an intellectual disability.

9. A physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker or medical records custodian) confirms an individual is receiving hospice services because of a terminal condition, including but not limited to terminal cancer
10. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional
11. End stage renal dialysis confirmed by a medical professional
12. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months
13. The member has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months

5.9.2.3 Presumptive Disability Certification Process

A medical professional must complete and sign the Medicaid Presumptive Disability form, F-10130 attesting to both the urgent need and the impairment, before an IM worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the medical professional beyond the Medicaid Presumptive Disability form. Once completed, place a copy of this form in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, certify Medicaid eligibility (see Section 5.9.5 Eligibility).

Changes in Urgent Need Prior to Presumptive Disability Medicaid Certification
Sometimes, an individual's medical condition improves between the date of the presumptive disability Medicaid application and the date of the presumptive disability Medicaid certification. This improvement results in the individual no longer meeting the urgent need criteria at the time of the presumptive disability Medicaid eligibility determination. The most common example of this situation is that of a person who is hospitalized on the date of the presumptive disability Medicaid application, but released from the hospital prior to being certified by the IM worker for presumptive disability Medicaid eligibility. Under these circumstances, if the presumptive disability applicant no longer has an urgent need as of the date that you are making the presumptive disability Medicaid eligibility determination/certification, the presumptive disability request must be denied. Follow the procedures described in Section 5.9.6.1 DDB Returns a Negative

Presumptive Disability Decision when notifying the applicant that their request for a presumptive disability eligibility determination has been denied.

Example 2: Bob is 55 years old and has been hospitalized since February 01, 2008 after suffering his second stroke in the last 4 months. Bob applies for Medicaid on February 07, 2008. His physician attests in writing that Bob has an urgent need (he is hospitalized), and that he has one of the impairments listed on the Medicaid Presumptive Disability form (F-10130). The IM worker has requested verification of Bob's non exempt assets and completion of the Medicaid Disability Application (MADA), F-10112. On February 14, 2008 Bob returns the completed MADA and asset verification information to his IM worker. He also indicates that he was released from the hospital on February 11, 2008 and is recuperating at home. On February 14, 2008, the IM worker has all the necessary information to make a presumptive disability Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for presumptive disability Medicaid must be denied.

Regardless of whether the IM worker makes the presumptive disability determination or DDB makes the presumptive disability determination, the Medicaid Disability Application (MADA) (F-10112) must be completed before the IM worker certifies the member for presumptive disability.

The following forms are required for the presumptive disability process:

- Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet, F-10101
- Medicaid Disability Application (MADA), F-10112
- Medicaid Presumptive Disability, F-10130
- Authorization to Disclose Information to Disability Determination Bureau (DDB), F-14014
- Authorized Representative, F-10126A Person or F-0126B Organization (if applicable)

Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (see Section 5.3 Disability Application Process and Process Help Chapter 12 Automated Medicaid Disability Determination). The Medicaid Disability Application (MADA) (F-10112) must be completed and sent to the DDB along with the necessary copies of the Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014).

The DDB will then process the disability application and make a final disability determination.

5.9.3 Presumptive Disability Determined By DDB

If the applicant has an urgent need, but does not have one of the listed impairments, the IM worker must request DDB to make a presumptive disability determination. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form, F-10130, that there is an urgent need for medical services.

Note: If someone has an impairment, but not an urgent need, follow the normal disability application process (see Section 5.3 Disability Application Process).

1. Document the urgent need by placing the Medicaid Presumptive Disability form, F-10130 in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:
   a. The MADA form (Medicaid Disability Application form, F-10112, formerly DES 3071).
   b. Release to Disability Determination Bureau form, F-14014.
3. See Process Help Section 9.4 Automated Medicaid Disability Determination for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM agency within three business days of receiving the request for presumptive disability and the Medicaid Disability Application form, F-10112 form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

5.9.4 Deceased Applicants

While a deceased person can be eligible for Medicaid in the months prior to his or her death, presumptive disability determinations are not allowed for individuals that are deceased. Process such requests for a final disability determination through the disability process through DDB.

5.9.5 Eligibility

Medicaid coverage based on a presumptive disability determination begins on the date the individual is found presumptively disabled, as indicated by DDB or the receipt of written attestation from a medical profession. If the presumptive disability determination is made by the IM worker, Medicaid coverage should begin the date the complete

Medicaid Presumptive Disability form (F-10130) was received by the agency, as long as all other eligibility requirements are met. The effective date should not be delayed based on the date the worker takes action to confirm the case.

Example 3: Jane contacted her IM agency and applied for Medicaid on July 3. She reported being in urgent need of medical services due to muscular dystrophy. The IM worker determines that Jane would be eligible based on presumptive disability, but requests that a medical professional complete and sign the Medicaid Presumptive Disability form (F-10130) to attest to the urgent need and impairment. Jane's physician completes and returns the form to the IM agency on July 12. A worker processes the verification on July 14. Jane is found presumptively disabled and eligible for Medicaid effective July 12.

Example 4: Bob is Jack's son and authorized representative. Bob applied for Medicaid on behalf of his father by telephone on June 20. He reported to the IM worker that Jack had a stroke six weeks ago and is in urgent need of medical services. The IM worker determines that Jack may be eligible based on presumptive disability, but requests that a medical professional complete and sign the Medicaid Presumptive Disability form (F-10130) to attest to the urgent need and impairment. Bob also needs to verify Jack's assets. The completed Medicaid Presumptive Disability form, attesting to the impairment and urgent need, is received by the IM agency on July 2, and verification of Jack's checking account is received July 12. The IM worker processes the verification on July 15. The worker determines that Jack is presumptively disabled and eligible for Medicaid effective July 2.

Because CARES usually certifies Medicaid from the beginning of the month, the IM worker must manually complete a Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 to apply the correct begin date. The form can be returned by fax to 608-221-8815 or by mail to the following address:

ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

Do not grant eligibility prior to the date the presumptive disability was determined until DDB makes a formal disability determination, (when the case folder is returned to the IM agency). Once DDB does the final determination, the case may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met.

When backdating eligibility after DDB has made the formal disability determination, the member could qualify for Medicaid by meeting a three-month deductible even if he or she had excess income in the three-month backdate period. This is an exception to the normal six month Medicaid deductible requirements. The deductible amount for this

three-month deductible period will be the total excess income for those same three months. All other deductible rules will apply and the individual can be certified for Medicaid for that period on the first day they meet the deductible during that three month period.

5.9.6 Disability Application Denials

5.9.6.1 DDB Returns a Negative Presumptive Disability Decision

If the DDB returns a negative Presumptive Disability decision, the IM worker must send a manual notice of decision to the applicant. The notice must state:

"Your request for Medicaid is based upon your statement that you are disabled. The final decision on your disability has not yet been made, however we have determined that you cannot be considered presumptively disabled. This means that you cannot be certified as eligible for Medicaid as a person with a disability until a final disability decision has been made. You will be informed when the Disability Determination Bureau makes the final disability decision. (Wis. Stats. ss. 49.46 and 49.47)”

5.9.6.2 Member Ineligible for Non-Medical Reasons

If a member is determined ineligible for non-medical reasons, you may terminate presumptive disability with timely notice without waiting for DDB's final disability decision. In such a case, notify DDB immediately at, (608) 266-1565, that a medical determination is no longer needed.

5.9.6.3 DDB Reverses Presumptive Disability Decision Made by DDB or by the IM Worker

If the DDB denies a disability application their decision reverses a presumptive disability decision made by the IM worker or by DDB. Terminate Medicaid eligibility following timely notice requirements. Medicaid eligibility based on a presumptive disability decision does not continue during the period a person is appealing DDB's decision that they are not disabled.

Benefits received while the disability decision was pending are not subject to recovery, unless the individual made misstatements or omissions of fact at the time of the presumptive disability determination.

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5.10 Medicaid Purchase Plan Disability

5.10.1 MAPP Introduction

When a *disability* determination for the *MAPP* is required, complete the application process in Section 5.3 Disability Application Process.

Section V – Work History of the Medicaid – Disability Application (F-10112) must be completed in full detail in all MAPP disability determination requests. The Disability page in *CWW* should be coded to indicate whether the request is for a MAPP disability determination or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an *applicant* may move from regular Medicaid disability to MAPP disability.

A determination of disability for MAPP excludes consideration of Substantial Gainful Activity (SGA), while a regular Medicaid disability determination does not.

5.10.2 Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement

An EBD Medicaid applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. Refer to 5.2.2 Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits.

For more information on MAPP, see Section. 26.1 Introduction.

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6 Residency

6.1 Residency Eligibility

6.1.1 Residency Eligibility Introduction

A person must be a Wisconsin resident to be eligible for Medicaid. He or she 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 Section 6.5 Absence), 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 here (see Section 6.2 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: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For Medicaid purposes, George is 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.

6.1.2 Migrant Farm Worker

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

1. His or her primary employment in Wisconsin is in the agricultural field or cannery work, **and**
2. He or she is authorized to work in the US, **and**
3. He or she is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crewleader"), **and**

4. He or she routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

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6.2 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. His or her I.Q. is 49 or less or he or she has a mental age of 7 or less, based on tests acceptable to Wisconsin's *DHS*; **or**
2. He or she is judged legally incompetent by a court of record; **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 he or she is incapable of indicating intent.

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

“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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6.3 Determining Residence

6.3.1 Under Age 21

6.3.1.1 In an Institution

The residence of an institutionalized person under age 21 when his or 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 or her and no legal guardian has been appointed, his or her residence is the state in which the institution is, if the person making the Medicaid application lives in that same state.

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

6.3.1.2 Not in Institution

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

- Age 18 or under age 18 and emancipated from his or her parents, or married, and 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.
- Under age 18 and not emancipated from his or her parents and not married, and is:

  1. Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.
  2. Living in another state when Wisconsin or one of its county agencies has legal custody of him or her.
  3. Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or *disability*).

6.3.2 Age 21 and Over

6.3.2.1 In an Institution

The residence of an institutionalized person aged 21 or over is the state in which he or she is residing with the intent to remain.

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

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6.4 Special Situations

6.4.1 State Supplementary Payment

The State Supplementary Payment (SSP) is the portion of an *SSI* payment paid by a state, not by the federal government. An SSP recipient's residence is the state making the SSP payment.

6.4.2 Homeless Persons

A homeless person living in Wisconsin meets the requirement of being physically present in Wisconsin. The agency must, by using its own address or some other fixed address, make Medicaid cards available to eligible applicants who have no fixed dwelling place or mailing address.

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6.5 Absence

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until one of the following:

- The person notifies the income maintenance agency that he or she no longer intends to reside in Wisconsin
- Another state determines the person is a resident in that state for Medicaid/Medical Assistance
- Other information is provided that indicates the person is no longer a resident

6.5.2 Temporary Absence

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

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6.6 Reserved

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6.7 Reserved

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6.8 Interstate Placements

6.8.1 Interstate Placements Introduction

An interstate placement occurs when a state or state contracted agency arranges for an individual to be admitted to an institution in another state.

"Arranges for" means any action by a state or state-contracted agency beyond providing information to the person or the person's family (or both). Do not consider the following to indicate interstate placement:

1. Giving information to individuals about another state's Medicaid program.
2. Giving information to persons about the availability of health care services and facilities in another state.
3. Helping a person locate an institution in another state when that person is capable of indicating intent and independently decides to move.

When a state or state-contracted agency makes the placement, the state making the placement is the person's Medicaid residence. The person's intent makes no difference. If Wisconsin places a person into an institution in Tennessee, Wisconsin remains the state of residence for Medicaid even if the person expresses an intent to reside in Tennessee.

If Tennessee places a person in Wisconsin, Tennessee is the Medicaid residence despite an indicated intent by the person to make his or her home in Wisconsin.

Follow this rule even when placement is made by a state because that state lacks a sufficient number of appropriate facilities to provide services to its residents.

Use the general rule of residency when a competent person leaves an institution in which he or she was placed by another state. If the person is not able to indicate intent, Medicaid residence continues to be that of the state that made the placement.

6.8.2 Reciprocal Agreement

Wisconsin has a reciprocal agreement with some other states (see the list below) in which persons that are placed in out-of-state institutions (not placed there as a result of an interstate placement) are the residents of the state where the institution is. For example, a person institutionalized in Wisconsin who would otherwise be considered a resident of Minnesota is a Wisconsin resident for Medicaid purposes.

These are the states with which we have this agreement:

- Alabama
- Arkansas

- California
- Georgia
- Idaho
- Kansas
- Kentucky
- Maryland
- Minnesota
- Mississippi
- New Mexico
- N. Dakota
- Ohio
- Pennsylvania
- S. Carolina
- S. Dakota
- Texas
- Virginia
- W. Virginia

6.8.3 Disputes

The state in which the person is physically present is the Medicaid residence when two or more states disagree about the person's residence.

If you determine that a state other than Wisconsin is the person's legal residence, contact the other state about providing Medicaid coverage.

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6.9 Reserved

Policy related to inmates has been moved to Chapter 13.

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7 U.S. Citizen or Qualifying Immigrant

7.1 US Citizens and Nationals

7.1.1 U.S. Citizens and Nationals Introduction

To qualify for Medicaid, persons who are otherwise eligible and declare that they are U.S. citizens or nationals must provide documentation of their citizenship, unless they are exempt or their citizenship is verified by the Social Security Administration through a data exchange.

A U.S. citizen is anyone who:

- Was born in the United States, the Commonwealth of Northern Mariana Islands, Puerto Rico, Guam or the U.S. Virgin Islands.
- Was born to a U.S. citizen who was living abroad.
- 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.

7.1.2 Child Citizenship Act of 2000

The Child Citizenship Act 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, **or**
- 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 one 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 U.S. citizen parent in the U.S.

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

1. **Adopted under the age of 16**, and have been in the legal custody of and have resided with the adopting parent or parents for at least two years,
2. **Adopted while under the age of 18**, and have been in the legal custody of and have resided with the adopting parent or parents for at least two years and are a sibling of another adopted child who is under 16,
3. **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, **or**
4. **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.

7.1.3 Compact of Free Association States

Persons from the Compact of Free Association States (*CFAS*) 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 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 Medicaid, unless they have obtained a qualifying immigration status. Those CFAS citizens who do not have one of the immigration statuses listed in Section 7.3.8 Immigration Status Chart may qualify for Medicaid Emergency Services only.

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7.2 Documenting Citizenship and Identity

7.2.1 Citizenship Verification Introduction

U.S. citizenship must be verified for persons applying for or receiving Medicaid (MA), BadgerCare Plus, or *FPOS* benefits and who have declared that they are a U.S. citizen, unless they are exempt from this requirement (See Section 7.2.1.2 Exempt Populations). Citizenship verification for health care must first be attempted using the real-time data exchange with the Social Security Administration before requesting documentation of citizenship from applicants. (See Section 7.2.3 Citizenship Verification through Data Exchange). Only those who are not exempt and for whom verification was not available through a data exchange may be required to submit documentation of their citizenship (See Section 7.2.4 Citizenship Verification through Documentation). Once citizenship has been verified for a person, verification may never again be required to receive health care benefits unless previously verified information becomes questionable.

7.2.1.1 Covered Programs

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

- BadgerCare Plus (except for the Prenatal Program)
- Medicaid
- Katie Beckett (Note: Since eligibility for Katie Beckett is determined by staff in the Bureau of Children's Long-Term Support Services, they will ensure citizenship and identity verification.)
- Tuberculosis (TB)-related Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)

Note: TB-related Medicaid and *WWWMA* eligibility are not determined in *CWW*. If citizenship has already been verified for one of these programs, do not require citizenship verification for applicants in CWW.

7.2.1.2 Exempt Populations

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

- Anyone currently receiving *SSDI* or a Disabled Adult Child benefit (SSDC)
- Anyone who is currently receiving *SSI* benefits
- Anyone currently receiving Medicare
- Anyone currently receiving *Foster Care* (Title IV-E and Non IV-E)

- Anyone currently receiving Adoption Assistance
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) at any time on or after July 1, 2006. This includes CENs born on or after July 1, 2005

The citizenship verification requirement does not apply to persons who are not applying for or receiving any health care benefits. This requirement also does not apply to persons who are not claiming to be a U.S. citizen.

Former Supplemental Security Income and Medicare Recipients
Medicare, SSDI, and SSI recipients lose their exemption from the citizenship verification requirement when their enrollment in these programs ends.

Note: Workers must use data exchanges to verify receipt of SSI, SSDI and Medicare prior to requesting verification from the member.

7.2.2 Reserved

7.2.3 Citizenship Verification Through Data Exchange

For individuals who meet the selection criteria below, CARES will automatically submit a request to the Social Security Administration (SSA), with the person's name, verified Social Security Number (SSN), and date of birth for comparison to SSA's data. If SSA is able to verify the person's U.S. citizenship, no additional verification of citizenship may be required.

Only persons meeting all of the following criteria will be selected for this data exchange:

- Requesting Medicaid, BadgerCare Plus, or Family Planning Only Services
- Declaring to be a U.S. citizen or national
- Provides an SSN
- Is not a member of an exempt population listed in 7.2.1.2
- Citizenship/nationality has not already been verified through other means

Non-exempt Medicaid applicants/members who do not provide an SSN or whose SSN cannot be verified, cannot have their citizenship verified through the data exchange. They must meet the citizenship verification requirement by providing documentation as defined in 7.2.4.

7.2.4 Citizenship Verification Through Documentation

Those who are not exempt from the citizenship verification requirement and have not had their citizenship verified by the Social Security Administration must provide

verification of citizenship. Verification will consist of either stand-alone documentation of citizenship (7.2.4.1) or documentation of both citizenship (7.2.4.2) and identity (7.2.4.3). Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period section (7.2.4.4).

If an individual has provided proof of citizenship in a state other than Wisconsin, 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 Wisconsin.

If an applicant/member contacts the agency for help with verifying citizenship, work with him or her to determine if anything on the document list in Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation is readily available to the applicant/member. In certain circumstances the agency can authorize payment of documentation for an applicant/member. See 7.2.5, Agencies Paying for Documentation.

Agencies may accept citizenship and identity documents from an individual 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 the different last names are found questionable, 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 or her first and last name, he or she must produce documentation from a court or governing agency documenting the change.

An electronic copy of documentation submitted by the applicant or member to satisfy the citizenship verification requirement must be maintained in the case record.

See Process Help, Section 68.1 Citizenship and Identity Verification, for tools that IM workers can use to assist members and applicants in meeting the citizenship verification requirement.

Once citizenship has been verified by a State or IM agency, verification may never be requested again, even after periods of ineligibility for health care benefits, unless other information is received causing past previously verified information to be questionable. This includes verification of citizenship or identity documented by a written affidavit.

7.2.4.1 Stand-Alone Documentation of Citizenship

Stand-alone documentation is a single document that verifies citizenship, such as a United States Passport. Stand-alone documentation of citizenship is the most reliable way to establish that the person is a U.S. citizen. If an individual presents a stand-alone document, no other citizenship verification is required. See the chart below or Process Help Section 68.3 Acceptable Citizenship and Identity Documentation for a list of stand-alone documents.

An applicant or member who does not provide a stand-alone document must provide documentation of citizenship and identity.

Stand-Alone Document	Description/Explanation
Certificate of Naturalization	Form N-550 or N-570. Issued by the Department of Homeland Security for naturalization.
Certificate of Citizenship	Form N-560 or N-561. The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
A State-issued Enhanced Driver's License	A special type of driver's license identified specifically as an "Enhanced Driver's License". It requires proof of U.S. citizenship to obtain. Five states currently issue enhanced driver's licenses (Minnesota, Michigan, New York, Vermont, and Washington), but more states are expected to issue these licenses in the future. Accept an Enhanced Driver's License issued by any U.S. state. REAL IDs are not Enhanced Driver's Licenses. REAL IDs only provide documentation of identity, not citizenship.
U.S. Passport	The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. Passports issued with a limitation may only be used as proof of identity.
Tribal Identification Documents	Documentary evidence issued by a federally recognized Indian tribe, which meets all the following criteria: • Identifies the federally recognized Indian tribe that issued the document • Identifies the individual by name • Confirms the individual's membership, enrollment, or affiliation with the tribe Such Tribal identification documents include, but are not limited to: • A Tribal enrollment card; • A Certificate of Degree of Indian Blood; • A Tribal census document; and • Documents on Tribal letterhead, issued under the

	signature of the appropriate Tribal official A photograph is not required to be part of these documents.

7.2.4.2 Evidence of Citizenship

If an applicant is unable to provide stand-alone documentation of citizenship (7.2.4.1), he or she must provide other documentation proving citizenship. 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. (See the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation for a list of acceptable documents of citizenship.) If an applicant is unable to provide any of the acceptable documents of citizenship, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

For any applicant born in Wisconsin, attempt to verify citizenship through the on-line birth query before requesting documentation of citizenship from the applicant.

Acceptable Documentation of Citizenship Only	Description/Explanation
Final Adoption Decree	The adoption decree must show the child's name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Birth Certificate	A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), , the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the State, Commonwealth, Territory or local

	jurisdiction. **Note:** A Puerto Rican birth certificate used to verify U.S. citizenship of anyone applying for health care benefits must have been issued on or after July 1, 2010. Older birth certificates that were used to verify citizenship for persons when they previously applied for any IM program before October 1, 2010, are still considered valid.
Birth Query	A birth record query confirms a person's birth in Wisconsin.
U.S. birth record amended more than 5 years after person's birth	An amended U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). Must show a U.S. birthplace.
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act 2000 (CCA)	An individual demonstrates that s/he has gained his/her U.S. Citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	U.S. Citizen ID Card The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Northern Mariana Card Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.
State or Federal census record	Must show birthplace and citizenship. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, member, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.
Education Document	The school record must show a U.S. birthplace and the name of the child.

Evidence of civil service employment by U.S. government	The document must show employment by the U.S. government before June 1, 1976. Persons employed with the U.S. Government prior to that date had to be U.S. citizens.
Hospital record	Extract of a hospital record on hospital letterhead established at the time of the person's birth and that indicates a U.S. place of birth. This is not a souvenir "birth certificate" issued by the hospital.
Life, health or other insurance record	Must show a U.S. place of birth.
Medicaid Birth Claim	When the Wisconsin Medicaid program pays the costs associated with the birth of an infant who either: • Did not qualify as a CEN, or • Was a CEN, but born before July 1, 2006, The infant will be considered a U.S. citizen who has met the citizenship documentation requirement. If citizenship is not verified through a data exchange, identity documentation is still required.
Medical record (doctor, clinic, hospital)	The document must show a U.S. birthplace. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Official Military record of service	The document must show a U.S. birthplace.
Admission papers from nursing home, skilled nursing care facility or other institution	The document must show a U.S. birthplace.
Other MA Program Verified Citizenship	An individual has already provided proof of citizenship while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
Birth Certificate Paid by IM Agency	A U.S. public birth certificate (paid for by the Income Maintenance agency) showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the State, Commonwealth, Territory or local

	jurisdiction.
Religious Record or Baptismal Certificate	An official religious record. The document must show a US birthplace and either the date of birth or the individual's age at time the record was made.
Certification of Report of Birth	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth.
Certification of Birth Abroad	Form FS-545. Issued by the Department of State consulates prior to November 1, 1990.
Consular Report of Birth Abroad of a US Citizen	Form FS-240. The Department of State consular office prepares and issues this. Children born outside the U.S. to U.S. military personnel usually have one of these.
SAVE database	Using the SAVE system to verify citizenship status for non-citizens who gained US citizenship.
Written Affidavit	If the applicant cannot produce the accepted documents verifying citizenship, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavits, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's citizenship, and • That contains the applicant's name, date of birth, and place of U.S. birth. • The affidavit must be signed under penalty of perjury. • The affidavit does not have to be notarized.

7.2.4.3 Evidence of Identity

If an applicant is unable to provide stand-alone documentation of citizenship (7.2.4.1), in addition to providing evidence of citizenship (7.2.4.2), they must also provide evidence of identity. The applicant may provide any documentation of identity listed in the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation to prove identity, provided such document has a photograph or other identifying information sufficient to establish identity such as name, age, sex, race, height, weight, eye color, or address.

In addition, you may accept proof of identity from a Federal agency or another State agency, including but not limited to a law enforcement, revenue, or corrections agency, if the agency has verified and certified the identity of the individual. If the applicant does not have any documentation of identity and identity is not verified by another Federal or

State agency, he or she may submit an affidavit, signed under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described above. The affidavit does not have to be notarized. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Acceptable Documentation of Identity Only	Description/Explanation
State or Territory Driver's license	Driver's license issued by a U.S. State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. REAL IDs only provide documentation of identity, not citizenship.
Education Document	For children under age 19, school records providing the name and other identifying information. School records would include, but not be limited to report cards, daycare or nursery school records.
FoodShare Identification Requirement met	Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FoodShare, it is also met for the identity verification requirement for health care.
Identification card issued by Federal, State, or local government	Must have the same information as is included on driver license.
Institutional Care Affidavit (Form F-10175)	If the applicant cannot produce the accepted documents verifying identity, a signed Statement of Identity for Persons in Institutional Care Facilities (F-10175) may be used. A residential care facility administrator signs this form under penalty of perjury attesting to the identity of a disabled individual in the facility.
U.S. Military card or draft record, Military dependent's identification card, or US Coast Guard Merchant Mariner card	Must show identifying information that relates to the person named on the document.
Medical record	Doctor, clinic, or hospital records for children under

	age 19 only.
Motor Vehicle Data Exchange	This is a data exchange update with the Division of Motor Vehicles or when verifying an individual's identity through the DOT Driver License Status Check website.
Multiple Identity documents	An individual may provide 2 or more corroborating ID documents to verify his/her identity. Examples include marriage license, divorce decree, high school or college diploma, or an employer ID card.
Other MA Program Verified Identity	An individual has already provided proof of identity while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
State ID Paid by Agency	Must have the same information as is included on driver license.
School Identification card	School identification card with a photograph of the individual and/or other identifying information.
Written Affidavit for Children (Form F-10154)	If the applicant cannot produce the accepted documents verifying identity for children under 18 years of age, a Statement of Identity for Children Under 18 Years of Age (F-10154) is acceptable. The affidavit must be signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of birth of the child. The affidavit does not have to be notarized.
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying identity, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavit, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's identity, and • That contains the applicant's name, and other identifying information such as, age, sex, race, height, weight, eye color, or address. • The affidavit must be signed under penalty of perjury. • The affidavit does not have to be notarized.

	A signed Statement of Citizenship and/or Identity (F-10161) may be used for individuals who are unable to obtain any level of acceptable documentation.

7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship

Applicants who are otherwise eligible for Medicaid or other health care benefits and are only pending for verification of citizenship (and identity when needed) must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are able to continue receiving health care benefits for which they are eligible, while the IM agency waits for citizenship verification. Applicants have 90 days after receiving a request for citizenship verification to provide the requested documentation. This 90-day period is called the reasonable opportunity period (ROP). The 90-day ROP starts on the date after the member receives the notice informing them of the need to provide citizenship verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than 5 days. If a member shows that a notice was received more than 5 days after the date on the notice, we must extend the deadline to 90 days after the date the member received the notice.

The 90-day ROP applies when citizenship verification is needed from a person at any time: applications, reviews and when a person is newly requesting benefits on an existing case.

Applicants are <u>not</u> eligible for backdated health care benefits while pending for citizenship verification. Once citizenship verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested.

The ROP ends on the earlier of the date the agency verifies the person's citizenship or identity or on the 95th day following the date the reasonable opportunity period notice was sent (unless receipt of the notice was delayed). If the requested verification is not provided by the end of the 95 days, the worker must take action within 30 days to terminate eligibility. Extensions of the reasonable opportunity period are not allowed for verification of U.S. citizenship.

An individual may only receive one 95 day reasonable opportunity period for verification of U.S. citizenship or identity in his or her lifetime. When a person is terminated from health care benefits for failure to provide verification of citizenship or identity by the end of the reasonable opportunity period, they are not eligible to have their benefits continued if they request a fair hearing. If a person later reapplies for health care

benefits, they must provide citizenship verification within regular verification deadlines and they are not eligible for health care benefits until they provide verification.

Benefits issued during a reasonable opportunity period (including benefits issued due to timely notice requirements) to a person otherwise eligible for BadgerCare Plus are not subject to recovery, even if the person never provides citizenship verification.

7.2.5 Agencies Paying for Documentation

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

- Has no documentation of citizenship or identity,
- 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 or her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement.

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

IM agencies should pay for a birth certificate or state ID card before relying on a written affidavit. If there is an opportunity to obtain a document that meets the guidelines, then that should be pursued.

However, when an applicant or 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 a written affidavit for citizenship and/or identity.

In order to obtain birth certificates or state ID cards for applicants or members, agencies need to follow the process outlined in Process Help Section 68.2.5 Agency Documentation Requests.

7.2.6 Reserved

7.2.7 Situations which Require Special Documentation Processing

7.2.7.1 Person Add

A person being added to a case is subject to the verification requirement at the time of his or her request for benefits. If not exempt and citizenship is not verified by *SSA*,

inform the applicant of the documentation requirement and give him or her the 95-day reasonable opportunity period to comply. Grant eligibility if the person is otherwise eligible. If documentation is not received timely, terminate Medicaid for that person only.

7.2.7.2 Reserved

7.2.7.3 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 or identity should be counted as part of the group when determining eligibility for other group members. See Process Help Section 68.2 Documentation and Verification Codes for processing instructions.

7.2.7.4 Child Citizenship Act of 2000

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act. Within the context of the Medicaid citizenship verification requirement, this means that for any applicant or member claiming citizenship through the Child Citizenship Act, 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 Child Citizenship Act, this is considered evidence of citizenship. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity.

See Section 7.1.2 Child Citizenship Act of 2000.

7.2.7.5 Non-U.S. Citizens

As a reminder, do not request or require citizenship and identity documentation from individuals who have not declared that they are U.S. citizens. Non-citizens who apply for IM programs are not subject to this policy. Legal non-citizens are subject to the verification process through *FDSH* and *SAVE* and undocumented non-citizens do not have any status that can be verified. (See Process Help, Section 44.2.2.11 Immigrant/Refugee Verification, for instructions on using FDSH and Process Help, Chapter 82 SAVE, for instructions on using SAVE.) Undocumented non-citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and should not be subject to the citizenship and identity verification policy.

When an individual who had legal non-citizen status subsequently gains U.S. citizenship, this is recorded in SAVE. Therefore, SAVE can be used to verify these individuals' citizenship. The verification result from SAVE will be "individual is a US

Citizen." See Process Help Chapter 82 SAVE for instructions on using SAVE. These individuals still need to provide proof of identity.

7.2.7.6 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, an *SNF*, *ICF*, *IMD*, and hospitals.

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7.3 Immigrants

"Immigrants" refers to all people who reside in the U.S., but are not U.S. citizens or nationals. Immigrants may be eligible for Medicaid and other categories of health care benefits if they meet all eligibility requirements and, in addition, declare that they have a satisfactory immigration status (see Section 7.3.1), and they are:

- "Qualified Immigrants" (see Section 7.3.3.1), or
- "Lawfully Present" (see Section 7.3.3.2), and
  - Are under age 19,
  - Are under age 21 and residing in an IMD, or
  - Are pregnant.

Immigrants who do not meet these additional requirements may still be eligible for the BadgerCare Plus Prenatal Program or Emergency Services.

Before health care benefits may be issued to immigrants, their immigration status must be verified with the Department of Homeland Security through the Federal Data Sources Hub or *SAVE* (See Section 7.3.2). Prior to verification of immigration status, benefits may also be issued for a temporary period under a Reasonable Opportunity Period (see Section 7.3.2.2).

7.3.1 Declaration of Satisfactory Immigration Status

To qualify for health care benefits, persons who are not U.S. citizens or nationals must declare (or have an adult member of their household declare on his or her behalf) a satisfactory immigration status, except for:

- Persons applying for Emergency Services.
- Pregnant women applying for the BadgerCare Plus Prenatal Program.
- Persons who are not requesting benefits.

This declaration is normally provided as part of a signed application for health care that provides some basic information regarding the immigration status of household members. However, in some cases, a person may only indicate on his or paper or ACCESS application that he or she is not a U.S. citizen and not provide any information about his or her immigration status. In such a situation, it is not known whether the person is telling us that he or she is lawfully present in the U.S. (i.e., that they have a satisfactory immigration status) or that they are undocumented.

Federal law requires that agencies obtain a declaration of satisfactory immigration status before taking any action to verify a person's immigration status, including granting eligibility during a reasonable opportunity period (see 7.3.2.2 Reasonable

Opportunity Period). To meet this declaration requirement, everyone who indicates that he or she is not a U.S. citizen or national must provide one of the following:

- His or her immigration status
- His or her immigration number (including an I-94, passport, SEVIS, or similar number)
- A signed declaration that says he or she has a satisfactory immigration status

Anyone who is required to and fails to provide immigration information or a declaration (or have an adult in the household provide it on his or her behalf) within standard verification timeframes must be denied health care benefits and must not be granted a reasonable opportunity period.

7.3.2 Verification

Primary verification of immigration status is done through the Department of Homeland Security (DHS) by use of the Federal Data Services Hub (FDSH) or SAVE, which is an automated telephone and computer database system. A worker processing an application can simply enter the immigrant's alien number and immigration document type into CWW. That information, along with demographic information of the individual, is sent in real time to the FDSH. The FDSH will immediately return verification of the immigrant's status, date of entry, and the date the status was granted if it's available from the Department of Homeland Security, along with other information. If the FDSH cannot provide verification of the immigration status, workers are directed to seek secondary verification though SAVE or take other action.

The verification query via the FDSH or SAVE most likely results in returning the latest date of any qualified alien status update for an individual, not his or her original date of arrival. The only way to obtain an accurate date of arrival for those who do not meet an exemption category and who report a date of arrival prior to August 22, 1996, is through the secondary verification procedure. The FDSH or SAVE will describe the immigrant's current status which may have changed from the original status. In some situations described later workers will need to maintain the original status in CARES.

It may be necessary to complete a secondary or third level verification procedure with the U.S. Citizenship and Immigration Services (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).
- 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 he or she is telling the IM worker.
- A non-citizen applicant tells an IM worker that he or she came to the U.S. prior to August 22, 1996. If he or she 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.
- The FDSH or SAVE returns the message "Institute Secondary Verification."
- The IM worker finds any questionable information in the initial verification process.
- Cuban/Haitian entrants when SAVE or the Hub indicates the need.

An Immigration Status Verifier at DHS will research the alien's records and complete the response portion of the verification request.

Consult the SAVE manual for more information.

Additional verifications from sources other than the Department of Homeland Security are sometimes required as well. For example, persons who are in an immigration status subject to the 5-year bar and who indicate that they, their spouse or parent is in the military service or is a veteran, that military status must also be verified.

The following documents are considered valid verification of military service:

- A signed statement or affidavit form from an applicant attesting to being a veteran, surviving spouse, or dependent child
- Military records

Immigration statuses for most immigrants are permanent and most often change when the immigrant become a U.S. citizen. For this reason, immigration status for most members should only be verified once, unless the status for an individual is questionable or it’s a status subject to reverification (see Section 7.3.2.1). Even if an immigrant loses health care eligibility for a period of time, his or her immigration status does not need to be re-verified unless the status is subject to reverification.

See Process Help, Section 44.3.9 Immigrant/Refugee Information Page for additional information on using the FDSH or the procedures in the SAVE Manual.

7.3.2.1 Reverification of Immigration Status

The following persons with a Registration Status Code of 20 – Lawfully Residing are required to verify their immigration status at application and renewal, even if they have previously verified their immigration status:

- Immigrant children under age 19
- Youths under age 21 in an Institution for Mental Disease (IMD)
- Pregnant women

Typically, these persons will be labelled with a “Non-immigrant” status by the United States Citizenship and Immigration Services. Reverifications are not to be done for children and pregnant women with other Registration Status Codes, as those statuses are permanent. The reverification requirement is only to be applied at the time of subsequent applications, renewals, or when an agency receives information indicating that the member may no longer be lawfully residing in the U.S. For pregnant women, the reverification is not to occur until the renewal is done to determine the woman’s eligibility after the end of the 60-day postpartum period.

7.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are to continue receiving health care benefits for which they are eligible, while the IM agency waits for immigration status verification. Applicants who are otherwise eligible and are only pending for verification of immigration will have 90 days after receiving a request for immigration verification to provide the requested documentation. This 90-day period is called the Reasonable Opportunity Period (ROP). The 90-day ROP starts on the date after the member receives the notice informing the member of the need for the member to provide immigration verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than 5 days. It also means that if a member shows that a notice was received more than 5 days after the date on the notice, we must extend the deadline to 90 days after the date the member received the notice.

The 90-day ROP applies when immigration verification is needed from a person at any time: applications, renewals and when a person is newly requesting benefits on an existing case.

Applicants are eligible for benefits beginning with the first of the month of application or request. However, they are not eligible for backdated health care benefits while waiting for verification of their immigration status. Once verification of an eligible immigration status is provided, the applicant’s eligibility must then be determined for backdated health care benefits if they have been requested.

When requested verification is not provided by the end of the *ROP*, the worker must take action within 30 days to terminate eligibility, unless one of the following situations occurs where the worker is allowed to extend the reasonable opportunity period:

- The agency determines that the person is making a good faith effort to obtain any necessary documentation.

- The agency needs more time to verify the person's status through other available electronic data sources.
- The agency needs to assist the person in obtaining documents needed to verify his or her status.

Applicants who fail to provide verification of immigration status and later reapply for health care benefits are not eligible for another ROP. If verification of immigration status is still needed, eligibility may not be granted until verification is provided. The regular verification deadlines apply.

Persons whose health care benefits were terminated for failure to provide verification of immigration status by the end of the ROP are not eligible to have their benefits continued if they request a fair hearing.

A person may receive a reasonable opportunity period more than once in a lifetime in the following situations:

- The person was not a U.S. citizen when first applying for benefits and received a reasonable opportunity period to verify immigration status. Later, the person became a U.S. citizen and applied for benefits. The person may receive a reasonable opportunity period to verify U.S. citizenship.
- The person is an immigrant who must reverify his or her immigration status at renewal (see Section 7.3.2.1 Reverification of Immigration Status). This person may receive an additional reasonable opportunity period for each subsequent renewal, as long as he or she provided the requested verification during the previous reasonable opportunity period.

Example 1: Vladimir is a 12-year-old lawfully present in the United States on a visa applying for health care benefits with his parents. When verification is attempted through the FDSH, the response requires the worker to submit a secondary verification request to SAVE. Vladimir is otherwise eligible for Medicaid, so the worker confirms Medicaid eligibility and sends the ROP notice to the family while waiting for the SAVE response. A week later, SAVE verifies the child is lawfully present in the U.S. under a Temporary Protected Status and the reasonable opportunity period ends.
A year later, the case is up for renewal. Since Vladimir has a Registration Status Code of 20 – Lawfully Residing, his immigration status must be verified again. Once more, the FDSH informs the worker that verification of the child's status must be done through SAVE. If Vladimir is otherwise eligible for Medicaid, the worker must again confirm eligibility without delay and send a new reasonable opportunity period notice to the family. Again, Vladimir may be eligible for up to 90 days after receiving the notice while the worker is waiting to verify his immigration status.

Benefits issued during a reasonable opportunity period to a person otherwise eligible for BadgerCare Plus are not subject to recovery, even if the person turns out to have an immigration status that makes him or her ineligible for BadgerCare Plus benefits.

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for BadgerCare Plus if they meet all other eligibility requirements and are either Qualifying Immigrants or are Lawfully Present as described below.

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants.

1. A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees his or 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 Medicaid even if his or 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 he or she requests permission to stay. An immigrant admitted under this asylee status may be eligible for Medicaid even if his or 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 Medicaid even if his or her immigration status later changes.

4. A Cuban/Haitian entrant. An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if his or her immigration status later changes.

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

6. 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).

7. Lawfully admitted for permanent residence under the INA.*

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

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

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

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

12. 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.*

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

- Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and the spouse , unmarried dependent child, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces
- Be a certain Amerasian immigrant defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, with Class of Admission codes: AM1, AM2, AM3, AM6, AM7 or AM8.
- Have resided in the U.S. for at least five years since his or her date of entry (see Section 7.3.6 Continuous Presence).

7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant Women

Children younger than 19 years old, adults younger than 21 years old who are residing in an IMD, and pregnant women do not have to wait five years to be eligible for full-benefit Medicaid and BadgerCare Plus if they meet one of the following criteria:

- Are lawfully admitted for permanent residence (see Registration Code #1 in the Immigration Status Chart in Section 7.3.8)
- Are lawfully present under Section 203(a)(7) (see Code #3 in the Immigration Status Chart in Section 7.3.8)
- Are lawfully present under Section 212(d)(5) (see Code #6 in the Immigration Status Chart in Section 7.3.8)
- Have suffered from domestic abuse and are considered to be a battered immigrant (see Code #16 in the Immigration Status Chart in Section 7.3.8)

Women who have an immigration status requiring a five-year waiting period before being eligible for BadgerCare Plus will have the waiting period lifted when their pregnancy is reported to the agency. The lift on the five-year waiting period 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.

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant women may qualify for BadgerCare Plus or Medicaid if they are lawfully present in the U.S. under many of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

Immigrants who are not a qualifying immigrant nor lawfully present (for example, someone with a status of *DACA*) and who apply for Medicaid and meet all eligibility requirements, except for citizenship and immigration status, are entitled to receive Medicaid Emergency Services only (see Chapter 34 Emergency Services).

Pregnant immigrants who are not a qualifying immigrant nor lawfully present and who apply for the BadgerCare Plus Prenatal Program and meet the eligibility requirements except for citizenship and immigration status, are entitled to receive BadgerCare Plus Prenatal Program benefits and/or BadgerCare Plus Emergency Services (see BadgerCare Plus Eligibility Handbook, Chapter 41 BadgerCare Plus Prenatal Program and Chapter 39 Emergency Services).

Immigration status is an individual eligibility requirement. An individual’s immigration status does not affect the eligibility of the Medicaid Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

7.3.4 Public Charge

The receipt of Medicaid 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 Medicaid, they are 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.

7.3.5 Immigration and Naturalization Service (INS) Reporting

Do not refer an immigrant to *INS* unless information for administering the Medicaid program is needed. For example, if Medicaid needs to determine an individual's location for repayment or fraud prosecution, or to determine his or her immigration status.

7.3.6 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 they gain 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 BadgerCare Plus and meet all eligibility requirements, are entitled to receive BadgerCare Plus benefits:

- A non-citizen who arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and changed his or her status to a qualified immigrant on or after August 22, 1996. This individual would not be subject to the five-year ban if he or she remained continuously present from his or her date or arrival in the U.S. until the date he or she gained qualified immigration status.
- A non-citizen who arrived in the U.S. before August 22, 1996, in undocumented status or who overstayed his or 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 or her date of arrival in the U.S. until the date he or she gained qualified immigration status, he or she would not be subject to the five-year ban.
- For those non-citizens who arrived in the U.S. with or without documentation on or after August 22, 1996, or for those whose 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 he or she:

- Did not have a single absence from the U.S. of more than 30 days, or
- 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 he or she 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

7.3.7 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 or her status with the 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 or her presence in the U.S. prior to August 22, 1996. This may include pay stubs, a letter from an employer, lease or rent receipts, or a utility bill in the applicant's name.

Example 2: 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 Medicaid in February 2008. The IM worker should first determine if 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 Medicaid. She can be enrolled in Medicaid after February 2, 2009 if she meets other financial and non-financial criteria.

Example 3: 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. Shariff is eligible to be enrolled in Medicaid if he meets other financial and non-financial criteria.

Example 4: Katrin entered the U.S. March 3, 1995, and gained qualified immigrant status June 20, 1995. She is applying for Medicaid 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 Medicaid if she meets other financial and non-financial criteria.

Example 5: Juan entered the U.S. as an undocumented immigrant on April 1, 1996. He applied for Medicaid 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 Medicaid if he meets other financial and non-financial criteria.

Example 6: Elena entered the U.S. on July 15, 1999, on a temporary work visa and obtained qualified immigration status on October 31, 2004. She applied for Medicaid February 1, 2008, and has been in the U.S. 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 since Elena's original entry date is after August 22, 1996. The five-year clock starts from the date she obtained qualified immigration status, so she would be able to apply for Medicaid after October 31, 2009.

Example 7: 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 Medicaid 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. If the IM worker had 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.

7.3.8 Immigration Status Chart

Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

CARES Registration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran* Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran* Arrived On or After August 22, 1996	Children Under 19 and Pregnant Women; Arrived on or

						after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 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 October 1, 2009 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 October 1, 2009 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 Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian	Eligible	Eligible	Eligible	Eligible	Eligible

	Entrant					
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 October 1, 2009 Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking**	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Bar	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible

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

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year bar. See Section 4.3.10 Victims of Trafficking for more information.

7.3.9 Iraqis and 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 BadgerCare Plus for as long as they have this Special Immigrant 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

7.3.9.1 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works (W-2) agencies and is made available for refugees who do not qualify for W-2.

Refugee "Reception and Placement" (R&P) payments are not counted as income for Medicaid. 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.

7.3.9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, he or she may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. Refugee Medical Assistance is considered a separate benefit from Medicaid but provides the same level of benefits. Refugee Medical Assistance 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 Refugee Medical Assistance for eight months and Afghan immigrants may be eligible for Refugee Medical Assistance for six months.

While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in Wisconsin Works (W-2) Manual, Section 18.3 Refugee Medical Assistance.

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

7.3.10 Military Service

Applicants with an immigration status that requires them to be in that immigration status for five years before being eligible for health care benefits are exempt from this five-year bar if they meet any of the following criteria related to military service:

- Honorably discharged veterans of the U.S. Armed Forces. This is defined as persons who were honorably discharged after any of the following:
    - Serving for at least 24 months in the U.S. Armed Forces.
    - Serving for the period for which the person was called to active duty in the U.S. Armed Forces.
    - Serving less than 24 months but was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
    - Serving less than 24 months but was discharged for family hardship.
    - Serving in the Philippine Commonwealth Army or as a Philippine Scout during World War II.
- On active duty (other than active duty for training) in the U.S. Armed Forces.
- The spouse, unmarried and non-emancipated child under age 18, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces. A surviving spouse is defined as meeting all of the following criteria:
    - A spouse who was married to the deceased veteran for at least one year.
    - A spouse who was married to the deceased veteran either:
        - Before the end of a 15 year time span following the end of the period of military service, or

        - For any period of time to the deceased veteran and a child was born of the marriage or was born before the marriage.
    - A spouse who has not remarried since the marriage to the deceased veteran.

7.3.11 Victims of Trafficking

Applicants claiming to be victims of trafficking (or have a Class of Admission (COA) code indicating that they are a victim – ST6 or T1), have not resided in the United States for at least five years, and are at least 18 years of age, must have a victim certification from the federal Office of Refugee Resettlement (ORR) in the Department of Health and Human Services to be treated like a refugee and be exempt from the five-year bar.

Persons with a COA code indicating they are a child, spouse, or parent of a trafficking victim (Codes ST0, ST1, ST7, ST8, ST9, T2, T3, T4, T5, or T6) are exempt from the five-year bar and do not need certification from the ORR. Victims of trafficking who are under 18 at the time they apply do not require a certification from the ORR. Victims of Trafficking who are 18 or older and do not have the certification will be subject to the five-year bar.

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8 Medical Support

8.1 Medical Support

8.1.1 Medical Support Introduction

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 *CSA* is responsible for establishing Medical support orders for some children receiving Medicaid 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.)

8.1.2 Recovery of Birth Costs

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

8.1.3 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 Medicaid 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 (DWSP 3080) only needs to be completed when the Absent Parent page cannot be completed in *CWW*.

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

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

1. A 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 Medicaid will continue during this period, regardless of her cooperation.

2. A child receiving *SSI* only if the caretaker requests child support services for the child. Do not sanction this caretaker if he or she does not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when:

a. A Statement of Paternity 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 he or she 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 was not legitimized after their marriage.

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8.2 Medical Support/ CSA Cooperation

8.2.1 Medical Support/Child Support Agency Cooperation

Unless the person is exempt, or has good cause for refusal to cooperate (see Section 8.3 Claiming Good Cause), each *applicant* or *member* that is referred, must, as a condition of eligibility, cooperate in **both** the following:

- Establishing the paternity of any child born out of wedlock for whom Medicaid, including Medicare Savings Programs, is requested or received
- Obtaining medical support for the applicant and for any child for whom Medicaid, including Medicare Savings Programs, is requested or received

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

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the applicant.
2. Appear as a witness at judicial or other hearings or proceedings.
3. Provide information, or attest to the lack of information, under penalty of perjury.
4. Pay to the *CSA* any court-ordered medical support payments received directly from the absent parent after support has been assigned.
5. Attend office appointments as well as hearings and scheduled genetic tests.

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

8.2.2 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 Section 8.3.7 Determination). If there is a dispute, the CSA makes the final determination of cooperation. The member remains ineligible until he or she cooperates, establishes good cause, or cooperation is no longer required.

The following individuals are not sanctioned for non cooperation:

1. Pregnant women.
2. Minors.
3. Parents or caretaker relatives while the family is in a BadgerCare Plus 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 CSA determines that a parent is not cooperating because court ordered birth costs are not paid, the parent or caretaker is not sanctioned.

Example 1: Mary, a disabled parent, is applying for Medicaid 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 Medicaid and EBD Medicaid.

Mary is not eligible for EBD Medicaid or Medicaid, 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 Medicaid.

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8.3 Claiming Good Cause

8.3.1 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. He or she must:

1. Specify the circumstance that is the basis for good cause, **and**
2. Corroborate the circumstance according to the evidence requirements in Section 8.3.5 Evidence

8.3.2 Notice

The *IM* agency must provide a Good Cause Notice, DCF-F-DWSP2018, to all applicants and to members whenever a child is added to the Medicaid 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.

8.3.3 Good Cause Claim

The Good Cause Claim form, DCF-F-DWSP2019, must be provided to any Medicaid 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 good cause claim is made at application.

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

8.3.4 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.

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.

8.3.5 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 or her to a mental health professional for a report relating to the claim.

When a claim is based on his or 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, **and**
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 he or she 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 Medicaid to the applicant or disenroll the member from Medicaid. The sanctions remain in effect until there is cooperation or until it is no longer required.

8.3.6 Investigation

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

Good cause must be granted when both the member's statement and the investigation satisfy you that he or she 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 fair hearing.

When the ten days have expired and no option has been taken the IM agency will deny Medicaid to the applicant or remove the member from the Medicaid card, and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

8.3.7 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 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 Medicaid pending the determination.

If a fair hearing is requested on a good cause determination, Medicaid 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.

8.3.8 Good Cause Found

When good cause is granted, the IM 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 or her participation.
2. He or she 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.

8.3.9 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 he or she 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 none of the options listed above has been taken, the IM agency must deny Medicaid to the applicant or terminate the member’s Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

8.3.10 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 when there is new evidence or at redeterminations.

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 he or she 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 none options listed above has been taken, the IM agency must deny the individual's Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

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8.4 Cooperation Between IM & CSA

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

8.4.1 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.

8.4.2 Medicaid Discontinued

The CSA is notified through CARES when Medicaid is discontinued.

8.4.3 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 (Income Maintenance Manual Section 11.1 Public Assistance Fraud Program).

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9 Third Party Liability

9.1 Third Party Liability

9.1.1 Third Party Liability Introduction

TPL refers to the obligation a third party (not Wisconsin Medicaid program or the Medicaid *member*), has to pay the bills for a Medicaid member's medical services. Medicaid is the payer of last resort for the cost of medical care. This means that if a Medicaid member also has coverage under a private health insurance plan, that plan is to be billed first for any medical services. Medicaid then pays any amount remaining after the private insurer has paid what they owe, up to the Medicaid reimbursement rate. Another common example of TPL is when someone receives an insurance settlement resulting from an accident. If Medicaid paid for any medical services resulting from that accident, the Medicaid 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.

9.1.2 Third Party Liability Cooperation

All Medicaid 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 Medicaid is received. In addition, Medicaid 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, he or she could be sanctioned.

9.1.3 Third Party Liability Cooperation Requirements

The Medicaid member must cooperate in providing TPL information unless he or she 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 Medicaid, the adult is ineligible until he or she cooperates.

Do not sanction the following for non-cooperation:

1. Minors, including *minor* caretakers.

2. A parent or caretaker 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).

9.1.4 Third Party Liability Good Cause Claim

When good cause is claimed (see Section 8.3 Claiming Good Cause), 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.

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9.2 Nursing Home, Hospital, and Long-Term Care Insurance

9.2.1 Nursing Home, Hospital, and Long-term Care Insurance Introduction

All members must cooperate in providing *TPL* coverage information for nursing home, hospital, and long-term care insurance policies. All members must do the following:

1. Assign to the state of Wisconsin their rights to payments from a nursing home, hospital, or long-term care insurance policy (see Section 9.2.2 Assignment).
2. Send any payments to the state of Wisconsin that they received from a nursing home, hospital, or long-term care insurance carrier while receiving Medicaid (see Section 9.2.3 Recovery of Payments).

Any nursing home, hospital, or long-term care insurance payments that exceed the amount that Medicaid has paid in benefits for that *member* will be refunded to that member.

Terminate Medicaid eligibility for the individual who is not cooperating in providing TPL insurance information (see Section 9.1.2 TPL Cooperation), unless they have good cause (see Section 9.1.4 TPL Good Cause Claim).

9.2.2 Assignment

To assign hospital or long-term care insurance payments, the member must complete the Long-Term Care Insurance Policy – Assignment of Benefits form (F-01567) that requests all current or future payments be made payable to the state of Wisconsin.

The member must send the completed Long-Term Care Policy-Assignment of Benefits form to his or her long-term care carrier and mail a copy to the following address:

Wisconsin *DHS*
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The long-term care carrier must mail payments to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The assignment of payments includes all ongoing payments for as long as the member receives Medicaid. Terminate Medicaid eligibility for the individual who refuses to assign these payments.

9.2.3 Recovery of Payments

In some cases, the insurance policy will require that payments be made directly to the patient or member. The member must forward these payments to the state of Wisconsin. Failure to forward any payment may result in the member losing his or her eligibility for not cooperating with providing TPL coverage and access information. When forwarding payments, the member must write on the back of the check “Pay to the order of the state of Wisconsin” and sign the check.

Members should mail payments, along with the corresponding *EOB*, to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the member refuses to forward the third-party payments to the state.

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9.3 Health Insurance Risk Sharing Plan

Coverage under the *HIRSP* ended as of April 1, 2014.

For information about coverage prior to April 1, 2014, please call HIRSP Customer Service at 1.800.828.4777 or go to http://www.hirsp.org/.

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9.4 Health Insurance Premium Payment

HIPP pays the employee's portion of the employer subsidized health care coverage. The fiscal agent determines if it is cost effective to buy the employer's insurance.

9.4.1 Cost-Effective

If it is cost-effective to buy the employer-subsidized insurance, the HIPP Unit will notify those members who are required to enroll in an employer's health plan and provide additional information related to enrollment, coverage, and cooperation.

HIPP may pay the premium for a non-Medicaid family *member* if that member needs to enroll in the group health plan in order to obtain coverage for the Medicaid member. Medicaid will only pay for the premiums of the ineligible family member(s) and not any of their other cost sharing expenses (e.g., prescription co-pays). Medicaid will continue to cover the employer's health insurance premium, deductibles, and co-insurance for the Medicaid member.

9.4.2 Participation in HIPP

Members participating in HIPP will have Medicaid as a backup. If the employer's health insurance does not cover something that Medicaid does, then Medicaid will pick up the payment.

9.4.3 Cooperation

Effective January 1, 2014, HIPP is now voluntary for *MAPP* members as well as BadgerCare Plus members.

9.4.4 Not Cost-Effective

If it is not cost-effective to buy the employer-subsidized insurance, the member will remain eligible for MAPP.

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9.5 Casualty Claim Process (Subrogation)

9.5.1 Casualty Claims (Subrogation) Introduction

Casualty claims are those claims for Medicaid 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 Medicaid 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.

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

9.5.2 Reporting Accident or Injury Claims

If members are in an accident or are injured and receive a cash award or settlement due to the accident or injury and Medicaid (including SSI enrollees) pays for part or all of the care, it must be reported. When Medicaid pays for a claim that is related to an accident, a letter is sent to the member informing him or her of the requirement to report the information.

If a member has hired an attorney or is working with an insurance agency to settle the claim, that must also be reported. If a member reports a claim, he or she must report the accident or injury case to the Casualty Recovery Unit using one of the following methods:

- Mail:

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

- **Telephone:** 877-391-7471
- **Fax:** 469-359-4319
- **Email:** wicasualty@hms.com

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

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 and attorney information.

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9.6 Other Health Insurance

9.6.1 Other Health Insurance Introduction

The *IM* agency should collect insurance coverage information about applicants and members 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. This is because Medicaid is usually the payor of last resort, and any other insurance coverage will be billed before the Medicaid program.

9.6.2 Policies Not To Report

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

1. HMOs for which the state pays all or part of the premium.
2. Medicare Part A or Part B premiums (entered in CWW on the Medicare page).
3. *IHS* is the exception to the rule that Medicaid is the payer of last resort. For Native Americans who are Medicaid members, IHS is the payer of last resort. Do not enter these policies in CARES.
4. Policies that pay benefits only for treatment of accidental injury.
5. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's *disability* .
6. 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 he or she is insured against and if the benefits are assignable.
7. Life Insurance.
8. Other types of insurance types that do not cover medical services.

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9.7 Reserved

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10 SSN

10.1 SSN Requirements

10.1.1 Social Security Number Requirements

Medicaid applicants must provide an *SSN* or be willing to apply for one. Assist the applicant in applying for an SSN for any group member who does not have one. See Section 20.3.2 Social Security Number for more information on assisting an applicant with applying for an SSN. Non-applicants are not required to provide an SSN.

If an SSN application was made in good faith and the applicant cooperated fully with the application process, do not deny benefits if the SSN application was denied for reasons beyond the applicant's control. See Section 20.3.2 Social Security Number for more information on health care eligibility without a verified SSN.

An applicant does not need to provide a document or Social Security card. He or she only needs to provide a number, which is verified through data exchanges.

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

Verify the SSN only once.

10.1.2 Social Security Number Exceptions

Do not require an SSN for:

- Pre-adoptive infants living in a foster home.
- Non-qualifying immigrants applying for or receiving emergency services.
- Someone without an SSN who may only be issued one for a valid non-work reason.
- Someone who refuses to obtain an SSN because of well-established religious objections. ("Well-established religious objections" means that the applicant or member is a member of a recognized religious sect or division of the sect and that the applicant or member 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 SSN due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

10.1.3 SSN Mismatches

Refer to Process Help, Section 44.4 Discrepancy Processing and Match Access, if the SOLQ-I process returns a mismatch record.

Inform the applicant or member if the SOLQ-I process returns a different SSN or suggests that another person is using the same SSN. If it appears that the incorrect SSN was provided by the applicant or member, ask the applicant or member to clarify the correct SSN. If it appears that another person is using the same SSN, advise the applicant or member to contact the SSA. The applicant or member may request SSA conduct an investigation. Do not provide the applicant or member with any information that would identify the person who is using the applicant or member's SSN.

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11 Premium or Cost Share

11.1 Premium or Cost Share

Nonpayment of a *MAPP* premium will result in nonfinancial ineligibility. See Section 26.1 Medicaid Purchase Plan Introduction for more information.

Nonpayment of a Home and Community-Based Waivers cost share will result in nonfinancial ineligibility. See Section 28.1 Home and Community Based Waivers Long-term Care Introduction for more information.

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12 Change Reporting

12.1 Change Reporting Introduction

Members must report to the *IM* agency, within 10 days of the occurrence, a change in address, income, assets, need, medical expenses or living arrangements which may affect eligibility.

Some changes may be reported through ACCESS.

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13 Inmates

View History

13.1 Introduction

When a Medicaid applicant or member is an inmate, they may be eligible for suspended Medicaid. Suspension is a type of eligibility in which an inmate continues to be enrolled in Medicaid while incarcerated, and does not have to complete a new application to regain benefits when released.

An inmate is someone who resides in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

The following individuals are not considered to be inmates for the purposes of Medicaid:

- 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 that are appropriate to the person's needs.
- An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet.
- People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision).

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see Section 27.1 Institutions), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which *Foster Care* maintenance payments are made under Title IV-E. People residing in these situations are not inmates.

Even though the following institutions may accommodate 16 or fewer residents, they are not considered to be publically operated community residences. People residing in these institutions may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

- Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.
- Correctional or holding facilities for people who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

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View History

13.2 Covered Services

Individuals who are inmates of a public institution may be eligible for suspended SSI-related Medicaid or Wisconsin Well Woman Medicaid if they otherwise meet eligibility requirements. See Chapter 24 SSI Related Medicaid and Deductibles or Chapter 36 Wisconsin Well Woman Medicaid for information about these programs.

If a member of a different health care program becomes incarcerated, eligibility for that program will be terminated. However, the member will be evaluated for eligibility in a program that can be suspended.

During the suspension, Medicaid will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

While enrolled in suspended Medicaid, members are not eligible to enroll in an HMO.

Copay limits still apply to suspended members for any services they receive.

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View History

13.3 Suspension Start Date

13.3.1 Applicants

If the applicant is already incarcerated and has been since at least the beginning of the application month, their suspension will start the first of the month of application.

Example 1: Mark is incarcerated on January 17, 2021. He applies for health care on April 20, 2021, and is found eligible for suspended SSI-related Medicaid. Mark's suspension start date is April 1, 2021.

If the applicant was incarcerated after the first of the application month, the suspension will start the first of the month following the application month.

Example 2: Jane is incarcerated on April 15, 2021. She applies for health care on April 20, 2021, and is found eligible. She is certified for full-benefit SSI-related Medicaid from April 1, 2021, until April 30, 2021. Jane's suspended SSI-related Medicaid starts on May 1, 2021.

13.3.2 Backdated Eligibility

If an applicant is determined eligible for a Medicaid backdate and was incarcerated during any of the backdated months, they will open in a suspended status for any backdated months in which they were incarcerated for the entire month. For any backdated months in which the person was not incarcerated for the entire month, they will open for full-benefit Medicaid.

The earliest a suspension can start is October 1, 2020. If an applicant is requesting backdated benefits for month(s) prior to October 1, 2020 and they were incarcerated during the entire backdated month, they would not be eligible for suspended or full-benefit Medicaid during that month.

Example 3: Sophia is incarcerated on December 4, 2020. Her husband applies for health care for their household on May 21, 2021, and requests three months of backdated benefits. They are found eligible for SSI-related Medicaid. Sophia is open for suspended SSI-related Medicaid starting February 1, 2021. Her husband is open for full-benefit SSI-related Medicaid starting February 1, 2021.

Example 4: Brady is incarcerated on February 9, 2021. He applies for health care on April 20, 2021, and requests three months of backdated benefits. He is found eligible for SSI-related Medicaid, and opens for full-benefit SSI-related Medicaid from January 1, 2021, until February 28, 2021. He is open for suspended SSI-

related Medicaid starting March 1, 2021.

13.3.3 Existing Members

Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported. This policy applies even when the incarceration is reported untimely. See Section 12.1 Change Reporting Introduction. An untimely change report may result in an overpayment. See Section 22.2 Corrective Action.

Example 5: Olivia is open for full-benefit SSI-related Medicaid. On December 23, 2020, Olivia reports she is incarcerated as of December 20, 2020. Olivia's SSI-related Medicaid is suspended starting January 1, 2021.

13.3.4 Deductibles

Suspended members who met a deductible before being incarcerated will maintain their existing certification period and renewal date, which is the end of the six-month deductible period.

Example 6: Jordan has a Medicaid deductible period from April 1, 2021, until September 30, 2021. He meets his deductible on May 10, 2021, and becomes eligible for full-benefit Medicaid. He is incarcerated on June 19, 2021. His suspension starts July 1, 2021, and his certification period goes to September 30, 2021.

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13.4 Suspension End Date

When a member in a suspension is released from prison or jail and this information becomes known to the income maintenance agency, full-benefit Medicaid eligibility can be reinstated without a new application for benefits. Upon release, the suspended member's eligibility must be redetermined. If eligible, the member's Medicaid coverage will start the first of the month in which the member is released. The member's health care certification renewal date will not change.

Example: Cameron is incarcerated and enrolled in suspended Medicaid. His renewal date is June 30, 2021. Cameron is released on December 15, 2020. Cameron opens for full-benefit Medicaid starting December 1, 2020. His renewal date remains June 30, 2021.

The suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. However, this retroactive lifting may only go as far back as the last renewal. This is an exception to the normal backdating policy that only allows up to three months of backdated eligibility. See Section 2.8.2 Backdated Eligibility.

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View History

13.5 Renewals

Members in a health care suspension will go through the normal renewal process at the end of their certification period, including administrative renewals when applicable (see Chapter 3 Renewals). Members must complete the renewal and continue to meet program eligibility criteria in order to maintain their suspension. If the member does not complete the renewal or no longer meets program eligibility criteria, the member's suspension will end and Medicaid eligibility will be terminated.

Note: If a member has appointed the prison or jail or an employee of the prison or jail as their authorized representative, that entity can complete the renewal on the member's behalf. See Section 22.5 Representatives.

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View History

13.6 Change Reporting

Existing change reporting policy applies for members in a suspension (see Chapter 12 Change Reporting). The exception is a suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. See Section 13.4 Suspension End Date.

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View History

13.7 Household Composition

If the individual who is incarcerated belongs to a household, the person will be considered “temporarily absent” from the household and remain a countable member of the household for Medicaid during the suspension. The other household members will also remain countable within the incarcerated member’s suspended assistance group. There is no limit to how long inmates can be considered temporarily absent from the Medicaid household, as long as they continue to meet program rules.

Applicants and members are responsible for determining if an individual who is incarcerated is part of their household or not. They will be able to include this information in the application and when reporting a change. IM workers should accept this information that is provided by the applicant or member. Verification of this information is not required. Members can also report changes to the household status during the incarceration period.

Example: Quinton and Meg are married and both are enrolled in Medicaid. Quinton is the Primary Person on the case. Meg is incarcerated on January 3, 2021. Quinton reports Meg’s incarceration and that she is still part of the household. Meg’s suspension starts on February 1, 2021, and she continues to be on the same case as Quinton. On June 7, 2021, Quinton decides that Meg is no longer part of the household. He reports that Meg is still incarcerated but is no longer part of the same household as him. Meg is removed from the case and her suspension ends June 30, 2021. Meg must fill out a new application for herself if she wants to continue having suspended health care benefits going forward.

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View History

13.8 Special Rules

13.8.1 Children Whose Parent/Caretaker is an Inmate

If the only parent(s)/caretaker(s) in the household are incarcerated, any children on the case open for Medicaid will remain eligible for a three-month grace period. Eligibility for the children will end after the three-month grace period unless they open for health care on another case.

Example 1: Faye and her 10-year-old daughter, Chantelle, are both enrolled in health care. Faye is enrolled in medically needy Medicaid and Chantelle is enrolled in BadgerCare Plus. On March 9, 2021, Faye is incarcerated. Faye's suspended Medicaid starts April 1, 2021. Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for the three-month grace period. Chantelle's BadgerCare Plus will end June 30, 2021. Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.

13.8.2 Pregnant Women

Pregnant women who are incarcerated will have their eligibility determined under the BadgerCare Plus Prenatal Program (see BadgerCare Plus Eligibility Handbook, Section 41.1 BadgerCare Plus Prenatal Program).

When the pregnancy ends, BadgerCare Plus Prenatal Program members must have their health care eligibility redetermined for the next month. If determined eligible for Medicaid, the member will open for suspended Medicaid.

13.8.3 Huber Law

Some inmates may be allowed to leave jail for various reasons under the Huber Law, also known as the Huber Program. Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for full-benefit Medicaid if both the following are true:

- They intend to return to the home.
- They continue to be involved in the planning for the support and care of their minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for full-benefit Medicaid. They may be eligible for suspended Medicaid.

13.8.4 Out-of-State Inmates

If a person is incarcerated in Wisconsin and then involuntarily transferred to a correctional institution in another state, the person is still considered a Wisconsin resident.

Example 2: Oscar resides in Wisconsin. He commits a crime in Wisconsin and is incarcerated in a Wisconsin Department of Corrections facility. Due to a shortage of space, Oscar is transferred to a prison in Minnesota. Oscar remains a Wisconsin resident and may be eligible for suspended Medicaid or Medicaid while he is residing in the prison in Minnesota.

If a person has committed a crime outside of Wisconsin and is incarcerated by that state in a correctional facility in that state, the person is considered to be a resident of that state and not Wisconsin.

Example 3: Connor resides in Wisconsin. He commits a crime in Illinois and is incarcerated in an Illinois correctional facility. Connor is an Illinois resident while he is residing in the facility in Illinois. He is not eligible for suspended or full-benefit Medicaid in Wisconsin since he is not a Wisconsin resident.

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View History

13.9 State Correctional Institutions

The following is the list of correctional institutions administered by the Wisconsin Department of Corrections.

Brown
Green Bay Correctional Institution (GBCI)
Sanger Powers Correctional Institution (SPCI)

Chippewa
Chippewa Valley Correctional Treatment Facility (CVCTF)
Stanley Correctional Institution (SCI)

Columbia
Columbia Correctional Institution (CCI)

Crawford
Prairie du Chien Correctional Institution (PDCI)

Dane
Oakhill Correctional Institution (OCI)
Oregon Correctional Center (OCC)
Thompson Correctional Center (TCC)
Mendota Juvenile Treatment Center (MJTC)

Dodge
John Burke Correctional Center (JBCC)
Dodge Correctional Institution (DCI)
Fox Lake Correctional Institution (FLCI)
Waupun Correctional Institution (WCI)

Douglas
Gordon Correctional Center (GCC)

Fond du Lac
McNaughton Correctional Center (MCC)
Taycheedah Correctional Institution (TCI)

Grant
Wisconsin Secure Program Facility (WSPF)

Jackson
Black River Correctional Center (BRCC)

Jackson Correctional Institution (JCI)

Kenosha
Kenosha Correctional Center (KCC)

Lincoln
Copper Lake School (CLS)
Lincoln Hills School (LHS)

Milwaukee
Marshall E. Sherrer Correctional Center (MSCC)
Milwaukee Secure Detention Facility (MSDF)
Milwaukee Women's Correctional Center (MWCC)
Felmers O. Chaney Correctional Center (FCCC)

Racine
Robert E. Ellsworth Correctional Center (RECC)
Racine Correctional Institution (RCI)
Racine Youthful Offender Correctional Facility (RYOCF)
Sturtevant Transitional Facility (STF)

St. Croix
St. Croix Correctional Center (SCCC)

Sauk
New Lisbon Correctional Institution (NLCI)

Sawyer
Flambeau Correctional Center (FCC)

Sheboygan
Kettle Moraine Correctional Institution (KMCI)

Waushara
Redgranite Correctional Institution (RCI)

Winnebago
Drug Abuse Correctional Center (DACC)
Oshkosh Correctional Institution (OSCI)
Winnebago Correctional Center (WCC)
Wisconsin Resource Center (WRC)

FINANCIAL (CHS. 15 - 19)

15 Income

15.1 Income Introduction

15.1.1 Elderly, Blind, or Disabled Fiscal Test Group

An *EBD* fiscal test group (FTG) usually includes the individual who is non-financially eligible for Medicaid and anyone who lives with him or her and who is legally responsible for him or her. EBD fiscal test groups are groups of one or two. Spouses who live together are in each other's FTG. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The FTG size for this living arrangement is two.

There are some exceptions to this Policy:

- Blind or disabled minors (or dependent 18-year-olds): A blind or disabled *minor* (or *dependent 18-year-old*) living with his or her parents would be a one-person FTG. Special instructions for deeming parental income to the disabled minor are described in Section 15.1.2 Special Financial Tests for Disabled Minors

- Children and young adults who are applying for HCBW Medicaid for enrollment into the CLTS waiver program are a one-person FTG and have eligibility determined under the policy in Section 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program.

- SSI recipients: If one spouse is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the applicant's FTG. For this situation, you would have a one-person FTG when determining the Medicaid eligibility of the non-SSI spouse.

- Medicaid Purchase Plan (MAPP): Children are included in the FTG of a MAPP applicant or member, so the FTG for this program could be greater than two people. See Section 26.2.2 Fiscal Test Group for more information.

An individual applying for Long-Term Care Medicaid, including Institutional Medicaid, *HCBW*, Family Care, *PACE*, Partnership, or *IRIS*, would be a one-person fiscal group. If the individual is married, refer to Section 18.1 Spousal Impoverishment Introduction for special instructions regarding spousal impoverishment procedures.

15.1.2 Special Financial Tests for Disabled Minors

A blind or disabled minor (or dependent 18-year-old) must have his or her Medicaid eligibility determined according to the following special procedures. This process deems parental income to the disabled minor. The deemed parental income is added to the disabled minor's income when determining the disabled minor's financial eligibility for EBD Medicaid.

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household member and therefore not included in any of the following procedures. The following procedures are also different from those used to test for HCBW Medicaid eligibility for the Children's Long-Term Support Waiver Program (see Section 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program).

An ineligible child in this section is a minor child who is neither disabled nor blind.

An eligible child in this section is a minor child who is disabled or blind or both.

Calculate the countable income of everyone in the household using the following six steps.

1. For each ineligible child in the household:

    a. Subtract the ineligible child's unearned and earned income from the EBD Deeming Amount to an Ineligible Minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).
    b. The remainder is the amount to be allocated to the ineligible child from parental gross unearned income. Subtract this amount from the parental unearned income.

    If there is not enough parental unearned income to allocate the whole amount, allocate the rest from parental gross earned income.

2. If there was any remaining parental unearned income from step 1(b), subtract $20, the general income exclusion, from the amount.

    If there is not enough unearned income to subtract the full $20, subtract the rest of the $20 from the parental earned income.

3. Starting from what is left of the parental earned income, first subtract $65, and then subtract half of the remainder.

4. To this remaining parental earned income, add any parental unearned income remaining after steps 1(b). and 2. This is the total parental income.

5. From the total parental income, subtract the appropriate Parental Living Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances). Use the amount for an individual if one parent lives in the home or the amount for a couple if both parents, or one parent and a spouse, live in the household.

The remainder is the total parental income to be deemed to the eligible child(ren).

6. Divide the parental deemed income equally among the eligible children. Use the EBD-Related Determination Worksheet (Worksheet 06) (see Section 40.1 Worksheets Table of Contents) to calculate each child's Medicaid eligibility.

Example 1: Mr. and Mrs. Darwin have two children. Matthew, eight years old, is disabled, and is the eligible child. Jenny, 10 years old, is the ineligible child. Neither child has income. The Darwins have no unearned income. Parental earned income is $3,006 a month.

EBD deeming amount to an ineligible minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) = -$392

Remaining earned income $2,614
General income exclusion -$20
Remaining earned income $2,594
Earned income exclusion -$65

Remaining earned income $2,529
1/2 remaining earned income -$1,264.50

Parental living allowance -$1,157

Income deemed to eligible child = $107.50

Example 2: Lawrence has three children. One is disabled. None have any income. His monthly income is $2,050 earned and $402 unearned.

Unearned income = $402.00

EBD Deeming Amount for two ineligible minors (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) -$784.00

After subtracting this from unearned income, there is $382 remaining allocation that can be applied to earned income.

Lawrence's earned income $2,050
Excess allocation -$382

Remaining earned income $1,668
General income exclusion -$20

Remainder $1,648
Earned income exclusion -$65
Remainder $1,583
1/2 remaining earned income -$791.50
Parental living allowance -$771

Income deemed to eligible child $20.50

15.1.3 Income

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for EBD income limits. See Section 39.5 Federal Poverty Level Table for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income that you compare to the income limits.

See BadgerCare Plus Eligibility Handbook Section 43.2 Financial Test for *TB*-Related income limits.

15.1.4 Supplemental Security Income-Related Test

A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test (see Section 24.1 SSI-Related Medicaid Introduction for more information).

If an SSI-related fiscal group’s income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. If the fiscal group’s income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid deductible. Refer to Section 24.2 Medicaid Deductible Introduction for

more information about Medicaid deductibles and to Section 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid deductible.

15.1.5 Availability

General Rules:

1. Only count income when it is available.
2. Some income is disregarded (see Section 15.3 Exempt and Disregarded Income).
3. Always use gross income when calculating income.
4. Some income, even though it is unavailable income, must be counted (e.g., garnishments).

Income is available if all the following are true:

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

Note: Available income can include more than a person actually receives if amounts are withheld from earned or unearned income because of a garnishment or to pay a debt or any other legal obligation.

Examples of income sources that someone can make available are Social Security and unemployment compensation. This includes income increases such as *COLA*s.

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

1. Count the income if the amount is known. Count it as if the person is receiving it.
2. Ignore the income if the amount is not known.

> **Example 3:** Ms. M. turned 62 years old and is entitled to Social Security benefits of $900. However, she opted to wait until she turns 65 years old to start collecting her benefits. Since she is entitled to $900 at 62 years old, $900 is considered available income.

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

- It will not be available for 31 days or more.
- They have started the process to make it available.

Unavailability is usually documented by a letter from an agency stating when the person will receive the benefit. Thus, if he or she has just applied for benefits, do not add it to his or her income yet. The income is not ignored; it is only suspended until it becomes available.

15.1.6 Countable Income

Countable income is the prospective gross monthly amount used in the eligibility determination and post-eligibility calculations.

15.1.6.1 Migrant Workers

Annualize migrant workers income (see Chapter 31 Migrant Workers).

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15.2 Prospective Income

15.2.1 Prospective Budgeting

Budget the gross monthly earned and unearned income amount. See Process Help Section 16.3 Unearned Income for instructions on budgeting unearned income when other programs are requested along with Medicaid.

Verification is required for all sources of non-exempt income for EBD Medicaid applicants and members at the time of application, review or change in income source or amount.

Use all available data exchanges to verify income.

Note: The Employment Wage Match Query should not be used to verify current income. The income displayed on this match is the total income for a past quarter. It does not verify current monthly wages.

15.2.2 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 and prorated over the months between payments.

> **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.

Farm and self-employment income (see Section 15.6 Self Employment Income) is either averaged or prorated.

When an assistance group applies, do not count the prorated income until it is received.

> **Example 2:** Joe receives semiannual 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.

Prorated Income Is an Unavailable Asset
A source of income which is received in a particular month cannot also be counted as an asset for that same month. This policy also applies to income which has been prorated and will be budgeted over the appropriate prorated period (e.g., 12 months). The client is expected to use this prorated income for their personal needs over an extended period of time. Therefore, any unbudgeted balance is an unavailable asset during the period of time for which the prorated income is being counted. The amount of the unavailable asset will decrease with each month in which the prorated income is budgeted.

> **Example 3:** Jay regularly receives a $1200.00 annual payment from a wealthy relative every January. This income is prorated over 12 month so $100 per month is counted as unearned income beginning in January. The initial $1200 payment and any remaining unbudgeted balance is an unavailable asset during the 12 month budgeting period. In January the entire $1200.00 is considered unavailable. In February, $1100.00 is considered unavailable. The unavailable amount will decrease with every month that income from this source is counted.

15.2.3 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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15.3 Exempt/Disregarded Income

"*Disregard*" and "exempt" in this section mean "do not count." When calculating the total amount of income a person has received, disregard the following kinds of income:

15.3.1 Adoption Assistance

Disregard adoption assistance payments.

15.3.2 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling In Re "Agent Orange" Product Liability Litigation, M.D.L. No. 381 (E.D.N.Y.).

Apply this disregard retroactively to January 1, 1989, and continue to disregard these payments for as long as they are identified separately.

15.3.3 Combat Pay

Disregard 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 be excluded when determining the household's income.

Example 1: John's wife Bonnie and their daughter have an open Medicaid case. John is in the military stationed overseas, and 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 exempt income and not counted in the determination. The pre-combat pay of $1,000 is budgeted as unearned income for Medicaid.

15.3.4 Crime Victim Restitution Program

Disregard any payments received from a state-established fund to aid victims of a crime.

15.3.5 Disaster and Emergency Assistance

Disregard major disaster and emergency assistance payments made by federal, state, county, tribal, or local government agencies, or disaster assistance organizations.

15.3.6 Dottie Moore Payments

Disregard any penalty payment paid as a result of the Dottie Moore lawsuit.

These court-ordered $50-$200 penalty payments can be imposed when the *IM* agency or *CSA* does not correctly process child support refunds.

15.3.7 Foster Care

Disregard *foster care* payments. Foster care payments are considered to be the income of the child or *adult* who is receiving foster care and these payments are exempt income for the foster care recipient. However, in some situations the foster care recipient uses these payments to pay the foster parent for his or her room and board expenses. The room and board payments that are received by the foster parent are not disregarded and should be counted as non-exempt earned income (see Section 15.5.15 Earned Income Tax Credit) for the foster parent's Medicaid eligibility determination.

15.3.8 General Income Disregard

Disregard $20 from the *EBD* fiscal test group's net income.

15.3.9 Individual Development Account Payments

Disregard *IDA* payments that are made in the form of matching funds to buy a home, start a business, or to complete post-secondary education.

15.3.10 Inconsequential

Disregard income that is infrequent, irregular, and has no appreciable effect on ongoing need.

Infrequent income is defined as income that an individual receives only once during a calendar quarter from a single source and that the individual did not receive in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not those payments occur in different calendar quarters.

Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

Exclude the following income that is received either infrequently or irregularly:

- The first $30 per calendar quarter of earned income.
- The first $60 per calendar quarter of unearned income.

15.3.11 Kinship Care

Disregard Kinship Care payments.

15.3.12 Life Insurance

Disregard life insurance policy dividends.

15.3.13 Nutrition Benefits

Disregard benefits received from the following:

1. Emergency Food and Shelter National Board
2. *FEMA*
3. FoodShare coupon allotment
4. Home produce for household consumption
5. National School Lunch Act
6. Supplemental food assistance under the Child Nutrition Act of 1966
7. Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965
8. *USDA* Child Care Food Program
9. USDA-donated food and other emergency food
10. WIC, the supplemental food program for women, infants, and children

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims
3. Payments under the Alaskan Native Claims Settlement Act
4. Payments under the Maine Indian Claims Settlement Fund
5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000
7. 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
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot

10. For EBD Medicaid 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
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, Minnesota reservations
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe
15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000
16. Payments under the settlement of the Cobell v. Salazar class-action trust case
17. 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 one of the following:
        - 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
        - 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.

18. Disregard Tribal Per Capita payments from gaming revenue up to the first $500 of the monthly payment per individual. If the payments are received less than monthly, prorate the gross payment amount over the months it is intended to cover and disregard $500 from the monthly amount.

This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons **except** the following:

- SeniorCare
- *LTC* programs, such as the following:
    - Institutional Medicaid
    - *HCBW*
    - Managed LTC or *IRIS*

For these subprograms, which are treated differently because they are covered under a different section of federal law, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

19. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
20. Payment from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
21. Money from selling things that have cultural significance
22. Tribal general welfare payments that are based on the individual's demonstration of need, even if the source of the payment is gaming revenue

15.3.15 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

15.3.16 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid 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 or her surviving *spouse*, children, parents, or grandparents.

Apply this disregard retroactively to October 15, 1990, and continue to disregard these payments for as long as they are identified separately.

15.3.17 Refugee Cash Assistance

Disregard cash payments from the *RCA* program. RCA is administered by *W-2* agencies and is made available for refugees who do not qualify for W-2.

15.3.18 Refugee "Reception and Placement" Payments

Disregard federally funded "Reception and Placement" payments made to refugees during the first 30 days after their arrival in the U.S. Reception and Placement payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual or family or to a vendor.

15.3.19 Reimbursements

A reimbursement is a payment that a person receives for out-of-pocket expenses. Disregard reimbursements for expenses an *AG* member has incurred or paid. Do not disregard reimbursements for normal household living expenses, such as rent, clothing, or food eaten at home (see Section 15.4.21 Reimbursement of Living Expenses).

The following are some examples of reimbursements you should disregard:

- 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.
- For volunteers' out-of-pocket expenses incurred during their work.
- Medical or dependent care reimbursements.
- 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.
- Reimbursements received from the Social Services Block Grant Program for expenses in purchasing Social Services Block Grant services, (e.g.,, 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.

15.3.20 Relocation Payments

Under Wis. Stat. § 32.19, relocation payments are available to displaced persons. The following are examples of costs that the relocation payments are intended to cover: moving expenses, replacement housing, and property transfer expenses. Disregard the amounts paid by any governmental agency or organization listed in Wis. Stat. § 32.02. Disregard Title II, Uniform Relocation Assistance and Real Property Acquisition Policies Act payments. Its purpose is to treat people 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.

Disregard Experimental Housing Allowance Program payments. The program's purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the U.S., and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

For Medicaid applicants or members, disregard housing assistance payments received under the following acts:

- United States Housing Act of 1937
- National Housing Act
- Section 101 of the Housing and Urban Development Act of 1965
- Title V of the Housing Act of 1949
- Section 202(h) of the Housing Act of 1959

15.3.21 Repayments

A repayment is money the member has received from an IM program and must give back because of a program error or violation. Since he or she is not entitled to the money, he or she must repay it. Therefore, it should not be counted as income to the member.

Disregard the following repayments:

- Money withheld from an economic assistance check due to a prior overpayment.
- 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 2: Richard receives $50 a month from the *VA* and $250 from Social Security. The income from the two sources is added together in one lump sum 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.

- Social Security income used to repay an overpayment previously received from the Social Security Administration, whether SSA or *SSI*.

15.3.22 Special Programs

Disregard income from all of the following:

- Active Corps of Executives
- Emergency Fuel Assistance
- Foster Grandparents Program
- Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing *HUD* housing rent
- *Homestead* Tax Credit
- Low Income Energy Assistance Program
- Programs funded under Title V of the Older Americans Act of 1965 (see Section 15.5.13 Title V—Older Americans Act of 1965), except wages or salaries, which are counted as earned income.
- Retired Senior Volunteer Program
- Service Corps of Retired Executives
- University Year for Action Program
- Volunteers in Service to America

- Wisconsin's Family Support Program (Wis. Stat. § 46.985). This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.
- Senior Companion Program
- AmeriCorps State and National and AmeriCorps NCCC

15.3.23 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any *disability* resulting from the child's spina bifida.

15.3.24 Susan Walker Payments

Disregard 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.

15.3.25 Travel Tickets

In Medicaid cases, disregard the value of any commercial transportation ticket that the member, the member's spouse, or the member's parents (if the member is a minor) receives as a gift if it is:

- For travel among the 50 states, District of Columbia, American Samoa, Guam, Northern Mariana Island, Puerto Rico, and the Virgin Islands, and
- Not converted to cash.

15.3.26 VA Allowances

Disregard the following VA allowances:

- Unusual medical expenses that are received by a veteran, his or her surviving spouse, or his or her dependent.
- Aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses.

Unusual medical expenses, aid and attendance, and housebound allowances for institutionalized and community waiver cases, in eligibility and post-eligibility determinations, except for residents of the State Veterans Homes at King, Chippewa Falls, or Union Grove (see Section 15.3.26.1 Residents of a State Veterans Home).

Example 3: Jack is a single veteran living in his home. He is disabled (as determined by the VA) and receives VA pension benefits in the amount of $1,450 per month. Because he requires assistance with his daily living tasks, Jack receives an aid and attendance allowance that is part of the $1,450. The aid and attendance

allowance that Jack receives is $589 per month. Aid and attendance is disregarded income.

$1,450 VA pension
- 589 aid and attendance allowance (disregarded income)
$ 861 budgetable income

Example 4: Donald is a married veteran living with his wife and two children. He is disabled (as determined by the VA) and receives VA compensation benefits in the amount of $2,600 per month. He does not receive aid and attendance, housebound, or unusual medical expense allowances.

The full $2,600 is budgetable income to the household.

15.3.26.1 Residents of a State Veterans Home

For any veteran who resides at a State Veterans Home at King, Chippewa Falls, or Union Grove, in the eligibility determination, exempt the amounts identified by the VA as unusual medical expenses, aid and attendance, and housebound allowances.

In the post-eligibility test, exempt $90 for those who meet **all** of the following conditions:

- He or she receives aid and attendance, unusual medical expense, or housebound allowance payments in an amount greater than $90.
- He or she is a veteran who has no spouse or child or is a childless surviving spouse of a veteran.

Example 5: John is a veteran residing at the State Veterans Home at King. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded in eligibility and post-eligibility determinations. The personal needs allowance for institutionalized members is deducted from the $55 annuity payment. John's remaining budgetable income in the Medicaid post-eligibility determination is $10, and that $10 will be applied to his patient liability.

Example 6: Scott is a veteran residing at the State Veterans Home at King. His total monthly income consists of a $590 VA pension ($200 of which is for unusual medical expenses) and a $50 annuity payment. The portion of the VA pension for unusual medical expenses is totally disregarded in the Medicaid eligibility test. The $50 annuity payment and remaining $390 of the VA pension is non-exempt income. For the post-eligibility test, only $90 of the VA pension is disregarded. The patient liability calculation includes the personal needs allowance, so Scott will have to contribute $505 to his patient liability.

Eligibility Calculation
$590 VA Pension

+ 50 Annuity
$640
-200 (exempt income)
$440 countable income

Liability Calculation
$590 VA Pension
+ 50 Annuity
$640
- 90 (exempt income)
- 45 (personal needs)
$505 patient liability

15.3.27 Wartime Relocation of Citizens

Disregard restitution payments under PL 100-383 to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during World War II. There is no child support and maintenance disregard for Medicaid.

15.3.28 Wisconsin Works Payments

Disregard W-2 stipends and payments, including Case Management Follow-up Plus (CMF+) payments, made directly to a member as part of his or her participation in W-2. Earnings obtained through W-2's subsidized employment programs, such as Trial Jobs or Transform Milwaukee Jobs, are countable earned income.

15.3.29 Subsidized Guardianship Payments

Disregard subsidized guardianship payments.

15.3.30 Federal Coronavirus Recovery Rebates (Stimulus Payments)

Do not count Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments) received as part of the federal CARES Act.

Note: These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.

15.3.31 Federal Pandemic Unemployment Compensation (FPUC)

Do not count Federal Pandemic Unemployment Compensation (FPUC) payments.

Note: These were the $600 checks issued weekly from late April through July 2020, and were in addition to regular unemployment insurance benefits.

15.3.32 Retroactive Pandemic Unemployment Assistance (PUA)

Disregard retroactive Pandemic Unemployment Assistance (PUA) payments.

15.3.33 Retroactive Pandemic Emergency Unemployment Compensation (PEUC)

Disregard retroactive Pandemic Emergency Unemployment Compensation (PEUC) payments.

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15.4 Unearned Income

Unearned income is income that a *member* receives from sources other than employment. Unless it is disregarded income (see Section 15.3 Exempt and Disregarded Income) or an income deduction (see Section 15.7 Income Deductions), count gross unearned income in a person's income total.

When two payments from the same income source are received the same month due to mailing cycle adjustments, count each payment only for the month it is intended. Income sources commonly affected by such mailing cycle fluctuations include general assistance, other public assistance programs, *SSI*, and *SSA* benefits.

Note: Occasionally, a regular periodic payment (e.g., Title II or *VA* benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.4.1 Income From Trusts

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the 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 hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

- A Medicaid member.
- The *spouse* of a Medicaid member.
- 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.
- 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 payments (including interest and dividends) from a trust to the beneficiary are unearned income to the beneficiary. See Section 15.4.9 Interest and Dividend Income for instructions on counting interest.

If the beneficiary does not receive payments (including interest and dividends) from the trust, but they are added back to the trust principal, do not count them as income to the beneficiary if the beneficiary is elderly, blind, or disabled.

Note: If the grantor is an institutionalized person or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (see Section 17.13 Trusts).

15.4.2 Sick Benefits

Sick benefits are payments, such as income continuation, received from insurance. Do not count the following:

- Reimbursement for medical or social services
- Payments restricted to the future purchase of a medical or social service
- Any flat-rate benefits, such as per diem hospitalization or disability insurance, cancer insurance policies, or dismemberment policies

15.4.3 Unemployment Compensation

Count normal *UC* that is received. Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars.

15.4.4 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends. Examples of retirement benefits include:

- Pension disability or retirement plans administered by an employer or union
- Accounts owned by the individual, such as *IRA*s
- Plans for self-employed individuals, sometimes referred to as Keogh plans

Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

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.

Example 1: Mike withdraws $2,000 he has in an IRA and deposits it into a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another.

15.4.5 General Relief and Charity

Count unrestricted General Relief and charitable payments as follows:

1. Subtract the process month's Family Allowance from the AFDC Assistance Standard (see Section 39.3 AFDC-Related Income Table) for this size fiscal group.
2. Multiply the difference by 12 to get the maximum payment you can disregard.
3. Ignore any payment that is less than the maximum.
4. Subtract from the maximum the amount of any payment that is greater than the maximum.
5. Count the remainder as unearned income.

15.4.6 Gifts

A gift is something a person receives that 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).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is unearned income only in the month of receipt. Count the gift as an asset in the months following the month of receipt.

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less for each *AG* member for each calendar quarter.

Funds received through a crowdfunding account, such as GoFundMe and Kickstarter, would be considered a gift and counted as unearned income in the month of receipt and as an available asset in subsequent months as long as the funds are still in the person's possession (i.e., the person did not spend it in the month of receipt).

Funds that are not accessible for a person to withdraw are an unavailable asset. Disbursements would be unearned income in the month withdrawn and an available asset in subsequent months if the funds are still in the person's possession.

15.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. If the land contract cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be

considered an available asset. Count any repayments toward the principal of the loan as income. If the land contract can be sold, it is counted as an available asset, and the principal portion of the repayment remains an asset. Disregard any repayments toward the principal of the loan as income. 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 2: Bob receives land contract payments from Farmer Brown twice a year: one $5,000 payment in March and another $5,000 payment in September. Ten percent of that payment is interest.

If Bob is applying in February, prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a $5,000 land contract payment, divide the total countable income ($5,000 times 10 percent equals $500) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month ($500 divided by six months equals $83.33). Begin budgeting this amount in March.

15.4.8 Loans, Promissory Notes, and Mortgages

If an AG member makes a loan, promissory note, or mortgage (including a land contract), treat the repayments as follows:

1. Count the interest as unearned income in the month received.
2. Count any repayments toward the principal of the **loan**, regardless of whether it is a full payment, a partial payment, or an installment payment, as an asset but only if the **promissory note** itself is an available counted asset.
3. When the **promissory note** cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be considered an available asset. Count any repayments toward the principal of the **loan** as income.
4. 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.

15.4.9 Interest and Dividend Income

15.4.9.1 Elderly, Blind, or Disabled Interest and Dividend Income

Most interest and dividend earnings are excluded income so are not counted when determining Medicaid eligibility. See Section 15.4.9.1.1 Excluded Sources of Interest or Dividend Income for excluded sources of interest or dividend income and Section

15.4.9.1.2 Interest and Dividends Income Not Excluded for Elderly, Blind, or Disabled Medicaid for interest and dividend income not excluded for *EBD*.

Most interest and dividend income from a resource excluded under SSI rules will be an excluded source of income for all Medicaid eligibility and post-eligibility determinations. The are, however, some exceptions (see Section 15.4.9.1.2 Interest and Dividends Income Not Excluded for Elderly, Blind, or Disabled Medicaid).

15.4.9.1.1 Excluded Sources of Interest or Dividend Income

Do not count the following sources of interest or dividend payments:

- Interest or dividend income from a non-exempt resource, such as savings accounts, checking accounts, stocks, or bonds
- Medicaid resources that are exempt by federal statute other than the Social Security Act:

  - Agent Orange Settlement Payments
  - Austrian Social Insurance Payments
  - Corporation for National Community Service (formerly ACTION) Programs
  - Interests of *IDA*s—TANF-Funded
  - IDAs—Demonstrated Project
  - Japanese-American and Aleutian Restitution Payments
  - Low Income Energy Assistance
  - Payments to Victims of Nazi Persecution
  - Netherlands WUV Payments to Victims of Persecution
  - Department of Defense Payments to Certain Persons Captured and Interned by North Vietnam
  - Radiation Exposure Compensation Trust Fund
  - Ricky Ray Hemophilia Relief Fund
  - Payments to Veterans' Children with Certain Birth Defects

- Interest and dividends that accrue to revocable and irrevocable trusts
- Interest and dividends from a life insurance policy

15.4.9.1.2 Interest and Dividends Income Not Excluded for Elderly, Blind, or Disabled Medicaid

Count the following interest and dividends income for Medicaid:

- Interest earned on the unspent portion of *EITC*.
- Interest earned on the unspent portion of Child Tax Credits.
- Interest and dividends on gifts to children with life-threatening conditions.
- Interest earned on the unspent portion of federal, state, or local relocation assistance payments.

- Interest earned on the unspent portion of retroactive Social Security or SSI payments.
- Interest earned on the unspent portion of Crime Victim's Compensation Payments.
- Interest portion on repayments of promissory notes or other loan agreements as non-exempt unearned income.
- Interest and dividend payments from a revocable or irrevocable trust as non-exempt unearned income only when the trustee makes an actual payment of the interest or dividend to the trust beneficiary.

Count the non-excluded interest and dividend income listed above as unearned income only when both the following are true:

- It is received regularly and frequently.
- It is more than $20 a month.

15.4.10 Social Security Benefits

Count Social Security benefits as unearned income in the month received.

15.4.11 Property Settlement

See Section 16.7.10 Property Settlement.

15.4.12 Lump Sum Payments

See Section 16.7.11 Lump Sums Payments.

15.4.13 Money for School

For elderly or disabled cases, apply the disregards listed in Section 15.4.13.1 Total Disregards and Section 15.4.13.2 Partial Disregards but count all other money that is derived from any other student loan or grant not listed below. Use the Student Financial Aids Report (F-16021) to obtain the type and amount of the student's aid package. Also, use it to inform the student financial aids office of assistance granted.

See Section 15.4.13.3 Workforce Investment Act for instructions on how to treat income that is earned under the *WIA*.

15.4.13.1 Total Disregards

For elderly/disabled cases, totally disregard all of the following sources of money for education or training:

- Supplemental Educational Opportunity Grant
- Perkins Loans (formerly National Defense Student Loans)

- Federal Direct Student Loan Program (formerly the Guaranteed Student Loan Program and the Federal Family Education Loan Program)
- Wisconsin Direct Student Loan
- Talent Incentive Program/State Student
- Incentive Grant (Talent Incentive Program or State Student Incentive Grant)
- College Work Study Program
- Basic Educational Opportunity Grants (Pell Grants)
- Wisconsin Indian Grant
- Bureau of Indian Affairs Grant
- Any other undergraduate loan or grant made or insured under any program administered by the U.S. Commissioner of Education
- Any other loans and grants obtained and used under conditions that prevent their use for current living costs
- County training program allowances granted by an *IM* agency

15.4.13.2 Partial Disregards

For elderly/disabled cases, partially disregard all other money for education or training as follows:

1. Determine the cost of tuition, fees, books, transportation essential to education or training, and day care.
2. Subtract the total in "1" from the grant, loan, scholarship, etc. total.
3. Count any remaining money as unearned income only as of when the student gets the money **and** over the months the money is intended to cover.

> **Example 3:** The remaining $600 of a grant is intended to cover January through June. If it is received in:
> - May, count $100 in each of the income months of May and June
> - July, budget $0
> - December, count $100 in each of the income months of January through June.

15.4.13.3 Workforce Investment Act

For both family and elderly/disabled Medicaid cases, disregard all unearned income from WIA to any *adult* or *minor* participating in WIA, including:

- "Need-based payments" paid to people as allowances to enable them to participate in a training program.
- "Compensation in lieu of wages" paid to people in "tryout employment." This is arranged when private-for-profit opportunities are not available and is generally limited to people younger than 22 years old. Ask any *applicant* younger than 23 years old or the local WIA staff if he or she is participating in "tryout employment." If he or she is, count this as unearned income.

- "Payments for supportive services" paid to people in training programs who are not able to pay for training-related expenses (e.g., transportation, health care, child care, meals).

Earned WIA income is paid in the form of wages from on-the-job training and work experience activities. Disregard all earned WIA income of a minor for up to a total of six months per calendar year. Negotiate with the Medicaid group which six months of income to disregard. The six months do not need to be consecutive. Budget WIA income earned by a minor in other than these six months according to (Section 15.5.8. Student Income).

Count the **earned** WIA income of adult participants.

The **Job Corps Program** is a part of WIA. Consider a minor who is participating in the Job Corps as a student when you calculate the income disregards for full-time students and part-time students who are not employed full-time.

Consider Job Corps payments to adult participants as unearned WIA income.

15.4.14 Child Support

Count child support income as unearned income.

Child support payments (including arrearage payments) made to or on behalf of a disabled child are counted as unearned income to the child.

One-third of the amount of a child support payment made to or for a disabled child by an absent parent is excluded as income. This income exclusion applies to both court-ordered and voluntary child support payments.

This exclusion only applies to payments made by an absent parent. Sometimes a family is reunited, and the parent is still making child support payments, in compliance with a court order, even though that parent is now living with the child. Under these circumstances, the one-third income exclusion is not allowed since the parent is no longer considered to be an absent parent.

The one-third income exclusion described above only applies to EBD Medicaid eligibility determinations; it does not apply to BadgerCare Plus eligibility determinations.

15.4.15 Profit Sharing

Count profit sharing income as unearned income.

15.4.16 Income Received by Members of a Religious 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.

Count the compensation as earned income if it meets the criteria in Section 15.5.12 Income Received by Members of a Religious Order.

15.4.17 Federal Match Grants for Refugees

Some refugee resettlement agencies have grants available for refugees for their second, third, and fourth month after arrival in the U.S. These are cash grants and can vary in the amount issued. Count these payments as unearned income.

15.4.18 Gambling Winnings

Gambling winnings are counted as unearned income in the month of receipt. Gambling losses cannot be used to offset the winnings.

15.4.19 Payments to Native Americans

Disregard the first $500 of the monthly income from Tribal Per Capita payments from gaming revenue. If the payments are received less often than monthly, prorate the gross payment amount over the months it is intended to cover and disregard $500 from the monthly amount.

This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons **except** SeniorCare and *LTC* programs such as Institutional Medicaid, Family Care, and *HCBWs,* including Partnership and *PACE*. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.4.20 Alimony, Maintenance, and Other Spousal Support Payments

Count all alimony, maintenance, and other spousal support payments.

15.4.21 Reimbursement of Living Expenses

Count reimbursements for normal living expenses, such as rent, utilities, clothing, and food eaten at home, as income. For examples of reimbursements that are not counted as income, see Section 15.3.19 Reimbursements.

15.4.22 Income Allocation from Institutionalized Spouse to Community Spouse

Income allocated from an institutionalized spouse to a community spouse per Section 18.6 Spousal Impoverishment Income Allocation is counted income to the community spouse if that community spouse is receiving a form of EBD Medicaid.

15.4.23 Rental Income

When a Medicaid group member reports rental income to the *IRS* as self-employment income, see Section 15.6.4 Self-Employed Income Sources.

If he or she does not report it as self-employment income, the net rental income is counted as unearned income. Determine net rental income as follows:

A. When the owner is not an occupant, net rental income is the total rent payment(s) received minus the interest portion of the mortgage payment(s) 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 such improvements as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or 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 (see Section 16.8.1.6 Life Estate) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. The operational costs are the same as the costs the holder was liable for when living on the property.

B. When the owner is an occupant (of a duplex, triplex, etc.) and lives in one of the units, determine net rental income as follows:
    1. Add together the annual interest portion of the mortgage payment and other annual verifiable operational costs common to the entire operation to get the total annual expenses.
        - Operational costs include ordinary and necessary expenses, such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses, such 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 such improvements as finishing a

basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.

2. Divide the result in step 1 (the total annual expenses) by the total number of units to get the proportionate annual share of expenses.
3. Multiply the amount in step 2 (the proportionate annual share of expenses) by the number of rental units (rental units means the total number of units minus the unit the owner lives in) to get the member's total annual expenses.
4. Subtract the result in step 3 (the member's total annual expenses) from the total annual rental income to get the member's net annual rental income.
5. Divide the result of step 4 (the member's net annual rental income) by 12 to get the member's net monthly rental income. Budget this amount.

Example 4: George owns a four unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is $9,765. His operational expenses, including taxes on the building, from the most recent taxes is $12,359. This totals $22,124. This amount divided by four units equals a proportionate share of $5,531.

$5,531 multiplied by three rental units equals $16,593. This represents his total budgetable annual expenses. His total annual rental income equals $28,800 ($800 per unit per month).

$28,800
–$16,593
$12,207

$12,207 / 12 = **$1,017.25** net monthly rental income.

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15.5 Earned Income

Earned income is income from employment. The gross earned income before any deductions are taken out is counted. Count earned income only for the month in which it is received, except when the average number of payments increase due to mailing cycle adjustments.

Note: Occasionally, a regular periodic payment (e.g., wages, Title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.5.1 Income In-Kind

Count in-kind benefits as earned income if they meet all of the following criteria:

- Regular
- Predictable
- Received in return for a service or product

Do not count meals and lodging for armed services members.

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. In order to determine the value of the in-kind benefits, the verification must include the amount of time the person does the work activity each month.

Example 1: Sue weeds her neighbor's garden about an hour a week in exchange for a hot meal. The in-kind value of this exchange is the prevailing wage, not less than minimum wage, for the weekly hour of weeding that Sue does for her neighbor. The value is not based on the value of the hot meal. Sue is not a landscape architect or a master gardener, so the prevailing wage would be minimum wage. The required verification for this in-kind income is documentation, such as a signed statement, from her neighbor that Sue weeds an hour a week for her neighbor in exchange for a hot meal.

Example 2: Roy walks his neighbor's dog a few times a month in exchange for transportation to and from his doctors' appointments. Roy tells the worker that he thinks this is worth $20 a month for the 8 hours a month he walks the dog, which would equal $2.50 an hour. The worker would ask for verification that includes how often and for how long each time Roy walks the dog in exchange for transportation to and from appointments. Since Roy is not a bonded dog walker or a professional

dog trainer, the worker would enter minimum wage as a reasonable prevailing wage for this exchange.

15.5.2 Contractual Income

This provision applies primarily to teachers and other school employees.

When an employed Medicaid group member is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, determine the period of the contract and then prorate the income from the contract over that period. For example, if the contract is for 18 months, prorate the contract's income over 18 months regardless of the number of installments made in paying the income. Do this even if any of the following are true:

- There are predetermined vacation periods.
- He or she will only be paid during work periods.
- He or she will be paid only at the end of the work period, season, semester, or school year.

15.5.3 Rental Income

When a Medicaid group member reports rental income to the *IRS* as self-employment income, see Section 15.6.4 Self-Employed Income.

If the owner does not report it as self-employment income, see Section 15.4.23 Rental Income.

15.5.4 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.

15.5.5 Wage Advances

Count advances on wages as earned income in the month received.

15.5.6 Worker's Compensation

Worker's compensation is compensation for lost wages that would have been earned, except for an injury suffered during the course of employment. Count worker's compensation as unearned income. The amount of the income is the amount that the applicant or member can access. This may be the entire lump sum if distributed at once or the monthly amount available for withdrawal if the total sum was placed in a restricted account (for example, as a result of a settlement).

15.5.7 Income Tax Refunds

Effective January 1, 2010, income tax refunds are disregarded income (see Section 16.7.7 Income Tax Refunds).

15.5.8 Student Income

Disregard a member's income if he or she meets any of the following criteria:

- Meets the definition of a dependent 18-year-old
- Is younger than 19 years old and is enrolled as a full-time student
- Is younger than 19 years old and is enrolled as a part-time student working less than 30 hours per week

Count the earned income of anyone younger than 19 years old who does not meet any of the criteria listed above.

15.5.9 AmeriCorps

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.

15.5.10 Census

Disregard all wages paid by the Census Bureau for temporary employment related to the Census.

15.5.11 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 or her employer as earned income when he or she would have received the amount had it not been deferred.

15.5.12 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives as earned income if the compensation is for employment, even if the compensation is turned back over to the order.

15.5.13 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:

- Green Thumb
- Experience Works
- The National Urban League
- National Senior Citizens Education and Research Center (Senior Aides)
- National Indian Council on Aging
- *USDA* Forest Service
- Wisconsin Senior Employment Program
- 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 (see Section 15.3.19 Reimbursements).

15.5.14 Room and Board Income

Calculate the net amount by deducting one of the following from the gross amount received from each roomer and/or boarder:

- $15 roomer only
- $111 boarder only
- $126 roomer and boarder

15.5.15 Earned Income Tax Credit

Effective January 1, 2010, disregard *EITC* payments.

15.5.16 Make Work Pay Credit

Effective January 1, 2010, disregard actual payments made under Make Work Pay.

15.5.17 Special Tax Credit for Certain Government Retirees

Effective January 1, 2010, disregard actual payments made under the Special Tax Credit for Certain Government Retirees.

15.5.18 Prison or Jail Job

Count income that an inmate earns from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). This income does not need to be verified.

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15.6 Self-Employment Income

15.6.1 Definitions

15.6.1.1 Income

Self-employment income is income directly from one's own business rather than as an employee with a specified salary or wages from an employer.

15.6.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

15.6.1.3 Operating

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 has been a significant change in circumstances (see Section 15.6.5.3 Anticipating Earnings).

A business is not operating when it cannot function in its specific purpose. For instance, if a mechanic cannot work for four months because of an illness or injury, he or she may claim his or her business was not in operation for those months.

15.6.1.4 Income Maintenance Income

IM income is self-employment income that is counted in determining IM eligibility and benefits.

15.6.1.5 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

15.6.1.6 Non-real Property

Non-real property means all property other than real property.

15.6.2 Ways to Identify

Identify a farm or other business according to the following criteria.

15.6.2.1 By Organization

A farm or other business is organized in one of the following 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 owners' loss is limited to their investment in the corporation while the owners of unincorporated business is also personally liable.
4. An *LLC*, a business structure that combines the pass-through taxation of a partnership or sole proprietorship (the members are taxed directly) with the limited liability of a corporation.

15.6.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return with the *IRS*. 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 or multi-member LLC
2. Form 1120 - Corporation or LLC electing to be taxed as a corporation
3. Form 1120S - S Corporation
4. Form 4562 - Depreciation & Amortization
5. Form 1040 - Sole Proprietorship or single member LLC
    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

15.6.2.3 Employee Status

A person is an employee if he or she 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 or her own business, and all of the following applies:

1. Does not have federal income tax and FICA payments withheld from a paycheck.

Note: A babysitter who works in someone else's home is considered an employee of that household, even if the individual employing him or 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 or her own work schedule.

15.6.3 Self-Employment Income Assets

15.6.3.1 Business Assets

Business assets are generally income producing property. Exclude assets directly related and essential to producing goods or services.

In EBD cases, all real and non-real business property is exempt if the business is currently operating (see Section 15.6.1.3 Operating) for the self-support of the EBD individual. There is no profitability test.

Note: See Section 16.9 Non-Home Property Exclusions.

Ask the EBD person to furnish the documents needed to:

1. Describe the business, its properties, and its assets.
2. Show the number of years it has been operating.
3. Identify any co-owners.
4. Show the estimated gross and net earnings for the current tax year.

If the property is not currently operating, exempt it if there is reasonable expectation it will resume operating within the next 12 months. Base your reasonable expectation on the following information:

1. Date of last use.
2. Reason property is not in current use.
3. Estimated date the person expects to resume use.

If he or she decides not to resume, the property becomes a countable asset in the month after the decision not to resume.

Extend the 12 months only when a disabling condition prevents the person from resuming business use of the property.

15.6.3.2 Bank Accounts

With corporations you can easily distinguish between personal and business checking and savings accounts. A corporation is a separate legal entity and the accounts it owns

must be in the corporation's name. Accounts in the name of the owners are personal accounts.

For partnerships and sole-proprietorships, a cash account is a business account if the person claims that it is a business account. Disregard a business account, if the profitability test is passed, even if a partner or sole-proprietor makes withdrawals from the account for personal use. You don’t need a profitability test for EBD cases.

15.6.3.3 Disallowed Expenses

Expenses that are allowed self-employment deductions on the IRS business tax forms are allowed expenses for Medicaid. Some specific expenses that have been identified as not allowed in the calculation of Self Employment Income on the IRS tax forms and therefore not allowed for Medicaid are:

1. Net loss carryover from previous periods,
2. Federal, State, and local income taxes,
3. Charitable donations,
4. Work-related personal expenses, such as transportation to and from work,
5. 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), **or**
6. Principal payments on loans for the purchase price of income producing real estate, capital assets/equipment, and durable goods.

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.

Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, you must judge whether or not it is self-employment income.

Self-employment income sources are:

1. **Business**. Income from operating a business.
2. **Capital Gains**. Business income from selling securities and other property is counted. Personal capital gains are not counted as income.
3. **Rental**. Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. If rental income is not reported to the IRS, see Section 15.4.23 Rental Income.

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.

15.6.5 Calculating Income Maintenance Income

IM income (see Section 15.6.1.1 Income) is anything you receive in cash or in-kind that you can use to meet your needs for food, clothing, and shelter by either:

1. Using IRS tax forms completed for the previous year, or
2. Anticipating earnings (see Section 15.6.5.3 Anticipated Earnings)

15.6.5.1 IRS Tax Forms and Worksheets

IM workers should not complete any IRS tax forms on an applicant's or member's behalf. It is the responsibility of the applicant or member to complete IRS tax forms.

Workers should only consult IRS tax forms only if **all** of the following conditions are met:

- The business was in operation at least one full month during the previous tax year.
- The business has been in operation six or more months at the time of the application.
- The person does not claim a significant change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see Section 15.6.5.3 Anticipated Earnings).

If you decide to use IRS tax forms, use them together with the charts in Process Help, Section 16.2 Self-Employment Income, or the self-employment income worksheets, which identify which income and expenses need to be entered onto the Self-Employment page by line on the IRS tax forms.

For each operation, select the worksheet you need (if applicable) and, using the provided tax forms and/or schedule, complete the worksheet (if applicable) and enter the income and expenses onto the Self-Employment page.

1. *Sole Proprietor* - Farm and Other Business
   There is no worksheet for Sole Proprietor. See Process Help, 16.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines need to be entered in CWW for each of the following IRS tax forms:

   - IRS Form 4797 - Capital & Ordinary Gains
   - IRS Schedule C or C-EZ (Form 1040) - Profit or Loss From Business
   - IRS Schedule E (Form 1040) - Rental and Royalty Income

- IRS Schedule F (Form 1040) - Farm Income

2. Partnership (F-16036)

    - IRS Form 1065 - Partnership Income
    - IRS Schedule K-1 (Form 1065) - Partner's Share of Income

3. Subchapter S Corporation (F-16035)

    - IRS Form - 1120S - Small Business Corporation Income
    - IRS Schedule K-1 (Form 1120S - Shareholder's Share of 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. Do not apply a loss from unearned income to a gain in earned income. Losses from self-employment cannot be used to offset other earned or unearned income.

15.6.5.2 Depreciation

Depreciation is an allowable deduction for EBD Medicaid cases.

15.6.5.3 Anticipated Earnings

If past circumstances do not represent present circumstances, workers should calculate self-employment income based on anticipated earnings. Anticipated earnings should also be used in the following situations:

- The applicant’s or member’s business underwent a significant change in circumstances. A significant change in circumstances is any change that can be expected to affect income over time. It is the applicant’s or member’s responsibility to report significant changes. The following are examples of significant changes:
    - The owner sold or closed down the business.
    - The owner sold a part of his or her 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 or her income will increase.
    - A farmer suffers unusual crop loss due to the weather or other circumstances.

    - There is a substantial cost increase for a particular material such that there will be less profit per unit sold.
    - Sales are consistently below previous levels for an unknown reason. The relevant period may vary depending on the type of business (consider normal sales fluctuations).
- The applicant's or member's business was not in operation for at least one full month during the previous tax year.
- The applicant's or member's business was not in operation for six or more months when the person applied for or renewed benefits or reported changes.

IM workers should determine whether it is necessary to use anticipated earnings on a case-by-case basis and document the reasons for the determination in case comments.

The date of an income change is the date a worker and applicant or member agree that a significant change in circumstances occurred. IM workers must also judge whether the person's report was timely to decide if the case was overpaid or underpaid. Changes are then effective according to the normal prospective budgeting cycle. IM workers should not recover payments made before the agreed upon date.

15.6.5.3.1 Reporting Anticipated Earnings

The Self-Employment Income Report form (F-00107) (also called a SEIRF) simplifies reporting income and expenses when earnings must be anticipated. It can be used to report income for any type of business with any form of organization. However, some people, especially farm operators, may find it easier to complete the applicable IRS Form 1040 schedule when income and expense items are more complex.

For anticipated earnings to be determined, the applicant or member must complete a SEIRF for the months of operation since the significant change in circumstances occurred, not to exceed 12 months. (**Note:** The beginning of a business is a significant change in circumstances.) When requesting verification, the SEIRF forms will be prepopulated with the individual's and business' information, and will identify each individual month for which income and expenses are needed. However, he or she may complete a separate SEIRF for each month or combine the months on one SEIRF.

When a new self-employment business is reported or when a significant change in circumstance occurs, recalculate self-employment income as follows:

- When **six or more months** of actual self-employment information is available (but tax information is not available), calculate monthly average self-employment income using all the months' (at least six months, but no more than 12 months) income.

Example 2: James applies for Medicaid on November 1, 2017. He reports that he was self-employed starting in April 2017. The agency asks James to complete SEIRFs for April, May, June, July, August, September, and October so that his prospective self-employment income can be determined for his Medicaid certification period (November 2017–October 2018).

- When **two or more full months but less than six months** of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information. Because at least three months of income is needed, if the business has only been in operation two months, calculate the monthly self-employment net income average using the actual income information for two months, and an estimate of net income for the next month.

Example 3: Bonnie applies for Child Care and Medicaid on April 5, 2016. She reports that she was self-employed starting in January 2016. The agency asks Bonnie to complete a SEIRF for January, February, and March so that her prospective self-employment income can be determined for her Child Care and Medicaid certification period (April 2016–March 2017).

- 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.

Example 4: Ricardo applies for FoodShare and Medicaid on February 5. He was self-employed starting December 15. The agency asks Ricardo to complete a SEIRF for December, January, and February so that his prospective self-employment income can be calculated. The completed SEIRF includes Ricardo's actual income and expenses for December and January, and his expected income and expenses for February. The worker divides the total by three to determine an anticipated monthly average income amount. This amount would be used until Ricardo reports a significant change in self-employment or until Ricardo renews his benefits.

- 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 significant change in circumstance occurred) and estimated income and expenses for the next two months.

Example 5: Jenny is a Medicaid member who has been self-employed as a hairdresser since 2012. Jenny's Medicaid certification period is December 2015 to November 2016. The worker used Jenny's 2014 tax return to establish a monthly income amount.

In March 2016, Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she will be able to return to work, but it will not be until at least May.

Jenny completes a SEIRF for February 17–February 28 (actual income since the significant change in circumstance occurred), and for March and April using a best estimate of income. The worker uses these three months (February, March, and April) to determine a prospective self-employment income estimate for the remainder of the certification period (through November 2016).

Use the average until the member's next renewal or if a significant change in circumstances is reported between renewals.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a significant change in circumstances.

15.6.6 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see Section 20.3.8 Income).

Completed IRS tax forms (see Section 15.6.2.2 By IRS Tax Forms) are sufficient verification of farm and self-employment income. A completed and signed SEIRF (or SEIRFs) is also sufficient verification.

If a Program Add request is made on a case with self-employment income, use the existing SEIRF information, instead of re-verifying it, if all of the following are true:

- A recent determination was made.
- SEIRFs were used.
- No significant change has been reported by the individual.
- The business has not filed taxes in the meantime.

Note: It is not necessary to collect copies of supportive verification, such as receipts from sales and purchases. However, verification can be requested when the information given is in question (see Section 20.4.1 Questionable Items Introduction). If requesting verification, workers must document the reason for the request in case comments.

15.6.7 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.

15.6.8 Backdated Months

Self-employment income is averaged over the number of months the business has been in operation in a tax year or anticipated based on an average of SEIRFs. It is not based on exact income for a single month, as that does not take into consideration seasonal work and fluctuating income for the business. If an individual had applied in a backdated month, eligibility would not be determined on the basis of one month of self-employment income; instead, eligibility would be based on an average of at least three months of income.

When a self-employed applicant or member requests backdated benefits for health care, workers must do the following:

1. Average self-employment income for the application month forward (to determine ongoing eligibility).
2. Determine eligibility for the backdated months as if the applicant or member had applied in the earliest backdated month requested:

    - If income is reported via federal taxes, the tax filing year has not changed, and no significant change in circumstances has occurred, the same averaged income and expenses from the tax forms can be used for ongoing and backdated eligibility.
    - In all other scenarios, workers must consider SEIRFs and the average to be counted if that earliest month was the application month. If estimates would have been used, but the month has passed, actual information should be provided on the SEIRFs.

3. Consider any significant changes that occurred during the backdated months that would require a new average to be calculated for the second and/or third month. If there has not been a significant change or a change in the tax filing year during the backdated months, the average calculated for the earliest month can be used throughout the backdated months.

Example 6: Maggie applied for Medicaid in June and requested backdated eligibility to March. She has been self-employed as a seamstress since February of the same year. She does not file taxes.

For the application month of June, SEIRFs would be used for all available months – February, March, April, and May to budget average income for the

month of June and ongoing.

If she had applied in March, her income would have been averaged based on actual income for the months of February, March, and April, so SEIRFs for February, March, and April would be used for determining her eligibility for Medicaid for the backdated months of March, April, and May.

Example 7: Glenn applied for Medicaid in September and requested backdated eligibility to June. He has been self-employed as a farmer, but reported having a true significant change in circumstances in May.

For the application month of September, SEIRFs would be used for all months since the significant change – May, June, July, and August to budget average income for the month of September and ongoing.

If he had applied in June, his income would have been average based on actual income for the months of May, June, and July, so SEIRFs for May, June, and July would be used for determining his eligibility for Medicaid for the backdated months of June, July, and August.

Example 8: Hershel applied for Medicaid and FoodShare for himself in April and requested backdated eligibility to January. He owns a bakery and filed taxes. However, he reports that his previous year's taxes no longer reflect his earnings due to a true significant change that occurred in March.

For the application month of April, SEIRFs would be used for all months since the significant change occurred in March, so Hershel's actual income for March and estimated income for April and May would be used to budget average income for the month of April and ongoing.

If he had applied in January, taxes would be used as verification of his income, so his taxes can be used for determining his eligibility for Medicaid for the backdated months of January and February.

However, because of the significant change in March, an average of March, April, and May SEIRFs would be used for determining his eligibility for Medicaid for the backdated month of March.

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15.7 Income Deductions

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from his or her income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the *SSI* payment level plus the E supplement for one person (see Section 39.4.1, Elderly, Blind, or Disabled Assets and Income Table). The amount is in addition to the personal needs allowance (see Section 39.4.2, Elderly, Blind, or Disabled Deductions and Allowances). It should be enough for mortgage, rent, property taxes (including special assessments), home or renters insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.

Make the deduction only when both the following conditions are met:

- A physician certifies (verbally or in writing) that the person is likely to return to the home or apartment within six months.
- The person's *spouse* is not living in the home or apartment.

Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six-month continuance. A physician must again certify that he or she is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time. It is not limited to the first six months the person resides in the medical institution.

Example 1: Bob entered a nursing home in June 2013 as a private pay patient. In June 2014, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2014. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of care, starting in June 2014.

15.7.2 Special Exempt Income

Special exempt income includes:

- Income used for supporting others (see Section 15.7.2.1 Support Payments).
- Court-ordered attorney fees (see Section 15.7.2.3 Fees to Guardians or Attorneys).

- Court-ordered guardian and guardian ad litem fees (see Section 15.7.2.3 Fees to Guardians or Attorneys).
- Expenses associated with establishing and maintaining a guardianship (see Section 15.7.2.3 Fees to Guardians or Attorneys).
- Expenses associated with a self-support plan (see Section 15.7.2.2 Self-Support Plan).
- *IRWE* (see Section 15.7.4 Impairment-Related Work Expenses).
- Maintaining a home or apartment (see Section 15.7.1 Maintaining Home or Apartment).
- Costs associated with *real property* listed for sale (see Section 16.2 Assets Availability).

For specific exemptions, see Section 15.3 Exempt and Disregarded Income.

15.7.2.1 Support Payments

Support payments are payments that a Medicaid *member* makes to another person outside the *FTG* for the purpose of supporting and maintaining that person. Support payments are either court-ordered (see Section 15.7.2.1.1 Court-Ordered or non-court-ordered (see Section 15.7.2.1.2 Non-court-Ordered).

Include the support payment amount as part of an institutionalized person's monthly need (see Section 27.6 ILTC Monthly Need) and cost of care (see Section 27.7 ILTC Cost of Care Calculation).

A person in the fiscal group who has legal responsibility for a person in a nursing home may be paying that person's patient liability. If so, deduct this amount from the group's income.

Note: Support payments are different from the community spouse income allocation (see Section 18.6.2 Community Spouse Income Allocation for more information).

15.7.2.1.1 Court-Ordered

The income deduction for monthly court-ordered support expenses is the amount that the member is "obligated" to pay as stipulated in the court order. Do not allow payments for *arrearages* and annual 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 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.

15.7.2.1.2 Non-Court-Ordered

Include non-court-ordered support payments only if they are paid to the following:

- Institutionalized spouse. The maximum amount that can be included is the *AFDC* cat needy income limit for a group size of one (see Section 39.3 AFDC-Related Income Table) minus the spouse's net income.
- Minor child who is living with a non-legally responsible relative. The maximum amount that can be included is the AFDC cat needy income limit for a group size of one plus the child's medical expenses minus the child's net income.

Do not include non-court-ordered payments if they are to one of the following:

- A spouse or minor child who receives *SSI*
- A spouse who is eligible for SSI but refuses to apply for it

15.7.2.2 Plan to Achieve Self-Support

A member whose eligibility is based on blindness or *disability* may deduct income that is received under an approved plan to achieve self-support (PASS). A PASS allows qualifying blind or disabled individuals to receive income and accumulate resources for training or purchasing equipment necessary for reaching employment goals that will lead to self-support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the member must perform in accordance with the plan. The plan must:

- Be specific, current, and in writing.
- Be approved by the Social Security Administration as verified by submission of the plan and the Social Security Administration’s approval letter.
- Specify the amount to be set aside and the expected cost and time required to accomplish the objective.
- Provide for identification and segregation of goods and money accumulated and conserved.

15.7.2.3 Fees to Guardians or Attorneys

15.7.2.3.1 Disallowed Deductions

The following fees to guardians or attorneys are not allowed income deductions:

- Fees paid to a legal guardian or attorney that are not court-ordered payments. Do not include such payments in the person's monthly need, and do not deduct them from his or her monthly income.
- Fees paid to a third party to reimburse a prepayment the third party made of a guardianship fee. Do not allow the payment even if the third party obtained a court order to recoup the prepayment.

Exception: Deduct this third party prepayment if all the following are true:

- The third party was the county acting as guardian ad litem. A guardian ad litem is someone appointed by the court to represent the best interests of a juvenile or disabled person during a particular court proceeding.
- The prepayment was to an attorney who was not a county employee at the time the services were delivered.
- A court ordered the institutionalized person to reimburse the county's prepayment.

15.7.2.3.2 Allowed Deductions

The following fees to guardians or attorneys are allowable income deductions:

- Court-ordered guardian and/or attorney fees paid directly out of the person's monthly income.
- Expenses paid by the person for establishing and maintaining a court-ordered guardianship or protective placement for himself or herself.

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- *HCBW* programs
- Patient liability calculations for residents of a medical institution
- Cost share and *MAPP* premium calculations
- MAPP eligibility calculation if expenses are over $500 monthly (see Section 26.4.2.1 Deduction for Medical and Remedial Expenses over $500 for more information on this MAPP specific deduction)

Medical expenses are anticipated, incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

- Deductibles and copayments for Medicaid, Medicare, and private health insurances
- Health insurance premiums.
- Bills for medical services that are not covered by Wisconsin Medicaid
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

Medicaid overpayments are not medical expenses and cannot be used as an income deduction to lower a patient liability, cost share, or to meet a deductible.

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

- Case management
- Day care
- Housing modifications for accessibility
- Respite care
- Supportive home care
- Transportation
- Services recognized under Wis. Stat. § 46.27
- Community Options Program expenses that are included in the person's service plan

Remedial expenses do not include housing or room and board services.

15.7.4 Impairment-Related Work Expenses

IRWE are expenses used to determine eligibility for Medicaid, MAPP, and premium calculations. IRWE are anticipated incurred expenses by the member (and for MAPP only, their spouse) related to the member's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as Medicaid, private insurance, or the member's employer. If an anticipated IRWE is later paid by an unanticipated source, it is still allowable for past months in which it was budgeted but not for future months.

Example 2: On March 25, Cecil was told by Harvey's Auto Repair Shop that his

wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of $2,000 for the repairs. The $2,000 estimate was determined to be a standard charge for this type of repair in the community.

On March 26, Cecil applied for MAPP in Milwaukee County. At this time, the anticipated expense of the van repair was deducted from Cecil's income.

Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time, Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his *IM* worker.

Cecil's IM worker should not deduct the anticipated cost of the van repairs for any subsequent eligibility and premium determinations.

Deduct any MAPP member's expenses which:

- Do not exceed his or her gross monthly earned income (plus room and board income, if any).
- Are reasonably related to his or her earned income. Expenses which are reasonably related to earned income include those incurred in performing on the job and improving the person's ability to do the job.

Bills from months prior to the months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the member's community. If you count an expense as an IRWE, do not also use the expense as a medical/remedial expense.

Some examples of IRWE are modified audio/visual equipment, typing aides, specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the member's disability.

Exceptions: Always count the expenses of getting to and from work and the child care expenses as an IRWE for blind individuals.

15.7.5 $65 and ½ Earned Income Deduction

The $65 and ½ earned income deduction is an *EBD* FTG deduction.

To calculate the $65 and ½ earned income deduction, subtract $65 from the member's monthly earned income. Divide the result by two, and add $65. This is the earned income deduction.

Example 3: Michelle has monthly income of $1,240. Her $65 and ½ earned income deduction is

$1,240.00
- 65.00
$1,175.00

$1,175.00/2 = $587.50 Countable Income

$ 587.50
+ 65.00
$ 652.50 Earned Income *Disregard*

Michelle's earned income deduction amount is $652.50.

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16 Assets

16.1 Assets Introduction

Children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including *MAPP*, community waivers, FamilyCare, etc.

SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals.

Do not count income as an asset in the month it was received when determining the countable asset amount.

> **Example 1:** Mr. Johnson has $2,600.00 in his checking account for the month of March. This includes his Social Security check of $700.00 that was deposited into the account on March 10. His countable asset amount for March is $1,900.00.

> **Example 2:** Mrs. Jones has $2,400.00 in her checking account for the month of March. She receives Social Security of $1,000.00 each month. She cashed her Social Security check and used the cash to pay her bills. Because her income is not included in the checking account balance, the income should not be deducted from the checking account balance.

Add together all countable, available assets (see Section 16.2 Assets Availability), the fiscal group owns including:

1. Joint accounts (see Section 16.4.1 Joint Accounts)
2. Burial assets (see Section 16.5 Burial Assets)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (see Section 16.7.2 Loans)
8. Life insurance (see Section 16.7.5 Life Insurance)
9. Non-burial trusts (see Section 16.6 Non-burial Trusts)
10. Land contract (see Section 16.7.12 Land Contract)
11. Mortgage (see Section 16.7.13 Mortgage)
12. Trailer home (see Section 16.8.1.2 Non-motorized Trailer Homes)
13. Non-home *real property*. (see Section 16.8 Real Property)
14. Some vehicles (see Section 16.7.9 Vehicles (Automobiles), 18.4 Spousal Impoverishment Assets)

The EBD fiscal group’s assets must be within the appropriate asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate asset limit are ineligible for Medicaid.

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16.2 Assets Availability

16.2.1 Assets Availability Introduction

An asset is available when:

1. It can be sold, transferred, or disposed of by the owner or the owner's representative, and
2. The owner has a legal right to the money obtained from sale of the asset, and
3. The owner has the legal ability to make the money available for support and maintenance, and
4. The asset can be made available in less than 30 days.

Consider an asset as unavailable if **either**:

1. The *member* lacks the ability to provide legal access to the assets, and
2. No one else can access the assets, and
3. A process has been started to get legal access to the assets.

Or, when the owner or owner's representative documents that the asset will not be available for 30 days or more, and the process has been started to obtain the assets.

Use the criteria above to determine whether an asset was available in a backdate month unless an asset is deemed unavailable in the month of application because it will not be available for 30 or more days (considered unavailable in any or all backdate months).

Note: Employer Health Reimbursement Arrangements (HRAs) are not an available resource. DHS's Third Party Liability Unit will consider an HRA to be a potential source of payment for health care services covered by Medicaid.

Example: Sylvia has life insurance that she cannot convert to cash within 30 days. She has a letter from the insurance company stating when she will receive the money. It becomes available the day she receives the money. Enter an expected change in *CWW* with the date the asset is expected to be available.

Note: An unavailable asset may still be considered when determining whether an institutionalized person has divested (see Section 17.2.10 Unavailability).

16.2.2 Real Property

Non-exempt *real property* (see Section 16.8 Real Property) is unavailable when:

1. The person who owns the property lists it for sale with a realtor (see Section 16.9 Non-home Property Exclusions).

If an institutionalized person owns property that is unavailable because it is listed for sale, he or she can use some of his or her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. Do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.

The non-exempt real property is unavailable and minimal maintenance costs are allowed as long as the person is making a good faith effort to sell the property at current market value.

If the member refuses a fair market value offer(s) while the property is listed for sale with a realtor, the member is no longer making a good faith effort to sell the property. In this case, the property is an available asset and minimal maintenance costs will no longer be allowed.

2. A joint owner who is outside the fiscal test group refuses to sell the property.

When the member is a co-owner of the property with someone outside the fiscal group, you must determine whether it is owned as a joint tenancy or tenancy-in-common.

Joint tenants have a right of survivorship. That is, upon the death of one joint tenant, the other inherits the share of the deceased. A joint tenant's interest may not be sold without forcing the sale of the entire property.

Tenants-in-common has no right of survivorship. A tenant-in-common may bequeath his or her share of the property to anyone he or she chooses. He or she may also sell his or her share during his or her lifetime.

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16.3 Separate and Mixed Assets

When a Medicaid group keeps an exempt asset in:

1. A separate account or an account with other exempt assets, exempt the exempt asset:

a. Indefinitely, for example, most payments to Native Americans (see Section 15.3.14 Payments to Native Americans), **or**

b. For as long as the exemption can be applied to the asset, for example, *EITC* (see Section 16.7.8 Earned Income Tax Credit), which is exempt for 12 months following the month of receipt.

2. An account mixed with other assets (some of which are non-exempt), exempt only the portion that is considered the exempt asset:
    a. For six months from the date the exempt asset was mixed with the non-exempt assets, **or**
    b. If the exempt asset has been prorated as income, exempt it for the period over which it is prorated.

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16.4 Accounts

16.4.1 Joint Accounts

Account means a deposit of funds with a financial institution (bank, savings and loan, credit union, insurance company, investment firm, etc).

Apply the following policy to accounts where the account holders have equal access to the funds.

Note: The following policy does not apply to joint ownership of securities such as stocks and bonds. Shares of stock represent ownership in a business, and their value shifts. Absent evidence to the contrary, assume each owner owns an equal share of the value of the security. For example, two owners would each own 50% of the value. The individual's stock certificate or statement of account should indicate their ownership percentage.

16.4.1.1 EBD Medicaid Applicant/Member EBD Co-owner

When an EBD Medicaid *applicant*/*member* shares a joint account with a co-owner who is another EBD applicant/member, deem an "equal share" to each account holder.

"Equal share" means an amount in proportion to the number of EBD-related applicant/member account holders. If there are three holders, an equal share means each is deemed 1/3 of the account balance.

EBD Medicaid applicant/members also include any of the Medicare Beneficiary programs *QMB*, *SLMB*, *SLMB+*, and *QDWI*.

SeniorCare applicant/members are not considered an EBD-related applicant/member when deeming joint accounts.

16.4.1.2 EBD Medicaid Applicant/Member Non EBD Co-owner

When an EBD Medicaid applicant/member shares an account with an individual or individuals who are not EBD Medicaid applicant(s)/member(s) count the full amount of the account as a countable asset for the EBD Medicaid applicant/member.

16.4.1.3 Exception to Joint Accounts policy

Do not apply Joint Accounts policies (see Section 16.4.1 Joint Accounts) to the following kinds of joint accounts:

- Accounts established for business, charitable or civic purposes.
- Trust or restricted accounts. A trust or restricted account is one in which the person named as holder of the account has no access or limited access to the funds in it.
- Special purpose accounts. A special purpose account has at least one holder acting as the power-of-attorney, guardian, or conservator for at least one of the other holders of the account.
- Convenience accounts

The following policy applies only to joint accounts of persons who are not married to one another:

When a person's name appears on a joint account, assume he or she is part owner of the assets in the account. Inform the member that he or she has a right to present evidence showing he or she did not deposit any assets into the account.

To show that he or she does not own or co-own any assets in the account, he or she must present all of the following:

- A signed statement explaining:
  - Who owns the funds in the joint account
  - The reason for establishing it
  - Who made the deposits to the account
- A signed corroborating statement from the co-holder of the account
- A copy of the change in the account which removes his or her name or restricts his or her access

If the co-holder is incompetent or a minor, obtain a statement from a knowledgeable third party. Then, decide whether to accept the person's statement. If you decide he or she is not a co-holder, apply the decision retroactively as well as prospectively. When no third party is available, document the reason.

16.4.2 Jointly Held Real Property

Apportion an equal share of any real property or any income derived from real property to each owner. To apportion, the equity or income must be available.

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16.5 Burial Assets

16.5.1 Burial Trusts

Exempt all burial trusts made in Wisconsin that are irrevocable by Wisconsin law, as noted in the trust agreement. If made in another state, exempt all that are irrevocable by the laws of that state. Refer any question about any state's law to your corporation counsel.

Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, they are a countable asset.

In non-*spousal impoverishment EBD* Medicaid cases, each fiscal group member may have one or more irrevocable burial trusts, of which the total *face value* may not exceed $4,500. Any principal amount over $4,500 is a countable asset. Although Wisconsin law allows $3,000 to be irrevocable, Wisconsin's Medicaid state plan allows an additional $1,500 to be considered as though it were irrevocable by law for these burial trusts. This is why $4,500 is allowed. (See Section 18.4 Spousal Impoverishment Assets for information about burial assets for persons with a *community spouse*.)

16.5.2 Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than the payment of the insured's burial expense. It is an insurance product sold by a state-licensed insurance company and is typically funded with an annuity or life insurance policy.

The following are not burial insurance policies:

- If a policy has *CSV* to which the member has access, the policy is life insurance, not burial insurance.
- If a burial policy calls for any excess proceeds to be paid to a secondary beneficiary (other than the deceased person's estate), it is life insurance, not burial insurance.
- Similarly, if a policy calls for the proceeds to be paid to a private party who is expected, but not legally required, to use the funds for the burial costs of the insured, the policy is life insurance.

The ownership of the annuity or life insurance policy is irrevocably assigned by the policyholder to a funeral expense trust established by the insurance company. The trustee or trust administrator is required to pay all trust proceeds toward the policy holder's funeral expenses at the time of the policyholder's death. If a trust's proceeds exceed burial costs, the excess must revert back to the deceased person's estate.

A burial insurance policy is unavailable if both the following are true:

- It includes language that says it is irrevocable.
- It states that all of the proceeds must be used for burial expenses.

The purchase of a burial insurance policy that meets the above conditions is not a divestment because the purchaser is presumed to receive *fair market value*.

16.5.3 Life Insurance-Funded Burial Contracts

A life insurance-funded burial contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Death benefits that exceed the actual costs of burial expenses must be paid to the insured's estate or the insured's beneficiary.

A burial contract that is funded with a life insurance policy must be in writing and must contain all of the following:

- Name of funeral home and the insurer.
- Statement of funeral goods and services.
- Effect of canceling or surrendering the insurance policy.
- Effect of changing the assignment of the policy proceeds.
- Nature and extent of any price guarantees for goods and services.

The assignment option (revocable or irrevocable) chosen by the customer impacts the determination of countable asset and/or divestment amount.

16.5.3.1 Irrevocable Assignment of Life Insurance-Funded Burial Contracts

An irrevocably assigned *LIFBC* is an unavailable asset because the member no longer owns it.

If a member has chosen irrevocable assignment of his or her LIFBC, the burial space exemption (see Section 16.5.4 Spaces) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (see Section 16.5.5 Burial Funds).

If the face value of the burial funds portion of the contract exceeds $1,500, it offsets the burial fund exclusion described in Section 16.5.5 Burial Funds.

If the face value of the burial funds portion does not exceed $1,500, determine the CSV of the LIFBC at the time that it was assigned and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in Section 16.5.5 Burial Funds to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by 1. and 2. above, purchased at fair market value .
4. Apply divestment policy to any remaining CSV (see Section 17.13.2 Revocable Trusts).

Example 1: Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see Section 16.5.5 Burial Funds), and so $1,500 of this LIFBC will be considered his exempt burial fund. The $1,300 casket does not reduce the burial fund exclusion (see Section 16.5.5 Burial Funds) and is not a countable asset because it is a purchase of a burial space.

Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 divestment (see Section 17.13.2 Revocable Trusts).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash surrender value (of the LIFBC at the time that it was assigned) and apply the divestment policy (see Section 17.13.2 Revocable Trusts). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the *divested amount*.

Example 2: Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurred because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

16.5.3.2 Revocable Assignment of Life Insurance-Funded Burial Contracts

When a member has chosen revocable assignment of his or her LIFBC, use the following procedures to determine the countable asset amount.

Identify all other burial assets and life insurance policies the member may have. Use burial fund logic (see Section 16.5.5 Burial Funds) to determine what portion of the LIFBC is a countable asset.

The value of the burial contract is equal to the CSV of the life insurance policy. If the face value of all life insurance policies is $1,500 or less, exempt the CSV under the life insurance exclusion.

If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion (see Section 16.5.5 Burial Funds), if applicable.

If one or more burial spaces are included in the statement of funeral goods and services, the burial space exclusion (see Section 16.5.4 Spaces) does not apply because the provider has not received payment and therefore no purchase of burial space(s) has been made.

Example 3: Mrs. White has a revocably assigned LIFBC and no other burial assets or life insurance policies. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (see Section 16.5.4 Spaces) does not apply to Mrs. White's contract, but $1,500 of the CSV is exempt under the burial funds exclusion (see Section 16.5.5 Burial Funds). The remaining $200 of the CSV is a countable asset.

Example 4: Mrs. White has a revocably assigned LIFBC. She additionally has a burial plot already paid for and a whole life insurance policy with a face value of $1,500 and CSV of $1,000. The face value of the LIFBC is $3,000, and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700.

The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (see Section 16.5.4 Spaces) does not apply to Mrs. White's contract. No portion of the CSV is exempt under the burial funds exclusion (see Section 16.5.5 Burial Funds) because the face value of her whole life insurance policy is $1,500. The burial plot is exempt, because it is paid for. The entire value of the LIFBC ($1,700) is a countable asset.

16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include all the following, if they have been paid for or are included in a contract to purchase with burial insurance that meets the criteria of Section 16.5.2 Burial Insurance or a LIFBC that meets the criteria in Section 16.5.3 Life Insurance-Funded Burial Contracts:

- Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons
- Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques
- Arrangements for opening and closing the grave site

Exempt multiple spaces of any value under the following conditions:

- The space(s) must be owned by the elderly, blind, or disabled person, that person's *spouse*, or, when the EBD person is a *minor*, by the minor's parents.
- Both a plot and a mausoleum space cannot be exempted for the same person.
- Each person may have more than one type of space.
- The space(s) must be for the use of the elderly, blind, or disabled member or one of the following:
    - Spouse.
    - Minor or *adult* natural, adoptive, or stepchild.
    - Brother or sister.
    - Natural or adoptive parent.
    - Spouse of any of the above.

If the burial space expenses are being paid for through burial insurance or a LIFBC for a relative with a qualifying relationship (other than the EBD person and that person's spouse), allow only those expenses listed above as exemptions. Any other goods or services purchased through the burial insurance or LIFBC would be a divestment.

Example 5: Bob, who is 12 years old, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: the first is for Bob, the second and third are for his parents, the fourth is for his older brother, who does not live at home, and the fifth is for Bob's uncle. All the plots and spaces are exempt except for the fifth.

Example 6: Harry is applying for HCBW. Last year he used his life insurance policy with a face value of $10,000 and a cash value of $8,000 to set up a LIFBC for his son. On the Statement of Goods and Services, $4,000 is designated for a casket, $1,000 for a vault, and $500 for the cemetery plot, for a total of $5,500 that is exempt burial space expenses. The remaining $2,500 that was put in to the LIFBC is considered divestment.

16.5.5 Burial Funds

Burial fund exemptions apply only to EBD Medicaid fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD Medicaid members and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add:

1. The face value of the person's irrevocable burial trusts.
2. The face value of all of his or her life insurance policies whose cash value is exempt.
3. The face value of his or her exempt burial insurance (see Section 16.5.2 Burial Insurance).
4. The CSV of revocably assigned LIFBC (see Section 16.5.3.2 Revocable Assignment of Life Insurance-Funded Burial Contracts).
5. The burial funds portion of irrevocably assigned LIFBC (see Section 16.5.3.1 Irrevocable Assignment of Life Insurance-Funded Burial Contracts).

If the total value of the above items is $1,500 or more, do not exempt any more burial funds. If the total is less than $1,500, subtract the total from $1,500. The result is the amount of his or her burial fund total that is exempt.

Example 7: Mrs. Smith, who is 74 years old, applies for EBD Medicaid. She has a $1,600 savings account designated as a burial fund, a $1,300 irrevocable burial trust, and two life insurance policies. The combined face values of the life insurance policies total $900. Add the values of exempted assets. The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed $1,500.

$1,300 Irrevocable burial trust
+900 Face value life insurance
$2,200

The total is more than $1,500, so no portion of the burial fund (savings account) is exempt.

Example 8: This time, Mrs. Smith, in addition to her $1,600 savings account designated as a burial fund, has a $300 irrevocable burial trust and two life insurance policies with a combined face value of $900.

$ 300 Irrevocable trust
+ 900 Face value life insurance
$1,200

The total is less than $1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund.

$1,500 Maximum burial fund exclusion
- 1,200
$ 300

Mrs. Smith can exempt $300 from her savings account as a burial fund. The remaining $1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which he or she first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.

The fund set aside for burial must be identifiable, but not necessarily segregated, from other funds.

16.5.6 Wisconsin Funeral Trust Program

The Wisconsin Funeral Trust is a single trust owned and operated by the *WFDA*. It was established and maintained according to the rules of the Wisconsin Department of Financial Institutions. It is available for use by all WFDA members statewide. Funds placed in the Trust will be invested in accordance with applicable state law.

WFDA has created two preneed funeral contracts: one is for a guaranteed price and the other is for a non-guaranteed price. These contracts are available to all individuals, not just those who are or may be EBD Medicaid applicants or members.

The agreement by the purchaser with the funeral home constitutes a purchase, even if revocable in whole or part. The contract nearly always includes burial spaces, which are excluded assets. The contract is not:

- An installment burial contract.
- An insurance funded burial contract.
- Divestment as the funds transferred are in exchange for equal amounts of goods and/or services.

In determining countable asset value:

1. Deduct first the amount considered as irrevocable under Wisconsin law and the Medicaid state plan (see Section 16.5.1) up to a maximum of $4,500.
2. Deduct next the amount equal to the value of all burial spaces purchased by the contract. Remember that "burial spaces" includes caskets and outer burial containers, vaults, liners, etc.
3. Deduct any amount that can be included in the applicant's or member's burial fund.
4. The remainder is the countable asset.

Example 9:

Total Contract Value	=	$6,700
Amount Designated as Irrevocable	=	- $4,500
		$2,200
Value of Excluded Burial Spaces	=	- $1,300
		$900
Amount of Excluded Burial Funds*=		- 0
Countable Asset	=	**$900**

* The amount of funds that may be excluded as the $1,500 "burial fund" is reduced by any amount of cash value in his or her life insurance and the amount of irrevocable burial trust. Whenever the burial contact specifies $1,500 or more as irrevocable, no funds can be excluded as "burial fund."

Example 10:

Total Contract Value	=	$4,200
Amount Designated as Irrevocable	=	- $1,300
		$2,900
Value of Excluded Burial Spaces	=	- $1,300
		$1,600
Amount of Excluded Burial Funds*	=	- 200**
Countable Asset	=	**$1,400**

**This example assumes that the person has not identified another insurance or irrevocable burial funds toward his or her "burial fund." The $1,500 maximum burial fund allowance, less the $1,300 this contract makes irrevocable, leaves room for an additional $200 to be allocated to the "burial fund". Note that in Example 1, the purchaser was able to achieve a higher exemption.

16.5.6.1 Statement of Funeral Goods and Services

The U.S. *FTC* requires funeral directors nationwide to use a "Statement of Funeral Goods and Services" as a way of indicating to their customers what is being purchased and their charges. This form looks like the first page of the WFDA preneed funeral contract. WFDA has advised their members to complete and provide to the family a copy of the Statement of Funeral Goods and Service along with the preneed funeral contact as a service to their customers and in compliance with FTC rules.

16.5.6.2 Cash Advances

On both the WFDA preneed funeral contract and the FTC’s Statement of Funeral Goods and Services is an area called "Cash Advance Items." These are expenses for services and goods not provided by the funeral home but often related to the funeral.

Usually, the funeral home asks the purchaser or family to reimburse it dollar-for-dollar equal to what was advanced. A funeral home can, however, charge additional sums for its service in making cash advances on behalf of the deceased’s family. For example, a funeral home may advance a $175.00 payment for an obituary charge to the local newspaper; when billing the family, the funeral home adds a $20.00 service fee for a total of $195.00. By FTC rule, whenever the funeral home bills for more than the actual amount of the cash advance, it must identify this to the purchaser or family with a standard phrase added to the Statement of Funeral Goods and Services; the phrase is “We charge you for our services in obtaining ... " This phrase appears on the WFDA preneed agreement and comes into effect whenever the small box to the left of each line under "Cash Advance Item" is marked.

Amounts identified on a preneed agreement under "Cash Advances Items" are not disregarded and are part of the "Total Contract Value" in the asset calculations (see the formula above) for EBD Medicaid. This is true whether there is an additional charge on the cash advance item or not.

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16.6 Non-Burial Trusts

16.6.1 Non-Burial Trusts Introduction

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the 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 hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The EBD Medicaid *member*,
2. His or her *spouse*,
3. A person, including a court or an 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 a guardian, **or**
4. 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.

If the principal of a trust includes assets of the *applicant*/member or spouse, and the assets of any other person or persons, apply the policies in Section 16.6.3 Revocable Trusts and Section 16.6.4 Irrevocable Trusts to the portion of the trust attributable to the assets of the applicant/member or spouse.

16.6.2 Trust Principal

The trust principal is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

16.6.3 Revocable Trusts

A *revocable trust* is a trust which can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

The trust principal of a revocable trust is an available asset.

16.6.4 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

16.6.4.1 Trust Established With Resources of a Third Party

If the resources of someone other than the individual or their spouse (i.e., a third party),were used to form the principal of an irrevocable trust, the trust principal is not an available asset unless the terms of the trust permit the individual to require that the trustee distribute principal or income to him or her.

16.6.4.2 Trust Established With Resources of the Individual or Spouse

If the resources of the individual or the individual's spouse were used to form all or part of the principal of the trust, some or all of the trust principal and income may be considered a non-exempt asset, available to the individual. If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual at any time no matter how distant, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered non-exempt assets, available to the individual.

This treatment applies regardless of:

- the purpose for which a trust is established;
- whether the trustees have or exercise any discretion under the trust;
- any restrictions on when or whether distributions may be made from the trust; **or**,
- any restrictions on the use of distributions from the trust.

Example 1: Doug is a 65 year old Medicaid applicant. Several years ago, Doug transferred his life savings of $60,000 to an irrevocable trust, naming himself as the beneficiary. Doug's brother, Jim was appointed as the trustee. Under the terms of the trust, Jim could disburse up to $10,000 annually, from either trust principal or trust income, either directly to Doug or indirectly to provide some benefit for Doug. The trustee had sole discretion as to when and how these trust disbursements would be made, but under no circumstance could they exceed $10,000 in a 12 month period. Because the entire *corpus* (principal of the fund) could eventually be distributed, $60,000 would be considered an available non-exempt asset for Doug's Medicaid eligibility determination, even if the trustee decides not to make any actual disbursements.

Example 2: Al is a 65 year old Medicaid applicant. Six years ago, Al sold his farm for $300,000 and put the entire proceeds from the sale into an irrevocable trust, naming himself as the beneficiary. Al's friend, Scott was appointed as the trustee. Under the terms of the trust, Scott could disburse any amount of trust principal or trust income, at any time, either directly to Al or indirectly to provide some benefit for Al. The trustee had sole discretion as to when and how disbursements would be made as well as the amount that could be disbursed. Therefore $300,000 would be

considered an available non-exempt asset for Al's Medicaid eligibility determination, even if the trustee never makes an actual disbursement.

Example 3: Dave is a 65 year old Medicaid applicant who won a $250,000 lottery several years ago and put the entire amount into an irrevocable trust, naming himself as the beneficiary. Dave appointed his brother Don as the trustee. Under the terms of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed.

The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4: In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution.

The half of the generated income that is paid to Dave would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note: If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (see Section 17.13 Trusts and Section 17.13.4 Exceptions).

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts described in Section 16.6.5 Special Needs Trust and Section 16.6.6 Pooled Trusts. The policies described above also do not apply to irrevocable trusts created by a will, unless the terms of the trust permit the individual/beneficiary to require that the trustee distribute principal or income to him or her.

16.6.5 Special Needs Trust

Disregard special needs trusts, also called supplemental needs trusts, whose sole beneficiary is under age 65 and totally and permanently disabled (under *SSI* program rules) if they meet all of the following conditions:

- Established for the sole benefit of the disabled person.
    - Trusts established prior to **December 13, 2016 may not** be set up by the member. They may only be established by the following:

        - the member's parent
        - the member's grandparent
        - the member's legal guardian
        - the court on the member's behalf
    - Trusts established on or after **December 13, 2016 may be set up by the member.** They may also be established by the following:
        - The member's parent,
        - The member's grandparent
        - The member's legal guardian
        - The court on the member's behalf
- Established with the resources of the disabled individual.
  Note: If a legally competent, disabled adult does not establish the trust, a parent or grandparent may establish a seed trust using a nominal amount of his or her money (e.g., $10). After the seed trust is established, the disabled adult's assets can be transferred into the trust.
- Contain a provision that, upon the death of the beneficiary, Wisconsin Medicaid will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

Trusts that meet the above criteria but are not called a special or supplemental needs trust are treated as special needs trusts for Medicaid purposes. Trusts that are called special or supplemental needs trusts but do not meet the above criteria are not treated as special needs trusts for Medicaid purposes and availability must be determined according to the criteria in 16.6.3 Revocable Trusts or 16.6.4 Irrevocable Trusts.

The funds deposited in, contributions to, and distributions from the special needs trust are disregarded. The exception continues after the person turns 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

16.6.6 Pooled Trusts

Disregard pooled trusts for disabled persons managed by:

1. WISH Pooled Trust
2. WisPACT Trust I
3. ARC of Greater Milwaukee, Inc. Community Trust II

The WISH Pooled Trust and the WisPACT Trust I must meet the following conditions:

1. Are established and managed by a non-profit association. The pooled trust can contain funds that hold accounts funded by third parties for the benefit of the disabled person's own assets or income.
2. Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of

funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a *disability*.

3. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court. If the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member.
4. For WISH Trusts, if the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member. This requirement does not apply to WisPACT trusts.
5. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.

    - This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.
    - This requirement can also be satisfied when the pooled trust account includes *real property*, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid member who is disabled (as established under SSI rules) or *elderly* (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid member.

Note: The assets that have been placed in a potential pooled trust pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by *DDB*, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.

16.6.7 Ho-Chunk Tribal Trusts

The Ho-Chunk Tribe, under its tribal ordinances and in conjunction with the Indian Gaming Regulatory Act, establishes irrevocable trusts for tribal members who are minors or determined to be legally incompetent. These irrevocable trusts are funded primarily with per capita distribution payments derived from gaming revenue. *DHS* has determined that funds placed in these trusts, for the benefit of minors and individuals who are legally incompetent, are considered to be owned by the Ho-Chunk Tribe and not the trust beneficiary. Therefore, the irrevocable Ho-Chunk Tribal Trusts established for minors or legally incompetent tribal members are considered to be unavailable assets for the tribal member’s Medicaid eligibility determination.

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16.7 Liquid Assets

16.7.1 Personal Property

16.7.1.1 Household Goods

Do not count household goods as an asset.

Household goods include both of the following:

- Items of personal property, found in or near the home, that are used on a regular basis
- Items needed by the household for maintenance, use, and occupancy of the premises as a home

Examples of household goods include, but are not limited to, the following:

- Furniture
- Appliances
- Electronic equipment, such as personal computers and television sets
- Carpets
- Cooking and eating utensils
- Dishes

Note: Items that are acquired or held because of their value or as an investment are not considered household goods (see Section 16.7.1.3 Other Personal Property).

16.7.1.2 Personal Effects

Do not count personal effects as an asset.

Personal effects are one of the following:

- Items of personal property originally worn or carried by the individual
- Articles otherwise having an intimate relation to the individual

Examples of personal effects include, but are not limited to, the following:

- Personal jewelry including wedding and engagement rings

- Personal care items
- educational or recreational items such as books or musical instruments
- Items of cultural or religious significance to an individual, such as ceremonial attire
- Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs

Note: Items that are acquired or held because of their value or as an investment are not considered personal effects.

16.7.1.3 Other Personal Property

Both the following are true of personal property that an individual acquires or holds because of its value or as an investment:

- It is a countable resource (asset).
- It is not considered to be a household good or personal effect.

Other personal property items include, but are not limited to, the following:

- Gems acquired or held because of their value or as an investment
- Jewelry that is not worn or held for family significance
- Collectibles acquired or held because of their value or as an investment

Example 1: Mr. Hollenback received $10,000 from an insurance settlement. Mr. Hollenback paid back creditors with $7,000 and purchased $3,000 in jewelry. Mr. Hollenback does not wear the jewelry. The *IM* workers must determine whether the jewelry is excluded from resources as a personal effect or is a countable resource in the form of other personal property. Mr. Hollenback's statements establish that the jewelry has no family significance and that he purchased the jewelry for its value as a means to spend down the $10,000. The IM workers correctly determines that the jewelry is not an excludable personal effect because an item purchased for its value cannot be a personal effect.

The IM worker correctly determines the jewelry as a countable asset.

16.7.2 Loans (including Home Equity Loans), Reverse Mortgages, and Promissory Notes

The following information applies except as directed otherwise in Section 16.7.2.1 Reverse Mortgage and Section 16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes.

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.

If an AG member makes a loan (except a land contract), treat the repayments as follows:

1. 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.
2. Count any interest payment on the loan as unearned income in the month received and as an asset in the months following the month it was received.

16.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, that is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month received and thereafter. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes

The current market value of a promissory note or loan made by an *AG* member will be assumed to be equal to the outstanding balance, and the promissory note or loan will be a countable asset in a Medicaid eligibility determination unless it cannot be sold.

An applicant who disputes the value used by the IM worker must provide credible evidence from a knowledgeable source that the note is non-negotiable or has a different current market value.

Promissory notes or loans that cannot be sold because they are not negotiable, assignable, enforceable, or otherwise marketable are considered unavailable assets (see Section 17.12.2 Promissory Notes on or after January 1, 2009 regarding divestment policy).

16.7.3 U.S. Department of Housing and Urban Development Payments

Disregard reimbursements resulting from federal regulatory changes in computing *HUD* housing rent as income in the month paid and assets in the next month.

16.7.4 Annuities

An annuity is a written contract under which, in return for payment of a premium or premiums, an individual will receive a series of payments at regular intervals for a specified time period.

The annuitant is the person entitled to the payments. A purchaser can name himself or herself or another person as the annuitant. The purchaser may also name a beneficiary to receive annuity payments after the annuitant's death.

16.7.4.1 Annuities Purchased After March 1, 2004

(For annuities purchased before March 1, 2004, refer to Section 16.7.4.2 Annuities Purchased Before March 1, 2004).

Treat annuities purchased after March 1, 2004, as available assets in accordance with the following:

16.7.4.1.1 Annuities That Can Be Surrendered

If the annuity's cash value is available for withdrawal (minus any penalty) the annuity can be "surrendered."

To determine the value of annuities that can be surrendered (for example, an annuity in the accumulation phase), use the following formula:

1. Total deposits made to the annuity.
Plus
2. Earnings on the deposits not previously paid out.
Minus
3. Withdrawals and surrender costs charged for withdrawal.
Equals
4. Annuity's value

16.7.4.1.2 Annuities That Cannot Be Surrendered (Effective March 1, 2009)

It has been established that a market exists for annuities that cannot be surrendered. Some companies have purchased such annuities. Check the annuity contract to see if it can be sold. If it is capable of being sold, consider it to be an available asset unless the *applicant* or *member* demonstrates that he or she has made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.

If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity, that amount will be considered an available asset.

The annuity will be considered to be an unavailable asset if documentation is provided from the company stating that it places no value on the annuity. Payments from an annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must also be evaluated for possible divestment, in accordance with Section 17.11 Annuities.

Example 2: Cynthia is 83 years old and applying for Medicaid. She owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferable. The agency has the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia's annuity contract at $82,000. Cynthia's annuity is therefore considered to be an available asset with a value of $82,000, which is the amount used to determine Cynthia's Medicaid eligibility.

Example 3: Sam is 66 years old and applying for Medicaid. He owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility.

16.7.4.2 Annuities Purchased Before March 1, 2004

Annuities that can be surrendered (in the accumulation phase)
The accumulation phase of an annuity is the period when the purchaser puts money into the annuity. During the accumulation phase, an annuity is an available asset because the annuitant can cash it in for its cash value.

Cash value (also known as surrender value) equals:

1. Total deposits made to the annuity.

   +

2. Earnings on the deposits not previously paid out.

   -

3. Withdrawals and surrender costs charged for withdrawal.

In determining the cash value, do not deduct income tax withheld or tax penalties for early withdrawal.

Annuities in the pay-out phase (cannot be surrendered)
The pay-out (annuitization) phase begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

An annuity becomes an unavailable asset on the date the settlement option is made final. This means even if the payment starts months later, it is unavailable on the date the settlement option is made final.

16.7.5 Life Insurance

Count the cash value of all life insurance policies. For persons 65 years old or older, blind, or disabled, count it only when the total face value of all policies, including riders and attachments, owned by each person exceeds $1,500. Do this calculation for each elderly, blind, or disabled person. In determining the face value, do not include any life insurance which has no cash value.

Face value is the basic death benefit of the policy including the value of riders and other attachments.

Cash value means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it.

Workers should enter the total of the face value plus any riders or other attachments as the “Face Value” on the Life Insurance Assets page.

Life insurance policies always have a face value, but do not always have a cash value. Term life insurance is limited to a defined time period as stated in the policy and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value. An endowment insurance plan generally has cash value.

Note: In calendar year 2000, some *VA* Term Life Insurance Policies were assigned a cash value. The VA put into effect a regulation to provide paid-up life insurance on term policies. When a veteran chooses this option to purchase paid-up insurance with his or her term insurance, the policy at that point has a *CSV*. The cash value amount is a countable asset.

16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees

A *CCRC* or Life Care Community typically provides a variety of living arrangements, from independent living through skilled nursing care. Potential residents frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Entrance fees paid by an individual to a CCRC or Life Care Community are counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when **all** of the following conditions apply:

- The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for his or her care. It is not necessary for the CCRC or Life Care Community to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met.
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community. It is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies.
- The entrance fee does not confer an ownership interest in the CCRC or Life Care Community. An ownership interest generally means the right to possess and convey property, but that might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not he or she has an ownership interest in the CCRC or Life Care Community by presenting documentation from the facility to that effect. If the CCRC or Life Care Community confirms that the entrance fee does not confer an ownership interest to the resident, then this third condition is met.

Entrance fees that meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the elderly, blind, and disabled, regardless of whether or not the individual is requesting *LTC* services. An entrance fee that does not meet all three conditions described above is an unavailable asset.

For Medicaid eligibility determinations, all normal *spousal impoverishment* rules regarding income and asset allocations for a *community spouse* are applicable to married couples who reside in a CCRC or Life Care Community, when one *spouse* resides in the skilled nursing care section of the facility and the other spouse (the community spouse) resides in a more independent living setting. CCRC and Life Care Community contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse before determining the amount of resources that a resident must spend on his or her own care.

16.7.7 Income Tax Refunds

Federal and state income tax refunds are available assets.

16.7.8 Earned Income Tax Credit

Disregard all *EITC* in the month received and for 12 months following the month of receipt.

After the 12-month disregard period has passed, count any remaining EITC payments as available, non-exempt assets.

16.7.9 Vehicles (Automobiles)

Vehicle refers to any registered or unregistered vehicle used for transportation. Vehicles used for transportation include, but are not limited to, cars, trucks, motorcycles, boats, and snowmobiles.

16.7.9.1 Determining Equity Value

Equity value is:

- The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book) or the value as estimated by a sales representative at a local dealership.
- Minus any encumbrances (loans or mortgages) that are recorded on the vehicle's title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the *FTG* while others may not. To find what the FTG's equity value in the vehicle is, do the following:

1. Find the vehicle's wholesale value.
2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle's title. The result is the equity value.
3. Divide the equity value by the total number of owners.
4. Add the prorated equity values of the owners who are in the FTG. The result is the FTG's equity value in the vehicle.

16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

- One vehicle per eligible individual or couple is excluded regardless of the value if it is used for transportation of the eligible individual or couple or a member of the eligible individual's or couple's household. Assume the vehicle is used for transportation, absent evidence to the contrary.
- When an individual owns more than one vehicle apply the exclusion as follows:

- Apply the exclusion in the manner most advantageous to the individual.
- Apply the total exclusion to the vehicle with the greatest equity value if the eligible individual or couple own more than one vehicle used for transportation of the eligible individual or couple or a member of the individual's or couple's household.
- The equity value of any vehicle, other than the one wholly excluded, is a resource when it:
  - Is owned by an eligible individual or couple **and**
  - Cannot be excluded under another provision (e.g., property essential to self-support, plan to achieve self-support.)

Do not apply the vehicle exclusion to the following vehicles:

- A vehicle that has been junked
- A vehicle that is used only for recreational purposes

- When an individual owns two or more vehicles, apply the following rules:
  - If only one vehicle is used for transportation, totally exclude the value of that vehicle.
  - If more than one vehicle is used for transportation, totally exclude the vehicle with the greatest equity value.

Example: George is applying for Medicaid. He has three vehicles: a car (equity value $2500), a truck (equity value $7500), and a snowmobile (equity value $750). He states that the snowmobile is used only for recreation in the winter. He uses the car and the truck interchangeably for transportation. The truck is excluded in the asset determination as it is used for transportation and has the highest equity value. While the car is also used for transportation, only one vehicle can be excluded. The equity value of the car counts in the asset determination. The equity value of the snowmobile also counts in the asset determination. Even if this was George's only vehicle, because he states that it is used for recreational purposes only, it would still be a counted asset.

For any vehicle that cannot be excluded for transportation reasons, consider excluding it under the provisions for property essential to self-support, plan to achieve self-support. If the vehicle does not qualify for the exclusion, count the equity value of the vehicle as a resource.

- If an individual owns a vehicle that is temporarily inoperable (e.g., needs repairs) and states that the vehicle will be repaired and used for transportation within the next 12 calendar months, exclude the total value of the vehicle until the repairs

are completed. At that point, apply the rules for determining if the vehicle should be excluded.

If an individual states that the vehicle will not be repaired and used for transportation in the next 12 calendar months, count the equity value of the vehicle as a resource.

16.7.10 Property Settlement

Money received as a property settlement is always an asset regardless of whether it is paid in one payment or in installments. It is never income.

16.7.11 Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, veterans benefits, sale of property, Railroad Retirement, unemployment compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

16.7.11.1 Retroactive SS Payments

The unspent portion of retroactive *SSI* and *RSDI* benefits received on or after March 2, 2004, are excluded from resources for the nine calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or nine months following the month the payment is received. A retroactive payment means it is paid later than the month in which it is due. After nine months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received before March 2, 2004, is excluded from resources for the six calendar months following the month in which the individual received the benefits.

16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case

The unspent portion of Cobell settlement payments is excluded from resources for one year following the month in which the individual receives the payment.

While some members received class payments, others may have received payments in exchange for their ownership interest in land. This buy-out is an asset conversion that receives special treatment under the act. Exclude funds received from the sale of this

land from resource counting for one year from the date of receipt. Funds retained longer than one year are countable as a resource.

Example 4: A class member receives a settlement payment (or a land buy-out payment) on October 5, 2011. Exclude this money for one year (November 2011 through October 2012). If retained, the money would be a countable resource starting November 2012.

During the year in which it is not counted, the unspent portion of these payments can be mingled with other funds, provided it can be distinctly and separately identified.

16.7.11.3 Reimbursement of Cost Share or Patient Liability Payments

To prevent the loss of eligibility due to counting a lump sum reimbursement of cost share or patient liability as an asset, the payment must be excluded as an asset in the month of its receipt, and for the next nine months. At the end of this period, any remaining available portion will be counted as an asset for purposes of determining eligibility. This time period gives members time to use these assets while also maintaining their Medicaid eligibility. This policy aligns with the treatment of lump sum payments received by members for retroactive Social Security payments (see Section 16.7.11.1, Retroactive SS Payments).

Example 5: Michelle is a former SSI recipient and now receives Social Security Disability Income and a surviving child benefit. She is considered a Disabled Adult Child (DAC) by the Social Security Administration. She applies for Medicaid but does not know when she stopped receiving SSI. Instead of being determined eligible for Medicaid as a DAC with no premium or cost share, she is determined eligible for Waiver Medicaid as a Group B with a cost share, which she pays each month. When her previous receipt of SSI is discovered, Michelle is owed the money that she paid towards her cost share and must be reimbursed that amount. Michelle has nine months after the month of receipt in which the reimbursed amount will not be considered an asset. If she receives the reimbursement in January, any remaining amount from the reimbursement will be counted as an asset in November.

16.7.11.4 Retroactive VA Aid and Attendance

Retroactive Aid and Attendance payments from the VA are an exempt asset through the month after the month of receipt.

Example 6: Gloria receives $5000 in retroactive VA aid and attendance as a lump sum payment in May. The amount of that payment is disregarded through June 30. Any remaining funds as of July 1 are a countable asset.

16.7.12 Land Contract

When a land contract is executed, the purchaser builds equity in the property through the payments he or she makes. The seller keeps legal title to the property until it is paid for. The seller's interest in the land contract is personal property, not *real property*.

The seller's legal title to the property can be sold and converted to cash for support and maintenance. To determine the value of the seller's legal interest in the land contract:

1. Find the original sale price or the *fair market value* (as determined by a qualified real estate appraiser). Of these two amounts, choose the one which more accurately reflects the contract's true value on the date it was originated.
2. From this amount subtract:
    a. Payments which the purchaser has already made on the principal.

> **Example 7:** The fair market value of the land contract is $50,000. The purchaser has already
> paid $10,000 on the principal.
>
> $50,000 Fair Market Value
> -10,000 Already Paid
> $40,000 Outstanding Balance

    b. Encumbrances on the contract (for example, a personal loan).
    c. The amount lost to a discount.

> **Example 8:** Company ABD purchases land contracts. They have offered to buy Mr. Graham's land contract at a 10 percent discount.
>
> $40,000 Outstanding Balance
> - 4,000 10%
> $36,000 Value of Mr. Graham's Interest in the Land Contract

3. The remainder, after subtracting 2. a., b., and c. from the original sale price, is the value of the seller's interest in the land contract. Count this as an available asset.

If the land contract is not an available asset, the person must document its unavailability by showing either one of the following:

- The terms of the land contract prohibit its sale.
- No one is willing to purchase it from him or her.

When the claim is that no one will purchase the land contract, it must be offered for sale to at least one individual or organization active in the land contract purchasing market. A written statement from the individual or organization that they will not buy it is sufficient to establish the land contract as an unavailable asset.

Notice that if it has been offered only to an individual or organization that never purchases land contracts, it remains an available asset.

16.7.13 Mortgage

Treat any mortgage held by and owed to a member the same as a land contract.

16.7.14 Wisconsin Higher Education Bonds

The state of Wisconsin sells Wisconsin Higher Education Bonds to the public as a way to save for higher education. To determine their net value, subtract broker's fees from market value.

The bonds may be sold back to the state, under certain time restraints:

1. Before the maturity date, a portion of their value is withheld. The amount withheld equals the school's tuition and fees. Any excess goes to the person.
2. On or after the maturity date, the value is the total amount received.

The bonds may be sold on the "secondary" bond market at any time. Since they can be disposed of on the market with no time limit, they are an available asset. To determine their net value, subtract broker's fees from market value. (Verify the amounts through a broker.)

16.7.15 Wartime Relocation of Citizens

Disregard restitution paid under PL 100-383 to Japanese-Americans and Aleuts or their survivors who were interned or relocated during World War II.

16.7.16 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling In Re "Agent Orange" Product Liability Litigation, M.D.L. No. 381 (E.D.N.Y.). Disregard as income in the month received and as an asset thereafter.

16.7.17 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death resulting from exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000).

When the affected person is deceased, payment is made to his or her surviving spouse, children, parents, or grandparents. The federal Department of Justice reviews the claims and makes the payments.

Apply this disregard retroactively to October 15, 1990, and continue to disregard the payment for as long as it is identified separately.

16.7.18 Self-Support Plan Assets

Disregard assets set aside to carry out an approved self-support plan (see Section 15.7.2.2 Self-Support Plan). The set-aside must be segregated from other funds. Disregard interest that accumulates, provided the set-aside does not exceed the provisions of the plan.

16.7.19 Replacing and Repairing Exempt Assets

Vehicles and homes are examples of exempt assets. If an exempt asset is lost, stolen, or damaged, disregard any cash (and interest earned) or in-kind replacement received from any source to repair or replace it.

The cash or in-kind payment must be used within nine months of the date it is received. After the end of the ninth month, count as an asset leftover cash not used for the repairs or replacement.

Extend the nine-month period for up to another nine months if the person has good cause for not repairing or replacing the thing. Good cause means circumstances beyond the person's control to prevent repair or replacement. This includes not being able to contract it out. When there is good cause, count as an asset any amount not used for repairs or replacement. Begin with the month after the end of the extension.

If, during a good cause extension, the person no longer intends to replace or repair the exempt asset, count the amount for replacement or repair as an asset. Begin with the month the person reports his or her change of intent.

16.7.20 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 *IRA*s and plans for self-employed individuals, sometimes referred to as Keogh plans.

- Employment related pension plans should be treated as follows:
    - If an applicant or member has the ability to cash in a work-related benefit, the net amount of the benefit (after any penalties but before any tax withholding) available to the applicant or member should be treated as an available asset. Some retirement benefit plans allow employees to cash in

their benefits as a lump sum payment when they leave their job instead of waiting until they reach retirement age to get the pension. However, do not count retirement funds as an available asset if the applicant or member has to quit a job to get at the retirement funds or if the applicant or member is receiving periodic payments from the retirement benefit plan.
    - If the applicant or member does not have access to the account's principal in his or her retirement benefit plan, the principal should be treated as an unavailable asset.
    - Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

- Individually-owned retirement funds, such as IRAs, Keogh plans, etc., that are owned by the applicant or member should be counted as available non-exempt assets (minus any early withdrawal penalty) for the Medicaid applicant or member. The applicant or member always has access to the principal in these accounts, subject to an early withdrawal penalty.

  Any periodic payments from these accounts should not be counted as income in the months of receipt. These payments are considered assets. They are considered the same as withdrawals from an applicant's saving account. Only interest earned on the funds in a retirement fund is to be counted as income (see Section 15.4.9.1 Elderly, Blind, or Disabled Interest and Dividend Income).

- Disregard work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs, of an ineligible spouse in an EBD case. This policy includes the disregard of retirement funds held by the community spouse in spousal impoverishment cases.

  Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 9: Mike withdraws $2,000 from his IRA and deposits it in a savings account. Continue to treat the $2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.

16.7.21 Gifts

A gift is something a person receives that 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).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is income in the month of receipt. It is an asset in the months after the month of receipt.

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $30 or less, for each assistance group member, for each calendar quarter.

16.7.22 U.S. Savings Bonds

Count the cash value of a U.S. Savings Bond unless it is unavailable. A bond is unavailable only if the Medicaid group proves it tried to cash the bond and was refused.

16.7.23 Indian Judgment Fund Purchases

Disregard assets purchased with Indian judgment funds (see 10. of Section 15.3.14 Payments to Native Americans), but do not disregard:

- Proceeds from the sale of these initial purchases.
- Subsequent purchases made with the proceeds from the sale of these initial purchases.

16.7.24 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

16.7.25 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

16.7.26 Uniform Gifts to Minors Act

Do not count funds held in an account for the benefit of a *minor* that are the result of transfers under the Uniform Gifts to Minors Act. This act is also called the Uniform Transfers to Minors Act. There is no asset test for minors for EBD eligibility determinations.

16.7.27 Individual Development Accounts Programs

*IDA*s are restricted accounts owned by people with low incomes. The IDA program provides matching funds for buying a home, starting a business, or post-secondary education. Member savings and interest are a countable asset if the IDA was established using the Assets for Independence Act or Refugee Assistance Act funds. However, if *W-2* or Community Reinvestment funds support the IDA program, the assets are exempt.

16.7.28 Crime Victim Restitution Program

Disregard any payments received from a state-established fund to aid victims of a crime. These payments are an excluded resource for nine months following the month of receipt.

16.7.29 The American Recovery and Reinvestment Act of 2009

Do not count the one-time $250 payment under the American Recovery and Reinvestment Act of 2009 as an asset either in the month of receipt or nine months following the month the payment is received.

16.7.30 Achieving a Better Life Experience Accounts

ABLE accounts are tax-sheltered money market savings accounts specifically designed for people with disabilities. Anyone may contribute to these accounts for the disabled beneficiary.

While Wisconsin does not offer residents a state-specific ABLE program, Wisconsin residents may open these accounts in any state where an ABLE program is offered. If an applicant or member has an ABLE account, treat the money in the account as follows:

1. Do not count the balance on the account as an asset.
2. Do not count contributions to the account, any interest or dividends earned, or other appreciation in value as income.
3. Exempt all distributions from these accounts to the beneficiary, as long as they are for qualified disability expenses. “Qualified disability expenses” means any expenses related to the eligible person’s blindness or disability that are incurred for the benefit of an eligible person who is the designated beneficiary. This includes the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses consistent with the purposes of the ABLE program. Unless the applicant or member reports that a distribution was used for non-qualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.
4. Disregard ABLE account distributions used for qualified disability expenses from a person’s total income when calculating cost of care for long-term care and home and community-based waivers.

ABLE account funds remaining after an applicant’s or member’s death are subject to estate recovery.

Note: If a third party contributes to someone else’s ABLE account, and then later applies for long-term care Medicaid, the contributed funds may be considered divestment.

16.7.31 Crowdfunding Accounts

Crowdfunding accounts, such as GoFundMe and Kickstarter, raise money from multiple people online to finance things like a new business venture, medical bills, or funeral costs. If the funds in these accounts are not accessible for the person to withdraw, the funds would be an unavailable asset. Disbursements or withdrawals would be unearned income (a gift) in the month withdrawn, and any withdrawn amount that is still available in subsequent months would be an available asset.

16.7.32 Independence Accounts

Independence account balances will be exempt assets for all Medicaid programs. Any "pre-Independence account balance" will be a counted asset. Only funds deposited in a registered Independence Account while the member is eligible for MAPP may be exempted from the asset limit. Any deposits made prior to MAPP enrollment or during periods of MAPP ineligibility are not exempt assets. Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited. See Section 26.4.1.1 Independence Accounts for more information on these accounts.

16.7.33 Federal Coronavirus Recovery Rebates (Stimulus Payments)

Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments) received as part of the federal CARES Act should be disregarded as assets for 12 months from the date the payment was received.

Note: These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.

16.7.34 Retroactive Federal Pandemic Unemployment Assistance (PUA)

Retroactive Pandemic Unemployment Assistance payments are counted as an asset the month they are received.

16.7.35 Retroactive Federal Pandemic Emergency Unemployment Compensation (PEUC) Payments

Retroactive Pandemic Emergency Unemployment Compensation payments are counted as an asset the month they are received.

16.7.36 Retroactive Federal Pandemic Unemployment Compensation (FPUC) Payments

Retroactive Federal Pandemic Unemployment Compensation (FPUC) payments are counted as an asset the month they are received. This policy is effective November 23, 2020.

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16.8 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

16.8.1 Home/Homestead Property

A home is a place of abode and lands used or operated in connection with it. In urban situations the home usually consists of a house and lot. A home can consist of a house and more than one lot. As long as the lots adjoin one another, they are considered part of the home.

Homestead property may have more than one building or house on it. This applies to urban home owners as well as farm families. In farm situations the home consists of the house and buildings together with the total acreage property upon which they are located that is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the home.

Land should be considered part of the home property if it is not completely separated from the home property by land in which neither the individual nor his or her *spouse* has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

If land is completely separated from the home property by land in which neither the individual nor his or her spouse has ownership interest it should not be considered part of the homestead property.

16.8.1.1 Multi-unit Dwelling

When a Medicaid fiscal group member lives in one unit of a multi-unit dwelling and owns all of the units, exempt all of the units and the property they are on. Consider the whole multi-unit dwelling as the group member's home.

16.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered real property, regardless of whether or not the member owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (see Section 16.8.1 Home/ Homestead Property) if the member currently lives in it or had lived in it before entering an institution, **or**

If the member owns the land that the non-motorized home is sitting on, consider it and any other buildings on that land as part of the homestead.

2. Non-home property if the member does not live in it or had not lived in it prior to entering an institution.

If the non-motorized trailer home is listed for sale, it is considered unavailable (see Section 16.2 Assets Availability).

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (see Section 17.2.3.1 Homestead Property).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while he or she continues to reside there.

Institutionalized Person. When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His or her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.

2. The institutionalized person expresses his or her intent to return to the home. If he or she is able to form an intent but unable to express it, determine his or her intent through other available evidence. Other evidence includes:
    a. His or her written statements.
    b. His or her oral statements made before incapacitation. Accept reports of these statements made by family members.
    c. Accept reports of his or her intent made by an *authorized representative*. If there is no evidence he or she disagrees with the statement, accept the authorized representative's statement.

If he or she appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his or her intent.

If he or she has been judged incompetent, accept the intent statement of his or her guardian. Use the guardian's intent statement even if it differs from the member’s.

If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

Refer to Section 18.4 Spousal Impoverishment Assets and Section 18.4.1 Spousal Impoverishment Assets Introduction for the definition of institutionalized spouse and home exemptions when Spousal Impoverishment policies apply.

16.8.1.4 Home Equity Over $750,000.00

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e., Institutional, community waivers, Family Care, Partnership or *PACE*) are not eligible for LTC services if the equity interest in their home is greater than $750,000. He or she is still eligible for card services if all other eligibility requirements are met.

This restriction does not apply if a spouse, *minor*, or disabled child resides in the home.

The $750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an "undue hardship" for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines outlined in Section 22.4 Undue Hardship.

This policy applies regardless of whether or not the applicant or member lists the home for sale.

The equity value of a home is the current *FMV* minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant*/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 1: Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of $760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob's health deteriorates and he applies for a community waiver program. That application is denied because Bob's equity interest in his home exceeds the LTC eligibility limit by $10,000.

On December 15, 2009 Bob reapplies for a community waiver program and reports that on December 1, 2009, he took out a $12,000 home equity loan and used the

entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob's December 15, 2009 application for community waivers is approved because Bob's equity interest in his home is now $748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 2: Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of $1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the $750,000 LTC eligibility limit, his wife resides in the home, which negates the $750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e., nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals who are current members of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC member who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the $750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

16.8.1.5 Sale of Home Property

Money from the sale of real property is an asset. When the property that is sold is a homestead, *disregard* the proceeds if they are placed in an escrow account and used to purchase another home within three months.

16.8.1.6 Life Estate

A life estate allows an individual to gift a home or other possession but retain certain property rights for his or her lifetime. Generally a life estate provides an individual the right to possess and use a gifted property, and to make money from it. The person does not have the title to or the right to sell the property. He or she usually may not pass it on to his or her heirs as an inheritance. He or she also has the right to sell his or her interest in it. He or she is liable for all costs of the property such as taxes and repairs, unless the will (or *deed*) states otherwise.

When property is conveyed to one person for life (life estate holder) and to another person (the remainder man), both a life estate interest and remainder interest are created. When the life estate holder dies, the remainder man holds full and unconditional title to the property and can dispose of it as he or she wishes (fee simple). Life estate values need to be determined for divestment calculation.

Example 3: Sidney gifted away his $100,000.00 home to his nephew Frank, but retained a $30,000.00 life estate, the *divested amount* is $70,000.00.

The life estate interest is an unavailable asset when determining Medicaid asset eligibility for Sidney. However, the remainder interest is an available non-exempt asset for Frank, the remainder person, for Medicaid eligibility determinations.

Determine the value of the remainder interest for the date you are determining Medicaid eligibility. To do this, use the age of the life estate holder on the date that you are determining eligibility for the remainder person. Also use the property's FMV as of that same date. Then select the remainder multiplier (the one that corresponds to the age of the life estate holder) from the life estate table and multiply the FMV by that number. The result should be the value of the property's remainder interest for the remainder person as of the date that eligibility for Medicaid is being determined for that person.

To determine the value of a life estate or remainder interest:

1. In the Life Estate and Remainder Interest Table (see Section 39.1 Life Estate and Remainder Interest), find the line for the person's age as of the transaction date.
2. Multiply the figure on that line in the Life Estate or Remainder column times the fair market value to determine the value of the life estate or remainder interest.

When a life estate holder moves off the property and the property is rented, follow the instructions in Section 15.5.3 Rental Income for counting the rental income.

If a remainder person sells the property for which a life estate is retained, the life estate holder is not entitled to any of the payments.

However, if the life estate holder gives up his or her life estate to secure the sale of the property, then the life estate holder would be entitled to some portion of the proceeds from the sale of the property. Treat money received as a result of property settlement as an asset (see Section 16.7.10 Property Settlement).

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16.9 Non-Home Property Exclusions

Non-home property is any countable asset other than a *homestead*. See Section 17.4 Exceptions for divestment. Exclusions of non-home property in EBD cases include:

1. *Real property* that is listed for sale with a realtor at a price consistent with its *fair market value*.
2. Property excluded regardless of value or rate of return. Property used in a trade or business is in this category (see Section 15.6.3.1 Business Assets). The property may be excluded as used in a trade or business when the *applicant*/member is actively involved in the business operation on a day to day basis. The information reported on the Schedule E, Supplemental Income and Loss, should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-Passive Income, the individual is actively engaged in the business.

   When determining if a trade or business exists in an LLC or other questionable situations workers should consider:

   - Does the *IRS* regard this as a trade or business?
   - Does the individual have documents to support the claim of trade or business such as licenses, permits, registration, etc.?
   - Is the individual a member of a business or trade association?

3. Property excluded up to $6,000, regardless of rate of return. This category includes non-business property used to produce goods or services essential to self-support. Any portion of the property's equity value in excess of $6,000 is not excluded.

   Non-business property essential to self-support can be real or personal property. It produces goods or services essential to self-support when it is used, for example, to grow produce or livestock solely for personal consumption, or to perform activities essential to the production of food solely for home consumption.

   Example 1: John owns two acres of land that he uses to grow fruits and vegetables for his personal consumption. Up to $6,000 of the equity value of the property would be exempt.

4. Property excluded up to $6,000 if it is nonbusiness property that produces a net annual income (either cash or in-kind income) of at least 6 percent.

   Nonbusiness income producing property is land or non-liquid property which provides rental or other income but is not used as a part of a trade or business. Nonbusiness income producing property includes, but is not limited to, the following:

- Structures producing rental income
- Land producing rent or other land use fees (non-liquid notes or mortgages, royalties for timber rights, mineral exploration, etc.)

Example 2: James is applying for EBD Medicaid. He lives in a *CBRF* and is renting out his home which has an equity value of $20,000. He does not intend to return to the home. The income from the rent exceeds 6 percent of the equity value of the home, so $6,000.00 of the equity value is exempt. The remaining $14,000.00 is a counted asset.

Example 3: Joan is applying for EBD Medicaid. She lives in her home but also owns a lake cottage in northern Wisconsin. She rents the cottage during the summer months. The income from the rent does not equal 6 percent of the equity value of the cottage. The entire equity value of the cottage is a countable asset.

If the excluded portion produces less than a six percent return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a six percent return, continue to consider the first $6,000 in equity as excluded.

Note: Rental property cannot be exempt as a business property unless the property owner is in the business of renting and managing properties. If a person simply owns a piece of property and is renting it, he or she is not considered to be the owner of a trade or business (see 2. above for more information).

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16.10 Indian Lands

Exclude a Native American's interest in or possession of land that is held by an individual Native American or tribe, and that can only be disposed of with the approval of other individuals, the tribe, or the federal government.

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17 Divestment

17.1 Divestment Introduction

Divestment can affect the eligibility for Long Term Care Medicaid. If it is determined that divestment occurred some time in the past, the *applicant* or member may be found ineligible for Long Term Care Medicaid for a period of time. Divestment does not affect eligibility for Medicaid card services for a person residing in a medical institution. An individual ineligible for Home and Community-Based Waivers due to a divestment may still be eligible for other non-Long Term Care Medicaid.

> **Example 1:** Joe applied for HCBW and was found ineligible for HCBW for nine months due to a divestment. Joe can still be eligible for *SSI*-Related Medicaid or *MAPP* while he serves his divestment penalty, if otherwise eligible for those programs.

> **Example 2:** Martha is residing in a nursing home and applies for Institutional Medicaid. Martha is ineligible for Institutional Medicaid for five months due to a divestment. During the penalty period, she is eligible for Medicaid card services.

Note: Effective 10/1/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a Medicaid case for a child.

The definitions and general rules found in Sections 17.2 - 17.5 apply to all divestments. The special situations in Sections 17.6 - 17.14, while falling under the same definitions and general rules, require extra treatment because of their complexity.

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17.2 Divestment Definitions

17.2.1 Divestment

"Divestment" is the transfer of income, non-exempt assets, and *homestead* property (see Section 17.2.3.1 Homestead Property), which belong to an institutionalized person or his or her *spouse* or both:

1. For less than the fair market value of the income or asset by:
    a. An institutionalized person, or
    b. His or her spouse, or
    c. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse, or
    d. A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse. This includes relatives, friends, volunteers, and authorized representatives.

2. It is also divestment if a person takes an action to avoid receiving income or assets he or she is entitled to. Actions which would cause income or assets not to be received include:
    a. Irrevocably waiving pension income.
    b. Disclaiming an inheritance.
    c. Not accepting or accessing injury settlements.
    d. Diverting tort settlements into a trust or similar device.
    e. Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.
    f. Refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate.

    This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of his or her spouse's estate. If the institutionalized person does not contest his or her spouse's will in this instance, the inaction may be divestment.

    Count the action as a divestment only if both of the following are true:
    - The value of the abandoned portion is clearly identified.
    - There is certainty that a legal claim action will be successful. The IM worker must ask the agency’s Corporation Counsel to make this determination.

3. The purchase of certain types of assets, even at the *fair market value*, may be considered a divestment, including:
    a. The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser resides in the home for a period of at least 12 consecutive months after the date of purchase (see Section 17.10.3 Purchase of a Life Estate in the Home of Another Person).
    b. The purchase of a promissory note, loan, or mortgage, on or after January 1, 2009 is a divestment unless such note, loan, or mortgage meets several criteria (see Section 17.12.2 Promissory Notes on or after 01/01/09.
    c. The purchase of certain annuities may be considered a divestment (see Section 17.11.2 Annuities Purchased On Or After 01/01/09 Or Had Transactions To Them On Or After 01/01/09.

4. Gambling losses at a casino, racetrack or in some other type of regulated gambling is not divestment. It is divestment if the *member* makes personal bets with friends or relatives or has losses from unregulated gambling.

17.2.2 Transfer

"Transfer" is the act of changing the legal title or other right of ownership to another person. Converting an asset from one form to another is not divestment. For example, buying a race horse for $12,000 and keeping the race horse is not divestment.

17.2.2.1 Date of Transfer

If the Medicaid member has transferred *real property*, such as a homestead, the official date of transfer is the date the Quit Claim *Deed* was signed and notarized. It is not the date the transfer was recorded with the county Register of Deeds.

17.2.3 Nonexempt Assets

"Nonexempt assets" are those that are counted in *SSI*-related asset tests. Assets that are not counted in these tests are called exempt assets. An available asset (see Section 16.1 Assets Introduction) can be either exempt or nonexempt.

17.2.3.1 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the Medicaid divestment policy. Homestead divestments are permitted only under the circumstances described in Section 17.4 Exceptions, #7.

17.2.4 Institutionalized Person

See Section 27.4 ILTC Definitions.

17.2.5 Community Spouse

See *community spouse* in Glossary. A divestment penalty period will be imposed on the Institutionalized Spouse if the Community Spouse divests assets within the first five years after the Institutionalized Spouse has been determined eligible for LTC services (Institutional Medicaid or any of the HCBW programs).

17.2.6 Fair Market Value

"Fair market value" is an estimate of the prevailing price an asset would have had if it had been sold on the open market at the time it was transferred.

17.2.7 Divested Amount

The *Divested amount* is the net market value minus the value received. To determine the divested amount for a life estate, see Section 17.10 Life Estates.

17.2.8 Net Market Value

"Net market value" is the fair market value at the time of the transfer minus any outstanding loans, mortgages, or other encumbrances on the property.

17.2.9 Value Received

"Value received" is the amount of money or value of any property or services received in return for the person's property. The value received may be in any of the following forms:

1. Cash.
2. Other assets as listed in Chapter 16 Assets.
3. Discharge of a debt.
4. Prepayment of a bona fide and irrevocable contract such as a mortgage, shelter lease, loan, or prepayment of taxes.
5. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment (see Section 17.8 Divesting by Paying Relatives).

17.2.10 Unavailability

If a Medicaid member or his or her spouse uses an asset in a way that makes it unavailable and does not receive *FMV*, treat that asset as divestment. An example is using an asset as collateral for someone else’s loan.

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17.3 Look Back Period

Effective January 1, 2014, the look back period is 60 months for all divestments.

The look back period is a period of time prior to application or entry into an institution. A divestment that has occurred in the look back period or any time thereafter can cause the *applicant* or member to be ineligible.

The look back period begins when an individual is both institutionalized and has applied for Long Term Care Medicaid or has requested one of the Home and Community-Based Waiver or Managed Long Term Care programs.

When you count backward, start counting with the month before the date of application or entry into the institution as month one. When determining which date to use, use the most recent date.

"Date of application" is the date the applicant or his or her representative signs the application. If he or she does not sign the application, it is not a complete application and no divestment penalty can be imposed.

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17.4 Exceptions

A divestment that occurred in the look-back period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment was not made with the intent of receiving Medicaid.

   The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that he or she was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

   Any of the following circumstances are sufficient to establish that the *applicant*/*member* transferred resources without an intent to qualify for Medicaid.

   - The applicant/member had made arrangements to provide for his or her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

     An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his or her long term care services for his or her remaining life expectancy.

     To measure "sufficient resources," use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets, and insurance held by the individual at the time of the divestment, **or**

   - Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**

- If an individual or couple had a pattern of charitable gifting or gifting to family members (i.e., birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15 percent of the individual's or couple's annual gross income. If the yearly gifted amount exceeds 15 percent of the individual's or couple's annual gross income, and/or there is a gap in the years the gifts occurred, the total amounts gifted for the years in the look-back period shall be considered divestment. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals, or

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for *IRS* tax purposes, or otherwise provide more than 50 percent of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

2. The community spouse divested assets that were part of the community spouse asset share **and** this transfer occurred more than five years after the institutionalized spouse was determined eligible. If it is more than five years after the institutionalized person is determined eligible, the community spouse can divest assets.

Example 1: When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. Six years after Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share, as long as it is more than five years after Ralph was determined eligible. If Edith applies for long-term care services within five years though, the gift to her nephew may be considered divestment when determining her eligibility.

Example 2: When Ralph went into the nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. One year after Ralph became eligible, Edith gave $30,000 to a favorite nephew. This divestment will result in a divestment penalty period for Ralph because it occurred within the first five years of his eligibility.

The transfer of *homestead* property to the community spouse and then to another person is treated as a divestment depending on when the transfers occur. If the institutionalized person transfers the homestead to the community spouse, and then the community spouse transfers it to someone else within five years of the institutionalized person becoming eligible for long-term care Medicaid, this would be considered a divestment, and it would affect the institutionalized person's eligibility. However, if five years have passed since the institutionalized person became eligible for long-term care Medicaid, the community spouse can transfer the homestead property without affecting the institutionalized person's eligibility.

Example 3: When Ralph applied for Institutional Medicaid, he and Edith owned a home together. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. After five years have passed, Edith can transfer the part of the homestead Ralph gave her without Ralph's eligibility being affected.

Note: While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination do not affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if he or she later enters an institution and applies for Medicaid.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession are not divestment. An exception to this is if someone voluntarily signs the property deed over to the bank rather than trying to sell the property or foreclosing due to defaulting on their loan. Banks may refer to this as a "voluntary foreclosure," which would be considered divestment.

5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 4: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7,300. When Gary applies for Medicaid, this divestment will be disregarded.

6. The agency determines that denial of eligibility would result in undue hardship for the person (see Section 22.4 Undue Hardship).

7. The institutionalized person or his or her spouse divests homestead property to his or her:

    a. Spouse
    b. Child who meets at least **one** of the following conditions/situations:

        - Is younger than 21 years old
        - Is blind
        - Is permanently and totally disabled
        - Has been residing in the institutionalized person's home for at least two years immediately before the person moved to a medical institution, and provided care to him or her which permitted him or her to reside at home rather than in the institution. This care must have been provided for the entire two years immediately before the person moved to a medical institution. Get a notarized statement that the person was able to remain in his or her home because of the care provided by the child.

            Note: The statement must be from his or her physician or from someone else who has personal knowledge of his or her living circumstances. A notarized statement from the child does not satisfy these requirements.

    c. Sibling who:

        - Was residing in the institutionalized person's home for at least one year immediately before the date the person moved to a medical institution.

        Verify that the sibling was residing in the institutionalized person's home for at least one year immediately before the person moved to a medical institution. Do not require a specific type of verification. Some examples of verification are written statements from non-relatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

        and

        - Has a verified equity interest in the home.

"Equity interest" means an ownership interest in a homestead.

Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

8. The institutionalized person or his or her community spouse divests a non-homestead asset or assets to:

a. A spouse

b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

9. The institutionalized person gives away an exempt asset. This includes an asset that is temporarily disregarded, but only during the time that it is being disregarded. This would include, but is not limited to, giving away funds from the following:
    a. Retroactive Social Security payments during the nine months after the payment was received,
    b. Patient liability or cost share refunds during the nine months after the refund was received, or
    c. Federal Coronavirus Recovery Rebate during the 12 months after the payment was received.

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17.5 Penalty Period

17.5.1 Penalty Period Introduction

If there was a divestment during the look-back period or any time after and if none of the exceptions in Section 17.4 Exceptions apply, the institutionalized person must be determined ineligible for long-term care services for a period of time.

During this penalty period, Medicaid will not pay the institutionalized person's daily care rate in the nursing home. He or she may, however, still be eligible for Medicaid card services (see Section 17.15 Medicaid Card Services).

A person applying for *HCBW*s would be ineligible for HCBW services for a period of time. A person ineligible for HCBWs due to a divestment may still be eligible for other non-LTC Medicaid, such as SSI-related Medicaid or MAPP, if they meet the eligibility requirements of the non-LTC Medicaid program.

17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated by days using the average daily nursing home private pay rate. The rate effective January 1, 2021 is $303.38. This rate may be updated annually (see Section 39.4.3 Institutional Cost of Care Values).

CWW will calculate the penalty period once a worker enters the appropriate information into the Transfer/Divestment of Assets page, runs eligibility, and confirms.

Example 1: Jeff applied for Family Care. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. Since $18,500 divided by $303.38 equals 60.97 days, CWW will calculate a divestment penalty period of 60 days for Jeff.

17.5.3 Penalty Period Begin Date for Applicants

For divestments that occurred **on or after January 1, 2009**, the penalty period for an applicant begins on the date **all** of the following have occurred:

- The person applies for Institutional LTC Medicaid, HCBW, or Managed LTC/IRIS.
- The person enters an institution or meets the appropriate *LOC* and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements (for waiver applicants this can be met regardless of whether or not the waiver funding is actually available).

Note: If a person who had excess assets divests those assets during the three-month backdated period of an application, he or she is ineligible for excess assets until the date that he or she divested those assets. The divestment penalty period as well as the potential eligibility for card services would begin on the date of the divestment.

Example 2: Jeff applied for Family Care on March 5. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. The worker receives verification of the divestment on March 30. Jeff's penalty period would begin on March 5, the date he applied for Family Care.

Example 3: Joan entered a nursing home on March 1 and applied for Medicaid on March 4. On her application, Joan reported that, in the previous month, she gave her adult daughter a $100,000 cash gift, which is determined to be a divestment. All requested verification is received on March 27, and Joan meets all other Medicaid eligibility requirements; therefore, Joan's divestment penalty period would begin on March 1. If Joan had been over the asset limit at the time of application, she would not have been "otherwise eligible for Medicaid," so her divestment penalty period would not start until she was under the asset limit.

Example 4: John applied for a HCBW program on April 7. He indicated on his application that he gave his adult son a $60,000 cash gift three months earlier. John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He resides in a county that does not have any available waiver slots, and he is therefore put on a waiting list. Verification was received on April 20, and the $60,000 cash gift was determined to be a divestment. John is therefore ineligible for HCBW for the length of the penalty period. His penalty period would begin on April 7, the day he applied for the HCBW program.

Example 5: Jeff entered a nursing home on March 1. He applied for Medicaid on April 15 and requested that his eligibility be backdated to March 1. John meets all other Medicaid eligibility requirements in March and April; however, he reported transferring $100,000 in stocks and bonds to his brother in February. John's divestment penalty period would begin on March 1, which is the date he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.

Example 6: Sam entered a nursing home on October 1. He applied for Medicaid on January 3 and asked for a three-month backdate. He reported giving away an inheritance on November 23. All necessary verification is received on January 17, and Sam is denied Medicaid for being over assets until November 23. Sam's divestment penalty period would begin on November 23, which is the date that he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.

17.5.4 Penalty Period Begin Date for Members

A member's penalty period begins on the first of the month after timely notice is given. Timely notice is outlined in the Income Maintenance Manual, Section 3.2 Adverse Action and Appeal Rights.

Example 7: Joe was determined eligible for institutional Medicaid effective March 1. On July 2, he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16, which impacted Joe's institutional Medicaid effective August 1. The penalty period begin date would be August 1, the date the worker was able to enter the divestment and give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after *adverse action* in July, the penalty period begin date would be September 1, the first day the benefit could be terminated with timely notice.

17.5.5 Recalculation of Penalty Periods

17.5.5.1 Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified or cured. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if he or she met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 8: Scott gave a *CD* to his adult son on March 10. On October 1, Scott entered a nursing home and applied for Medicaid. Based on the value of the CD that he divested to his son, Scott was ineligible for Medicaid coverage for the cost of his institutional care for 38 days. The divestment penalty period started on October 1 and ended on November 8. Scott was certified for Medicaid LTC on November 9.

Scott's son had already cashed in the CD, but, on December 5, he returned the entire value in cash to Scott as a refund of the prior gift from his father. Since the equivalent value of Scott's previously transferred asset has been returned, Scott is now potentially eligible for Medicaid LTC services for the period of October 1 through November 8. Scott met all other eligibility requirements during that retroactive period, and he is certified for Medicaid LTC services for that same period. The cash that Scott received from his son and reported on December 5 is counted as an asset beginning in December. Because the value of the cash exceeds the program asset limit, it would make him ineligible for Medicaid, effective January 1, unless his assets are reduced to program limits prior to January 1.

Full Refund for Multiple Divestments Occurring in the Lookback Period
A divestment penalty period resulting from multiple divestments that occurred during the lookback period can be cured when the applicant or member has demonstrated that all of the assets divested during the lookback period, or cash equal to the value of those assets, have been returned (Wis. Stat. § 49.453[8][a][1]).

17.5.5.2 No Reduction for Partial Refund

Beginning with penalty periods with a start date of November 11, 2013, or later, the total value of the divested amount must be returned in order to "cure" the divestment. A penalty period will no longer be recalculated based on a partial repayment (Wis. Stat. § 49.453[8][a]).

Example 9: Jerry divested cash to his daughter prior to applying for institutional Medicaid. He has a 373-day penalty period. His daughter returned half of the *divested amount*. Jerry's penalty period remains 373 days. If Jerry's daughter returned the entire amount that was divested, the divestment would be "cured," and Jerry would no longer have a penalty period.

17.5.5.3 Divestments During a Penalty Period

If another divestment occurs when a penalty period is in effect, another penalty period must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The new penalty period will not begin until the existing period has expired. The penalty periods cannot run concurrently.

Example 10: Jeff had a penalty period that lasted until July 25. In June, he transferred a large amount of cash to friends. Based on the verified value of this divestment, Jeff's additional divestment penalty period is 154 days. The new divestment period of 154 days begins July 26, the day after the original divestment penalty period has ended. The new divestment penalty period does not run concurrently with the original divestment period.

17.5.5.4 Changing Divestment Penalty Periods

If it is necessary to change an existing penalty period, IM workers must update the information in CARES and confirm. However, if the divestment penalty period has been shortened or removed (for example, it was cured), IM workers must also notify the fiscal agent. See Process Help Section 11.6.3 Changing Divestment Penalty Details for instructions.

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17.6 Multiple Divestments

Multiple divestments are two or more separate divestments made within the look back period or at any time thereafter.

During the Look Back Period

All divestments made by the institutionalized person or his or her spouse during the look back period must be added together to arrive at a total divestment amount. That total will be used to calculate the appropriate divestment penalty period. The total divestment amount must be returned in order to cure any divestment that occurred during the look back period.

After the Look Back Period

For multiple divestments that occur after the look back period, the worker must enter each individual divestment that occurred on separate Transfer/Divestment of Assets page sequences unless the divestments occurred in the same month. If the divestments occurred after the look back period, but in the same month, the worker must enter those divestments on one Transfer/Divestment of Assets page sequence, as they are considered one divestment, per Wis. Admin. Code § DHS 103.065(4)(am).

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17.7 Jointly Held Assets

When an institutionalized person owns an asset in common with another person and when he or she or the other person or any person acting on his or her behalf transfers the asset during the look back period or anytime thereafter, he or she may be penalized for divestment if the transfer:

1. Reduces or eliminates the institutionalized person's ownership or control of the asset, or
2. Limits the institutionalized person's right to sell or otherwise dispose of the asset.

"Holding an asset in common" means holding it through joint tenancy, tenancy in common, joint ownership, or partnership.

Example 1: For many years Debra held a joint account with her daughter, Donna. On October 15, 1996, Donna withdraws $13,000 from it. On December 3, 1996, Debra enters a nursing home and applies for Medicaid. The $13,000 withdrawal is a divestment. A penalty period must be calculated and imposed.

If placing another individual's name on the account, or asset actually limits the individual's right to sell or otherwise dispose of the asset, such placement would constitute a transfer of assets. For example, the addition of another individual's name requires that the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 2: John bought a piece of property with his nephew, Carl. Three months later John requested to participate in the community waivers program. John explained that his nephew, Carl, refused to sell the property and, therefore, it was unavailable and should not be counted as an asset. The *IM* worker agreed with John that the land was not available and would not be counted as an asset. But, the purchase of the property and the nephew's refusal to make it available (through liquidation) to meet John's needs was divestment. Therefore, John is subject to a penalty period starting from the first of the month in which the jointly owned property was purchased.

When a person's name appears as co-owner of a jointly held asset, assume he or she is part owner of the property. However, you must inform him or her that he or she has a right to present evidence showing he or she is not an owner (see Section 16.3 Separate and Mixed Assets).

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17.8 Divesting by Paying Relatives

17.8.1 Introduction

Divestment may occur when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him or her and any of the conditions below are not met. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services that the institutionalized person made to the relative in the last 60 months. Payment can include cash, property, or anything of value transferred to the relative. It is not divestment if all of the following conditions exist:

- The services directly benefited the institutionalized person.
- The payment did not exceed reasonable compensation for the services provided. "Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

Example 1: Kerry applies for community waivers on January 10. She paid her son $3,500 to remodel her bathroom the previous month. She shows that her son installed new tile and fixtures. You check with a local contractor who estimates the he would charge $4,000 for the same job. Since Kerry received *fair market value*, it is not divestment.

Example 2: Jennifer enters a nursing home on December 12 and applies for Medicaid. She reports she paid her daughter $7,000 in December for coming to her house each evening and fixing dinner for the previous two months. You check with a local agency that provides meals to homebound people. They charge $2 for each meal. Jennifer's daughter provided 61 meals. The fair market value of the meals was $122. You determine Jennifer overpaid her daughter. The *divested amount* is $6,878 ($7,000-$122).

- If the amount of total payment exceeds 10 percent of the *community spouse* asset share (see Section 18.4.3 Calculate the Community Spouse Asset Share), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:
  - Specify the service and the amount to be paid
  - Exist at the time the service is provided.

Example 3: Rosemary enters a nursing home and applies for Medicaid on November 1, 2016. When asked if she has transferred any assets in the past

36 months, Rosemary indicates that she paid her daughter $10,000 in exchange for her daughter providing personal care for her over the past two years. This $10,000 payment would ordinarily be counted as a divestment since it is above 10 percent of Rosemary's community spouse asset share; however, she shows you a written, notarized statement, dated October 9, 2014, in which she promises to pay $10,000 to her daughter for the specified care. As a result, there is no divestment.

If there is no community spouse, use 10 percent of the highest possible community spouse asset share indicated in Section 18.4.3 Calculate the Community Spouse Asset Share.

17.8.2 Room and Board

If an institutionalized person has made room and board payments to a relative, *disregard* them if **both** the following are true:

- The payments do not exceed fair market value of the room and board.
- The payments are for periods when the institutionalized person was receiving the room and board.

If the room and board is paid after the person has been institutionalized, treat the payment as divestment unless **one** of the following is true:

- The payment is only for the month immediately preceding the month that he or she entered the institution.
- The person provides a written lease that existed during the time that he or she was receiving room and board from the relative.

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17.9 Income Divestment

Income received by an institutionalized person and transferred in the month of receipt is considered divestment.

Example 1: Mr. M. resides in a nursing home. He receives a pension check of $3,000 a month. Mr. M. immediately signs the check over to his son. This is a divestment.

Unless there is reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of living.

However, there may be divestment if the person transferred amounts of regularly scheduled income that he or she ordinarily would have received. Such a transfer usually takes the form of a transfer of the right to receive income.

When you find the institutionalized person has transferred income or the right to receive income, calculate a penalty period based on the total amount of income transferred.

Example 2: Donald transfers his rights to his $325,000 pension to his daughter. The *divested amount* is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

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17.10 Life Estates

17.10.1 Life Estates Introduction

A life estate is created when a property holder transfers ownership of the property to someone else and retains the right to live on the property and the income from it. The new owner of the property is referred to as the remainder person.

Because he or she no longer owns the property, the life estate holder does not have the right to sell or dispose of the property. Because he or she cannot sell or dispose of the property, it is not counted as an available asset to the life estate holder. If the remainder person applied for *EBD* Medicaid and did not live in the home, the property, minus the value of the life estate, would be counted as an available asset to him or her (the remainder interest).

The value of the life estate is also not considered an available asset to the life estate holder.

If the property holder transferred the property to the remainder person for less than *FMV*, a divestment has occurred. The *divested amount* is the FMV of the property at the time of the transfer minus the life estate value. To find the life estate value, multiply the FMV of the property by the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to the age of the life estate holder at the time the property was transferred.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant* or *member* agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if he or she thinks it is incorrect.

There can also be divestment if the life estate is terminated and the life estate holder is not paid for the value of the life estate. To calculate the divested amount, multiply the FMV of the property at the time the life estate was terminated by the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to the age of the life estate holder at the time the life estate was terminated.

Example 1: Marion gave her home to her son John, retaining a life estate. The FMV of the house at the time of the transfer was $87,000. Two years later, Marion applied for Family Care. Since the transfer of her home occurred in the look back

period, the worker will have to determine a divestment penalty period. The divestment amount is the FMV of the house as of the time of transfer, minus the life estate value.

To determine the life estate value, multiply $87,000 by .38642 (the number from the Section 39.1 Life Estate and Remainder Interest table that corresponds to 83 years old).

The divested amount is $87,000 - $33,618.54 = $53,381.46.

Example 2: Three years later, John (from Example 1 above) sold the home for the current FMV of $102,000, and Marion terminated the life estate. He took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate, so a divestment has occurred. The divestment amount is the life estate value at the time the life estate was terminated.

To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in Section 39.1 Life Estate and Remainder Interest that corresponds to Marion's age, 86, at the time the life estate was terminated.)

$102,000 X .33764 = $34,439.28

The divested amount is $34,439.28 (see Section 17.5.4 Penalty Period Begin Date for Members).

Example 3: James sold his home to his son Robert when he was 75 years old and the home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149).(See Section 39.1 Life Estate and Remainder Interest for this value.) Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, there was no divestment.

A year later, James moved to a *CBRF*, and the home was rented out; however, James continued to retain the life estate. The home is not an available asset to James even though he is no longer living in the home. Because he holds a life estate on the home, James is entitled to any income produced by the property. The net rent from the home is countable income for James (see Section 15.6.4 Self-Employed Income Sources).

17.10.2 Joint Owners

When two or more people hold a life estate on a property, determine the life estate value for each individual by dividing the FMV of the property by the number of life estate holders to find each individual's share of the FMV. Then calculate the life estate value

by multiplying the individual share of the FMV by the number in the Section 39.1 Life Estate and Remainder Interest table that corresponds with the individual's age at the time of the transfer or termination of the life estate.

Example 4: Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The FMV of the home at the time of the transfer was $140,000. At the time George was 82 and Marie was 68. One year later, George applied for Family Care. Since the transfer occurred in the look back period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment, the worker must first determine the life estate values.

$140,000 divided by 2 = $70,000

George's age at the time of the transfer was 82. Multiply 70,000 x .40295 (see Section 39.1 Life Estate and Remainder Interest for this value.) = 28,206.50

Marie's age at the time of transfer was 68. Multiply 70,000 X .63610 = 44,527.00

The total life estate value for both Marie and George is $72,733.50.

The divested amount is the FMV minus the life estate value ($140,000 - $72,733.50 = $67,266.50).

17.10.3 Purchase of a Life Estate in the Home of Another Person

The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser:

- Resides in the home for a period of at least 12 consecutive months after the date of purchase; **and**
- Received FMV for the purchase.

Residency

Apply the following rules to determine if a person has resided in the home for 12 consecutive months:

- The 12-month period may start immediately after the purchase or at any time after the purchase.
- Absences from the life estate home for less than 30 consecutive days will not affect the 12-month determination.

Example 5: Ralph purchases a life estate interest in his brother's home on January 5 and moves into that home on the same date. He goes to Florida on January 20 and returns to the home three weeks later on February 10. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

Absences from the life estate home for 30 days or more for vacations, trips, or to stay elsewhere result in the 12-month period starting over.

Example 6: Vicki purchases a life estate interest in her sister's home on January 20 and moves into that home on the same date. On March 3, Vicki goes to Bermuda for a family vacation and returns on April 15. Since Vicki was absent from the home for 30 or more consecutive days, the consecutive month of residency string is broken. Vicki's 12-month residency clock is reset with April being her "new" first month of residency.

Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count toward the 12 consecutive months. However, such absences do not result in the 12-month period starting over.

Example 7: Jim purchases a life estate interest in his cousin's home on January 20 and moves into that home on the same date. Jim continues to reside in the home until April 10, at which time he is hospitalized as a result of an auto accident. Jim remains in the hospital until August 5 when he is discharged and returns home. Jim continues to reside in the home from August 5 until December 24.

Jim's residency in the home for the months of January, February, March, and part of April count as four consecutive months of residency. The months of May, June, and July are not included in the consecutive month count because he is absent from the home for those full calendar months. However, the absence from the home for those months does not cause the 12-month clock to be restarted because Jim's absence was the result of his hospitalization. When Jim returns to the home on August 5, August counts as the fifth month of continuous residency. Jim will meet the 12 months of continuous residency requirement in March, the fifteenth month of his ownership.

If the 12-month residency requirement has not been met at the time of the application for *LTC* Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until the penalty period ends or the date the individual meets the 12-month residency requirement, whichever occurs first. There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

Fair Market Value

If the 12-month residency requirement has been met at the time of the application for LTC, the local agency must also determine if the applicant paid the FMV for the life estate. The FMV of the life estate is determined using the age of the life estate holder on the date that the life estate was created and the property's FMV on that date. Multiply the FMV by the life estate multiplier on the table in Section 39.1 Life Estate and Remainder Interest. The result is the value of the property's life estate interest as of that

date. If the applicant paid more than the life estate interest value, the difference is the divested amount.

Example 8: Joyce, who is 75 years old, has $200,000 in her savings account. On February 3, she gives $200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of this transfer was $300,000. Joyce moved into her son's home on March 5 and has resided there continuously for more than 12 consecutive months. Fifteen months after moving in, Joyce applies for a community waiver program and meets the functional screen and all other Medicaid eligibility requirements. Joyce also establishes that as of her application date for community waivers, she has resided in her son's home for more than 12 consecutive months.

The divestment issue that now needs to be resolved is whether or not Joyce received FMV for the $200,000 that was used to purchase the life estate. Using the table in Section 39.1 Life Estate and Remainder Interest, it is determined that Joyce's life estate interest was worth $156,447 at the time of the purchase. Since Joyce paid $200,000 for a life estate that was worth $156,447, the divested amount is $43,553. Joyce is subject to a penalty period.

When a couple jointly holds a life estate, the institutionalized *spouse* must reside in the home for 12 consecutive months or his or her portion of the life estate value will be considered a divestment. See Section 17.10.2 Joint Owners for instructions on calculating the spouse's portion of the life estate value.

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17.11 Annuities

17.11.1 Treatment of Revocable Annuities

The following policy applies to both an *annuity* purchased by a *member* and an annuity purchased by a *community spouse*.

1. Determining Resource Value
    a. When the annuity is revocable and the funds deposited can be withdrawn, the value of the annuity principal, plus accumulated interest, is a countable resource.
    b. When an annuity company will apply a financial penalty for early withdrawal of the funds in an annuity account, the amount that the member would receive upon full surrender of the annuity contract is the counted resource value of the annuity.
2. Treatment of Withdrawals and Interest
    a. When a member makes withdrawals from the principal or accumulated interest on an annuity account, the withdrawals are a conversion of a resource.
    b. Interest accruing on an annuity account that is paid to the *annuitant* as it is earned is excluded income.
    c. Interest earned on a revocable annuity that is left in the account to accumulate is not considered income but instead is considered as an increase in the resource value of the annuity account.

17.11.2 Evaluating Irrevocable Annuities for Divestment

17.11.2.1 Irrevocable Annuities That Are Not Considered Divestment

Irrevocable annuities that are not considered divestment must name the “Wisconsin Department of Health Services Estate Recovery Program” (hereafter referred to as “the State”) as the remainder *beneficiary* if purchased or created on or after January 1, 2009. In cases where there is a spouse, disabled child, or *minor* child, the State must be the beneficiary in the second position.

In addition, the annuity must be **one** of the following:

1. Created from funds in a Roth *IRA*, 408 IRA, or other employer-sponsored plan
2. Considered an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC) or a deemed IRA under a qualified employer plan (according to Sec. 408(q) of the IRC)

3. Purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business **and** be actuarially sound, meaning that it meets **all** of the following:

    - Provides substantially equal monthly payments with no balloon, deferred, or graduated payments (variations in payment amounts due to changes in interest rates are allowed)
    - Is *annuitized* for the individual or spouse (currently issuing payments)
    - Is a period-certain annuity that will return the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table.
    - The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the Period Life Table by 12).

Note: Annuities that provide for indefinite "lifetime payments" may not return the full principal and interest within the member's life expectancy and are not actuarially sound.

Example 1: The member applies for HBCW. He had invested in a Roth IRA while he was working. He converted the IRA to an irrevocable annuity when he retired 6 months ago and named the State as the beneficiary. Since the annuity meets the conditions above, the purchase of the annuity is not considered divestment.

Example 2: The member applied for Institutional Medicaid on 7/28. This is a community spouse case. On 7/18, the community spouse used $126,500.00 of the couple's resources to purchase an irrevocable 9-year period certain immediate annuity from the XYZ Life Insurance Company. The community spouse is the annuitant. The community spouse was 74-years-old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of $1,488.75 for a set period of 9 years or 108 total months. The insurance company will pay out a total of $160,785.00 over the period of the annuity contract.

The annuity names the State as the beneficiary in the position after the institutionalized spouse. The contract date of the annuity was 7/18 and the first monthly payment was issued on 8/18. The annuity, which was purchased by the community spouse, names the State as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the requirements above, the purchase of the annuity is not considered divestment. The monthly annuity payments count as income to the community spouse.

17.11.2.2 Irrevocable Annuities that are considered divestment

When the annuity does not meet the criteria in Section 17.11.2.1 above, the annuity is considered as a divestment. The value of the annuity is considered a divestment as of the date the annuity was purchased, or the date it became irrevocable, whichever is later.

Example 3: The member applied for HCBW on 9/15. Also on 9/15, the member used $20,000 of his cash resources to purchase an immediate annuity from the ABC Insurance Company. The contract date is 9/15 and the first payment will be issued on 10/15. The annuity will issue payments of $200 per month for 10 years (120 monthly payments). This would result in a return of $24,000 over the proposed period of the contract. The member is currently 79-years-old and has a life expectancy of 7.40 years (88.8 months). The annuity does not name the State as the primary beneficiary.

In this example, the annuity was purchased from a life insurance company, will issue regular monthly payments and is currently issuing payments. However, the annuity does not meet the requirements because the state is not named as the primary beneficiary and the proposed period of payments (10 years) exceeds the member's life expectancy (7.40 years). Therefore, the full purchase price of the annuity is considered divestment. (See MEH 17.5 for policy regarding the penalty period begin date.) The $200 per month annuity payments are also counted as income in determining eligibility.

17.11.3 Verification

1. Verify the terms of a revocable or irrevocable annuity by obtaining a copy of the annuity contract and account statements from the annuity or insurance company;
2. Verify the beneficiary of an irrevocable annuity by obtaining:
    a. A copy of the annuity application the member signed at the time the member purchased the annuity (Annuity contracts generally never contain the name of the annuity beneficiary. The beneficiary will be listed on the application that the member signed at the time the annuity was purchased. Usually, it is a one page form completed by hand.)

17.11.4 Disclosure

Beginning January1, 2009, all applicants for Medicaid long term care services and all members of Medicaid long term care services undergoing an eligibility review are required to disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouses have an interest.

This requirement also applies to annuities purchased before January 1, 2009, if any action is taken by the individual that changes either the course of payment from the annuity or the treatment of the income or principal of the annuity. These transactions include:

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annuitize the contract,
- A change in ownership, **or**
- Any other non-routine action not listed below.

The following types of changes and events would not subject an annuity purchased prior to January 1, 2009 to treatment under the new policy rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;
- Changes that occur based on terms of the annuities which existed prior to January 1, 2009 and which do not require a decision, election or action to take effect; **or**
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A separate annuity disclosure form (Annuity Information - Disclosure F-10192) must be completed by applicants for each annuity owned by the *applicant* or the applicant's community spouse in order to meet the disclosure requirement. This form must also be sent to *SSI* recipients who are applying for HCBW and MLTC programs. The Disclosure form must be sent to all applicants and recipients who indicate that they have an annuity. A copy of the completed form and any documents verifying the status of the annuity must be scanned into the electronic case file (ECF).

The Wisconsin Medicaid for the *Elderly*, Blind, and Disabled Application (F-10101) has been updated to collect additional information about annuities and provide information about the requirement to designate the State as a remainder beneficiary of the annuities owned by applicants for LTC Medicaid or their spouses.

If the applicant/ member or his or her spouse (or representative) refuses to disclose the required information related to the annuity, the applicant/member is ineligible for Medicaid for the failure to cooperate in providing requested information.

17.11.5 Remainder Beneficiary Designation

The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, F-10190) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.

When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days of the date the Notice of Obligation form was sent, the *IM* agency must contact the issuer by phone and request that the issuer respond within 10 days.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation (F-10190). Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until one of the following occur:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,
- Verification has been received that the beneficiary designation change is in process,
- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, **or**
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

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17.12 Promissory Notes

17.12.1 Promissory Notes Prior to January 1, 2009

It is divestment if an institutionalized person signs a promissory note prior to January 1, 2009, that has at least one of the following:

- A provision that forgives a portion of the principal
- A balloon payment
- Interest payments only with no principal payments
- An inadequate interest rate (relative to current market rates) at the time the promissory note was signed

17.12.2 Promissory Notes on or after January 1, 2009

The purchase of a promissory note, loan, land contract, or mortgage, on or after January 1, 2009, is a divestment unless such note, loan, land contract, or mortgage meets all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the person's life expectancy). The standards that must be used to decide whether or not a promissory note, loan, land contract, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the *SSA*. The standards are found in the Period Life Table, which is available on the SSA website. Use this table to calculate the person's life expectancy as of the date the promissory note, loan, and contract, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that he or she would receive payment in full during his or her lifetime.
- Provides for payments to be made in equal amounts during the term of the loan with no deferral or *balloon payments* made. (Note: Voluntary prepayments that exceed the required regular monthly payment amount are not considered balloon payments.)
- Does not allow cancellation of the promissory note, loan, land contract, or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically canceled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a promissory note, loan, land contract, or mortgage contains language to cancel the balance upon the death of the lender, the promissory note, loan, land contract, or mortgage can be amended to remove this language and avoid a divestment penalty.

If all of the criteria above are not met, the purchase of the promissory note, land contract, loan, or mortgage is a divestment. The *divested amount* is the value of the outstanding balance due on the promissory note, loan, land contract, or mortgage as of the date of application for Medicaid *LTC* services.

If all of the criteria above are met, the purchase of the promissory note, land contract, loan, or mortgage is not a divestment. This applies even if the promissory note, land contract, loan, or mortgage cannot be sold because it is not negotiable, assignable, enforceable, or otherwise marketable.

Example 1: On February 1, 2009, Mary gave her adult daughter $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of $100 per month for the first 47 months and a $45,300 payment in the 48th month. Twelve months later, on February 1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid LTC services (February 1, 2010), Mary's daughter has repaid her mother only $1,200, and the outstanding balance on the note is $48,800. Mary's divested amount is $48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 2: John purchased a $60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid LTC services is $40,000. The divested amount that will be used in calculating John's divestment penalty period is $40,000.

Example 3: Jean gave her adult son $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy with regular monthly payments. Later that year, Jean entered a nursing home and applied for Medicaid. Since the terms of the promissory note were actuarially sound (meeting all the conditions in Section 17.12.2 Promissory Notes on or After January 1, 2009), the transfer was not considered a divestment. As of the date of Jean's application for Medicaid LTC services, her son had repaid her only $1,200, and the outstanding balance on the note was $48,800. The promissory note would be considered an available asset for Jean with an assumed value of $48,800.

17.13 Trusts

17.13.1 Trusts Introduction

"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 that is similar to a trust.

"Legal instrument or device similar to a trust" means any legal instrument, 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 hold, manage, or administer the property for the benefit of the grantor or of the beneficiary. For purposes of this section, an individual shall be considered to have established a trust if assets of the individual are used to form all or part of the *corpus* (principal) of the trust.

"Grantor" may be:

1. The Medicaid *member*.
2. His or her *spouse*.
3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or his or her spouse. This includes a power of attorney or a guardian.
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or his or her spouse. This includes relatives, friends, volunteers, or authorized representatives.

17.13.2 Revocable Trusts

A *revocable trust* is a trust that can be revoked, canceled, or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

1. The trust principal of a revocable trust is an available asset. “Trust principal” is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.
2. All payments from the trust to or for the benefit of the institutionalized person are income.
3. All payments from the trust that are not to or for the benefit of the institutionalized person are divestment.

17.13.3 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

The following actions are divestment if they took place during the look back period (see Section 17.3 Look Back Period) or any time after:

1. An irrevocable trust was created. The *divested amount* is the total amount of the created trust.

   Sometimes revocable trusts contain a clause that causes them to become irrevocable at a later date in the life of the trust. Divestment occurs on the date the trust changed from revocable to irrevocable.

Example 1: In 1998, Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July 2008. He divested the total amount of the trust on February 2, 2007.

2. Funds were added to the irrevocable trust. The *divested amount* is the amount of the added funds.

If either of these actions took place before the look back period, apply the following rules:

1. Payments to the institutionalized person from trust income or from the body of the trust are income.
2. Payments that could be disbursed to the institutionalized person from trust income or from any portion of the body of the trust but that are not disbursed are available assets.
3. Payments from the trust to anyone other than the institutionalized person are divestment.

17.13.4 Exceptions

The policies described in this trusts section do not apply to any of the following trusts.

1. Annuities (see Section 17.11 Annuities).
2. Irrevocable burial trusts (see Section 16.5.1 Burial Trusts).
3. Trusts established by a will.
4. Special needs trust: A trust containing assets of a person under age 65 who is totally and permanently disabled (under *SSI* program rules). *Disregard* the trust if it meets the conditions in Section 16.6.5 Special Needs Trust.
5. Pooled trusts (Effective 09-01-08).
   Pooled Trusts Not Subject to Divestment
   Pooled Trusts Subject to Divestment
   Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled
   List of Pooled Trusts

I. Pooled Trusts Not Subject to Divestment

These are trusts for disabled persons as determined by SSI rules. Disregard them if they meet the following conditions:

a. Are established and managed by a non-profit association, **and**
b. Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit people who do not have a disability, **and**
c. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

Note: If a WISH trust includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member. This does not apply to a WisPACT trust**, and**

d. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.
    i. This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.
    ii. This requirement can also be satisfied when the pooled trust account includes real property, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid member who is disabled (as established under SSI rules) or elderly (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid member**, and**

e. The trust was established with the funds of a disabled individual of any age. These would be considered “self-funded” trusts, and the age of the disabled individual at the time the trust was created, is irrelevant.

II. Pooled Trusts Subject to Divestment

A pooled trust established with the funds of a third party on or after September 1, 2008, for a disabled individual, age 65 or over will not be exempt from the divestment penalty provisions, if the third party subsequently applies for Medicaid. The divestment penalty is applied to the third party who created the pooled trust unless the trust beneficiary is the third party's disabled child. Similarly, contributions/additions to a pooled trust by a third party, made after the disabled beneficiary turns 65 will also be subject to divestment penalty provisions if the third party (trust grantor) subsequently applies for Medicaid.

III. Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled

Third party funded pooled trusts for individuals applying for disability status are not subject to divestment if:

a. They have placed their assets in a potential pooled trust, and
b. They meet all of the conditions in 5 I above, and
c. The potential disabled individual has initiated the disability determination process prior to September 1, 2008, and
d. They are over age 65.

"Initiating the disability determination process" means that the individual must have asked either the county agency, the SSA, or DDB for a disability determination.

6. Trusts for Disabled Individuals. A trust for a disabled individual is a trust established solely for the benefit of the grantor's disabled child (regardless of the child's age), or solely for the benefit of any other disabled individual who is under 65 years of age. The disability status is the same as that which is determined under SSI rules. The exception continues after the beneficiary turns age 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns age 65, unless the beneficiary is his or her disabled child. Anything added to the trust after the beneficiary turns age 65 (except for a beneficiary who is the grantor's disabled child) is a divestment. Money added before the beneficiary turns age 65 is not a divestment.

Note: Unlike special needs and pooled trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" which becomes effective upon the death of the beneficiary.

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17.14 Both Spouses Institutionalized

If the *community spouse* made a divestment that resulted in a penalty period for the institutionalized *spouse* (see Section 17.4 Exceptions), split the remaining penalty period between the spouses at the time the community spouse enters an institution, applies for Medicaid, and is found otherwise eligible.

Example: Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited $84,000 and immediately transferred it to Mildred. Mildred gave it to her church. This divestment resulted in a penalty period for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be apportioned to both spouses.

The penalty period must be apportioned follows:

1. Find the *divested amount* that was used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:

a. Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days of the penalty period already served.

b. Subtracting the result from the original divested amount.

3. Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
4. Divide the new penalty period equally between the two spouses.

CARES will calculate the new penalty period and amount left to be served for workers to apportion to the spouse’s case.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

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17.15 Medicaid Card Services

Medicaid card services are all the Medicaid-covered services (see Section 21.1 Benefits Introduction) except *SNF*/*ICF* payments and ancillary services (Wis. Admin. Code § DHS 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid members by a nursing home and that are reimbursed within the daily care rate.

17.15.1 Nursing Home

A person who, because of divestment, is not eligible for services reimbursed within the daily institutional care rate is still eligible for Medicaid card services.

17.15.2 Home and Community-Based Waivers

Home and Community-Based Waivers (HCBW) applicants/members who have divested cannot be tested using HCBW eligibility criteria. They are only eligible for card services if eligible under non-LTC Medicaid methodology (such as for *SSI*-Related Medicaid, *MAPP*).

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18 Spousal Impoverishment

18.1 Spousal Impoverishment Introduction

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular Medicaid financial limits. Spousal impoverishment policy applies to institutionalized persons. For purposes of spousal impoverishment, an institutionalized person means someone who:

1. Participates in Group B or B Plus Home and Community-Based Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution, or
4. Is residing in an *IMD*. There is no 30 day requirement for this population.

Note: An individual is not considered “institutionalized” for purposes of spousal impoverishment if he or she has resided in a medical institution for 30 or more consecutive days, is likely to reside in a medical institution for 30 or more consecutive days, or is residing in an IMD, and the sole purpose for residing in the medical institution or IMD is to receive residential substance use disorder treatment.

The policy's purpose is to prevent impoverishment of the *community spouse*. A community spouse is:

1. Married to an institutionalized person and
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community spouse is not an institutionalized person residing in an institution, his or her living arrangement can have no effect on his or her asset share (see Section 18.4.3. Calculate the Community Spouse Asset Share) or income allocation (see Section 18.6.2 Community Spouse Income Allocation).

Example 1: Joe is an institutionalized person living in a nursing home. His wife, Carla, is receiving HCBW services in a *CBRF*. Because Carla is not residing in a medical institution, Joe’s eligibility is determined using Spousal Impoverishment rules.

Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, he or she is allowed to retain additional assets and income without liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See Section 2.5.3 Spousal Impoverishment Medicaid Signatures for application and review signature requirements.

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18.3 Spousal Impoverishment Requirements

All institutionalized persons applying for Medicaid must meet the same nonfinancial requirements. *Spousal impoverishment* policy introduces no changes in Medicaid nonfinancial tests.

On the financial side:

1. **Assets**. The assets of both the institutionalized person and his or her *community spouse* are counted in the asset test.
2. **Income**. The income limit is the same as that for non-spousal impoverishment institutionalized persons. But, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse and family.

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18.4 Spousal Impoverishment Assets

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his or her *community spouse*. (**Note**: *Disregard* prenuptial agreements. They have no effect on *spousal impoverishment* determinations.) Add together all countable, available assets (see Section 16.1 Assets Introduction) the couple owns.

Do not count the following assets:

- *Homestead* property. If the institutionalized person and the community spouse each own home property and meet the criteria in Section 16.8.1.3 Exempt Home Property, exempt the institutionalized person's home but not the community spouse's home.

Example 1: One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home but exempt the spouse's home. Both homes cannot be exempt simultaneously.

- One vehicle, regardless of value or purpose. If the *AG* has more than one vehicle, completely disregard the vehicle with the highest equity value, regardless of purpose. Then, for the remaining vehicles, follow the *EBD* rules for vehicles (see Section 16.7.9 Vehicles [Automobiles]). Note: Do not allow additional vehicles to be exempted under Section 16.7.9, unless they meet the definition to exempt under the provisions for property essential to self-support, plan to achieve self-support or temporarily inoperable as outlined in the section.

  Example: Howard is applying for benefits. Howard is in an institution and Marianne is his community spouse. They own a boat with an equity value of $10,000 and an automobile with an equity value of $7,000. Because the boat has a higher equity value, it is disregarded. The automobile does not meet the criteria for exemption and so is a counted asset; count $7,000 in the asset assessment and the asset determination.
- All assets designated for burial purposes. This includes burial assets owned by the applicant/member and/or the community spouse for a child(ren).

- Any unreasonable amount should be supported by documentation of the burial-related costs or contract.

  Do not allow applicants and members to simply state that they are setting aside an unreasonable amount of cash (e.g., $1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

  For example, ask the *member* to document that he or she has arranged to purchase a $100,000 casket or that a funeral home will provide them with a $75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

  This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (see Section 16.5 Burial Assets).

- Household goods and personal items, regardless of their value.
- All assets not counted in determining EBD Medicaid eligibility.
- *IRA* and work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs of an ineligible community spouse (see Section 16.7.20 Retirement Benefits).

18.4.2 Asset Assessment

The *IM* agency must make an assessment of the total countable assets of the couple at one of the following, whichever is earlier:

- The beginning of the person's first continuous period of institutionalization of 30 days or more.
- The date the person was determined functionally eligible for *HCBW*s.

Complete an asset assessment when a person applies, even if he or she had one done in the past, to get the most current asset share.

If a member was not married on the first date of institutionalization or waivers request, apply the policy from the point he or she is married. If he or she has remarried since the first date of institutionalization or waivers request, apply the policy from the date he or she married his or her current spouse.

The IM agency should inform the person for whom an assessment is being made what documentation is required. He or she must document ownership interest in and the

value of any available assets the couple had at the time of his or her first period of continuous institutionalization. The same documentation procedures are used as when an application is filed (see Section 20.1 Verification Introduction).

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	**Then the community spouse asset share is:**
$260,760 or more	$130,380
Less than $260,760 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

18.4.4 Asset Test

When an institutionalized person applies for Medicaid, compare the total countable assets of the couple to $2,000 plus the greater of one of the following:

- Community spouse asset share.
- An amount ordered by a court or fair hearing.

If assets at the time of application are equal to or less than this amount, the institutionalized person is eligible. If they are more, the institutionalized person is not eligible.

18.4.5 Undue Hardship

An institutionalized person will not be denied Medicaid if the IM agency determines that the ineligibility caused by excess assets creates undue hardship for him or her (see Section 22.4 Undue Hardship for more information).

18.4.6 Asset Transfer

After the institutionalized person is found eligible, he or she may transfer assets to the community spouse. The maximum amount he or she can transfer is the community spouse asset share (or a greater amount ordered by a court or a fair hearing). If the community spouse already has some assets, the institutionalized person can transfer assets which, when added to the community spouse's assets, equal the community spouse asset share (or an amount ordered by a court or a fair hearing).

He or she is not allowed to transfer assets for less than *fair market value* to anyone other than the community spouse.

18.4.6.1 Asset Transfer Period

The institutionalized spouse must transfer the assets to the community spouse by the next regularly scheduled review (12 months). If his or her assets are above $2,000 on the date of the next scheduled review, he or she will be determined ineligible. He or she will remain ineligible until his or her assets no longer exceed the $2,000 Medicaid asset limit.

Example 2: Robert was first institutionalized September 2013. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2013. The couple's total combined assets were $42,000, $32,000 of which were owned solely by Robert. Robert had until the next scheduled review (August 2014) to get his total assets under the $2,000 Medicaid asset limit.

CARES does not generate sufficient notice regarding the transfer of assets by the next scheduled renewal. See Section 18.8 Spousal Impoverishment Notices for information on manual notices that must be sent to the couple.

By August 2014, Robert had only transferred $23,000 to Lucinda. Robert still had $9,000 in assets. Robert became ineligible September 2014 and will remain ineligible as long as his assets are over $2,000.

18.4.6.1.1 Leaves Institution or Becomes Ineligible During the 12-Month Transfer Period

If the institutionalized spouse **during** the 12-month transfer period:

1. Leaves the institution for 30 days or more **and** becomes institutionalized again, **or**
2. Becomes ineligible for Medicaid **and** then becomes eligible for Medicaid once again, **or**
3. Changes from Group B/B+ waivers to Group A waivers then becomes eligible once again for Group B/B+ waivers all within the 12-month transfer period.

The time allowed to transfer assets does not start over again.

If the individual left the institution or became ineligible during the 12-month transfer period, without regaining eligibility during the 12-month transfer period, and reapplies for

long-term care **after** the 12- month transfer period has ended, he/she is eligible for a new transfer period.

Example 3: Daniel is in a nursing home, while Susan, his wife is in the community. Daniel is found eligible for Medicaid beginning March 28, 2020 (the date of institutionalization), starting the 12-month asset transfer period. In May 2020, Daniel is discharged from the nursing home and his Medicaid eligibility ends. In July 2020, Daniel returns to the nursing home. Because Daniel became institutionalized again within the 12-month transfer period, the transfer period does not start over.

Example 4: Betsy was admitted to the nursing home on April 14, 2018 and applied for Medicaid on June 6, requesting a two-month backdate. Nicholas, her husband, remains in the community. Betsy was discharged from the nursing home on May 7, 2019, the 12th month of her asset transfer period. Betsy returns to the nursing home on March 6, 2020 and reapplies for Medicaid on March 13. Because Betsy returned to the nursing home after her 12-month transfer period, she is allowed a new asset transfer period.

18.4.6.1.2 Change in Marital Status During the 12-Month Transfer Period

If the community spouse passes away or is no longer married to the institutionalized person, then spousal impoverishment rules no longer apply and the institutionalized person is subject to the $2,000 asset limit.

Example 5: Sue was institutionalized in July 2017 and was married to Tom, who resided in the community. Sue was eligible for Medicaid in July 2017 and had until June 2018 to get under the $2,000 asset limit. On September 20, 2017, Sue reports that Tom passed away. Because spousal impoverishment rules no longer apply for ongoing eligibility, Sue would be subjected to the $2,000 asset limit beginning November 2017.

18.4.6.2 Institutionalized Spouse Is Eligible After the 12-Month Transfer Period

18.4.6.2.1 Leaves Institution for 30 or More Days Then Is Reinstitutionalized

If the institutionalized spouse remains in the institution and Medicaid-eligible after the expiration of the 12-month transfer period but then leaves the institution for 30 days or more and subsequently becomes institutionalized once again for 30 days or more, he or she would be subject to all spousal impoverishment rules upon becoming reinstitutionalized. This includes all of the following:

- An asset assessment (see Section 18.4.2 Asset Assessment) would be required for the purpose of determining the community spouse asset share.
- The couple would have to once again pass a joint asset test.

- The institutionalized spouse would receive another 12-month period to transfer all of his or her assets in excess of $2,000 to his or her community spouse.

Example 6: Peter was institutionalized and determined Medicaid eligible in March of 2002. Janice, Peter's wife, remained in the community. In February 2003, Peter's assets were below $2,000. Peter remained Medicaid eligible and institutionalized through May 2003. In June 2003, Peter left the nursing home and joined Janice in their home in the community. His Medicaid eligibility ended on June 30, 2003.

In August 2003, Peter inherited $100,000. In September 2003, Peter's condition worsened and he was institutionalized again and applied for Medicaid. All spousal impoverishment rules would be applied to Peter's September 2003 application. His eligibility would be based on a joint asset test, and, if eligible, he would have 12 months to transfer assets in his name that exceed $2,000 to his wife.

18.4.6.2.2 Loses Medicaid Eligibility but Remains Institutionalized

If the institutionalized spouse remains in the institution and remains Medicaid eligible after the 12-month transfer period but subsequently becomes ineligible and remains institutionalized, spousal impoverishment asset rules would not be applicable if he or she should reapply.

If the institutionalized spouse reapplies for Medicaid, his or her asset limit would be $2,000 and the community spouse's assets would not be counted.

If eligible, the institutionalized spouse would still be allowed to allocate some of his or her income to the community spouse.

Example 7: Gregory was institutionalized in December 2007. Gregory and his wife, Marcia, who remained in the community, passed the joint asset test. Gregory was found eligible and had until November 2008 to get under the $2,000 asset limit. By November 2008, Greg had transferred enough assets to Marcia to get under the asset limit.

In March 2009, while Gregory remained institutionalized, he refused to sign over to Medicaid a health insurance payment check. His Medicaid eligibility was discontinued March 31, 2009, for failure to cooperate with *TPL* requirements. Greg has never left the institution and now reapplies for Medicaid on June 3, 2009. Since Greg did not leave the institution for 30 days or more since his original Medicaid spousal impoverishment application was approved (December 2007), the assets of his community spouse are not counted when determining eligibility for the application filed June 2009. Greg's asset limit for this application is $2,000.

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18.5 Spousal Impoverishment Income

The income limit is the same as for institutionalized persons who do not have a *community spouse* (see Section 39.4 EBD Assets and Income Tables).

18.5.1 Nontrust Income

Count non-trust income as belonging to the person who receives the payment.

1. If the payment is received in both *spouse*s' names, count half for each.
2. If the payment does not specify the payee, count half for each spouse .
3. If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him or her, whether voluntarily or under a court order.

18.5.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him or her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it is not assigned to a specific family member, divide it equally between those who receive it.

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18.6 Spousal Impoverishment Income Allocation

18.6.1 Spousal Impoverishment Income Allocation Introduction

After an institutionalized person is found eligible, he or she may allocate some of his or her income to the *community spouse* and dependent family members living with the community spouse. Income that is allocated for the community spouse must actually be given to the community spouse each month in order for it to be allowed as a post-eligibility income deduction for the institutionalized spouse. However, income that is allocated for a dependent family does not have to be actually given to the dependent family member.

Dependent family members include:

- Dependent *minor* children (natural, adopted, step) of either parent who live with the community spouse.
- Children (natural, adopted, step), 18 years old or older, of either parent, who are claimed as dependents for tax purposes under the *IRC* and who live with the community spouse.
- Siblings of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.
- Parents of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

An institutionalized person must decide how much income to allocate. He or she may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or he or she may choose to allocate a lesser amount.

Since he or she may have medical costs that are not covered by Medicaid, he or she may wish to keep some income and not allocate it all.

Note: Income allocated to the community spouse is countable income for him or her and must be added to the community spouse's case.

Example 1: Caroline has monthly income of $400. She transfers $310 to her community spouse, keeping only her personal needs allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) and $45 to pay as her monthly patient liability. She incurs $80 in noncovered medical expenses each month. Those expenses will be charged first to her patient liability, but she must pay the remaining $35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.

18.6.2 Community Spouse Income Allocation

To determine how much of the institutionalized spouse's income to allocate:

1. The community spouse maximum income allocation is one of the following:
    a. $2,873.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,216.00.

"Excess shelter allowance" means shelter expenses above $862.00. Subtract $862.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,873.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

Community spouse shelter costs include the community spouse's expenses for:

- Rent
- Mortgage principal and interest
- Taxes and insurance for principal place of residence. This includes renters insurance.
- Any required maintenance fee if the community spouse lives in a condominium or cooperative.
- The standard utility allowance established under FoodShare:

If the community spouse pays:	**Add:**
Heat and utilities	Heating Standard Utility Allowance*
Utilities only	Limited Utility Allowance*
Telephone only	Phone Utility Allowance*
If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee. * See the FoodShare Wisconsin Handbook Section 8.1.3 Deductions for the current standard utility allowance amounts.	

For *HCBW* cases, follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:

- If the waiver person's community spouse lives with him or her, do not add the excess shelter cost to the income allocation.

- If the waiver person's community spouse does not live with him or her, add the excess shelter cost to the income allocation.

b. A larger amount ordered by a fair hearing decision or a court order. A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his or her necessary and basic maintenance needs with the amount allocated.

2. The maximum allocated amount is the difference between the allowable community spouse income allocation and the community spouse's monthly gross income. Use the *EBD* income rules, but do not give earned income, unearned income, and work-related deductions.

The institutionalized spouse may choose to allocate less than the maximum amount.

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $718.34 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $718.34 and the actual monthly income of the dependent family member.

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18.7 Reserved

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18.8 Spousal Impoverishment Notices

After the institutionalized person has been determined Medicaid eligible, the worker must send the following manual notices to both spouses:

1. Notice of Medicaid Income Allocation (F-10097). This notice contains the amount of income allocated to the *community spouse* and the amount of the institutionalized person's cost of care contribution. This notice must also be completed any time there is a change in the allocated amount.
2. Medicaid Recipient Asset Allocation Notice (F-10098). This notice specifies the amount of assets the member must transfer to the community spouse in order to retain Medicaid eligibility. It also specifies the date by which the transfer must be made.

Note: The Notice of Medicaid Income Allocation (F-10097) and Medicaid Recipient Asset Allocation Notice (F-10098) are not required to be sent for Group A eligible Waiver cases.

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18.9 Community Spouse's Medicaid Application

Count assets and income allocated and transferred to the *community spouse* by the institutionalized person when determining the community spouse's Medicaid eligibility. Beyond these, count only the assets and income belonging to the community spouse.

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18.10 Dual Spousal Impoverishment Cases

When both *spouses* are applying for community waivers, Family Care, or *PACE*/Partnership, and neither spouse resides in a medical institution, both eligibility determinations are done using spousal impoverishment policies.

The eligibility determination for both spouses is done on one case if the couple resides together.

Since income allocated to a *community spouse* is counted as income for that spouse, the couple should decide which spouse should allocate to the other spouse and how much to allocate.

One spouse may have more income or less expenses, so he or she could allocate to the other spouse with less income or more expenses. Each case will have to be assessed individually and the income allocation adjusted to meet the needs of the couple.

For instructions on entering income allocated paid out and allocated income received, see Process Help Section 11.5.3.1 Income Allocation in Dual Spouse Cases.

Asset Eligibility for Dual Spousal Cases

When both spouses are applying for Waivers and neither spouse resides in a medical institution, an asset assessment should be done for both spouses using the couple's combined assets. Both are tested using the Community Spouse Asset Share calculated with the asset assessment plus $2,000.

Asset Transfer Period

Both spouses have 12 months from the time of application to decrease their countable assets to less than $2,000. The assets can be transferred from one spouse to the other and used to purchase other exempt assets such as burial assets. The assets can also be used on other necessary living expenses for either spouse. Both spouses must have their countable assets below $2,000 at the next regularly scheduled renewal to remain eligible.

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19 Reserved

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PROGRAM ADMIN. (CHS. 20 - 23)

20 Verification

20.1 Verification

20.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances.

If the *member* is applying for other programs of assistance or if you are looking for sources of verification, see the specific verification chapters for those programs in their respective handbooks.

20.1.2 Documentation

Documentation is a method by which you accomplish verification. Case comments in *CWW* provide documentation, including worker notes regarding collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate *IM* agency or the next business day if verification is delivered after the agency's regularly scheduled business hours. IM agencies must stamp the receipt date on each piece of verification provided.

20.1.4 Verification 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.
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, email, or 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.

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 he or she requests help or has difficulty in obtaining it.

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

1. The applicant/member does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance.

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

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20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

Verify the following mandatory items:

1. *SSN* (see Section 20.3.2 Social Security Number).
2. Alien Status (see Section 7.3 Immigrants).
3. *Disability* and Incapacitation (see Section 5.2 Determination of Disability).
4. Assets for the *Elderly*, Blind, and Disabled (see Section 16.1 Assets Introduction).
5. Divestment, for EBD long-term care (see Section 17.1 Divestment Introduction).
6. Medical expenses, for deductibles only (see Section 24.7 Meeting the Deductible).
7. Medical/remedial expenses for noncovered services for an institutionalized person (see Section 27.7.7.2 Disallowed Expenses).
8. Documentation for Power of Attorney and Guardianship (see Section 20.3.7 Power of Attorney and Guardianship).
9. Migrant workers eligibility in another state (see Section 31.2 Simplified Application), if applicable.
10. Physician certification (verbally or in writing) that the person is likely to return to the home or apartment within six months for institutionalized persons maintaining a home or property (see Section 15.7.1 Maintaining Home or Apartment) and is entitled to a home maintenance allowance.
11. Income.
12. Citizenship and Identity (see Section 7.2 Documenting Citizenship and Identity).

Accept self declaration for all other items, unless you document them as questionable.

20.3.2 Social Security Number

Social security numbers (SSNs) need to be furnished for household members requesting Medicaid unless they are exempt from the SSN requirement (see Section 10.1.1 Social Security Number Requirements). SSNs are not required from non-applicants.

An *applicant* is not required to provide a document or social security card. He or she 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 a SSN, he or she must be willing to apply for one.

Agencies must assist any household that requests help with applying for an SSN for any applicant or member who does not have one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

Health care eligibility may not be delayed if the person is otherwise eligible for benefits and any of the following are true:

- The person has provided an SSN, even if the SSN has not yet been verified.
- The person has requested assistance with applying for an SSN.
- The person has verified that he or she has applied for an SSN.

In cases where an application for SSN has been filed with the Social Security Administration, an SSN must be provided by the time of the next health care renewal for the case or health care eligibility will be terminated for that individual. In addition, if eligibility for another program pends for provision of an SSN and the SSN application date on file is six months or older, eligibility for health care will also pend. Members must be given a minimum of 10 days to provide an SSN, but if they do not, health care eligibility must be terminated.

Even when citizenship cannot be verified due to a lack of a verified SSN, health care benefits should not be pended for lack of an SSN during the reasonable opportunity period for verification of citizenship (see Section 7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship).

20.3.2.1 Fraudulent Use of SSN

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 cannot 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:

- Recommend further action be taken.
- 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.

20.3.3 Immigration Status

Verification of the individual's immigration status is done through the *FDSH* or the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for BadgerCare Plus Prenatal Program (see BadgerCare Plus Handbook, Chapter 41 BadgerCare Plus Prenatal Program) and people applying for Emergency Services (see Chapter 34 Emergency Services do not have to verify their immigration status.

Applicants who are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits during the reasonable opportunity period (see Section 7.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status.

20.3.4 Disability

Disability and blindness determinations are made by the *DDB* in the *DHS*. Items that can be used to verify disability status include, but are not limited to:

- Proof of *SSI* or other SS Disability payment,
- SOLQ-I,
- Award letter or verbal statement from *SSA*, or
- Proof of *MADA* approval, including presumptive disability

20.3.5 Assets

Verification of *countable assets* is mandatory.

Note: The value of exempt assets, such as an EBD Medicaid member's burial plot, may not be verified unless the worker has information that deems the member-reported amount to be questionable.

If reported assets exceed the asset limit, do not pursue verification.

Do not verify cash on hand.

Verify AVS liquid assets using the Asset Verification System (AVS) integrated within CARES Worker Web. If current asset information is not available through AVS, the applicant/member is required to verify their assets through other sources (for example, bank statements). Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

20.3.5.1 Divestment

Verify if a member or *spouse* has divested assets when determining eligibility for institutional Medicaid and community waivers (see Section 17.1 Divestment Introduction).

20.3.5.2 Reasonable Compatibility for Assets

As defined in federal regulations, information from an electronic data source (in this case, AVS) is reasonably compatible if it results in the same eligibility outcome as self-reported information.

- If the individual reports assets that are above a given asset limit, the self-reported asset information will be used to deny or terminate health care benefits, regardless of what the outcome would be from using AVS information. Verification is not required.
- If both AVS and the self-reported information put the individual's total countable assets below a given asset limit, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
- If AVS puts the individual's total countable assets above a given asset limit, but the self-reported information puts his or her total countable assets below that same limit, the two data sources are not reasonably compatible and further verification is required as a condition of eligibility.

The reasonable compatibility test will only be applied to AVS liquid assets that have not otherwise been verified (for example, if a member submits bank statements as part of their initial application, or if the asset has been verified by another program). It can only be applied when asset information is available through the Asset Verification System.

20.3.5.2.1 Determination of Reasonable Compatibility

The reasonable compatibility test will be performed during the eligibility determination for EBD Medicaid if there is an AVS-returned amount for at least one unverified liquid asset. To determine reasonable compatibility, CARES will perform the following calculations:

Calculation	Description
1: Total Countable Assets (Self-Reported)	Sum of all the self-reported amounts for all countable assets. If the self-reported countable assets are over the asset limit, eligibility will fail right away and no reasonable compatibility test will be performed.
2: Total Countable Assets (AVS and/or Self-Reported)	Sum of the following: • All verified, countable asset amounts.

	• For all countable AVS assets, if an AVS amount was returned for an asset and that asset has not been verified: the higher of the AVS-returned or the unverified self-reported amounts. • All unverified, self-reported countable asset amounts with no AVS match, including non-AVS assets. • All countable AVS assets that were not reported.

CARES will compare the results of calculations 1 and 2 to determine reasonable compatibility.

- **If reasonably compatible**, verification of the AVS-matched asset amounts will not be requested, and eligibility will not pend for verification of these assets, even when there is a ?, Q?, WN, NV, or QV in the verification field. If otherwise eligible, the individual will receive a Notice of Decision listing the self-reported asset amounts. If eligibility is pending for other assets, a Verification Checklist will be sent.
- **If not reasonably compatible**, a Verification Checklist will be sent to the individual to request verification for all assets for which the individual has not already provided verification. If the individual does not provide the requested verification by the due date, eligibility will be denied or terminated for lack of verification.

Note: When there is an MSP request in addition to a request for EBD Medicaid, an additional, separate reasonable compatibility determination will be performed for MSP. In situations where the assets are reasonably compatible for MSP but exceed the asset limit for other programs, the individual may enroll in MSP without being required to provide further verification of assets for that program.

If an individual is applying for health care and has also requested MAPP, the reasonable compatibility test may provide different results based on the EBD Medicaid and MAPP asset limits. Because CARES considers these two programs to be part of the same health care request, the reasonable compatibility test will be performed using the MAPP asset limits only if the individual is found ineligible for EBD Medicaid because of excess assets or failure to provide verification of assets. This means an individual can still be eligible for MAPP based on the reasonable compatibility test for assets, even if they failed to submit verification of assets as required for EBD Medicaid (see Example 2 below).

If the worker is running with dates and an AVS amount is entered for a given asset, the reasonable compatibility test will be performed as long as the eligibility month is June 2018 or later.

The following examples show various results of the reasonable compatibility test.

Example 1: Lauren applies for EBD Medicaid and reports the following asset amount, without providing verification:

A. Checking account: $5

AVS returns the following information and the worker processes the information as shown:

- Savings account: $200 | Match with A
- Undisclosed checking account: $800 | Add as new information

Reasonable Compatibility Determination

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): **$5**
- 2. Total Countable Assets (AVS and/or Self-Reported): $200 + $800 = **$1,000**
- Result: **Reasonably Compatible**, because the sum of both calculations is less than the asset limit.

No further verification is requested from Lauren. A Notice of Decision is sent, listing only the self-reported amount.

Example 2: Mike applies for EBD Medicaid with a MAPP request and reports the following asset amounts, without providing verification:

A. Checking account: $500
B. Savings account: $700
C. Savings bond" $300 (non-AVS asset)

AVS returns the following information and the worker processes the information as shown:

- Checking account: $800 | Match with A
- Savings account: $400 | Match with B
- Undisclosed checking account: $900 | Add as new information

Reasonable Compatibility Determination for EBD Medicaid

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700**
- Result: **Not Reasonably Compatible**, because the sum of countable assets from data sources is above the EBD Medicaid asset limit.

In this case, the $700 savings account amount is used when calculating the total countable assets based on data sources, as it is the higher of the self-reported and AVS-returned information. A Verification Checklist is sent to Mike. All self-reported assets and the undisclosed checking account returned by AVS are included in the Proof Needed section.

If Mike provides verification of his assets and is found to be over the $2,000 asset limit for EBD Medicaid, CARES will then consider his MAPP eligibility without a reasonable compatibility test because all assets have been verified. If he meets all financial and non-financial rules for MAPP, his MAPP eligibility will be approved.

However, if Mike provides verification of his savings bond (the non-AVS asset) but fails to verify his checking and savings accounts, CARES will consider his MAPP eligibility using a reasonable compatibility test based on the MAPP asset limit.

Reasonable Compatibility Determination for MAPP

- MAPP Asset Limit: $15,000
- Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500**
- Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700**
- Result: **Reasonably Compatible**, because the sum of countable assets from data sources is below the MAPP asset limit.

No further verification is requested from Mike. A Notice of Decision is sent, listing only the self-reported amounts.

Example 3: Tasha applies for EBD Medicaid and MSP and reports the following asset amounts, without providing verification:

A. Checking account: $1,000
B. Savings account: $500

AVS returns the following information and the worker processes the information as shown:

- Checking account: $2,000 | Match with A
- Savings account: $2,500 | Match with B

Reasonable Compatibility Determination for EBD Medicaid

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500**
- Result: **Not Reasonably Compatible for EBD Medicaid** because the sum of countable assets from data sources is above the EBD Medicaid asset limit.

Reasonable Compatibility Determination for MSP

- MSP Asset Limit: $7,730
- 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500**
- Result: **Reasonably Compatible for MSP** because the sum of countable assets from data sources is below the MSP asset limit.

A Verification Checklist is sent to the Tasha to request verification of the checking and savings account for EBD Medicaid. However, if Tasha does not return verification of these accounts, she will remain eligible for MSP.

20.3.5.2.2 Programs for Which Reasonable Compatibility Will Apply

The reasonable compatibility test will be performed as part of any eligibility determination for all EBD Medicaid programs with asset tests.

Populations not subject to an asset test (for example, children under age 19 and children who are members of the Children's Long-Term Support Waiver Program) will not have a reasonable compatibility test.

20.3.6 Medical or Remedial Expenses

Medical or remedial expenses used to meet a deductible or calculate patient liability, cost share, or premium amounts must be verified. The expense amount, any third party liability amount, and date of service must all be verified. If verification is not provided, do not include the expense to determine when a deductible has been met or in the liability, cost share, or premium calculation. Do not deny or terminate eligibility for failure to provide the requested verification.

For HCBW, Family Care, Family Care Partnership, PACE, and IRIS members, Care Managers, ADRC staff, and IRIS Consultant Agencies (ICAs) calculate medical and remedial expenses. Because care managers, ADRC staff, and ICAs already verify all medical and remedial expenses before reporting those expenses to IM, additional verification is not needed. Refer to 28.6.4.5 Medical/Remedial Expenses.

20.3.7 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. For applications and other relevant applicant information, refer to Power of Attorney as "Power of Attorney for Finances."

The *IM* agency must determine the guardianship type specified by the court. Only the person designated as "guardian of the estate," "guardian of the person and estate," or "guardian in general" may attest to the accuracy of the information on the application form and sign it. Do not require a "conservator" or "guardian of the person" to sign the application form.

If verification is not provided, do not grant the claimed power of attorney or guardian access to case notices or follow any direction provided by that person unless he or she is an authorized representative. Do not deny or terminate eligibility for failure to provide the requested verification.

20.3.8 Income

Verify all sources of nonexempt income for EBD Medicaid applicants and members. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/member is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e., checkstubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

a. Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member);
b. Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.
c. Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment, pensions, retirement income, etc.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e. check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely 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. In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

Note: Accept a member's or suspended member's statement and do not require verification of income earned by an inmate from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). See Section 15.5.18 Prison or Jail Job.

20.3.8.1 Reasonable Compatibility for Income for Health Care

This section addresses reasonable compatibility for income. Reasonable compatibility for assets can be found in Section 20.3.5.2 Reasonable Compatibility for Assets.

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see Section 15.5.18 Prison or Jail Job), or information

from the data source is not “reasonably compatible” with what the applicant has reported. Information from the data source is “reasonably compatible” if it results in the same eligibility outcome as member-reported information:

- If both the electronic data source and the member-reported information put the individual’s total countable income below a given income threshold, the two data sources are considered to be reasonably compatible and **further verification may not be requested or required.**
- If the electronic data source puts the individual’s total countable income above a given income threshold, but the member-reported information puts the individual’s total countable income below that same threshold, the two data sources are not reasonably compatible and **further verification is required as a condition of eligibility.**
- If the member reports income that is above a given threshold, the member-reported income information will be used to deny or terminate health care benefits, regardless of what the outcome would be using information from the electronic data source. In this scenario, **verification is not required.**

The reasonable compatibility test will only be applied to job earnings that have not otherwise been verified (for example, as part of another program’s verification process). It can only be applied when earnings information is available through the State Wage Information Collection Agency (SWICA) or through Equifax from the Federal Data Services Hub (FDSH).

Unearned income (as defined in Section 15.4) will continue to be verified as outlined in this chapter and in Process Help Chapter 44. If there is an electronic data source available to use for verifying a type of unearned income, it should be used as verification for that income. If no data source is available, the applicant or member must provide verification of the unearned income.

Self-employment and in-kind job income will continue to be verified as outlined in Section 15.6 and 15.5.1 and Process Help Sections 16.2 and 16.6

20.3.8.1.1 Programs for Which Reasonable Compatibility Will Apply

The reasonable compatibility test will be performed as part of any eligibility determination for the following categories of Medicaid:

- Elderly, Blind or Disabled Medicaid (EBD MA), except deductibles
- Medicaid Purchase Plan (MAPP)
- Medicare Savings Program (QMB/SLMB/SLMB+)

20.3.8.1.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each AG for which earned income is reported, has not been already been verified, and for which SWICA and/or Equifax data is available. Because different AGs are subject to different income and premium thresholds, the thresholds described below will be used by population to determine whether reported information is reasonably compatible. Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

- EBD Categorically Needy SSI-Related MA and Medically Needy MA thresholds are based on the income limits shown in Section 39.4.1.
- MAPP and MSP thresholds are based on the income limits shown in Section 39.5.
- MAPP Premium thresholds are based on 100% FPL for a group of one as shown in Section 39.5. and described in the table below.

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	**And total gross income using the monthly earnings reported by SWICA or Equifax is:**	**Is it reasonably compatible?**
Below the MAPP premium threshold (100 percent of the FPL)	Below the MAPP premium threshold (100 percent of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
Below the MAPP premium threshold (100 percent of the FPL)	At or above the MAPP premium threshold (100 percent of the FPL)	No. Further verification must be requested.
At or above the MAPP premium threshold (100 percent of the FPL)	At or above the MAPP premium threshold (100 percent of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
At or above the MAPP premium threshold (100 percent of the FPL)	Below the MAPP premium threshold (100 percent of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

20.3.8.1.3 Reasonable Compatibility Test

The reasonable compatibility test is based on whether using member-reported information about earnings and information about earnings from data exchanges results in the same eligibility outcome when all other countable income is taken into account.

Reasonable compatibility will first be tested based on the household's total countable income as reported to the agency or verified through other sources. This test will determine whether the member is required to provide verification of earnings.

If the member-reported earnings amount is not reasonably compatible (based on the household's total reported income), verification of earnings will be required at the same time that verification is required for unearned income, self-employment, and/or tax deductions.

A second verification request will be required if the initial test leads to a determination of reasonable compatibility but the earnings are no longer reasonably compatible after other income types or deductions have been verified.

If earnings are determined to be reasonably compatible, the amount reported by the member should be used to determine eligibility and premium amounts for health care.

If the earnings are later verified (for example, because verification is required for another program), the verified earnings should then be used to determine eligibility and premium amounts for health care.

In this situation, members are not liable for overpayments because the initial determination was based on income that was reasonably compatible with a data exchange.

Members with eligibility determinations that were based on income that was reasonably compatible are subject to regular change reporting rules and can be subject to benefit recovery if they fail to report income that exceeds their reporting threshold.

20.3.8.1.4 Use of Equifax Data for Verification of Income

Agencies may not consider Equifax data to be the final "verified" income amount unless the Equifax data is the same as what the member reported. Agencies may not deny or terminate health care benefits based on earned income data received from Equifax without giving the applicant or member an opportunity to verify their reported earned income amount.

If the member reports that he or she is unable to obtain the requested verification, the worker should assist the member in obtaining verification (see Section 20.1.4). If the applicant and/or worker have made reasonable efforts to obtain verification and are not able to do so, then the agency should determine the income amount based on "best available" information, and then document how this amount was determined.

Note: The same policies for use of Equifax data apply when a member is reporting a change in income. Equifax data can be used for verification if it is the same as what the member has reported. If it is not the same, health care will apply a reasonable compatibility test to determine whether further verification is required.

20.3.9 Proof of Temporary Hardship for MAPP members

Verify a temporary hardship for MAPP applicants and members who apply for a temporary MAPP premium waiver due to hardship, Section 26.5.8.

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20.4 Questionable Items

20.4.1 Questionable Items Introduction

Information is questionable 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 or her representative is unsure of the accuracy of his or her own statements.
4. The member has been convicted of Medicaid member fraud or has legally acknowledged his or her guilt of member fraud.
5. The member is a *minor* who reports that he or she is living alone. This does not apply to minors applying solely for *FPOS*.
6. Unclear or vague (i.e., information provided, but not clear).

20.4.2 Tuberculosis

See BadgerCare Plus Handbook, Chapter 43 Tuberculosis-Related Medicaid for appropriate verification items if information provided is questionable.

20.4.3 Farm and Self-Employment Income

See Section 15.6.6 Verification for appropriate verification items if information provided is questionable.

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20.5 Member Responsibility

Assist the Member

The *IM* worker has a responsibility to use all available data exchanges to verify information, but the *member* has primary responsibility for providing verification. The member must likewise resolve questionable information. Do not deny eligibility when the member does not have the ability to produce verification.

Assist the member in obtaining verification if he or she 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 member does not have the power to produce verification, **and**
2. Information is not obtainable timely even with your assistance.

In this situation, seek verification later. When you have received the verification, you may need to adjust or recoup benefits based on the new information. Explain this to the member when requesting verification.

20.6 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 Section 12.3 FEV Case Application of the Income Maintenance Manual).

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20.7 When to Verify

Verify mandatory and questionable items at application, renewal, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. Do not reverify one time only verification items.

Exception: Veterans benefits, including allowances for Aid and Attendance, Housebound, and Unusual Medical Expenses usually increase only once a year, in January. If an *IM* agency verifies the January veterans benefit increase, it does not have to re-verify the veteran benefit income at the time of the next scheduled eligibility renewal, which occurs later in that same year. If another change in the veterans benefit does occur between January and the next scheduled eligibility renewal, that income change will have to be verified. This exception is being adopted to reduce the verification workload for both the IM agency and Veterans Administration staff, who routinely pursue and provide veterans benefit income verification every January.

20.7.1 Application and Renewal

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days. Advise the *applicant* of the specific verifications required within the 30-day processing time. Give the applicant a minimum of 10 calendar days to provide any necessary verification.

Do not deny eligibility for failure to provide the required verification until the later of:

1. The 10th day after requesting verification, **or**
2. The 30th day after the application filing date.

If you request verification more than ten days prior to the 30th day you must still allow the applicant 30 days from the application filing date to provide the required verification.

20.7.1.2 Eligibility Renewals

Do not deny the group's eligibility for failure to provide the required verification until the 10th day after requesting verification.

Example 1: Fred's eligibility renewal is due in April. He submits a paper renewal form on April 10. The worker requests verification of his income on April 11 with a due date of April 21. If the verification is not submitted by April 21, the worker would update the verification code on April 21 to QV and close benefits effective April 30. If Fred submits the verification by April 30 and is otherwise eligible, his benefits would reopen for May.

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 Medicaid eligibility would end June 30 because she had not yet completed her renewal. A telephone interview was conducted on June 30. A request for verification, with a July 10 due date, was sent to Shannon. Because the required verification (including signature) was not submitted by July 10, her eligibility beginning July 1 was denied.

20.7.1.3. Late Renewals

Effective December 22, 2014, agencies must accept and process health care renewals and renewal-related verifications up to three calendar months after the renewal due date. Late renewals are only permitted for individuals whose eligibility has ended because of lack of renewal and not for other reasons. *Members* whose health care benefits are closed for more than three months because of lack of renewal must reapply.

This policy will apply to the following programs:

- BadgerCare Plus (BC+)
- Family Planning Only Services (FPOS)
- SSI-related Medicaid
- Home and Community-Based Waivers (HCBW)
- Institutional Medicaid
- *MAPP*
- *MSP* (*QMB*/*SLMB*/*SLMB+*/*QDWI*)

The policy will apply to members receiving health care benefits based on a met deductible, but not to members with an unmet deductible.

Late submission of an online or paper renewal form, or a late renewal request by phone or in person, is a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verifications are required during the completion of a late renewal, the member will have 10 days to provide it.

Example 3: Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day and verification is requested, the verification will be due on March 25, 2015. If she provides verification on or before this due date and meets all other eligibility criteria, her eligibility and certification period will start on March 1, 2015. Her next renewal will be due February 28, 2016.

The three-month period starts from the month the renewal was due. It does not restart when a late renewal has been submitted.

Example 4: Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day, and verification is requested, the verification will be due on March 25, 2015. If Jenny does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date.

If a member has a gap in coverage because of his or her late renewal, he or she may request coverage of the past months in which the gap occurred and must provide all necessary information and verifications of income and assets for the current month and the gap months and must pay any required premiums to be covered for those months.

Because QMB coverage is not retroactive, the ability to request coverage for past months does not apply for this program.

Example 5: Jenny's renewal is due on January 31, 2015. She completes her renewal on January 20, 2015, and a VCL is generated requesting income verification for the 30 days prior to January 20. Jenny does not submit the requested verification, and her BadgerCare Plus eligibility is terminated as of January 31, 2015. On April 27, 2015, she submits her paystubs for April 10 and April 24. If she meets the eligibility criteria for BadgerCare Plus, her certification period will start on April 1, 2015, and her next renewal will be due March 31, 2016. If she had submitted the verification of her income for January, a new VCL should be generated asking for verification of her current income for April.

20.7.2 Changes

Advise the member of the specific verification required and allow a minimum of 10 days to provide it.

20.7.3 Date of Death Matches

When a Social Security Administration data exchange indicates that an eligible member or applicant has died and the IM agency has not received any other information to confirm the death, the member, another family member, or the member's representative must be allowed 10 days to correct any misinformation prior to benefits being impacted. For ongoing cases, the member for whom a death match was received will still be considered to be alive and benefits for the member or others on the case will not be changed or pended during this time. The case should be pended when verifications, such as earned income, are needed. Benefit changes due to changes in eligibility will still need to be processed. However, for an application, person add or renewal, it means allowing at least the minimum 10 days for a response before a worker confirms eligibility for the application, renewal or person/program add.

This 10-day period is known as the "refutation period." A letter is automatically sent to the primary person requesting a response if the individual is not deceased. The

response due date must be extended to a longer period to allow for mailing delays due to weekends or holidays (will follow the VCL due date logic). The refutation period may only be shortened when either:

- A member, family member, or his or her representative, confirms the date of death.
- A worker verifies a date of death through a third party source, such as a local newspaper obituary.

At the end of the refutation period, if no response is received from the member/applicant or the household, the date of death is considered verified and eligibility for the household must be redetermined and a notice of decision issued.

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20.8 Actions

20.8.1 Positive Actions

Begin or continue benefits when:

- The *member* provides requested verification within the specified time limits and is otherwise eligible.
- Requested verification is mandatory, but the member does not have the power to produce the verification and he or she is otherwise eligible.

20.8.2 Delay

Notify the member of a processing delay when:

- Verification is needed.
- He or she has the power to produce the verification.
- The minimum time period allowed for producing the verification has not passed.

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.

20.8.3 Negative Actions

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

- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- The requested verification is needed to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility.

Note: Do not deny or terminate eligibility for failure to verify expenses. The disallowance of unverified expenses is the only penalty to be imposed.

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20.9 Release of Information

You need someone's written release to get information from a verification source only when the source requires it.

When a source requires a written release:

1. Explain the requirement to the *member*.
2. Ask the member, his or her *spouse*, or another appropriate *adult* in the household to sign the necessary release form(s). The form may be:
    a. The CARES-generated or alternate pre-printed application forms.
    b. Release to Disability Determination Bureau form (F-14014).

Deny, discontinue or reduce benefits only when:

1. No appropriate person will sign the release form, and
2. The missing verification is necessary to determine eligibility, and
3. The member is unwilling or unable to provide the verification directly, and
4. The source requires a release, and
5. The release is the only way you can obtain the verification.

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20.10 Verification Resources

Workers can verify many sources of information, such as income, Social Security, *UC*, and birth records, through data exchanges. See Process Help Handbook Chapter 44 Data Exchange for instructions.

Verification of some liquid assets can be obtained electronically using the Asset Verification System (*AVS*). For instructions on using AVS, see Process Help Section 50.4 Asset Verification System (AVS).

Verification of immigration status can be obtained through the Federal Data Services Hub (FDSH) or the SAVE system. For instructions on using the SAVE system, see Process Help Handbook Chapter 82 SAVE.

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21 Benefits

21.1 Benefits Introduction

Medicaid covers many health care services. However, limitations apply that ensure only medically necessary services are provided.

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

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21.2 Full Benefit

Those subprograms of Medicaid that are eligible to receive full-benefit Medicaid services include:

1. Katie Beckett Medicaid (see Section 29.1 Katie Beckett)
2. *HCBWLTC* (see Section 28.1 Home and Community-Based Waivers Long-term Care Introduction)
3. Institutional Medicaid (see Section 27.1 Institutions)
4. BadgerCare Plus (see the BadgerCare Plus Handbook)
5. SSI-related Medicaid (categorically or medically needy)
6. *Foster Care* Medicaid (see the BadgerCare Plus Handbook)
7. Adoption Assistance Medicaid
8. Medicaid Met Deductibles (see Section 24.2 Medicaid Deductible Introduction)
9. *MAPP* (see Section 26.1 Medicaid Purchase Plan Introduction)
10. *WWWMA* (see Chapter 36 Wisconsin Well Woman Medicaid)
11. *SSI*-Medicaid

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21.3 Limited Benefit Medicaid

Limited benefit subprograms of Medicaid includes:

1. Medicare Savings Programs (see Section 32.1 Medicare Savings Programs).
2. Emergency Services for Non-Qualifying Aliens
3. *TB*-Related Medicaid (see See BadgerCare Plus Handbook, Chapter 43 Tuberculosis-Related Medicaid).
4. Presumptively Eligible Pregnant Women (see the BadgerCare Plus Handbook)
5. SeniorCare (see Section 33.1 SeniorCare Introduction)
6. Family Planning Only Services (see the BadgerCare Plus Handbook)

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21.4 Covered Services

21.4.1 Covered Services Introduction

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook.

A covered service is any medical service that Medicaid will pay for an eligible *member*, if billed. *DMS* enrolls qualified health care providers and reimburses them for providing Medicaid-covered services to eligible Medicaid members. Members may receive Medicaid services only from enrolled providers, except in medical emergencies. Medicaid reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-certified provider.

Medicaid providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain Medicaid services.

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid), including *SSI* recipients, are referred to as dual eligible individuals. Effective January 1, 2006, Medicaid no longer provides prescription drug coverage for these individuals. These dual eligible individuals do not have to file an application for "Extra Help" and are deemed eligible for "Extra Help" from *CMS* to pay their Medicare Part D costs.

A Medicare Part D Prescription Drug Plan (PDP) card will be issued to them, and it must be used for prescription drugs instead of their ForwardHealth card.

Individuals who are enrolled in Medicare (Part A and/or B) and are Medicare Beneficiaries (see Section 32.1 Medicare Savings Programs), except for *QDWI*, are also considered to be dual eligibles. These dual eligibles are also be deemed eligible for "Extra Help" from CMS to pay their Medicare Part D costs.

Examples of Medicaid covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. *FQHC* services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment & ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.

8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.
11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    a. under 21 years of age.
    b. under 22 years of age and received services immediately before reaching age 21.
    c. 65 years of age or older.
12. Intermediate care facility services, other than services at an institution for mental disease.
13. Laboratory and X-ray services.
14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services), including residential substance use disorder treatment.
32. TB services.
33. Transportation to obtain medical care.

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

21.4.2 Transportation

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, *SMV*, or common carrier.

21.4.2.1 Ambulance

Ambulance transportation is a covered service if it is provided by a BadgerCare Plus 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.

21.4.2.2 Specialized Medical Vehicle

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 Wis. Admin. Code § DHS 105.39.

SMV transportation is a covered service if provided by a BadgerCare Plus SMV enrolled provider and a health care provider has documented why the member's condition prevents him or her from using a common carrier or private vehicle.

21.4.2.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

21.4.2.4 Transportation Coordination

NEMT is coordinated by the *DHS* 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. Members must schedule routine rides at least two business days before their appointment.

The NEMT manager does not coordinate transportation for the following members:

- Members residing in a nursing home. Members residing in a nursing home have their NEMT services coordinated by the nursing home.

- Members enrolled in Family Care. Members enrolled in Family Care receive NEMT services from the Family Care *MCO*.

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21.5 Copayment

21.5.1 Introduction

An EBD Medicaid *member* may be required to pay a part of the cost of a service. This payment is called a “copayment” or “copay.”

21.5.2 Copay Exempt Populations

Providers are prohibited from collecting copays from the following members:

- Children under age 19 regardless of income or benefit program.
- Children in foster care, regardless of age. or
- Children in adoption assistance, regardless of age..
- American Indians 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, 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.
- Former Foster Care Youth
- Anyone receiving services through Express Enrollment
- Pregnant women

21.5.3 Copay Exempt Programs

Copays will not be charged for members enrolled in the following subprograms:

- Family Planning Only Services
- Institutional Medicaid (**not including** childless adults (CLAs) enrolled in BadgerCare Plus and residing in an institution)
- Katie Beckett
- Wisconsin Well Woman Medicaid

21.5.4 Copay Exempt Services

The following services do **not** require copayment:

- 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.
- Private Duty Nursing (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.
- Residential substance use disorder treatment services.
- School-based services.
- Substance abuse day treatment services.
- Surgical assistance.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

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21.6 HMO Enrollment

21.6.1 HMO Enrollment Introduction

Most Medicaid *members* who are eligible for BadgerCare Plus, MAPP, or SSI-related Medicaid and reside in a Medicaid 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 exemption from enrollment.

This is the enrollment process:

1. Members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.
2. If the member does not choose an HMO within two weeks of receiving the enrollment packet, he or she receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in an HMO.
3. If the member has not chosen an HMO after four weeks and lives in an area covered by two or more HMOs, he or she will be assigned an HMO. A letter explaining the assignment will be sent to him or her. He or she will receive another enrollment form and have an opportunity to change the assigned HMO.
4. He or she 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, he or she should contact the enrollment specialist at 1-800-291-2002.

21.6.2 Exemptions

A member may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns.

If the member believes he or she has a valid reason for exemption, he or she should call the HMO enrollment specialist at 1-800-291-2002. The number is also in the enrollment materials they receive.

21.6.3 Change of Circumstances

Members who lose Medicaid 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), he or she will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, if the HMO is no longer accepting reassignments, or if the HMO has exceeded its enrollment level, he or she will receive an enrollment packet, and the enrollment process will start over.

Note: The policies in this section also apply to members whose Medicaid was suspended due to incarceration but have regained full Medicaid eligibility upon release from jail or prison.

21.6.4 Disenrollment

Members are automatically disenrolled from the HMO program if:

- Their medical status code changes to a BadgerCare Plus or Medicaid subprogram that does not require enrollment in an HMO.
- They enroll in an Adult LTC program.
- They become eligible for Medicare.
- They lose eligibility.
- They move out of the HMO's service area.
- Their Medicaid is suspended due to incarceration in jail or prison.

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, he or she remains *fee-for-service*.

21.6.5 HMO Ombudsmen

Members with questions about their rights as HMO enrollees may call 1-800-760-0001 or write to:

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823

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21.7 ForwardHealth Cards

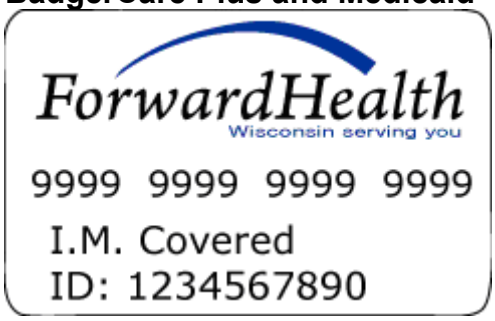
21.7.1 ForwardHealth Cards Introduction

ForwardHealth cards are issued to Medicaid *members*. These cards are permanent, plastic, and display the word "ForwardHealth" on them. Members use the same ForwardHealth card each month. Monthly cards are not issued.

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.

Cards should not be thrown away. If a member becomes eligible again, he or she will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can log into ACCESS or call Member Services at 1-800-362-3002.

BadgerCare Plus and Medicaid



SeniorCare

Each person in the family who is eligible for Medicaid receives his or her own card. The cards do not display eligibility dates. All Medicaid services are paid for under the Medicaid ID number on the card.

Members will know if they are eligible based on positive and negative notices sent from the *IM* agency. Members who receive a notice that they are no longer eligible for

Medicaid should keep their ForwardHealth cards. Cards should not be thrown away. If a member becomes eligible again,he or she will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can call you or Member Services at 1-800-362-3002.

21.7.2 Homeless

Make ID cards available to homeless Medicaid members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

21.7.3 Pharmacy Services Lock-in Program

A program called Pharmacy Services Lock-In is available in cases of benefit misuse. 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 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:

Division of Medicaid Services
Bureau of Benefits Management
P.O. Box 309
Madison, WI 53701-0309

21.7.4 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering from the fiscal agent.

21.7.5 Lost/Stolen Cards

If a member needs a replacement card, he or she 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 F-10110 (formerly DES 3070) or CARES.

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21.8 Waiver of Medicaid Benefit Limitations

A person who is eligible for Medicaid but has been refused a specific, medically necessary Medicaid benefit by a provider can work with his or her provider to apply for a discretionary waiver or variance. The waiver or variance cannot be used to receive noncovered services. If a waiver or variance is requested, the Division of Medicaid Services would consider whether to grant the waiver or variance to allow the person to receive the benefit.

The provider of the service must request the waiver. The written request must meet all requirements detailed in Wis. Admin. Code § DHS 106.13 and should be sent to the following address:

Division of Medicaid Services
Waivers and Variances
P.O. Box 309
Madison, WI 53701-0309

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21.9 Third Party Coverage

See Section 9.1 Third Party Liability.

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21.10 Good Faith Claims

21.10.1 Definition of Good Faith Claims

A good faith claim is a claim that has been denied by Medicaid with an eligibility-related *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 the fiscal agent 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, the fiscal agent will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) is used for this purpose. A good faith claim cannot be reimbursed until the fiscal agent member file is updated.

21.10.2 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.

21.10.3 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 did not update CARES or send the fiscal agent an F-10110 (formerly DES 3070) to update the member's eligibility file. The fiscal agent 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 a F-10111 and the information that is needed.
    b. The provider suspects the member of misusing or abusing a Medicaid ID 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 the fiscal agent can tell that it was altered, the fiscal agent will contact you to verify the member was eligible or forward it to the *DMS* for review.

2. The member's name has changed since the card was issued. The fiscal agent can usually resolve claims that are denied with code "029" and "614." If necessary, the fiscal agent will contact you to confirm the information.

With the implementation of the ForwardHealth ID cards, providers are less likely to receive one of the eligibility-related denials used for good faith claim submissions. 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 MMIS. Therefore, it is unlikely that they will be told the *member* is eligible when he or she 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 Medicaid before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case, if the member presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the good faith claim, the fiscal agent will update the member's eligibility file with a good faith segment and pay the claim immediately.

The fiscal agent 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 does not send a copy of the ID card with the claim, the fiscal agent must confirm eligibility with you before the claim can be paid.

The definition of a valid card is either a:

1. ForwardHealth card that indicates eligibility for the dates of service through the EVS.
2. A temporary paper card showing dates of eligibility.

21.10.4 Process

The fiscal agent initiates the good faith claim process by sending you a Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) that they have partially completed and one or two letters, depending on what documentation of eligibility the provider included with the claim. Complete F-10111 for new members (cert. 1) or F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

ForwardHealth
Good Faith Unit
P.O. Box 6215

Madison, WI 53784

Send completed F-10110 forms by fax to 608-221-8815 or by mail to:

ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

21.10.5 Instructions

Agency Denial
If the member identified on this 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.

Member 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 Medicaid 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 Medicaid in your agency.

Dates of Services
The fiscal agent 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
The fiscal agent will check one of these boxes:

1. Initial Certification
   The fiscal agent will place an "X" in this box when the member and Medicaid number submitted on the claim cannot be found on the eligibility master file.

2. Amended Certification

The fiscal agent will place an "X" in this box when the member is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number
The fiscal agent will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number
The fiscal agent will enter the known or suspected MMIS case number (primary person's *SSN* + tie-breaker) of the member listed on the provider's claim.

Action Date
The fiscal agent enters the date they completed the Good Faith form.

Medical Status Code
When the fiscal agent 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), the fiscal agent 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, the fiscal agent enters a "71" medical status code and pays the claim immediately. The fiscal agent 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 a F-10110 (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the member was eligible for Medicaid.

Period of Certification
If the fiscal agent has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete a 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
The fiscal agent 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 fiscal agent file.

Current ID Number
The fiscal agent will enter the member's current Medicaid ID number.

Date of Birth

The fiscal agent completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate 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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21.11 Five Percent Cost Share Limit

Members may not pay more than five percent of their household income for monthly premiums and copays for BadgerCare Plus or Medicaid card services. This limit does not apply to deductibles, patient liability for Institutional Medicaid, or cost sharing for Home and Community-Based Waiver services.

The five percent cost share limit applies to members eligible for BadgerCare Plus, SSI Medicaid, and most EBD Medicaid programs. Members enrolled in MAPP and SeniorCare do not have a cost-sharing limit.

For members subject to the cost-sharing limit, a copay limit will be set on a monthly basis. The copay limit is based on the assistance group's income used to determine eligibility. Copays are tracked based on copays the individual has incurred, not the amount of copays actually paid.

21.11.1 Copay Limits for Members and Programs exempt from copays

Members who are in a copay exempt category (21.5.2 Copay Exempt Populations) will not have a copay limit while they are copay exempt since they have no copays.

Members who are enrolled in any copay exempt subprograms (21.5.3 Copay Exempt Programs) will have a copay limit of $0 as there are no copays for members enrolled in these programs.

21.11.2 Programs Excluded from the Five Percent Cost Share Limit

Members enrolled in the following subprograms will continue to be charged premiums and copays with no five percent cost share limit set based on their income:

- Medicaid Purchase Plan (MAPP)
- SeniorCare

Note: Members who are enrolled only in Medicare Savings Programs (except for Qualified Medicare Beneficiaries (QMB)) do not receive Medicaid card services and thus do not have copays.

21.11.3 Determining the Copay Limit

For members enrolled in BadgerCare Plus or EBD Medicaid subprograms that have a copay limit, copay limits will be based on the assistance group's income used to determine eligibility. Per-member copay limits will be set based on the income tiers (39.12 Five Percent Copay Limit Tiers).

If the member is married and both spouses are enrolled in a health care program that has a copay limit (and neither spouse is exempt from copays), the copay limit will be prorated between them. If one spouse is exempt from copays (for example, due to pregnancy), the other spouse will have the full individual copay limit for their income tier.

Example 1: Jane and Benji are married and enrolled in medically needy SSI-related Medicaid. The assistance group has counted income which puts their household income in the 50-100% of FPL income tier for an assistance group size of 2.

Since both Jane and Benji are eligible and have to pay copays, the $26 copay limit for the household will be prorated between Jane and Benji. They will each have a monthly copay limit of $13.

Note: If needed, use the following formula to determine the assistance group income FPL percentage and the appropriate tier:

Assistance Group Income / (100% FPL for the group size) = Assistance Group Size % FPL.

If spouses are enrolled in two different health care programs (and both programs have a copay limit), the copay limit for the household will be calculated based on the assistance group with **lower** income and prorated between spouses. This will prevent the spouse with lower income from paying cost sharing expenses in excess of the five percent limit.

Example 2: Dave, his wife Debbie, and their son Derek receive health care benefits. Dave is enrolled in SSI-Related Medicaid and Debbie and Derek are enrolled in BadgerCare Plus. Due to the different income budgeting rules for SSI-Related Medicaid and BadgerCare Plus:

- The countable income for SSI-Related Medicaid is 69% of the FPL for a group size of two. That puts the SSI-Related Medicaid assistance group income in the >50-100% of FPL income tier.
- The countable income for BadgerCare Plus is 48% of the FPL for a group size of three. That puts the BadgerCare Plus assistance group income in the 0-50% of FPL income tier.

To determine the copay limit for the household, the lower BadgerCare Plus assistance group income tier of 0-50% of FPL will be used. Debbie, Dave, and Derek each have a $0 copay limit, meaning they will not be charged any copays.

If a member who is enrolled in a health care program that has a copay limit is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the member will have the full individual copay limit for his or her income tier.

Example 3: Sean and Sandra are a married couple. Sean is enrolled in SeniorCare and Sandra is enrolled in medically needy SSI-related MA. The countable income for Sandra's SSI-Related Medicaid assistance group is 72% of the FPL, which puts this assistance group in the >50-100% of FPL income tier. Because Sean is enrolled in a program that has no copay limit, Sandra will pay the full individual copay limit of the income tier.

For members who are eligible for both QMB and a full benefit health care program that has a copay limit, the income used to determine eligibility for the full benefit program will be used to calculate the member's copay limit.

Example 4: Dwayne is eligible for both SSI-Related Medicaid and Medicare. He also qualifies for QMB. Under SSI-Related Medicaid, Dwayne's income is in the >50-100% of FPL tier. His copay limit is $26 per month based on his SSI-Related Medicaid eligibility. Since QMB is a limited benefit program, no copay limit will be set for QMB.

If Dwayne were only eligible for QMB, his copay limit would be set based on the income used to determine his eligibility for QMB.

For CLA members who pay a monthly premium, the premium amount will be subtracted automatically when the member's copay limit is calculated in CARES. For married couples with at least one spouse subject to CLA policy, the total household premium amount will be prorated evenly between the married couple's copay limits even if the spouses are on different benefit programs.

Example 5: Destiny and Marcus are married. Destiny is eligible for BadgerCare Plus as a childless adult with an $8 household premium. Marcus is eligible for SSI-Related Medicaid. The income used falls within the >50-100% FPL tier. However, since Destiny has a household premium, the premium is split and deducted evenly from both copay limits (subtract $4 from each copay limit). After the premium is counted, they each have a copay limit of $9 ($13-$4=$9).

Example 6: Alice and Barry are married and both eligible for BadgerCare Plus as childless adults with income at 85% of the FPL. They have a household premium of $6 because Alice completed a health survey and reported healthy habits while Barry did not. Their copay limit would be prorated at the >50-100% FPL tier and the $6 premium would be split evenly and deducted from their prorated copay limit (subtract $3 from both). Alice and Barry would each have a $10 copay limit.

Alice suffers injuries from a car accident. She is verified as disabled and becomes

eligible for SSI-Related Medicaid. Because Alice is no longer a childless adult, her health survey response does not result in a premium reduction for the household. Barry's household premium will increase to $8. The $8 premium would be split evenly and deducted from both Alice and Barry's copay limits (if they continue to have income greater than 50% of the FPL).

21.11.3.1 Determining Copay Limits for Community Waivers Group B and B Plus

For Group B and B Plus Home and Community Based Waiver members, the copay limit will be based on the member's cost share amount for Waiver services rather than the income used to determine the member's eligibility.

- If the Waiver services cost share amount is less than $27 (the full individual copay limit for the >50-100% of FPL income tier plus one dollar), the Group B or B Plus Waiver member will have the copay limit for the 0-50% of FPL income tier ($0).
- If the Waiver services cost share amount is $27 or greater, the Group B or B Plus Waiver member will have the copay limit for the >50-100% of FPL income tier ($26).

Example 6: Marge is a Group B waiver member. Her Waiver cost share amount is $15. Because this amount is less than $27, Marge's copay limit is $0, which means that she will not be charged any copays.

Example 7: George is a Group B waiver member. His Waiver cost share amount is $120. George's copay limit is $26 because his cost share amount is greater than $27.

If a Group B or B Plus Waiver member is married to someone who is also a Group B or B Plus Waiver member or is enrolled in another Medicaid subprogram that has a copay limit (and who is not exempt from copays), the copay limit calculated for the spouse in the lower copay limit tier will be prorated between the two spouses.

Example 8: If Marge and George in examples 6 and 7 above were a married couple, the copay limit for the household would be based on the spouse in the lower copay limit tier (in this case, Marge). Marge and George would therefore each have a copay limit of $0.

Example 9: Trevor and Kate are married and enrolled in different health care benefits. Trevor is eligible for SSI-Related Medicaid and his income falls in the >0-50% FPL tier. Kate is eligible for Community Waivers Group B. Her Waiver cost share amount is $65. Since Trevor's income would be in a lower FPL tier than Kate's Waiver cost share amount, Trevor and Kate would each have a copay limit of $0.

If a Group B or B Plus Waiver member is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the Waiver member will have the full individual copay limit for his or her copay limit tier.

Example 10: Steve and Angela are a married couple. Steve is a Group B Plus Waiver member and Angela is enrolled in MAPP. Steve's Waiver cost share amount is $30, so his copay limit is based on the >50-100% of FPL income tier. Angela has no copay limit.

21.11.3.2 Determining Copay Limits for Members in SSI Medicaid

- For SSI Medicaid members, whose Medicaid eligibility is determined by the Social Security Administration (SSA) rather than income maintenance agencies, per-member copay limits will be based on the >50-100% of FPL income tier (see Appendix 39.12 Five Percent Copay Limit Tiers).

If an SSI Medicaid member is married to someone who is enrolled in BadgerCare Plus or an EBD Medicaid subprogram that has a copay limit, each spouse's copay limit will be calculated individually and the copay limit will not be prorated between spouses.

Example 11: Chantal and Peter are married and both are receiving health care benefits. Chantal is eligible for SSI Medicaid and Peter is eligible for SSI-Related Medicaid with income at 84% of the FPL. Chantal and Peter will each have individual copay limits as listed in Appendix 39.12 Five Percent Copay Limit Tiers.

21.11.4 Changes to the Copay Limit

Once determined, the copay limit will remain the same from month to month unless changes are reported that affect the copay limit, such as a change in income or household composition. Members have the right to appeal their monthly copay limit.

Increases in copay limits may not be made without providing timely notice to the member. If a change results in an increase in the member's copay limit and eligibility is confirmed prior to adverse action for the month, the copay limit increase will be effective the following month. If eligibility is confirmed after adverse action, the copay limit increase will be effective two months after the month in which the change occurred.

If a change results in a decrease in the monthly copay limit, the decrease should be effective during the month in which the change occurred or, if the change was reported untimely (more than ten days after the change occurred), the month in which the change was reported, whichever is later.

21.11.5 Meeting the Copay Limit

Members are notified once they have incurred enough copays before the end of the month to meet their monthly copay limit. This notification is informational only and members may not appeal the date the copay limit was determined to have been met. Once the copay is met for a given month, it can never become “unmet” in the same month and the member will not be charged any more copays in that month.

Example 12: Tamika is enrolled in HCBW and has a copay limit of $26 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of $26. CARES issues Tamika an automated notice stating that her $26 copay limit has been met for the month of August and that she will have no copays for the remainder of the month. On August 21, Tamika has a doctor’s appointment. She will have no copay for the doctor’s appointment since her copay limit has already been met for the month of August. On September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

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22 Administration

22.1 Estate Recovery

22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and *LTC* benefits by:

- *Liens* against a home
- Claims against estates
- Affidavits
- Voluntary recoveries

These procedures are the *ERP*. No ERP recovery may be made for Medicaid services provided before October 1, 1991.

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the *member's* age and residence when he or she received the benefit.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members age 55 or older on or after April 1, 2000.
4. All *HCBW* services (*COP-W*, *CIP* 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:

. Prescription/legend drugs received by waiver participants.

a. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.

5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:

. Prescription/legend drugs received by waiver participants.

a. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.

6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All *IRIS* services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.
8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014.

   LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and *PACE*). The capitation payment made to the *MCO* on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.

9. Costs that may be recovered through a lien are:

   . Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.

   a. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

22.1.2.1 Medicare Savings Programs

As of January 1, 2010, payments for premiums, copayments, and deductibles for QMB and Medicare Part B for any *MSP* member are not recoverable through ERP.

22.1.3 Nursing Home Definition

For ERP purposes, a "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes *SNF*, *ICF*, in-patient psychiatric facilities, and Facilities for the Developmentally Disabled (FDD). A "nursing home" does not include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.
2. A hospice, as defined in Wis. Stat. § 50.90(1), that directly provides inpatient care.
3. Community waiver residence.
4. *IMD*.

22.1.4 Liens

DHS will not file a lien on:

1. Non-home property.
2. *Homestead* property sold by land contract.
3. Property outside Wisconsin (see Section 22.1.4.2 Out-of-State Property).
4. A mobile home or the land it sits on when the *member* does not own the land.

DHS may file a lien on:

1. A home and all property used and operated in connection with that home.
2. A mobile home and the land it sits on, when the member owns the land.
3. A home placed in a *revocable trust* (see Section 22.1.4.8 Homes Placed in Revocable Trusts).
4. Life estates created on or after August 1, 2014.

When a home is sold, DHS uses the lien to recover certain payments for Medicaid services provided as listed in Section 22.1.2 Recoverable Services. The lien's value is "open ended." The lien's value increases as the amount of recoverable Medicaid services paid accumulates.

Payment of the lien is made directly to DHS. Do not accept any payments relating to liens filed by DHS.

Contact the ERP Estate Recovery Specialist if the member's home is sold within 45 days after the Notice of Intent to File a Lien is completed.

The lien has no effect until filed.

Example 1: Mr. A applies for Medicaid on March 6, 1995. He has a home and his circumstances require a lien. The *IM* agency sends a Notice of Intent to File a Lien on March 10, 1995. ERP staff cannot file a lien until April 24, 1995, because of the required 45 day waiting period. Mr. A's legal representative sells the property on April 10, 1995. Recovery of Mr. A's Medicaid payments by a lien on that property is not possible as the property was sold before a lien was filed. The IM agency contacts the ERP Lien Specialist to report on the home's sale.

22.1.4.1 Notice of Intent to File a Lien

Complete a Notice of Intent to File a Lien (F-13038 paper form) when a Medicaid member meets all the following criteria. He or she:

1. Lives in a nursing home or inpatient hospital and is required to contribute to the cost of care. (Individuals eligible under a *MAGI* group are not required to contribute to the cost of care and are not subject to liens on their homes.)
2. Has a home (see Section 16.1 Assets Introduction).
3. Is not expected to return to live at that home.

   Base this decision on the person's medical condition. His or her physician's statement that he or she can reasonably be expected to return home is sufficient support for the person's claim that he or she will return.

   The physician's statement should include a description of the diagnosis and prognosis for the member. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

   When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the member, family, guardian, power of attorney, or physician that the person will return home, consult with the ERP's Estate Recovery Specialist. Do **not** file a Notice of Intent to File a Lien until ERP staff has checked with DHS medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.

4. None of these relatives of the member reside in that home.
   a. *Spouse*.
   b. Child who is:
      - Under age 21, **or**
      - Blind, **or**
      - Disabled.
   c. Sibling, if the sibling:
      - Has an equity interest in the home; **and**
      - Lived in the home continuously beginning at least 12 months before the member's nursing home or hospital admission.

When you have completed the Notice:

1. Mail or give the original to the member or his or her *authorized representative*.
2. Send a copy to the ERP office.
3. Attach a legible copy of the latest property tax bill or a copy of the property *deed* (if available) for any homestead property reported. This gives ERP staff the information necessary to obtain the legal description needed to file a lien.

4. File a copy in the case record.

ERP staff delays further action until the period given the member to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

22.1.4.2 Out-of-State Property

If a Medicaid member has property outside Wisconsin that would be subject to a lien if located in Wisconsin, provide the same data you would provide on Wisconsin property. Do not give a Notice of Intent to File a Lien.

DHS may not file liens against out-of-state properties. However, ERP staff wants data on these cases to assist in negotiating lien agreements with other states.

22.1.4.3 Returns Home to Live or No Longer Owns the Home

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live or if the member no longer owns the home, the lien must be released. Notify the ERP. ERP staff will release the lien.

22.1.4.4 Change in Circumstances

At review and other times, at local option, reexamine the circumstances of the member's home. If conditions change such that a lien must be filed, complete a Notice of Intent to File a Lien.

22.1.4.5 Special Cases

ERP staff applies special consideration for the following two case situations:

1. When a child (age 21 or older) of the member lives in the home, DHS is able to file a lien. It will not enforce the lien until that child moves or the home is sold if he or she:
    a. Lived in the home with the member for at least two years before the resident's admission to the nursing home or hospital, **and**
    b. Assisted the parent such that he or she helped delay the member's admission.
2. When a sibling of the member (other than a sibling described in Section 22.1.4.1 Notice of Intent to File a Lien) lives in the home, DHS is able to file a lien. It will not enforce the lien until that sibling moves or the home is sold if the sibling resided in the home for at least 12 months before the member's admission to the nursing home or hospital.

Alert the ERP when your member meets either of these two case situations.

22.1.4.6 Adjustment for Burial Trust

DHS may adjust the amount of its lien to allow a member to use proceeds from the sale of the home to establish or supplement a burial trust. ERP staff will review each situation individually. Refer any questions regarding lien satisfaction amounts or lien releases to the ERP staff.

22.1.4.7 Administrative Hearing: Liens

A member or his or her representative may request an administrative hearing if he or she feels the statutory requirements for imposing the lien have not been met. The IM agency attends the hearing to explain the decision to file the Notice of Intent to File a Lien. The only issue at the hearing will be whether the following requirements were satisfied:

1. The member has an ownership interest in a home.
2. The member resides in a nursing home or hospital.
3. The member cannot **reasonably** be expected to be discharged from the nursing home or hospital and return home to live.
4. None of the following lawfully reside in the home:
    a. The member's spouse .
    b. The member's child who is:
        - Under age 21, **or**
        - Disabled, **or**
        - Blind.
    c. The member's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the member was admitted to the nursing home or hospital.

The request for an administrative hearing must be made in writing directly to the *DHA* at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request must be clearly marked "Medicaid Lien" and must be filed within 45 days of the mail date on the Notice of Intent to File a Lien. The date the written request is received by DHA is the date the hearing request is considered filed.

22.1.4.8 Homes Placed in Revocable Trusts

If a Medicaid member places his or her home in a revocable trust (see Section 16.1 Assets Introduction), he or she retains an ownership interest in the home. Complete a

Notice of Intent to File a Lien if the member meets the conditions for a lien to be filed (see Section 22.1.4.1 Notice of Intent to File a Lien).

22.1.5 Estate Claims

DHS recovers Medicaid benefit costs from the member's estate or from the member's surviving spouse's estate

Recovery from a member's surviving spouse's estate will be limited to 50 percent of the marital property that the member had an interest in immediately prior to death.

When DHS learns of the death of a member or a member's surviving spouse, it files a claim in probate court in the amount of Medicaid recoverable benefits.

The probate court will not allow a claim on the estate to be paid if any of the following survives the member:

1. A spouse.
2. A child, if the child is:
    a. Under age 21, **or**
    b. Blind, **or**
    c. Disabled.

Do not negotiate a settlement, accept any funds, or sign any release for estate claims that have been filed by DHS. ERP staff should be notified if a claim is filed by the county against an estate for recovery of overpayments or incorrect Medicaid benefits for those 55 years of age or older or for any member who has resided in a nursing home.

Refer any questions about specific estate claims to the ERP staff.

22.1.5.1 Waiver of Estate Claim

In estates of members who die on or after April 1, 1995, an heir or beneficiary of the deceased member's estate or co-owner or beneficiary of a member's non-probate property may apply for a waiver of an estate claim filed by ERP. To be successful, the person applying for the waiver must show one of these three hardships exist:

1. The waiver *applicant* would become or remain eligible for AFDC, *SSI*, FoodShare, or Medicaid if ERP pursued the estate claim.
2. The deceased member's *real property* is part of the waiver applicant's business (for example, a farm) and the ERP recovery claim would affect the property and result in the waiver applicant's loss of his or her means of livelihood.
3. The waiver applicant is receiving general relief or veteran's benefits based on need under Wis. Stat. § 45.40(1m).

The waiver application must be made in writing within 45 days after the day:

1. ERP mailed its recovery claim to the probate court or its affidavit to the heir, beneficiary, or co-owner **or**
2. ERP mailed its notice of waiver rights, whichever is latest.

The waiver application must include these points:
1. Relationship of the waiver applicant to the deceased member.
2. The hardship under which the waiver is requested.

ERP staff must issue a written decision granting or denying the waiver request within 90 days after the waiver application is received by ERP. In determining its decision, ERP must consider all information provided to it within 60 days of its receipt of the waiver application.

22.1.5.2 Notice of Hardship Waiver Rights

ERP will provide notice of the waiver provisions to the person handling the deceased member's estate. If ERP is not able to determine who that person is, the notice will be included with the claim when ERP files it with the claim court.

The person handling the estate is then responsible for notifying the decedent’s heirs and beneficiaries of the waiver provisions.

ERP will provide notice of the waiver provisions to co-owners and beneficiaries of the member’s non-probate property.

22.1.5.3 Administrative Hearings: Hardship Waivers

If a waiver application is denied, the waiver applicant may request an administrative hearing. ERP staff will attend the hearing to defend their denial of the hardship waiver.

The hearing request must be made within 45 days of the date the ERP decision was mailed.
The hearing request must:
1. Be made in writing.
2. Identify the basis for contesting the ERP decision.
3. Be made to the DHA at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The date the request is received at DHA is used to determine the timeliness of the request.

ERP staff will maintain DHS' claim in the estate pending the administrative hearing decision. If collections are made and the waiver is ultimately approved, those funds will be returned.

To introduce evidence at a hearing not previously provided to DHS, the applicant must mail that evidence to DHS with a postmark at least seven working days before the hearing date.

22.1.5.4 Personal Representative's Notice

The personal representative of the estate of a Medicaid member must notify DHS that the estate is being probated (Wis. Stat. § 859.07[2]). The notification must be by certified mail and include the date by which claims against the estate must be filed.

22.1.5.5 Real Property as Part of the Estate

When a real property **is part of the estate,** ERP may file a lien equal to the Medicaid payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example 2: Mr. A dies. A claim on his estate is filed and the estate includes his real property. His spouse is deceased, and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. A's home. A lien is placed on the real property but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased member:
    a. Resides in the member's home, **and**
    b. That child resided in that home for at least 24 months before the member entered the nursing home, hospital, or received HCBW services, **and**
    c. That child provided care that delayed the member's move to the nursing home, hospital, or his or her receipt of HCBW services.
2. A sibling of the deceased member:
    a. Resides in the member's home, **and**

b. Resided in that home for at least 12 months before the date the member entered a nursing home, hospital, or received home and community-based services.

The lien filed in one of these two instances will be payable at the death of the child or sibling or when the property is transferred, whichever comes first.

However, if the caretaker child or sibling sells the home covered by the DHS lien and uses the sale proceeds to buy another home to be used as that child's or sibling's primary residence, then:

1. DHS will transfer the lien to the new home if the amount of the child or sibling's payment or down payment for the new home is equal to or greater than the proceeds from the original home.
2. If the down payment on the new home is less than the proceeds from the sale of the original home, DHS will recover the amount of the proceeds above the down payment, but no greater than the lien amount. If there is an amount in the lien still not satisfied, DHS will file a lien for the remaining amount on the new home.

22.1.5.6 Affidavits in Small Sum Estates

Heirs, guardians, and trustees of revocable trusts created by a deceased Medicaid member must notify ERP before transferring any of the deceased's property through a Transfer by Affidavit ($50,000 and under) (Wis. Stat. § 867.03). The heir, guardian, or trustee must send a copy of the affidavit to ERP by certified mail, return receipt requested. Examples of property include bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/member and negotiable; real estate; etc.

If an heir, guardian, or trustee transfers the deceased's property, ERP will send an affidavit to the heir, guardian or trustee to recover any funds remaining after burial and estate administration costs have been paid. Funeral costs are limited to those expenses connected with the funeral service and burial. A marker for the grave is considered a burial cost. Memorials and/or donations to churches, organizations, persons, or institutions are not considered burial costs.

ERP will also send its affidavit to the co-owners and/or beneficiaries of a member's non-probate property. Non-probate property is property that passes outside an individual's estate. This means that non-probate property does not go through probate before it is transferred to those who inherit it. Non-probate property subject to recovery includes, but is not limited to, life estates, property held in joint tenancy, life insurance proceeds, property held in revocable trusts, and property that is payable-on-death or transfer-on-death to a beneficiary.

Co-owners and beneficiaries of a member's non-probate property have the right to request a fair hearing as on the value of the member's interest in the property.

The value of the member's interest for jointly owned property is the percentage interest attributed to the member when Medicaid eligibility was determined or, if not determined at eligibility, the fractional interest the member had in the property at his or her death. For life estate interests, the value is the percentage of ownership based on the member's age at the date of death, according to the life estate tables used for Medicaid eligibility.

The value of the property is the *fair market value*. Fair market value is the price a willing buyer would pay to a willing seller for purchase of the property. It is the co-owners' or beneficiaries' responsibility to establish that value through a credible method like an appraisal by a licensed appraiser.

ERP staff will attend the fair hearing to present DHS' position on the value of the property.

Real property of a Medicaid member, whether non-probate or transferred by affidavit, is subject to a lien if the state's claim cannot be satisfied through other assets.

The DHS may not enforce the lien while any of the following survive:

1. Spouse,
2. Child who is:

a. Under age 21, **or**
b. Blind, **or**
c. Disabled.

ERP will recover any funds that remain from a burial trust after costs have been paid.

Direct specific questions about questionable allowable costs to ERP staff.

22.1.5.7 Patient Fund Account

Nursing homes are required to notify ERP when a Medicaid member dies with money left in his or her nursing home patient fund account if he or she has no surviving spouse or minor or disabled child.

ERP will claim from the nursing home any funds remaining in the patient account after payment of funeral and burial expenses and outstanding debts from the last month of illness that are not chargeable to Medicaid.

22.1.5.8 Native Americans

Native Americans: Income, Resources and Property Exempt from Medicaid Estate Recovery

The following income, resources, and property are exempt from Medicaid estate recovery:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
    a. Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
    b. For any federally -recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
    c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom

Native Americans: Income, Resources and Property Not Exempt from Medicaid Estate Recovery

The following income, resources and property from the estates of Native Americans are not exempt from estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in items 1-5.

22.1.5.9 Reparation Payments to Individuals

Government reparation payments to special populations are exempt from Medicaid estate recovery.

22.1.5.10 Voluntary Recovery (ERP)

When a member age 55 or older wishes to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce a potential claim in an estate, forward the payment to ERP. First check BVCI to make sure there is not an outstanding Medicaid claim for an overpayment since the money should be applied to an overpayment first. Voluntary payments, except for prepayment of a deductible, may only be up to the amount of Medicaid paid to date. (See Section 22.1.10 Voluntary Recovery (Not ERP) for voluntary recoveries for members under age 55.)

The check or money order should be made payable to DHS.

Mail the payment to:

Estate Recovery
313 Blettner Blvd
Madison WI
53714-2405

With the payment, include:
1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.
3. Name and address of the person who should receive the receipt.

These refunds will be credited to the member and will be used to offset any claim that may be filed in the member's estate.

Incentive payments of five percent will be paid to the IM agency for refunds.

Advise heirs and beneficiaries of deceased members who wish to make a voluntary refund to call ERP staff.

22.1.6 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form and data received through the *SSA* State Data Exchange (SDX) tape (for SSI/Medicaid members) is on the database.

The database is compared to the death record files of the *DMS*, Vital Records and State Registrar Section.

When a match shows a Medicaid member or his or her surviving spouse has died, a report record is produced. ERP staff checks the report against new probate proceedings listed on the Wisconsin Circuit Court Access website. This is a back up to the requirement that DHS be notified of the last date for filing claims.

22.1.7 Notify Members

A copy of the Wisconsin Medicaid Estate Recovery Program Handbook (P-13032) must be provided to every Medicaid member 54 1/2 years old or older or institutionalized at application, except members who are only applying for or a member of one of the Medicare Savings Programs. CARES will send this documentation automatically. Have each member or his or her representative read the notice of liability on the application form ("Estate Recovery"). He or she acknowledges understanding of this notice when signing the application.

22.1.8 Disclosure Form

The Estate Recovery Program (ERP) must be provided with asset information whenever a Medicaid member:

1. Enters or resides in a nursing home, **or**
2. Enters or resides in an inpatient hospital and is required to pay a Medicaid cost of care liability, **or**
3. Becomes 55 years old.

This information must be provided even if he or she has zero assets. CARES will send this information automatically.

22.1.9 Estate Recovery Program Contacts

The ERP address is:

Estate Recovery Program Section
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer members to Member Services at 1-800-362-3002.

Direct case-specific questions about:

1. Estate recovery disclosure forms and liens to the Estate Recovery Specialist, 608-264-6755.
2. For small estates of $50,000 or less, provide the phone number of the "Affidavit Help Line," 608-264-6756, to heirs of deceased members who have questions about ERP. The Help Line provides recorded messages that answer the most frequently asked questions regarding small sum estates. It also provides the caller with an opportunity to either leave a message or talk to ERP staff.
3. Tribal inquiries should be re-directed to the ERP Section Chief, 608-261-7831.

22.1.10 Voluntary Recovery (Not Estate Recovery Program)

Accept payments from a member under age 55 made for purposes of Medicaid eligibility or prepaying a Medicaid deductible.

Instruct the member to make the payment payable to your IM agency. Report the receipt on the Community Aids Reporting System (CARS) labeled as a Medical Refund.

22.1.11 Incentive Payments

DHS will return to local agencies five percent of collections made through a lien, voluntary payments, and probated estate recoveries. We will pay this incentive to the last agency certifying the member for Medicaid.

The payments are discretionary. DHS will make them based on compliance with program requirements.

22.1.12 Other Programs

ERP also recovers for Community Options Program (COP), *WCDP*, and non-Medicaid Family Care.

Note: Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from those who received benefits under this program prior to May 1, 2003.

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22.2 Corrective Action

22.2.1 Overpayments

An overpayment occurs when Medicaid benefits are paid for a person who was not eligible for them or when Medicaid payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the Medicaid benefits incorrectly provided. Some examples of how overpayments occur are:

- Concealing or not reporting income.
- Failure to report a change in income, expenses, or assets.
- Providing misinformation at the time of application that would affect eligibility.

Note: Non-Medicaid Family Care no longer exists as of May 1, 2003. However, *ERP* could recover from those who received benefits under this program prior to May 1, 2003.

22.2.1.1 Recoverable Overpayments

Initiate recovery for a Medicaid overpayment if the incorrect payment resulted from one of the following:

- **Applicant or Member Error.** Applicant or member error exists when an *applicant*, *member*, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates (financial or nonfinancial) facts, which results in the member receiving a benefit that he or she is not entitled to or more benefits than he or she is entitled to.

  Failure to report nonfinancial facts that impact eligibility or cost share amounts is a recoverable overpayment.

  Applicant or member error occurs when there is a:

  - Misstatement or omission of facts by an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf at a Medicaid application or renewal.
  - 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 (income, assets, expenses) or nonfinancial information that affects eligibility, premium, patient liability, or cost share amount.

  A Medicaid member is responsible for notifying his or her *IM* agency of changes within 10 days of the occurrence.

An overpayment occurs if the change would have adversely affected eligibility benefits or the post-eligibility contribution amount (cost share, patient liability).

Example 1: Ed applied for *EBD* Medicaid and was found eligible effective November 1, 2013. Ed originally reported $1,800 of nonexempt assets (checking and savings accounts), which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several nonexempt vehicles with an equity value of $1,000. The agency discovers Ed's ownership of these vehicles on February 10, 2014. On February 20, 2014, the agency receives verification that the equity value of Ed's nonexempt vehicles and other nonexempt assets has continuously exceeded the $2,000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Decision on February 22, 2014, advising him that his eligibility is being discontinued effective March 31, 2014. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Ed from November 1, 2013, through March 31, 2014.

Example 2: Sally, determined eligible for a *HCBW* in January with a cost share, experienced a reduction in her health insurance expense as of July 1, but did not report that to her worker until her November review. The worker made the changes in CARES and increased her cost share for December.

Had Sally reported timely, her cost share would have increased beginning in August. The overpayment is the difference between the new cost share and the old cost share for August, September, October, and November.

Example 3: Shana was determined eligible for *WWWMA* in February. She had private insurance that covered treatment of breast or cervical cancer, but due to a waiting period for preexisting conditions, her treatments were not covered. The waiting period ended July 31, and the private insurance began to cover Shana's treatment effective August 1. Shana did not report this to her worker, so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30.

Since her case would have closed August 31 if she had reported the change timely, Shana has an overpayment for September through November. The *fee-for-service* claims paid for September, October, and November are recoverable.

Example 4: Joe has been a Medicaid member since January 1, 2012. During a December 2013 eligibility review, the agency discovered that Joe won a $10,000 lottery that was paid to him on June 12, 2013. Joe never reported the receipt of these lottery winnings and still has about $8,000 from the lottery proceeds. The agency verified that Joe's nonexempt assets have been in excess of the $2,000 Medicaid asset limit since June 12, 2013, and sent him a

Notice of Decision, advising him that his Medicaid eligibility is being discontinued effective January 31, 2014. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 2013, through January 31, 2014. June 2013 and July 2013 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe would have reported this change timely (no later than June 22, 2013), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 2013.

- **Fraud.** Fraud exists when an applicant, member, or any other person responsible for giving information on the member's behalf does any of the following:
    - Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
    - Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
    - Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
    - 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.

- **Member Loss of an 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 **or the amount of claims and HMO capitation payments the state paid for each month (whichever is less)**.

Note: As of February 1, 2002, there should be no compromise of overpayment claims. If it is determined that a recoverable overpayment exists, recovery may not be waived.

22.2.1.2 Nonrecoverable Overpayments

Do not initiate recovery for a Medicaid overpayment if it resulted from a non-member error, including the following situations:

- The member reported the change timely, but the worker could not close the case or reduce the benefit due to the 10-day notice requirement.
- Agency error (keying error, math error, failure to act on a reported change).
- Normal prospective budgeting projections based on the best available information.

- A change in the Medicaid category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

Example 5: A Medicaid EBD member reports on March 25, 2014, that he received a $50,000 inheritance on March 23, 2014. The agency sends the member the required Notice of Decision discontinuing his eligibility effective April 30, 2014. Even though the member had excess assets during March and April 2014, there is no Medicaid overpayment for those months because the change was reported timely, and the agency was required to provide appropriate and timely notice before discontinuing the member's eligibility. Benefits issued only because of the timely notice requirements are not overpayments and are not subject to recovery.

22.2.2 Overpayment Calculation

22.2.2.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial Medicaid application or renewal, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (Section 22.2.2.2 Overpayment Amount). The ineligibility period could begin as early as the first month of eligibility, including any backdated benefits.

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 the month the case would have closed or been adversely affected if the change had been reported timely.

Fraud

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.

22.2.2.2 Overpayment Amount

Use the actual income that was reported or required to be reported when determining if an overpayment has occurred. The amount of recovery may not exceed the amount of the Medicaid benefits incorrectly provided.

If a case was ineligible due to excess income, recover whichever is less of the following:

- Fee-for service claims and any HMO capitation payments Medicaid paid, or
- The amount the member would have paid toward a deductible (if eligible for a deductible)

To calculate the overpayment amount, use ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). The overpayment amount depends on the Medicaid category and whether the case is fee-for-service or enrolled in an HMO or MCO.

If a case or person was ineligible for reasons other than excess income or not eligible for a deductible, recover the amount of fee-for-service claims paid by the state and any HMO and MCO capitation rates the state paid. Use ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). Deduct any contribution made by the member (for example, premium or cost share) for each month in which an overpayment occurred from the overpayment amount.

For the overpayment amounts for institutional (Section 22.2.2.1 Overpayment Period), home and community-based waivers (Section 22.2.2.2.1.2 Family Care, Family Care Partnership, PACE, and IRIS), Medicaid Purchase Plan (Section 22.2.2.2.4 [MAPP]), and deductible (Section 22.2.2.3 Deductible) cases see the appropriate sections.

22.2.2.2.1 Institutional Overpayments

The overpayment amount for an institutional case is the amount Medicaid paid.

If a member failed to report a divestment that would have resulted in a penalty period and the member is still otherwise eligible for long-term care, do not recover benefits Medicaid paid during the time in which the penalty period would have been served. Instead, impose the penalty period for ongoing eligibility as outlined in Section 17.5.4 Penalty Period Begin Date for Members.

Note: Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.

22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact

If a member is still eligible for long-term care benefits but a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability or cost share amount and the one the member originally paid is the overpayment amount.

Do not send a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) to retroactively increase the patient liability on MMIS.

22.2.2.2.1.2 Family Care, Family Care Partnership, PACE, and IRIS

For Family Care, Family Care Partnership, PACE, or IRIS cases in which an omission of fact results in either of the following conditions:

- The individual's income has been underreported, which has resulted in CARES calculating a cost share that is less than it should be.
- The individual's income has been underreported, which has resulted in CARES calculating no cost share for the individual when there should be a cost share.

Follow the instructions in Process Help, Section 31.3.6.1.

An individual may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the individual was ineligible, the benefits received while awaiting the decision can be recovered.

22.2.2.2.2 Deductible

If a member error increases the deductible 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 Medicaid paid for services after the deductible had been met, there is an overpayment. Recover the lessor of:

- The difference between the correct deductible amount and the previous deductible amount.
- The difference between the correct deductible amount and any fee-for-service claims and HMO capitation payments Medicaid paid over the six-month period.

If the member was ineligible for the deductible, determine the overpayment amount. If the member prepaid his or her deductible, deduct any amount he or she paid toward the deductible from the overpayment amount.

Example 6: Sean had a deductible of $2,000 for a six-month period. He met the deductible by paying $1,000 and sending in verification of $1,000 in outstanding medical bills. An IM worker discovers an undisclosed bank account that puts Sean over the asset limit for the program. After determining his overpayment amount, the IM worker must decrease the amount overpaid by the $1,000 that Sean prepaid toward his deductible. The IM worker will not decrease the overpayment amount by any of the medical bills that helped Sean meet his deductible.

If the deductible was prepaid with a check that is returned for insufficient funds, an overpayment may have occurred. Discontinue the member’s eligibility, determine

whether Medicaid paid for any benefits on behalf of the member and, if so, establish a claim for benefit recovery.

22.2.2.2.3 Medicaid Purchase Plan

If a person was ineligible for MAPP, recover the amount of fee-for-service claims and any HMO capitation payments paid by the state. Deduct any amount the person paid in premiums for each month in which an overpayment occurred from the overpayment amount.

If a MAPP member was still eligible for the time frame in question, but there was an increase in the premium, there is an overpayment. Recover the lessor of:

- The difference between the premiums paid and the premium amount owed.
- The difference between the premiums paid and the amount of any fee-for-service claims and HMO capitation payments Medicaid paid for each month in question.

Premium adjustments are only made on months where there is an overpayment. If there is a month without an overpayment, then the premium calculation for that month should not be adjusted.

Example 7: Stephanie was eligible for MAPP with a premium of $50. She forgot to report a part-time job that would have increased her MAPP premium to $75 a month. During the overpaid months, the state paid a monthly capitation rate of $200. For the months during the overpayment time period, the overpayment each month is $25 because the difference between the premium paid and the premium owed each month is $25, and $25 is less than the monthly capitation rate of $200.

22.2.2.2.4 Overpayments for Qualified Medicare Beneficiary Cases

The overpayment amount for *QMB* cases is both the following:

- Medicare Part A premium if paid by the state (Some are free, and others are paid by the state.)
- Medicare Part B premium

22.2.2.3 Liable Individual

Except for minors, collect overpayments from the Medicaid member, even if the member has authorized a representative to complete the application or renewal for him or her. Join liability for married couples is as follows:

- Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments.

- For cases for which spousal impoverishment rules have been applied, the legally married spouses who signed the application or renewal are jointly liable even though one of the spouses may be institutionalized.

Example 8: Sofie applied for Medicaid in December and at that time designated her daughter, Lynn, as her *authorized representative*. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for Medicaid. Sofie was determined to be ineligible for Medicaid from December–March. Recover from Sofie any benefits that were provided to her from December–March. Even though Lynn failed to report the information as the authorized representative, Lynn is not liable.

Example 9: Mary and Herman are married, living together, and eligible for SSI-related Medicaid without a deductible. At their annual renewal, the IM worker discovers an undisclosed pension that would have pushed the couple above the income limit for the program, requiring them to meet a deductible before being eligible. Because they are married and were living in the same household at the time of the overpayment, Mary and Herman will be jointly liable for the entire overpayment that is calculated for the time period in question.

Example 10: Jill and Samuel are married and living together. Jill is eligible for SSI-related Medicaid. Samuel receives federal and state SSI. At renewal, the IM worker discovers that Jill receives disability income from her former employer. This income was not disclosed at application. Because they are married and were living in the same household at the time of the overpayment, both Jill and Samuel are jointly liable for any overpayment calculated for the benefits incorrectly paid to Jill.

If a minor received Medicaid 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.

22.2.3 Overpayment Process

22.2.3.1 Overpayment Process Introduction

Follow the instructions in Chapter VIII of the CARES Member Assistance for Re-employment & Economic Support Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered. You are responsible to:

1. Enter the claim into CARES.
2. Send a manual Medicaid Overpayment Notice (F-10093) indicating the reason for the overpayment and the period of ineligibility.
3. Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.
4. Record payments on CARES screen BVCP within five days of receipt.

CARES will:

1. Track the issuance of notices of non-payment and send automated dunning notices (i.e., past due notices).
2. Refer past due claims for further collection action (i.e., tax intercept) to the Central Recoveries Enhanced System.
3. Close the claim when the balance is paid.

22.2.3.2 Member Notice

Notify the member or the member's representative of the period of ineligibility, the reason for his or her ineligibility, and the amounts incorrectly paid and request arrangement of repayment within a specified period of time.

22.2.4 Refer to District Attorney

See Income Maintenance Manual Chapter 13, Public Assistance Fraud for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

22.2.5 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.

22.2.6 Agency Retention

The IM agency can retain 15 percent of the payments recovered (see Income Maintenance Manual, Section 13.8 Local Agency Retention.)

22.2.7 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his or her Medicaid from the date of the incorrect denial or termination through the time period that he or she would have remained eligible.

If the member was incorrectly denied or terminated for BadgerCare Plus or MAPP (MAPP offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through Wisconsin Medicaid.) with a premium obligation, allow the member to pick the months in which he or she would like

to receive benefits. Collect all premiums owed for all prior months before certifying the member for the months he or she chose.

If a member already paid for a Medicaid covered service, inform the member that he or she will need to contact his or her provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid 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.

22.2.8 Incorrect Member Contribution

22.2.8.1 Premiums

If a MAPP premium is calculated in an amount that is incorrect and higher than it should have been, the excess amount must be refunded to the member when the error is discovered. See Process Help Section 25.4.3 .

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22.3 Interagency Case 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 BadgerCare Plus, Child Care, EBD Medicaid, FoodShare, 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 verification policy in Chapter 20.

CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.

The renewal date will remain the same after case transfer.

Do not require a review or new application for case transfers, except in the following programs:

- Community Wavers (28.1 HCBWLTC Introduction)
- Family Care (29.1 Family Care Long Term Care (FCLTC) Introduction)
- Deductible Met (24.11 Deductibles and Inter-Agency Transfers)

See Process Help Section 6.1 Interagency Case / RFA Transfer in for information on how to process case transfers.

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22.4 Undue Hardship

22.4.1 Application of Policy

Undue hardship may apply only when eligibility for long-term care services is denied or terminated for any of the following situations:

- A community spouse has refused to sign the application or provide required information (see Section 2.5.3 Spousal Impoverishment Medicaid Signatures).
- The applicant's or member's home has equity interest of more than $750,000 (see Section 16.8.1.4 Home Equity Over $750,000.00).
- A divestment penalty period has been imposed (see Section 17.4 Exceptions # 6).
- A spousal impoverishment case has excess assets (see Section 18.4.5 Undue Hardship).

Undue hardship occurs if denial or termination of an applicant's or member's eligibility for coverage of long-term care services would deprive the person of any of the following:

- Medical care, which then endangers the person's health or life
- Food
- Clothing
- Shelter
- Other necessities of life

22.4.2 Undue Hardship Waiver Request Process

If an applicant or member is denied long-term care services as a result of any of the situations listed in Section 22.4.1 Application of Policy, the applicant or member must be sent the following:

- Undue hardship letter (F-10187).
- Undue Hardship Waiver Request form (F-10193).

See Process Help Section 11.7 for information on how these forms are sent. If the situation requires an IM worker to manually send these forms, the forms must be mailed the same day or, at the latest, within 24 hours after CWW or the IM worker mails the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) informing the applicant or member that long-term care services will be terminated or denied.

22.4.3 Valid Request

A completed Undue Hardship Waiver Request form (F-10193) must be submitted to the IM agency. A written and signed request that fulfills the minimum request requirements listed in Section 22.4.5 Required Documentation is also acceptable.

The long-term care facility in which the applicant or member is residing may also file an undue hardship request on behalf of the institutionalized person. However, the long-term care facility must have the applicant or member's, or his or her authorized representative's, power of attorney's, or legal guardian's written permission, using the Undue Hardship Waiver Request form, to file the undue hardship request.

The long-term care facility can also represent the institutionalized person in any subsequent fair hearing activity involving an undue hardship request or denial, as long as the facility has the applicant's or member's (or his or her authorized representative's, power of attorney's, or legal guardian's) written permission to do so. This can also include the facility requesting a fair hearing.

Note: A long-term care facility could include a nursing home, *CBRF*, or *IMD* (see Section 27.1 Institutions).

22.4.4 Effective Date of Approved Undue Hardship Waivers

IM agencies are required to process any valid request for an undue hardship waiver, whether the request is submitted timely or untimely. Completed requests must be scanned into the ECF and case comments entered documenting the receipt of the undue hardship request.

22.4.4.1 Timely Request—Received Within 20 Calendar Days After Notification Is Mailed

If the valid request for an undue hardship waiver is received by the IM agency within 20 calendar days of the undue hardship letter (F-10187) mailing date, and the request is approved, the effective date of the waiver will be as follows:

- For divestment, the entire divestment penalty period will be waived.
- For all others, the effective date will be the date initial eligibility would have begun, including any requested backdated months.

Example 1: Amy receives a notice dated February 10 that her January 20 application for *HCBW* Medicaid is denied and she will have a 100-day divestment penalty period beginning January 20. Amy submits an undue hardship request to the IM agency that is received on February 15. The undue hardship request is approved by the IM agency and Amy's penalty period is waived. Amy is eligible for HCBW Medicaid beginning on the enrollment date provided to the IM agency by the

ADRC.

Example 2: Chris submits an application for institutional Medicaid on April 30. He receives a notice dated May 20 that his application is denied due to his community spouse's refusal to sign the Medicaid application. He entered the nursing facility on April 5. Chris has been separated from his wife for many years, and she has refused all attempts to make contact to sign Chris's application. Chris submits an undue hardship request to the IM agency that is received on June 5. The undue hardship request is approved by the IM agency and Chris is eligible for institutional Medicaid beginning April 5.

22.4.4.2 Untimely Request—Received Later Than 20 Calendar Days After Notification Is Mailed

A request may be submitted later than 20 calendar days after the IM agency mails out the undue hardship letter (F-10187), but if approved, the hardship waiver effective date will not be earlier than the date the request is received by the agency. For divestment cases, the remaining penalty period will be waived from the date the request is received by the agency.

Example 3: Alice applies for Institutional Medicaid on January 20. She receives a notice dated February 10 that her application is denied and that she will have a 350-day divestment penalty period beginning January 20. In June, Alice's health deteriorates and her monthly income decreases by 60 percent. Alice submits an undue hardship request to the IM agency that is received on June 25. The undue hardship request is approved by the IM agency and Alice's remaining penalty period is waived. Alice is eligible for Institutional Medicaid beginning June 25.

Example 4: Shane applies for HCBW Medicaid on April 30. He receives a notice dated May 20 that his application is denied due to having more than $750,000 in home equity. Shane lives in his home and has other assets under the asset limit. He is functionally eligible at a nursing home level of care. Shane explores options for selling his home and moving, but the market is poor for his area, and his home has had many modifications that make it easier for Shane to live in the community with his physical disabilities but less likely for the house to sell. Shane's options for housing that meets his physical needs are limited in his community. Shane submits an undue hardship request that is received by the IM agency on June 30. The agency approves the undue hardship request and the effective date of June 30 is communicated to the Aging and Disability Resource Center (ADRC). Shane is eligible for HCBW Medicaid to begin with the enrollment date provided to the IM agency by the ADRC.

22.4.5 Required Documentation

An applicant or member (or his or her authorized representative, power of attorney, or legal guardian) must submit both of the following verifications of undue hardship (unless otherwise noted):

- A statement signed by the applicant or member (or his or her authorized representative) which describes the following:
    - In cases where a community spouse refuses to cooperate with the application process, documentation of all attempts to get cooperation from the community spouse,
    - In cases of divestment, whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets,
    - In cases when an individual is denied due to having more than $750,000 in home equity, an explanation of why the home equity cannot be accessed
    - In cases where an individual in a spousal impoverishment case is denied due to excess assets, an explanation of why the excess assets cannot be accessed.
- Proof that an undue hardship would exist if eligibility is terminated or denied or the divestment penalty period is applied (required for all four situations to which Undue Hardship policy may apply) as follows:
    - **If the applicant or member is currently institutionalized**, he or she must submit a copy of the notification from the long term care facility which states both of the following:
        - The date of involuntary discharge
        - An alternative placement location

      Or other proof that if the undue hardship waiver is not approved, the applicant or member will:

        - Not receive medical care resulting in his or hers health or life to be endangered
        - He or she will not have food, clothing, shelter, or other necessities of life.
    - **If the applicant or member is applying for HCBW**, including FamilyCare, FamilyCare Partnership, PACE, or IRIS he or she must submit an estimate of the cost of the long term care services needed to meet his or her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing, and other necessities of life.

      These two estimates must be compared to the applicant, member, or couple’s income and assets. If the IM agency determines that the applicant or member does not have enough income and/or assets to pay for his or her

long term care and other needs (i.e., food, shelter, etc.), consider the applicant or member's health to be endangered.

If the required documentation is **not** submitted with the request for an undue hardship waiver, send a written request for verification to the applicant or member, giving a verification due date of 10 calendar days from the date the request is mailed. If the applicant or member fails to submit the required verification within 10 calendar days after the request is mailed, deny the undue hardship waiver request and notify the applicant or member by sending a Notice of Denial of Benefits/Negative Change in Benefits (F-16001). The deadline to submit the required documentation may be extended for up to ten calendar days if the individual communicates to the agency a need for additional time or assistance to obtain verification.

22.4.6 Determination Process Time Frame

A decision about whether to approve or deny an undue hardship waiver must be made by the IM agency within 30 calendar days after receipt of the Undue Hardship Waiver Request form (F-10193). Send the applicant or member the appropriate manual Notice of Approval of Benefits/Positive Change in Benefits (F-16015) or Notice of Denial of Benefits/Negative Change in Benefits (F-16001) based on the IM agency's decision.

If the undue hardship request is denied, the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) must include the agency's reason for the denial: "You have not provided proof that the denial of long term care services will create an undue hardship for you." The applicant or member has the right to make another subsequent request if and when his or her circumstances change.

If an undue hardship waiver is approved, a new undue hardship request is not required to be completed at renewal unless there has been a change in the circumstances surrounding the original reason for the request.

22.4.7 Bed Hold Payments and Notifications (Divestment Only)

When an undue hardship waiver request is received by an IM agency from an institutionalized individual, the IM agency must inform the institution that the request was received and that a bed hold payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 calendar days.

The IM agency must notify the institution of the agency's decision about the undue hardship waiver.

If the request for an undue hardship waiver is approved, the divestment penalty period will be waived and the need for a bed hold payment is therefore unnecessary.

If the undue hardship waiver request is denied, the IM agency must indicate the dates for which the state will make the bed hold payments.

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e., nursing homes, etc.) who are requesting an undue hardship waiver. Bed hold payments will not be made for individuals not residing in a medical institution.

See Process Help Section 11.7.2.1 for more information for a bed hold due to undue hardship.

22.4.8 Fair Hearing Rights

If the request for an undue hardship waiver is denied, the individual has the right to appeal the decision through a written request to the *DHA* (see the Income Maintenance Manual Chapter 3 Fair Hearings). The individual has 45 calendar days from the date of the notice issuance to file the appeal. These same hearing rights are also applicable to the facility in which the individual resides, as long as the facility has the institutionalized individual's written permission to represent him or her in the appeal process.

22.4.9 Referrals to Adult-at-Risk Agency

If a power of attorney, legal guardian, or other *authorized representative* transferred the asset, the IM agency must consider making a referral to the local Adult-at-Risk agency for investigation of possible financial exploitation of an elderly, blind, or disabled individual.

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22.5 Representatives

22.5.1 Authorized Representatives

Applicants or members can appoint either an individual or an organization as authorized representative. An authorized representative can be appointed through any of the following means:

1. ACCESS, when applying
2. Federally Facilitated Marketplace (Note: 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. Paper form:

    - Appoint, Change, or Remove an Authorized Representative: Person, F-10126A
    - Appoint, Change, or Remove an Authorized Representative: Organization, F-10126B

If an applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal guardian of the person to act on his or her behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an “X,” a valid appointment requires a witness signature. If any of the required signatures are missing, the following three conditions apply:

4. The authorized representative appointment is not valid.
5. This authorized representative cannot take action on behalf of the applicant or member.
6. The agency cannot disclose information about the case to the invalid authorized representative.

There can be only one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The

appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new Appoint, Change or Remove Authorized Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

7 Apply for or renew benefits
8 Report changes in the applicant or member's circumstances or demographic information
9 Receive copies of the applicant or member's notices and other communications from the agency
10 Work with the IM agency on any benefit related matters
11 File grievances or appeals regarding the applicant or member's eligibility

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or (Organization F-10126B) to his or her IM agency.

To remove an authorized representative, the member needs to let the agency know of the removal in writing. For example, by completing Section One of the Appoint, Change, or Remove an Authorized Representative form or submitting a signed letter indicating the removal. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

Example 1: Penny is due for renewal of her BadgerCare Plus benefits on August 31. In July, she receives her case summary as part of the administrative renewal process. Penny's case summary lists her mom, Darlene, as her authorized representative. Penny no longer wants Darlene to be her authorized representative.

Penny crosses out the authorized representative information on the case summary, signs it, and mails it to the IM agency. The IM agency receives the case summary on August 3. Based on Penny's handwritten update on the case summary, the IM agency removes Darlene as Penny's authorized representative effective on August 3.

22.5.2 Additional Responsibilities

The applicant or member can choose to appoint the person who is acting as his or her authorized representative to receive the member's ForwardHealth card and is also be allowed to do the following tasks:

12 Enroll the applicant or member in an HMO
13 Contact Member Services or the HMO about a bill, service or other medical information, including Protected Health Information (PHI)

An authorized representative who is appointed by the member to have these additional functions is coded in CARES as a Medicaid (MA) Payee. The authorized representative and the MA Payee must be the same person, and the MA Payee cannot be an organization. If the member's authorized representative is an organization and the member wants to appoint a MA Payee, the member will need to change the authorized representative to a person and authorize that person to have the MA Payee functions.

The applicant or member can appoint his or her authorized representative to fulfill the additional responsibilities listed on Section 1 Part C of the Appoint, Change or Remove Authorized Representative: Person form (F-10126A). The applicant or member acknowledges that he or she is authorizing the disclosure of PHI to the authorized representative since the authorized representative will have access to medical information such as health care services or treatments, medical bills, etc.

There is no time limit on the MA Payee designation. An applicant or member can request removal of the MA Payee in writing at any time. For example, the applicant or member can submit the Appoint, Change or Remove Authorized Representative form or write a letter indicating the MA Payee removal.

22.5.3 Community Spouse as Representative

In Spousal Impoverishment cases, when a Community Spouse cooperates with providing his/her signature at application and/or renewal (Section 2.5.3), the Community Spouse can act on the applicant's/member's behalf without requiring the completion of the Appoint, Change, or Remove an Authorized Representative form (F-10126A). The act of signing the application/renewal allows the Community Spouse to do the following on the applicant's/member's behalf:

- Provide information for the member's application and/or renewal

- Report changes in the applicant's/member's circumstances or demographic information
- Receive copies of the applicant's/member's notices and other communication from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant's/member's eligibility

Note: In Spousal Impoverishment cases, the applicant or member's signature and the community spouse's signature are **both required** at application and renewal.

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23 Reserved

23.1 Reserved

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SUBPROGRAMS (CHS. 24- 38)

24 SSI-Related Medicaid and Deductibles

24.1 SSI Related Medicaid Introduction

SSI-related Medicaid is the original, basic Medicaid program for individuals who are *elderly*, blind, or disabled. SSI related individuals must meet all appropriate Medicaid nonfinancial eligibility requirements. SSI related Medicaid has the lowest income and asset limits of all EBD Medicaid programs/categories. It has two income limits which are referred to as the categorically needy limit and the medically needy limit.

Allow the following income disregards and expenses to the fiscal group's income in the order below to determine the countable net income.

- Excess Self Employment Expenses
- The 65 & ½ earned income *disregard*
- Child support and maintenance
- $20.00 SSI general income disregard
- Impairment related work expenses (IRWE)

A fiscal group with countable net income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test.

If a fiscal group’s countable net income exceeds the categorically needy income limit, their income is then compared to a medically needy limit of 100% FPL, which is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. If the fiscal group’s countable net income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

If a fiscal group fails the medically needy income test because their countable net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 24.2 Medicaid Deductible Introduction for more information about Medicaid Deductibles and to chapter 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid Deductible.

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for more information.

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24.2 Medicaid Deductible Introduction

When a Medicaid *applicant* is ineligible for Medicaid solely because he or she has income that exceeds the Medicaid medically needy income limit, he or she can become eligible by meeting the Medicaid deductible. "Meeting the Medicaid deductible" means incurring medical costs that equal the dollar amount of the deductible.

The Medicaid deductible is the group's total excess monthly income over the 6 consecutive months of the Medicaid deductible period (See 24.3 Deductible Period).

"Excess monthly income" is the amount which is above the group's monthly medically needy income limit.

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24.3 Deductible Period

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. It begins in the month which the *applicant* chooses, and it ends six months later. See 5.9.5 Eligibility for an exception to the 6 month deductible period for backdate periods after a formal *disability* determination has been made for a *member* certified under a PD.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month after the month of application.

Example 1: John applies for Medicaid in July. He can choose to begin his six month Medicaid deductible period in April, May, June, July, or August.

The applicant may choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month after the month of application. However, the first month of a deductible period may not be a month in which the person is ineligible for excess assets or is non-financially ineligible. The applicant may choose a 6-month Medicaid deductible period which includes a month or more (except for the first month) in which he or she is ineligible for excess assets or for a non-financial reason. Excess income is still calculated and included in the deductible amount for any months that the applicant may be ineligible due to assets or a non-financial reason. If the applicant meets the deductible, the individual may only be certified for Medicaid during the dates when he or she was non-financially and asset eligible.

Example 2: Doyle applies for Medicaid in July. He has excess income in July. He wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the $5,000 on May 31, so he can begin his Medicaid deductible period in May.

Example 3: Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.

In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31, but no longer had the $5,000 on June 30. Her deductible period will run from April through September. However, if she meets the deductible in April, she would only be eligible through the end of April and from June 1 to September 30. If she meets the deductible in May, she would only be eligible from June 1 to September 30. Due to excess assets in May, she may not be eligible for any day in that month.

Example 4: Marion applies for Medicaid in July. She has excess income in July.

She wants a Medicaid deductible period that goes from April through September.

Marion was incarcerated from April 30th through May 18th. She meets the deductible with a countable expense from April 10th, so she should be certified from April 10th through April 29th, and May 19th through September 30th.

Example 5: Janet applies for Medicaid in July and requests a Medicaid 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.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his or her eligibility in the backdate month is determined by whether or not he or she had excess assets on the last day of the month.

Example 6: Jack applies for Medicaid in July. He wants a Medicaid deductible period that goes back two months to include May and June. In May, he received a $10,000 gift. On May 29 he spent the $10,000 on a new roof. His assets were below the asset limit by the last day of the month, and he is otherwise eligible except for excess income for both backdated months, so his deductible period can begin in May.

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period.

Example 7: Jeff applies for Medicaid on 1/1/14 and his monthly excess income is $100.00. His Medicaid deductible is $600.00 and his deductible period is January 01, 2004 through June 30, 2014. In April 2014, Jeff's monthly excess income decreases to $10.00 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have his worker recalculate the original $600.00 deductible which would then become a $330.00 deductible (three months of $100.00 excess income and three months of $10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2014 through September 30, 2014 with a $60.00 deductible obligation ($10.00 x 6 = $60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (See 24.6.1 Changes During the Deductible Period> Income Changes.)

Individuals who have been certified for Medicaid after meeting a deductible, will have to complete a review to establish a new deductible period. CARES does not send a review notice to the member regarding the new deductible period if he or she did not meet the deductible for the current period.

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24.4 Choosing Not to Have a Deductible

An *applicant* 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 Medicaid deductible. He or she can choose to be certified in the months he or she is eligible and to accept the ineligibility of the other months where he or she has excess income.

Example 1: Horace applies for Medicaid in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants Medicaid eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets.

But in May and June he had excess income of $20 each month. He has 2 choices:

Choose a Medicaid deductible period of April through September. After meeting the Medicaid deductible of $40 he would be certified for Medicaid from April through September.

Not choose a Medicaid deductible period. He would not have to meet a Medicaid deductible. He could be certified immediately for April and July. But he would have to forego Medicaid for May and June because of the excess income in May and June.

If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, he or she does not have to include them in a deductible period. He or she can be certified for them immediately, and can begin the Medicaid deductible period with the month of application.

Example 2: Roslyn applies for Medicaid in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her Medicaid deductible period in July.

24.5 Calculating the Deductible

To calculate the dollar amount of the Medicaid deductible for a regular Medicaid fiscal test group:

24.5.1 Fiscal Test Groups

Determine the Medicaid deductible period (see Section 24.3 Deductible Period) for this fiscal test group.

Find the fiscal test group's total net income for each month in the deductible period.

For the months after the month of application, subtract the income deductions (see Section 15.7 Income Deductions), including any applicable special exempt income, *IRWE*, the $65 and ½ earned income deduction, and the $20 disregard, from the applicant's gross income to get the monthly countable net income. Some of the income deductions allowed in other forms of Medicaid, such as the COLA for Special Status Medicaid or medical/remedial expenses for MAPP, are not deducted when calculating a deductible.

Compare the total net income of each month with the group's medically needy income limit. If the group is an:

SSI-related fiscal test group, see Section 39.4 Elderly, Blind, Or Disabled Assets and Income Tables.

If a month's income is less than or equal to the medically needy limit, ignore it.

If a month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net in-come of that month.

Add together the excess income of the months in the deductible period. The result is the Medicaid deductible.

24.5.2 Institution Cases

24.5.2.1 Backdating

Institutionalized and non-institutionalized persons can be eligible back to the 1st of the month, 3 months prior to the month of application. Even if they are ineligible in the month of application, they may still be eligible for retroactive coverage. When an institutionalized person requests retroactive Medicaid, test him or her against the nonfinancial and financial standards that are appropriate to the month being tested. For the months he or she was not institutionalized, use the EBD asset and income limits (39.4 EBD Assets and Income Table). For the months he or she was institutionalized, use the institutional eligibility criteria found in 27.1 Institutions.

24.5.2.2 Deductible

For the months in which he or she was not institutionalized, he or she may be eligible in some, but ineligible in others, due to excess income. In this situation, he or she has two choices:

1. To be certified for the months he or she is eligible, and accept the ineligibility of the other months in which he or she has excess income, **or**
2. To meet a deductible. The deductible period begins in the backdate month that he or she chooses, and extends 6 months. Calculate the deductible for the full 6-month deductible period. Calculate the deductible by comparing his or her monthly income for each of the 6 months to the SSI-related medically needy income limit, not the institutional income limit.

Expenses which can be counted against the deductible are those listed in 24.7 Meeting the Deductible plus his or her cost of care (27.7 ILTC Cost of Care Calculation). Expenses that cannot be counted are listed in 24.7.2 Meeting the Deductible> Noncountable Costs.

When he or she meets the deductible, she can be certified to the end of the deductible period. At the end of the deductible period, redetermine his or her eligibility using the institutional financial tests.

24.5.3 Deductible Examples

Example 1: Artie applies for Medicaid in July. He wants to backdate his Medicaid three months. His Medicaid deductible period is April through September. In April, May, June, and July his *AG* had excess income of $50 each month. His prospective excess income for August and September is $50 each month. 6 X $50 = $300. Artie's Medicaid deductible is $300.

Example 2: Clarice applies for Medicaid in July. She wants to backdate her Medicaid to May 1. Her Medicaid deductible period is May 1 through October 31. In May and June her AG had excess income of $100 each month. In July it has excess income of $200. Its prospective excess income for August, September, and October is $200 a month. Clarice's Medicaid deductible is $1,000.

Example 3: Myron applies for Medicaid in July. He wants to backdate Medicaid to June 1. His Medicaid deductible period is June 1 through November 30. In June his AG had excess income of $50. In July it has no excess income. Its prospective excess income for August, September, October, and November is $0. Myron's Medicaid deductible is $50.

Example 4: Tyler applies for Medicaid in July. He wants his Medicaid to begin July 1. His Medicaid deductible period is July 1 through December 31. In July his AG has $100 excess income. Its prospective excess income for August, September, October, November, and December is $100 each month. Tyler's Medicaid deductible is $600.

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24.6 Changes During the Deductible Period

24.6.1 Income or Deduction Changes

If there are income or deduction changes during the Medicaid deductible period, that result in a decrease in the deductible amount, recalculate the Medicaid deductible amount. Beginning July 1, 2020, the deductible amount will no longer be increased when an unmet deductible assistance group has an increase in income or a decrease in deductions. Once a deductible period and deductible amount are determined and the member has been notified of his or her deductible amount, the deductible amount will never increase during the same deductible period.

At the time of initially determining a deductible period, the amount of the deductible must be determined by taking into account all changes in income, deductions and household composition known at the time the deductible is created.

To determine the amount of a decreased deductible:

1. Add together the monthly excess income of the months of the Medicaid deductible period that have already gone by.
2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.
3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.
4. Add the results of #1, #2, and #3.

Example 1: Cicely applied for Medicaid in July. She had excess income of $20 a month. Her Medicaid deductible was $120. In November she reports a pay decrease of $10 a month. Now you must recalculate her Medicaid deductible.

1. Add together the excess income of months July through October. The result is $80.
2. Calculate her November excess income. The result is excess income of $10.
3. Prospective income for December is $10.
4. Cicely's new Medicaid deductible: $80 + $10 + $10 = $100.

If the income change results in **lower excess income** in the month of change, the *applicant* can choose to:

1. Recalculate the Medicaid deductible, **or**
2. Create a new deductible period.

Example 2: Winston goes from full time to part time employment in the fourth month of his Medicaid deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his Medicaid deductible or to have a new deductible period.

If he recalculates, the resulting deductible will be lower than the previous one.

His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he 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.**

Example 3: If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

24.6.2 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, you must recalculate the deductible if the result is a decrease in the deductible amount. Beginning July 1, 2020, the deductible amount may no longer be increased when an unmet deductible assistance group has a change in group size. Once a deductible period and deductible amount are established, the deductible amount will never increase during the same deductible period. Deductible amounts may be decreased due to changes in group size. Compare the new group's income with the new group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes (24.6.1 Income or Deduction Changes).

Example 4: John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group. On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be recalculated using the smaller group size (one person fiscal test group) as of March 1.

If after subtracting John's income the amount of excess income above the new income limit for the group of one is lower than it was for the group of 2, use the lower income and deductible amount to recalculate Sally's deductible. However, if the amount of excess income above the income limit for a group of one is higher

than what it was for the group size 2, and using that amount would increase the amount of the deductible, leave the deductible amount unchanged.

24.6.3 Asset Changes

If the fiscal test group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible for that month. Excess income may still be calculated during the dates the individual is ineligible due to assets, however the individual can only be certified for Medicaid during the dates he or she has assets below the asset limit.

24.6.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period excess income may still be calculated during the dates the individual is non-financially ineligible, however the individual can only be certified for Medicaid during the dates he or she is/was non-financially eligible.

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24.7 Meeting the Deductible

The fiscal test group meets the deductible by incurring medical 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 group can be certified for Medicaid.

If the group has not yet met the deductible within the deductible period, it may choose to start a new deductible period that begins with a later month in the current deductible period with a new application (see Section 24.3 Deductible Period).

Example 1: Stanley's deductible period is from January through June. In April Stanley incurs a large medical expense that would meet his deductible. Stanley requests to start his deductible April 1st. His new deductible period is April through September. Stanley will have to submit a new application.

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in Section 24.7.1 Countable Costs below.

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant /member's FTG.

Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example 2: Sally's spouse died of leukemia in April 2014. In September 2014, Sally requests that a medical bill incurred for her spouse be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in (24.7.1.1 Countable Expenses)

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 Medicaid 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.
- 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 3: From May- July 2013 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2014, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for Medicaid on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the member would never be billed for the charges, but if he or she 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 4: Lestat applies for Medicaid in July, 2014. An Medicaid deductible of $700 is calculated for him. In 2013 he had a blood transfusion. The bill for the transfusion was $800. He never paid it and still owes it to the service provider. He can use the unpaid bill to meet his Medicaid 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 5: Frank and Estelle apply for Medicaid on March 1, 2014,

requesting that their deductible period begin January 1, 2014. Their deductible for the period January 1 - June 30th is $340. In April, they had a ten-year-old medical bill of $300 written off. They can count the $300 toward the January - June 2014 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 6: 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 7: Malcolm is in his second deductible period which began March 1, 2014. 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 2013. He may not apply this toward his current deductible.

Example 8: Norah is in her second deductible period which began in September 2014. In June 2014, Norah met her first deductible period and was certified for Medicaid through August. After certification, and before the first deductible period ended in August, Norah paid for medical services that were not Medicaid covered services. Norah can apply these paid bills to the second deductible period that began in September 2014.

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 9: Sierra and Skyler apply for Medicaid on August 10, 2014, requesting that their deductible period begin on August 1, 2014. Their deductible for the period from August through January is $1500. On May 10th the couple had paid off a $2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining $500 cannot be applied to future deductible periods.

Example 10: Anna applied for Medicaid on July 25, 2020, with no request for any backdated months. Her deductible period is from July 2020 through December 2020. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May, and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.

Example 11: Anna applied for Medicaid on July 25, 2020, requesting a one month backdate. Her deductible period is from June 2020 through November 2020. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 24.7.1 Countable Costs:

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 Medicaid. Medical expenses for services or prescriptions acquired outside of the United States 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 and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

   Note: ForwardHealth interChange (iC) data may be used to calculate Medicaid 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 participant'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 participant'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.

CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation (21.4.2 Transportation).

4. Medical insurance premiums paid by a member of the fiscal test group or FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. This includes all Medicare premiums paid by the member. 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. This includes all Medicare premiums owed by the member during the 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. 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 24.7.1. # 3.

   Examples include:
   a. General Assistance
   b. Community Options Program
   c. AIDS Drug Assistance Program (ADAP)

Example 10: Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 11: 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 Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in 24.7.1 # 3

Example 12: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid 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 13: Charlie received a medical service in January which was paid by

Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

24.7.2 Noncountable Costs

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 Medicaid, Medicare, or other Insurance.

Example 14: Medical services provided to an incarcerated person. In this case, 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 24.7.1 Countable Costs.

Example 15: An applicant incurs a $300 medical bill. She applies the $300 toward her deductible even though he or she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the $300 bill. But she cannot use it to meet her current deductible because she already used it to meet the prior deductible.

24.7.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/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.

If the member is **55 or older**, forward the payment to:

ForwardHealth
Estate Recovery/Casualty Collections
313 Blettner Blvd
Madison WI
53714-2405

Prepayment checks or money orders should be made payable to: "The Department of Health Services."

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.

If he or she is **under 55**, instruct the member to make the payment payable to your *IM* Agency. Report the receipt on the Community Aids Reporting System (CARS) labeled as a Medical Refund.

24.7.3.1 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 16:** 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 Medicaid eligibility begins on March 1st.

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.2 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 17:** Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is $1,800. Chad submits a medical bill with a March 8th date of service for $800. On July 15th, he submits payment of $1,000. Chad's Medicaid eligibility begins March 8th. Submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update (F-10109) identifying the provider of service on March 8th and the $800 member share amount.

Enter the incurred medical expense first. Perform a PF23 sort. The remaining balance is the amount that can be paid to meet the deductible. Enter the payment date as the same date of the last incurred medical expense, which equals the balance of the deductible, on CARES screen AGTM. Complete and submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update (F-10109) to the fiscal agent. Enter the deductible met date as the date of the last incurred medical expense. Enter the member share as the amount of the last incurred medical expense.

24.7.3.3 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 18:** Roberta's deductible period is from March 1st through August 31st. The total Medicaid 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 Medicaid eligibility begins March 1st.

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.4 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.

24.7.3.5 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.

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24.8 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.

24.8.1 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 difficult sometimes 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 whatever the deductible was on the date of admission, count the deductible as having been met on the date of admission. Set that date as the begin date of Medicaid certification. Apply the hospital bill to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example 1: 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.

24.8.2 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.

In determining whether these "global" pregnancy fees meet the deductible, treat them the same way as you would a hospital bill. If the "global" pregnancy fee is equal to or above the deductible, count the deductible as having been met as of the date an agreement was signed.

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24.9 Notice to Fiscal Agent Concerning Any Remaining Deductible

When the *member* receives a medical bill that is equal to or greater than the amount he or she still owes on the deductible, he or she can be certified for Medicaid. He or she must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update (F-10109) to the fiscal agent indicating the amount of the bill that the member owes. The fiscal agent subtracts this amount from the bill and Medicaid pays the rest.

Fill out the Medicaid Remaining Deductible Update (F-10109) only if:

A Medicaid certified provider has provided the billed services.

The person, having met the deductible, is being certified. If he or she is not being certified, Medicaid 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 he or she has met the deductible, he or she still owes for all bills prior to that date.

If more than one bill was incurred on the date the deductible was met, send additional Medicaid Remaining Deductible Update (F-10109) forms for any other bills for which the member would be responsible.

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24.10 Late Reporting of Deductible Information

If the client 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 he or she reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin Medicaid certification on that date.

24.11 Reserved

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24.12 Changes After Meeting a Deductible

24.12.1 Changes After Meeting a Deductible Introduction

When the fiscal group has met the deductible, it can be certified for Medicaid to the end of the deductible period.

24.12.2 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period once the deductible has been met. However, workers must determine if eligibility for the deductible should have begun on an earlier date due to a reduced deductible amount and manually certify eligibility for the appropriate dates. A met deductible period may not be shortened due to any changes which would have increased the amount of the deductible.

24.12.3 Asset Changes

If the Medicaid group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue Medicaid eligibility.

If the group's assets fall below the limit before the end of the met deductible period, reopen the deductible for the remainder of the original deductible period.

Example 1: Jim has a deductible period from July through December. He meets his deductible on July 18. In August, Jim reports that he inherited $5,000 and he still has it as of August 31. His case closes for October for excess assets. On November 5, Jim reports that he spent the money and his assets are now below $2,000. Since he is still in his deductible period and no longer ineligible because of his assets, his deductible should be reopened for November 1 through December 31.

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

The deductible period (24.3 Deductible Period) for which excess income is calculated may include a month(s) in which, if a *member* had applied, he or she would have been ineligible for a non-financial reason.

If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.

If an *adult* caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his or her name will appear on the Medicaid card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, reopen Medicaid for the dates when he or she was non-financially eligible.

24.13 Death During a Deductible Period

24.13.1 Death During a Deductible Period Introduction

If the *member* dies during the deductible period, and is not already certified, look at all countable costs (see Section 24.7.1 Countable Costs) prior to death. If those countable costs meet the deductible, certify the deceased person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income for a group size of 1. For a group size of 2, if the spouse passes away, the deductible amount should be recalculated for all months after the date of death with a group size of 1 and only with the surviving spouse's income. In both cases, the deductible amount must be recalculated.

If the deductible was met, met on a date after the first day of the deductible period and before the member dies, recalculate the amount of the deductible. If the new deductible amount will cause the member to meet the deductible on an earlier date, recertify the deductible using that earlier date. Eligibility will be granted from the point from which the deductible was determined to have been met through the date of death.

24.13.2 Prepaid Deductible

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 is refundable.

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25 Special Status Medicaid

View History

25.0 Special Status Medicaid Introduction

Federal provisions require *DHS* to continue to consider specified groups of former *SSI* beneficiaries as SSI beneficiaries for Medicaid purposes, as long as they would otherwise be eligible for SSI payments “but for” the income disregards required to be given in each special status group.

These “special status” Medicaid groups include the following:

- 503 cases (see Section 25.1 "503" Eligibility)
- *DAC* (see Section 25.2 Disabled Adult Child)
- Widows and widowers (see Section 25.3 Widows and Widowers)
- 1619 cases (see Section 25.5 1619 Cases)

When determining the eligibility for Special Status Medicaid applicants and members, the appropriate *COLA* and *OASDI* income disregards, as described in the policy for each group, must be given.

Each Special Status Medicaid group has a specific set of requirements that must be met before the member can be considered a Special Status MA member (see sections listed above). Simply losing SSI or receiving a DAC or Widow/Widower payment does not automatically qualify a member for a Special Status disregard. To receive the Special Status Medicaid considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not always.

Note: "Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which SSA recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI.

"Concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits.

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25.1 "503" Eligibility

25.1.1 "503" Introduction

Federal law requires that the *IM* agency provide Medicaid eligibility to any person for whom the following conditions exist:

- He or she is receiving OASDI benefits.
- He or she was receiving *SSI* concurrently with OASDI but became ineligible for SSI **for any reason**.
- Total countable income, excluding the "503" disregarded income, is less than or equal to the categorical income limits for SSI-related Medicaid.
- Total countable assets must be below the categorical asset limits for SSI-related Medicaid.

Note: "Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which *SSA* recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits. To receive the 503 eligibility considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive the OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not always.

An assistance group with these two characteristics is often referred to as a "503" assistance group. The name comes from Section 503 of the law that implemented this policy (Public Law 94-566).

Example 1: Kathy received SSI and SSSS (Social Security Surviving Spouse) payments for five years. She lost her SSI payment due to an increase in unearned income when she began receiving a pension payment in January of this year. While an increase in the COLA was not the reason for her loss of the SSI payment, she is still entitled to receive a COLA disregard on any OASDI payments she receives because she received OASDI concurrently with SSI and lost SSI.

Kathy will receive COLA disregards on her SSSS payment in order to determine her eligibility for special status Medicaid.

25.1.2 Identifying a "503" Assistance Group

When a "503" assistance group applies for Medicaid, *disregard* all OASDI COLAs the assistance group has received since the last month he or she was eligible for and received both OASDI and SSI benefits.

To identify a "503" assistance group, complete the following steps:

1. Determine whether, after April 1977, there has ever been a month in which one of the following conditions existed for the applicant or member:

    - He or she was eligible for both OASDI and SSI (a person who received SSI fraudulently does not qualify as a "503" case).
    - He or she received an OASDI check or a retroactive OASDI check and a SSI check for the same month in which he or she was eligible for both OASDI (or retroactive OASDI) and SSI.

    a. If the answer to both questions is "No," the applicant or member is not considered a "503" assistance group.
    b. If the answer to either of the questions is "Yes," the applicant or member is no longer receiving SSI. Proceed to Step 2.

2. Determine if the applicant or member is now receiving an OASDI check.
    a. If the answer is "No," he or she is not a "503" assistance group.
    b. If the answer is "Yes," he or she is a "503" assistance group and will receive a COLA disregard. Enter “Y” on the Individual Nonfinancial>Prior SSI page in *CWW*.

If the applicant or member was receiving *SSI-E*, the state SSI-E will also be deducted (see Section 39.4.1 Elderly, Blind, or Disabled Assets and Income Table). SSI-E assistance groups are SSI recipients who receive a higher state supplement than regular SSI. People who receive SSI-E payments must live in one of the following:

- In substitute care
- At home and need more than 40 hours a month of primary long-term support services.

25.1.3 Calculating the Cost-of-Living Adjustment Disregard

To calculate the COLA disregard amount, do the following:

1. Find the assistance group's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.

    Do not include in the gross income any Medicare Plan B premiums, which the state has paid for the assistance group.

2. On the COLA Disregard Amount Table (see Section 39.6 Cost-of-Living Adjustment), find the last month in which the person was eligible for and received a check for both OASDI (or retroactive OASDI) and SSI.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

Example 2: Newby's current gross OASDI income is $820. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI and received benefits from both was April 2013. On the COLA Disregard Amount Table (see Section 39.6 Cost-of-Living Adjustment), April 2013 falls between January–December 2013.

The decimal figure that applies to April 2013 is 0.031247. Multiply 0.031247 by $820 to find Newby's COLA disregard amount of $25.62. Subtract the $25.62 disregard amount from the $820 OASDI. Newby’s income is then $794.38. This amount is below the EBD income limit of $816.78, which makes him eligible.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard again.

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25.2 Disabled Adult Child (DAC)

25.2.1 Disabled Adult Child Introduction

A *DAC* is a person who meets the following criteria:

- At least 18 years old at the time *SSI* was lost.
- Classified by *SSA* as disabled before age 22.
- Receives an *OASDI* (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.

Note: Receipt of Railroad Retirement is not considered OASDI for this policy.

- Was receiving SSI but lost SSI eligibility because the OASDI (DAC) payment or an increase in the OASDI (DAC) payment exceeded the SSI income limits.

Federal law requires that the *IM* agency provide Medicaid eligibility to any DAC for whom the following condition exists:

- Total countable income, excluding the "DAC" disregarded income, is less than or equal to the SSI-related categorical income limits.
- Total countable assets are less than or equal to the categorical asset limit for SSI-related Medicaid.

25.2.2 Disabled Adult Child Payment Disregard

When a Disabled Adult Child applies for Medicaid, *disregard* all OASDI (DAC) payments which caused him or her to lose SSI eligibility.

Example 1: Disregard the **entire** OASDI (DAC) payment when the initial OASDI (DAC) payment caused the member to be ineligible for SSI:

Harvey is an SSI recipient. While his father worked, Harvey received a monthly SSI payment of $686.78. When his father retired, Harvey began receiving an OASDI (DAC) payment of $900. The OASDI payment exceeded the SSI income limits, causing his SSI to end. It is not necessary for the payments to be received concurrently (in fact, often they will not be) but the SSI payment must have ended because of the OASDI increase.

When Harvey applies for *EBD* Medicaid, the **entire** initial OASDI (DAC) payment of $900 (and any subsequent COLA disregards) will be disregarded when his EBD Medicaid eligibility is determined.

Example 2: George is an SSI recipient. While his father worked, George received a monthly SSI payment of $686.78. When his father retired and began receiving social security retirement, George began receiving an OASDI (DAC) payment of $500 a month. While George's SSI payment decreased, the initial OASDI (DAC) payment did not cause him to lose SSI eligibility.

When his father died, George's OASDI (DAC) payment increased to $750 a month. The increased amount put him over the SSI income limit, and he lost SSI.

George applies for EBD Medicaid. The IM worker must disregard the OASDI (DAC) payment increase of $250 ($750 - $500 = $250) because it was the **increase** that caused George to lose SSI eligibility.

Example 3: Jane is an SSI recipient. While her father worked, Jane received a monthly SSI payment of $686.78. When her father retired and began receiving social security retirement, Jane began receiving an OASDI (DAC) payment of $1372 a month. The OASDI payment exceeded the SSI income limits, causing her SSI to end.

When Jane applies for EBD Medicaid, the **entire** initial OASDI (DAC) payment of $1372 (and any subsequent COLAs) will be disregarded when her EBD Medicaid eligibility is determined.

Two years later, Jane's DAC payment increased to $2539 because her brother graduated from high school. Because this increase did not cause Jane to lose her SSI, only the initial DAC payment ($1372 plus any subsequent COLAs) is disregarded.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.

25.2.3 COLA Disregard

When a Disabled Adult Child applies for Medicaid, disregard all OASDI COLAs since the last month he or she was eligible for and received both OASDI and SSI benefits. Calculate the *COLA* disregard amount (25.1.2 Identifying a "503" AG).

If the Disabled Adult Child was receiving *SSI-E*, disregard both the state SSI-E Supplement (39.4 EBD Assets and Income Tables) and the COLA.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.

Example 3: In Example 1, because Harvey received SSI concurrently with the OASDI (DAC) payment, he is also eligible for a COLA disregard for any OASDI payments he receives.

Example 4: In Example 2, because George received SSI and an OASDI (DAC) payment concurrently and then lost SSI eligibility, he must also receive a COLA disregard on any OASDI payments he receives.

25.2.4 Disregards For People Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase in DAC Benefits

People who lose their SSI eligibility due to the receipt of an initial OASDI (DAC) benefit or increase in their current OASDI (DAC) benefit is entitled to the following disregards when their Medicaid eligibility is being determined:

1. The OASDI (DAC) payment, either the initial payment or the increase in payment, whichever made them ineligible for SSI.
2. The SSI-E supplement, if they were receiving the E supplement at the time they became ineligible for SSI.
3. All COLAs received since the last month that they were eligible for and received both OASDI (DAC) and SSI benefits.

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25.3 Widows and Widowers

A widow, widower, or surviving ex-spouse who lost *SSI* remains eligible for Medicaid if he or she meets all of the following conditions:

- Is considered elderly, blind, or disabled.
- Is at least 50 years of age.
- Is receiving *OASDI* benefits as a widow or widower (Section 202, Title II, Social Security Act).
- Received SSI or a State Supplementary Payment (SSP) (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables) in the month before the month in which he or she began to receive Widow/Widower OASDI payments.
- Became ineligible for SSI or SSP due to the receipt of the Widow/Widower benefits.
- Would be eligible for SSI or SSP except for the receipt of the Widow/Widower OASDI payment. *Disregard* the entire OASDI amount.
- Is not entitled to Medicare Part A.

Note: In some cases a Widow/Widower, who loses eligibility for the Widow/Widower Medicaid benefit due to receipt of Medicare, may be eligible as a “503” case. See Section 25.1 “503” Eligibility.

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25.5 1619 Cases

Section 1619 of the Social Security Act applies to people with severe impairments who work. If they would be ineligible for *SSI* because of their earnings, they keep their *SSI* Medicaid eligibility.

1619(a): They are working people with earnings at or above the *SGA* who continue to receive a small SSI check. They retain SSI Medicaid eligibility.

1619(b): They are working people who do not receive a SSI check but are still eligible for SSI Medicaid. For the *COLA disregard* determination, use the date cash payments ended.

To determine the person's SSI status, contact the local Social Security Office. Social Security processes Medicaid eligibility for these members.

The SSI benefits of a 1619 person entering an institution continue for up to two months.

If a *member* loses 1619 status, but also is a widow/widower, *DAC*, or 503, he or she is entitled to all disregards that are appropriate for these special status cases when determining eligibility. Losing 1619 status is considered the same as losing SSI eligibility.

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26 Medicaid Purchase Plan

26.1 MAPP Introduction

MAPP is a subprogram of the Wisconsin Medicaid Program. It allows disabled people who are working or want to work to become or remain Medicaid eligible, even if employed, since there are higher income limits.

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26.2 MAPP Application

26.2.1 Begin Month

Certify applicants for *MAPP* retroactively for any or all, up to three prior months, if he or she met all of the eligibility criteria at that time. The *member* is responsible for any premium due for the previous months in which he or she elects coverage.

Clients can also choose to begin MAPP eligibility during any future month that can be processed in CARES.

Example 1: Jack applies for MAPP on September 30th and requests a retroactive determination of eligibility. His application is processed on October 21st. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November or December.

26.2.2 Fiscal Test Group

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (*AG*). Enter them in CARES on the same application. The member's *spouse* is a countable member of the *FTG* . A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP *applicant* chooses not to disclose or verify assets, a case may fail for a higher Medicaid eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the member's spouse and test children in the FTG. Test children include the member's *minor* natural or adoptive children. Do not include the member's stepchildren in the FTG. Do not count the income or assets of the test children.

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26.3 Nonfinancial Requirements

26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction

Members must:

- Meet general Medicaid nonfinancial requirements (see Section 4.1 Who is Nonfinancially Eligible for Medicaid?).
- Be at least 18 years old (there is no maximum age limit).
- Be determined disabled, presumptively disabled, or *MAPP*-disabled by the *DDB*, regardless of age (see Section 5.2 Determination of Disability and Section 5.10 Medicaid Purchase Plan Disability).
- Be working in a paid position or participating in an *HEC* program (see Section 26.3.4 Work Requirement Exemption).

Note: People who are receiving Medicaid through *SSI*'s 1619(b) program are nonfinancially eligible for MAPP. People who are *SSI*-eligible under 1619(b) can be on SSI Medicaid and MAPP at the same time. These people are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals. Because this group is the most likely to move from SSI Medicaid to MAPP, *DHS* has decided to allow them to be eligible for both at the same time.

26.3.2 Disability

Disability is a non-financial eligibility requirement for MAPP, even for members who are age 65 and older. DDB must certify disability (see Section 5.10 Medicaid Purchase Plan Disability). There is no requirement that a member be a current or former SSI or *SSDI* beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If an applicant or member does not have a disability determination from *DDB*, complete the disability application process outlined in Section 5.3 Disability Application Process even if the applicant or member is age 65 or older (unless the applicant or member fits the policy on converting from SSDI to SSRE). The rest of the MAPP application must be completed at this time, and MAPP eligibility can only be pending for the disability determination before the *MADA* will be sent to DDB through the automated process (see Process Help Section 9.4 Automated Medicaid Disability Determination).

Applicants and Members Converting from SSDI to SSRE
An applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began

receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. The member is not required to provide verification of the disability unless the worker is not able to use data exchanges or other information from SSA to confirm that the individual received disability payments immediately prior to receiving SSRE.

Redeterminations
Follow the rules in Section 5.7 Redetermination on when to review disability determination.

Members Who Have Lost Their SSDI Due to Exceeding Substantial Gainful Activity
A current MAPP member who loses SSDI because he or she exceeds the Substantial Gainful Activity level remains MAPP-eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with *adverse action* notice for the reason "not MAPP disabled."

26.3.3 Work Requirement

To meet the work requirement, a member must engage in a work activity at least once per month or be enrolled in an HEC program (see Section 26.3.4 Work Requirement Exemption). Consider a member to be working whenever he or she receives something of value as compensation for his or her work activity. This includes wages or in-kind payments (see Section 15.5.1 Income In-Kind). The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

26.3.3.1 Self-Employment

If a member engages in a self-employment activity that generates some compensation at least once in the calendar month, the individual is employed for purposes of MAPP.

A member does not need to realize a profit from self-employment for it to be defined as work.

26.3.3.2 Contractual Employment

If a member is under contractual employment for the entire year, he or she is employed for the purposes of determining MAPP eligibility for the entire year. Do not consider members employed for any months in which they do not have a contractual employment agreement.

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. Eligibility cannot be terminated until one full calendar month has passed since employment ended.

Example 1: Kerrie reported on March 15 that her employment ended March 5. She has until April 30 to become employed again, and her eligibility cannot be terminated due to not having employment before then.

26.3.3.4 Temporary Employment

If a member has signed up with a temporary service agency and is not actually working, he or she is not working for purposes of MAPP. If a member is engaged in work activity for which compensation will be received at least once in a calendar month, he or she is employed for the purposes of determining MAPP eligibility in that calendar month.

26.3.4 Work Requirement Exemption

If there is a serious illness or hospitalization that causes the member to be unable to work, the work requirement can be suspended for up to six months. He or she can continue to be MAPP eligible. The member must contact the *IM* agency to request the exemption. Have the member complete the Medicaid Purchase Plan (MAPP) Work Requirement Exemption form (F-10127). This provision is not available unless he or she:

- Has been enrolled in MAPP for six months and has paid any applicable premiums prior to the request of an exemption.
- Is expected to return to work in the next six months.
- Provides an expected date of recovery.
- Provides the reason that an exemption is needed (e.g., illness or hospitalization).
- Has had no more than two exemptions (maximum of six months each) to the work requirement in a three-year time period. The two exemptions cannot be consecutive.

Based on the criteria outlined above, the IM agency will approve or deny the request. If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

If the member has received MAPP services in error, due to failure to report a change or other reason that would have made the member ineligible, he or she is not able to receive a work requirement exemption.

In the sixth month of an exemption, mail the member a notice indicating the date the medical work exemption will end as well as steps the member may take to continue MAPP eligibility.

26.3.5 Health and Employment Counseling Program

The HEC Program is a program certified by the *DHS* to arrange services that help an applicant or member reach his or her employment goals. HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months, members can re-enroll in HEC to meet the eligibility criteria for MAPP as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

26.3.5.1 Health and Employment Counseling Processing

Applicants or members wishing to enroll in HEC are required to complete the Health and Employment Counseling (HEC) Application (F-00004) and send it to the HEC Coordinator at the following address:

Employment Initiatives Section
HEC Coordinator
Room 527
1 W. Wilson St.
Madison, WI 53708

Fax: 608-223-7755
Phone: 866-278-6440

The HEC Coordinator will make a final approval or disapproval decision within 10 working days.

If the application is not approved, the member will be informed that he or she has not been approved and that he or she has the right to file a fair hearing.

If the application is approved, the HEC Coordinator will send the member an approval letter and send a copy to the CDPU/MDPU.

IM workers should give the Health and Employment Counseling (HEC) Application along with the Medicaid Purchase Plan Fact Sheet (P-10071) to any MAPP applicant who requests HEC. The applicant can complete the application on his or her own or with the assistance of the HEC Coordinator or an advocate. IM workers are not expected to assist with filling out or submitting the form to the HEC Coordinator.

26.3.5.2 Health and Employment Counseling Extension

A participant can apply to extend an HEC period by contacting HEC to request an extension.

If the HEC period is ending prior to the member meeting his or her employment plan goals, but the goals can be met within the three months after the regular HEC period will end, the HEC Coordinator can extend the HEC participation for three months.

26.3.5.3 Health and Employment Counseling Participation Changes

Whenever a member notifies the IM agency that he or she has stopped participating in the HEC program and is not meeting the work requirement in another way, MAPP eligibility will be terminated with an adverse action notice.

When a HEC participant notifies the IM agency that he or she is now employed, information about the employment will be needed and eligibility will need to be redetermined.

26.3.6 Health Insurance Premium Payment

See Section 9.4 Health Insurance Premium Payment for information about *HIPP* and cooperation requirements.

26.3.7 Spousal Impoverishment

There are no *spousal impoverishment* protections for MAPP. An institutionalized member who was determined ineligible for Medicaid using the Medicaid Institutions tests can qualify for Medicaid through MAPP. However, because only the member's assets count in determining MAPP eligibility, do not apply the spousal impoverishment provisions for assets. Similarly, because there is no post-eligibility treatment of income and instead calculate a premium using only the member's income, there is no *community spouse* income allocation or family member maintenance allowance for MAPP.

26.3.8 Institutionalization

Members in an institution may qualify for MAPP if they do not qualify for institutional Medicaid. If the member's income exceeds 100 percent of the *FPL* for a group of one (see Section 39.5 Federal Poverty Level Table), he or she is responsible to pay a monthly premium instead of a patient liability or cost share (see Section 27.7 Cost of Care Calculation and Section 27.7.3 Partial Months).

26.3.9 Community Waivers

MAPP is a full-benefit Medicaid subprogram for community waiver participation (see Section 21.2 Full-Benefit Medicaid). If the member's monthly income exceeds 100 percent of the FPL for a group of one (see Section 39.5 Federal Poverty Level Table), he or she is responsible to pay a monthly MAPP premium instead of a cost share.

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26.4 MAPP Financial Requirements

Follow EBD rules in Chapters 15.1 Income Introduction and 16.1 Assets Introduction to determine countable assets and income. The following are *MAPP* financial eligibility requirements.

26.4.1 Assets

Total countable assets of the *member* must be $15,000 or less. Only count the assets of the MAPP *applicant* for the MAPP asset eligibility test.

26.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account after MAPP eligibility has been confirmed. These accounts are an exempt asset. There is no limit to the number of accounts, and no restriction on what the money can be used for. The accounts are for the member to deposit earned and unearned income into. They cannot be used for the member to deposit other assets, such as an inheritance.

Only funds deposited in a registered Independence Account while the member is eligible for MAPP may be exempted from the asset limit. Any deposits made prior to MAPP enrollment or during periods of MAPP ineligibility are not exempt assets.

Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited:

- **Existing retirement/pension accounts** may be registered as Independence Accounts after the applicant has been approved for MAPP. The amount that was already accumulated in the retirement/pension account before it was designated as an Independence Account is called the “Pre-Independence Account Balance.” The Pre-Independence Account Balance is considered a countable asset when MAPP eligibility is determined. Funds may be deposited in a retirement/pension account designated as an Independence Account during periods of MAPP ineligibility. However, any funds deposited during a period of MAPP ineligibility must be added to the account’s Pre-Independence Account Balance and considered a countable asset.
- **Non-retirement/pension accounts** may only be opened and registered as Independence Accounts after the applicant has been approved for MAPP. Non-retirement/pension accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP. **If**

any funds are deposited in a non-retirement/pension account during a period of MAPP ineligibility, the Independence Account's entire balance will be considered a countable asset.

- For non-retirement/pension accounts registered as Independence Accounts **on or after August 1, 2020,** there should be no Pre-Independence Account Balance at any time because the only deposits that are allowed into these accounts are those made while the account owner is a MAPP member.
- For non-retirement/pension accounts that were registered as Independence Accounts **prior to August 1, 2020,** any existing amount entered in the Pre-Independence Account Balance field will continue to count for all Medicaid programs, and the Independence Account Balance will be exempt for all Medicaid programs that have an asset test. However, no new funds may be deposited in non-retirement/pension accounts during months when the member is ineligible for MAPP. If new funds are deposited during months when the member is ineligible, the entire asset will be counted.

Example 1: Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was considered a countable asset during her eligibility determination. Sheila registers the retirement account as an Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance will continue to be a countable asset.

Example 2: Mac is approved for MAPP in October. He fills out the Independence Account form to register his already established savings account as an Independence account. The IM worker will be unable to approve this account as an Independence Account because it was opened and established with funds deposited prior to Mac's MAPP eligibility.

Example 3: Tom is approved for MAPP. After he receives his Notice of Decision, he opens a savings account and registers it as an Independence Account. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November to December, and eligible for MAPP again in January. Although his Independence Account will be considered exempt when his eligibility for both MAPP and Medically Needy SSI-related Medicaid is determined, he may not deposit any money into the account during November and December because he is not eligible for MAPP during that time. If he does deposit money during those months, the Independence Account's entire balance will be considered a non-exempt asset.

Example 4: Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance

of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

To qualify as an Independence Account, an account must be:

1. Registered with the *IM* Agency. Completing the F-10121 Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency. Scan the completed F-10121 to ECF and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the following exceptions
    - Pension and retirement accounts (See 26.4.1.3 Pension or Retirement Accounts)
    - Non-retirement accounts that were registered as Independence Accounts before August 1, 2020 during a member's previous period of MAPP eligibility

(Note that cash, escrow accounts for a home sale, money owed, prepaid debit cards, and tax refunds may not be designated as Independence Accounts.)

A member’s deposits (earned or unearned income) in an independence account may total up to 50% of gross earnings over a 12-month period, without penalty. If the member’s deposits, from actual (earned or unearned income), exceed 50% of his or her actual gross earnings over the same twelve-month period, a penalty is assessed (See 26.5.1.1 Penalty). Amounts withdrawn from a MAPP Independence Account during a twelve month period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 5: Fred earns $5000 gross from January - December. Total deposits into the independence account were $3000 for the same period. Although a $500 withdrawal was made in December of that same year to pay for car repairs. $500 withdrawal is irrelevant when determining the penalty.

The penalty is based solely on total deposits which exceeded 50% of gross earnings over a twelve month period. The result in this example would be a $500 penalty (50% of $5000 = $2500. The $3000 in deposits - $2500 = $500 penalty). (See 26.4.1.3 Pension or Retirement Accounts)

26.4.1.2 Independence Account Exemption Status

If a member with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) will remain exempt for all future application(s) for all EBD Medicaid programs.

26.4.1.3 Pension or Retirement Accounts

A member who has a pension or retirement account can designate that account as an Independence Account. The initial balance is a countable asset (16.7.21 Retirement Benefits). Any dividends, interest, and deposits to the account while they are MAPP eligible are exempt from the date the Independence Account is approved. Continue to count the initial balance and any dividends, interest, and deposits to the account during periods of MAPP ineligibility as a countable asset.

26.4.2 Income

The *spouse* and applicant or member's net income must not exceed 250% of the *FPL* (See 39.5 FPL) for appropriate fiscal test group size. To determine this, do the following:

1. Determine earned income. Count the member and his or her spouse's income if residing together.
2. Deduct the $65 and ½ of the earned income *disregard* from the spouse and member's earnings (15.7.5 $65 and ½ Earned Income Deduction).
3. Deduct the member's and spouse's IRWEs (15.7.4 Impairment Related Work Expenses (IRWE)). The result is the adjusted earned income.
4. Determine unearned income. Count the applicant or member's unearned income and his or her spouse's unearned income if residing together.
5. Add the adjusted earned and unearned income together.
6. Deduct $20 from the combined income.
7. Deduct special exempt income (15.7.2 Special Exempt Income).
8. Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (or his or her spouse, if living together), if the monthly total of those expenses is above $500.
9. If a MAPP member receives Social Security payments, subtract the current *COLA* disregard between January 1st and the date the FPL is effective in CARES for that year.

Example 6: Ed's Social Security payment amounts were $875 a month for the previous year and $900 for the current year. Calculate the current COLA disregard by subtracting Ed's previous Social Security payment amounts from the current payments. Allow $25 as the current COLA disregard.

10. Subtract the historical COLA *Disregard* Amount (39.6 COLA) for MAPP members who are also determined to be a 503 (25.1 503 Eligibility) or Disabled Adult Child (DAC) (25.2 DAC).
11. Compare the result to 250% of the FPL (39.5 FPL Table). Include the member's minor dependent children (natural or adoptive) when determining fiscal test group size. Include the member's *dependent 18-year-old* child(ren) in the FTG. Do not include the member's stepchildren in the fiscal test group size.

26.4.2.1 Deduction for Medical and Remedial Expenses over $500

For MAPP only, if an applicant or member (or his or her spouse, if living together) has verified monthly out-of-pocket medical and remedial expenses that total over $500, the total amount of these expenses will be deducted from the applicant or member's and his or her spouse's income when determining whether that income is above 250% FPL in the calculation shown in 26.4.2 Income.

Example 7: Shelly applies for MAPP. She verifies $350 in out-of-pocket remedial expenses for herself and $200 in out-of-pocket medical expenses for her spouse that cannot be covered by MAPP or any other third party. $550 will be deducted from income as a part of Shelly's eligibility determination.

Example 8: Mary applies for MAPP. She verifies $600 in monthly out-of-pocket medical and remedial expenses, which brings her under the 250 percent of FPL income limit for MAPP. It is possible that these expenses might be covered by MAPP once Mary is eligible, but the IM worker correctly processes the application using these verified out-of-pocket expenses. One month later, Mary realizes that MAPP is now paying for $500 of these medical and remedial expenses. Mary is required to report this change in expense within 10 days. She reports that her medical expenses have dropped to $100. The IM worker enters this change, and Mary is no longer financially eligible for MAPP because the decrease in her out-of-pocket medical and remedial expenses increases her countable income. If Mary applied again using the same expenses, the IM agency would not allow the expenses because they are now known to be covered by Medicaid.

Example 9: Jim applies for MAPP. He verifies $500 in out-of-pocket medical expenses. Because the expenses are not above $500, these expenses cannot be allowed as an income deduction for the MAPP eligibility determination.

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26.5 MAPP Premiums

26.5.1 Calculation

Calculate premiums using only the *member*'s income. Calculate a premium if the member's monthly Premium Gross Income exceeds 100 percent of the *FPL* (see Section 39.5 Federal Poverty Level Table) for a group of one.

To calculate monthly premium amount:

1. Determine the member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income.
2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:
    - The member's own verified monthly impairment-related work expenses (any amount)
    - The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    - The current COLA disregard from January 1 through the date the FPL is effective in CARES for that year, if applicable
3. Determine Premium Net Income by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number, change it to zero.
4. Multiply the premium net income by three percent (0.03).
5. Add the $25 Base Premium Amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount (see the Medicaid Eligibility Handbook, Section 26.5.1.1 Independence Account Penalty).

The result is the member's monthly premium amount.

Note: 503, DAC, widow or widower disregards allowed in eligibility determinations cannot be allowed in premium calculations.

Example 1: Shannon applies for MAPP. Her Premium Gross income is under 100 percent of the FPL. She has no premium.

Example 2: Michael applies for MAPP. His Premium Gross income is 105 percent of the FPL. Even though his impairment-related work expenses and medical/remedial expenses decrease his Premium Net Income to $0, Michael will still have a $25 monthly MAPP premium.

Example 3: Susan is a MAPP member whose Premium Gross income is 206

percent of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below:
$2,200 Premium Gross Income
− $300 monthly IRWE deduction
− $150 monthly medical/remedial deduction

$1,750 Countable Net Income
− $1,063.33 (100% of the FPL)

$686.67 Premium Net Income
$686.67 Premium Net Income
X 0.03 (3%)

$20.60
+$25 Base Premium Amount

$45.60 (round down to nearest whole dollar)
Susan's monthly MAPP premium is $45.

26.5.1.1 Independence Account Penalty

If the member deposits income (earned or unearned) in an amount that exceeds 50 percent of the member's gross earnings into an Independence Account, the member will be penalized using the following formula. At renewal or re-application for MAPP, look back 12 months and:

1. Take the total verified Annual Deposits minus 50 percent of verified annual gross earned income divided by 12 to get the monthly assessment.
2. Add this monthly assessment to the premium for the next 12 months of eligibility. CWW will only impose Independence Account penalties if the member is otherwise required to pay a premium.

Example 4: Brenda deposited $1,200 more than 50 percent of her actual annual gross earned income in her Independence Account. If Brenda's income exceeds 100 percent of the FPL (see Section 39.5 Federal Poverty Level Table) and she is responsible for a monthly premium, add the monthly assessment of $100 to her monthly premium for the next 12 months. If Brenda's income is less than or equal to 100 percent of the FPL, do not impose a penalty.

26.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the member must pay applicable premiums for the initial benefit month and for any backdated months for which the member is eligible and requests coverage. If determining eligibility in the

month after application, the premium for the second month also must be paid before confirming eligibility.

Example 5: Eric applies for MAPP on January 29, but his application is not processed until February 11. The *IM* agency determines that he owes a $50 premium per month. Before eligibility is approved (confirmed), Eric must pay a $50 premium for January and a $50 premium for February.

Example 6: Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

CARES will send premium information to MMIS and the Medicaid Purchase Plan Premium Information/Payment (F-00332) is sent to the member with the verification checklist (VCL). The IM worker continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the member is eligible for and requests coverage and recording receipt of the premium payment in CARES. Refer to Process Help 25.1.6 Processing a MAPP Application Requiring a Premium.

26.5.3 Payment Information

26.5.3.1 Payment Methods

When requested, the fiscal agent will provide members with instructions for choosing the payment method they want. Members can contact Member Services at 1-800-362-3002.

The payment methods are:

- Direct payment by check or money order.
- *EFT*.
- Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in premium wage withholding. If the employer decides not to participate, the participant will have to choose direct pay or EFT.)

Provide members with the Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form (F-13023) and the Medicaid Purchase Plan Premium Employer Wage Withholding form (F-13024) to allow the member to choose a payment method other than direct payment. Since it takes some time to set up EFT and wage withholding, the member pays directly until the fiscal agent informs him or her otherwise.

26.5.3.2 Advance Payments

Members can make advance payments, but the payment cannot exceed the 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, recalculate the premium. The member will be notified through CARES that his or 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.

26.5.3.3 Refunds

The fiscal agent issues refunds if the premium was paid and is for a month in which one of the following situations occurs:

1. The individual was ineligible for MAPP.
2. A change is reported that results in no premium or a lower premium amount. If the change is reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which the change occurred. If the change is not reported within 10 days of when the change occurred, the lower premium amount is effective during the month in which it was reported. The fiscal agent will refund any excess premium that was paid. See Section 26.7 MAPP Changes for information on change reporting.

   Note: When determining if a change was reported within 10 days of when the change occurred, the worker should use the reported date of change from the member. If the worker has information that makes the reported date of change questionable, the worker can request verification of the date of change.

3. The individual overpaid and the excess cannot be applied to the next month's premium.
4. The member requested to close MAPP and already paid the premium.

The member's estate can receive a refund if he or she dies between adverse action and the beginning of the benefit month.

26.5.4 Ongoing Cases

Ongoing premium payments are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the 10th of the benefit month regardless of which payment method is chosen. For members who have chosen "direct pay' as their payment method, the fiscal agent sends the premium coupon on the 20th of the month before the benefit month. The payment must be received by the fiscal agent by the 10th of the benefit month. EFT occurs on the third business day of the benefit month.

26.5.5 Late Payments

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Members must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 4: If a member owed a premium for September and does not pay it until October, then he or she will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

26.5.5.1 Between Due Date and Adverse Action of the Benefit Month

The case will stay 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.

26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month

If a member pays between adverse action of the benefit month and the last day of the benefit month, he or she can reopen. Run eligibility with dates and confirm.

Example 5: Adverse action is September 16. Jim's September premium was due September 10. Jim has not paid his September premium by September 16. He does pay on September 26. The case closed effective September 30. Run with dates to open for October. Then run without dates for November eligibility.

26.5.5.3 Anytime in Month After the Benefit Month

If the member pays any time in the month after the benefit month, he or she can reopen. He or she must pay the premium that closed them. If they owe a premium for that following month, he or she must pay that premium before CARES will open MAPP. The member must pay the IM agency directly (not the fiscal agent). The IM worker can check with the fiscal agent to see if a premium has already been collected for that month.

When the payment(s) is received, record the payment in CARES and run eligibility for the benefit month and confirm. Then run eligibility for the following month and confirm.

Example 6: Adverse action is September 16. Jim has not paid his September premium by September 16. He pays on October 26. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen his case, run eligibility for October and confirm. Finally, run eligibility for November and confirm. (The November premium

is not due until November 10 and does not have to be paid in advance.)

26.5.5.4 Two Months After the Benefit Month

If the member pays in the second month after the benefit month, it is a non-payment (see 26.5.6 Non-Payment below).

26.5.6 Non-Payment

If a MAPP member does not pay the monthly premium by adverse action in the benefit month, apply an *RRP* (see Section 26.6 Restrictive Re-enrollment Period, unless there is good cause (see Section 26.6.2 Good Cause). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, lift the RRP.

26.5.6.1 Insufficient Funds

You will be notified with a 056 Run SFED/SFEX alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply an RRP, unless there is good cause (anything that is beyond the member's control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists and process the overpayment.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, anytime prior to the beginning of the next benefit month, close the case in CARES for the next possible month and do not impose an RRP. Refer to Process Help 25.1.9 Opting Out.

A MAPP applicant's decision to opt out does not affect other family members' eligibility for Medicaid or Medicaid-related programs.

26.5.8 Temporary MAPP Premium Waivers due to Hardship

MAPP applicants and members who experience a temporary hardship that makes them unable to pay their premium can apply for a temporary premium waiver. There is no limit to how many temporary premium waivers may be requested, but the temporary premium waiver cannot exceed 12 months in duration **for the same hardship reason**. Applicants and members may request the premium waiver for a backdated period of up to three months, but the premium waiver cannot exceed 12 months. If a temporary premium waiver is approved for months where a premium has already been paid, those premiums must be refunded.

To request a temporary premium waiver, MAPP applicants and members will use the Request for a Temporary Waiver of Your Medicaid Purchase Plan Premium Because of a Difficult Situation (F-02603) form. The applicant or member must describe the short-

term hardship and state when it began (up to three months in the past) and its expected duration.

Note that temporary premium waiver periods can begin no earlier than August 1, 2020.

A temporary hardship may include, but is not limited to, the following:

- The applicant or member has an unusual expense related to his or her health or ability to work. An unusual expense is an expense that is necessary for the ability of the individual to work or take care of his or her health that is not a regular, recurring, or planned expense. The expense cannot be anything that was used to establish eligibility or the premium amount for the individual, as these should be regular and recurring.
- The applicant or member has experienced a decrease in work hours.
- The applicant or member has lost a job but remains non-financially eligible due to a medical exemption or participation in a HEC plan.
- The applicant or member is the survivor of a crime, such as someone who has experience domestic violence or sexual assault, battery, theft, and other crimes. As a result, the member has incurred extra expenses or is unable to access his or her funds due to the crime.
- The applicant or member is experiencing temporary transportation issues, causing a decrease in the hours he or she can work.
- The applicant or member is experiencing temporary child care issues, causing a decrease in the number of hours he or she can work.
- The applicant or member has experienced a sudden increase in household expenses such as rent, vehicle insurance, utilities, gas, etc.

IM workers will be required to review temporary premium waiver requests and approve or deny them within 30 calendar days after receipt of the request.

In determining whether there is hardship, the IM worker may only consider circumstances that are documented. Hardship must be verified (see Section 20.1 Verification). Proof includes, but is not limited to, the following:

- Agency form
- Employer statement/paystub/taxes/Employer Verification of Earnings form (EVF-E)
- Collateral contact
- A statement from a health care or mental health provider, such as a medical doctor, psychiatrist, social worker, AODA professional, or psychologist, that identifies there is an issue and time period in which the individual cannot work.
- A receipt for the unusual health or work related expense.

Verification must be received by the due date (or the extended due date if additional time is requested) in order to process an application for a temporary waiver of premium. If verification is not received by the due date or extended due date, the request must be denied. This denial does not prevent the applicant or member from submitting another request for the same time period and being approved once verification has been received, as long as the request does not include a backdate of longer than three months prior to the month the request is received.

Example 7: On November 1, John requested a temporary waiver of premium starting August 1, but he did not provide the requested verification, so the request was denied. On December 1, John submits a new request for a temporary waiver of premium with the appropriate verification. The earliest that the waiver could be approved is September 1.

If the request for temporary waiver of premium is denied, the waiver applicant will be notified. The waiver applicant has the right to appeal the decision through a written request to the Division of Appeals (DHA). The waiver applicant has 45 calendar days from the date of the notice issuance to file the appeal.

If the request is approved, the premium waiver period will begin on one of the following:

- The first day of the month in which the temporary premium waiver request was received.
- The first day of the month after the month in which the temporary premium waiver request was received.
- The first day of the month one, two, or three months prior to the month in which the temporary premium waiver request was received, if the applicant or member stated on the request form that the temporary hardship began in the past.

Note: When processing temporary premium waiver requests received before October 2020, IM workers should remember that the premium waiver period can begin no earlier than August 1, 2020, even if the hardship began before August 1.

Example 8: Susie requests a temporary waiver of premium on March 31. If approved, the premium waiver period could start as early as December 1 and as late as April 1, depending on the request and the verification.

The member's premium will be waived for the duration approved by the agency (up to 12 months). Temporary premium waivers that have been granted for a shorter duration than 12 months can be extended at the member's request for up to the full 12-month limit for a given hardship reason.

Example 9: Mae is a MAPP member who uses a car to get to work. Her vehicle requires an expensive fix by a mechanic. She requests a three month temporary premium waiver to help her redirect the funds toward the repairs on the car. The

request is approved. When the repairs are completed, they were twice what she was quoted. She requests a three month extension of her temporary premium waiver in order to redirect those funds to the remaining repair bill. That request is approved.

Example 10: Stan is a MAPP member. He is experiencing health concerns that impact his ability to work the number of hours he typically works. While the IM worker has adjusted his premium due to the decrease in income, his doctor tells him it could be nine months before he will be back to normal work hours. He requests a temporary premium waiver and is approved. At month eight of his premium waiver, Stan's doctors inform him that they cannot approve an increase in his hours for another six months. Stan requests an extension to his temporary premium waiver. Because he has an approved nine month waiver and the maximum time a waiver can be granted for the same hardship reason is 12 months, the IM worker can only approve an additional three months to extend the waiver.

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26.6 MAPP Restrictive Re-Enrollment Period (RRP)

26.6.1 MAPP Restrictive Re-enrollment Period Introduction

A MAPP member who fails to pay the premium on time will lose his or her MAPP benefits and will be subject to an RRP of three months, beginning with the month after the missing payment month. (For example, if the member does not pay the December premium by the due date (December 10), an RRP will be imposed at December adverse action from January to March). A MAPP member will be able to regain eligibility during the RRP if any of the following conditions are met:

- The member pays all past-due premiums by the last day of the RRP. Members must pay the overdue premium(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.
- The member becomes eligible for MAPP without a premium (that is, the member's gross monthly income is reduced to at or below 100 percent of the FPL). Note: The RRP will still run in the background and will be reinstated if the member's income increases above 100 percent of the FPL during the RRP.
- The member is granted a temporary premium waiver for the duration of the RRP or makes the past due payments for any RRP months not covered by the temporary premium waiver.

Example 1: Amy is eligible for MAPP with a premium. She misses her April MAPP premium payment and an RRP is imposed for May, June, and July. In May, she applies for and is granted a temporary MAPP premium waiver for April 1 through August 31. The RRP is lifted and Amy is eligible for MAPP with no premium effective April 1. She will be required to pay premiums again starting in September.

Example 2: Lynn is eligible for MAPP with a premium. She misses her June premium payment and is placed in an RRP on July 1. Lynn pays for June and July's premiums on July 30 to end her RRP and become eligible for MAPP. Her August premium is not due until August 10, so she is not required to pay that amount in order to end the RRP.

Example 3: John is eligible for MAPP with a premium. He misses his January MAPP premium payment and an RRP is imposed for February, March, and April. In March, his employer decreases his work hours and John's gross income is now under 100 percent of the FPL, making him eligible without a premium starting March 1. He pays the January and February premium arrears and regains MAPP eligibility effective January 1. If John did not pay the January and February premiums, he would open as of March 1.

RRPs are tied to non-payment of premiums only. RRPs do not apply to recipients who have not met HEC requirements.

26.6.2 Good Cause

The following are good cause reasons for not paying a MAPP premium:

1. Problems with electronic funds transfer.
2. Problems with an employer's wage withholding.
3. Administrative error in processing the premium.
4. Fair hearing decision.
5. Those you determine are beyond the member’s control.

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26.7 MAPP Changes

26.7.1 MAPP Changes Introduction

The *member* must report within ten days all changes to income, household composition, allowable deductions, including medical and remedial expenses that were once out of pocket but are covered once the applicant is a MAPP member, and other non-financial changes, including loss of employment, which affect eligibility. The *IM* worker should re-determine eligibility as a result of the changes. If it is determined that he or she remains eligible for *MAPP* and owes a premium, recalculate the premium amount.

Example 1: Nancy does not have health insurance and currently pays $550 a month for a variety of medical/remedial expenses. She applies for MAPP and is found eligible as of December 1. Once she is eligible, MAPP will cover some of her medical/remedial expenses and reduce her out of pocket medical/remedial expenses down to $50 a month in December. Because Nancy must wait until the end of December to determine the final decrease in her monthly out of pocket expenses, she must report this decrease no later than January 10th.

26.7.2 Reduced Premiums or No Premiums

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. If the change results in no premium, the IM agency may have to run eligibility with dates in CARES for the month the change occurred or was reported (which ever is later) and any subsequent months as well as for recurring.

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26.8 MAPP Prepaid Deductibles

If the client prepaid a deductible and then becomes eligible for *MAPP* without a premium, he or she can only get a refund of the prepayment if the deductible period has not started. Use the Community Aids Reporting System (CARS) to report the accounting.

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26.9 MAPP Notices

For manual *MAPP* eligibility determinations:

1. Use the Notice of Approval of Benefits/Positive Change in Benefits (F-16015) when MAPP is approved or the premium decreases.
2. Use the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) when eligibility is denied or terminated or the premium increases.

Note: The client must be given *adverse action* notice of any negative action (e.g. premium increase).

Use the following notice text that is applicable to the denial reason. Use §49.472 WIS STATS as the citation for each of the reasons.

You are not eligible for the MAPP because:

1. Your assets exceed the $15,000 asset limit.
2. Your income exceeds 250% of the *FPL* (39.5 FPL Table) for your family size.
3. You have not paid your MAPP premium.
4. You have been determined 'not' disabled under MAPP rules by the Disability Determination Bureau.
5. You are not working.
6. You no longer meet the work or HEC participation requirement of MAPP.

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26.10 Health and Employment Counseling Program Specialists Contact Information

For more information about the *HEC* Program, call 866-278-6440.

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27 Institutional Long-Term Care

27.1 Institutions

27.1.1 Institutions Introduction

For Medicaid purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (*SNF*), intermediate care facilities (*ICF*), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,
2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,
3. Is authorized under State law to provide medical care, and,
4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

27.1.2 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs (27.11 Institutions for Mental Disease (IMDs)).

27.1.2.1 Eligible Age

IMD residents under age 21 and over age 64 may be Medicaid eligible. Persons aged 21 through 64 are not eligible unless:

1. They are receiving residential substance use disorder treatment in the IMD; or
2. They were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge (a 21 year old can be transferred from one IMD into another and remain eligible for Medicaid) or until turning age 22, whichever comes first.

27.1.2.2 Temporary Leave

A person aged 21 through 64 who is not eligible for Medicaid can go on conditional release from an IMD or convalescent leave and become eligible for Medicaid while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.

a. The trial period must last no less than four days. It must be no longer than 30 days.
b. The trial period begins after the initial three days of community residence following discharge.
c. A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

For purposes of Medicaid, conditional release is permitted only once every calendar year.

2. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD. A person under age 22 who leaves the IMD on Convalescent Leave remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

27.1.2.3 Minors in IMD

When a *minor* applies for Medicaid after being discharged from the IMD, certify the individual as a member, if eligible, for the inpatient IMD days only. Certify for the remainder of the month if he or she would be eligible after being tested for Family Medicaid with his or her parents and siblings.

27.1.3 Hospitals

Hospitals are medical institutions that:
1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,
3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (27.4.1 Institutionalized Person) if he or she:
1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered “institutionalized” if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

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27.2 Licensing and Certification

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Bureau of Quality Assurance, is the licensing agency.

In order to receive Medicaid payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency that certifies their compliance is *DMS*.

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27.3 Facilities Not Medicaid Certified

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. Medicaid will not pay cost of care for these persons, but they may still be eligible for Medicaid card services (17.15 Medicaid Card Services).

27.4 Definitions

27.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Participates in Community Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until he or she is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered “institutionalized” if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

27.4.2 Community Spouse

See *community spouse* in Glossary.

27.4.3 SSI Recipient and Institutional Medicaid Application

An *SSI* recipient who has resided or is likely to reside in a medical institution for 30 days or more may apply and be non-financially eligible for institutional Medicaid if the *SSA* will discontinue the person's SSI because of the financial effect of his or her residence in the medical institution.

An SSI recipient who has not resided or is not likely to reside in a medical institution for 30 days or more is non-financially ineligible for institutional Medicaid. The person remains Medicaid eligible through SSI.

27.5 Financial

27.5.1 ILTC Assets

Refer to 16.1 Assets Introduction to determine when an asset is countable. If countable assets exceed the appropriate limit, the Medicaid *applicant* /member is ineligible.

Note: Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his or her support and maintenance (16.2 Assets Availability).

1. Unmarried member - See 39.4 EBD Assets and Income Tables or the EBT asset limits for an unmarried member
2. Married member (*Spousal Impoverishment*) -The assets of both the institutionalized person and his or her *community spouse* are counted in the initial asset test. For information about how to determine a married member's asset limit and the community *spouse* asset share refer to 18.4 Spousal Impoverishment Assets.

27.5.2 ILTC Income

Follow the policies listed in 15.1 Income Introduction to determine an applicant's income. The income limit is the same for non-spousal impoverishment institutionalized persons as for spousal impoverishment cases. But, for spousal impoverishment cases, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse. (See 18.6 Spousal Impoverishment Income Allocation)

If income is greater than Institutions Categorically Needy Income Limit (39.4 EBD Assets and Income Tables) the person is ineligible for categorically needy Medicaid.

If the income is greater than need (See 27.6 ILTC Monthly Need) the person is ineligible for medical needy Medicaid.

Sometimes, when both spouses are institutionalized, the income of one is greater than his or her monthly need and the income of the other is less than his or her monthly need. When this occurs, calculate the couple's combined monthly need and compare it with their combined income. If the total need is greater than the total income, and if the spouse with greater income is willing to combine it with his or her spouse's lesser income, both spouses could be eligible.

27.5.3 Divestment

See 17.1 Divestment Introduction for Divestment policies.

27.5.4 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution (27.1 Institutions) residents with no *community spouse*.
   Use the Medicaid Institution Worksheet (Worksheet #4).

2. Medical institution residents who have a community spouse and who became institutionalized before 09-30-89:

   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the Medicaid Institution Worksheet (Worksheet #4).

3. Medical institution residents who have a community spouse and who became institutionalized on or after 09-30-89:

   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form and the Spousal Impoverishment Income Allocation Worksheet (Worksheet #7).

4. Community waiver applicants with no community spouse:
   Use the F-20919

5. Community waiver applicants with a community spouse:

   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form the Medicaid Waiver Eligibility and Cost Sharing Worksheet , and the Spousal Impoverishment Income Allocation Worksheet (Worksheet #7).

27.6 Monthly Need

27.6.1 Intermediate and Long-Term Care Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his or her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (39.4 EBD Assets and Income Tables).
2. Cost of institutional care (use the private care rate of the institution where the applicant or member resides).
3. Cost of health insurance (27.6.4 Health Insurance).
4. Support payments (15.7.2.1 Support Payments).
5. Out-of-pocket medical costs.
6. Work related expenses (15.7.4 Impairment Related Work Expenses (IRWE)).
7. Self-support plan (15.7.2.2 Self-Support Plan).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.
10. Other deductible expenses.

27.6.2 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See 39.7 Hospital Daily Rates. If his or her hospital is not on the list, enter $2,318.08 on Long Term Care Gatepost/ Institutions screen.

27.6.3 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his or her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

27.6.4 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

Example 1: Mr. W. pays a health insurance premium of $600 every quarter. The monthly amount, prorated over three months, is $200. Deduct $200 from Mr. W's monthly income. Each quarter, exempt $600 of Mr. W's assets until that quarter's premium due date.

27.6.4.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance polices are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that he or she resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments

All members must cooperate in providing Third Party Liability (*TPL*) coverage and access information (9.2 Nursing Home and Hospital Insurance). All members must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (9.2.2 Assignment). Terminate eligibility for any individual that will not cooperate in:

1. Providing TPL coverage and access information.
2. Turning over payments from indemnity insurance policies.

27.6.5 Support Payments

Support payments are payments which an institutionalized Medicaid *member* makes to another person for the purpose of supporting and maintaining that person. See 15.7.2.1 Support Payments.

27.6.6 Fees to Guardians or Attorneys

See 15.7.2.3 Fees to Guardians or Attorneys.

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27.7 Cost of Care Calculation

27.7.1 Introduction

After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount the person will pay each month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution, including those enrolled in Family Care, Family Care Partnership, or PACE who are in or likely to be in a medical institution for 30 or more days. Institutionalized people are expected to pay their patient liability to the institution they are residing in, or to their MCO if they are enrolled in Family Care, Family Care Partnership, or PACE, as of the first day of the month.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a *community spouse*, subtract the following from the person's monthly income:
    a. $65 and ½ earned income *disregard* (see Section 15.7.5 $65 and ½ Earned Income Deduction).
    b. Monthly cost for health insurance (see Section 27.6.4 Health Insurance).
    c. Support payments (see Section 15.7.2.1 Support Payments).
    d. Personal needs allowance (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).
    e. Home maintenance costs, if applicable (see Section 15.7.1 Maintaining Home or Apartment).
    f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (see Section 27.6.6 Fees to Guardians or Attorneys).
    g. Medical or remedial expenses (see Section 27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services).

2. For a Medicaid member in a medical institution who has a community spouse, follow the directions in Section 18.6 Spousal Impoverishment Income Allocation.
3. For a community waivers member with or without a community spouse, follow the directions in Section 28.6.4 Cost Share Amount.
4. There is no cost of care for *SSI* recipients.
5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

Note: 503, DAC, Widow or Widower, and COLA disregards that are used in eligibility determinations for Special Status Medicaid are not used in Patient Liability Calculations.

If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

27.7.2 Hospitalized People

Effective December 1, 2008, hospitalized people will be responsible for paying a patient liability. See Section 27.7.4 Transfers Between Institutions for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

27.7.3 Partial Months

If a member is residing in an institution (see Section 27.1 Institutions) and not Medicaid-eligible as of the first of the month, there is no patient liability for that month.

If a member was not institutionalized as of the first of the month or was discharged to the community prior to and including the last day of the month, there is no patient liability. However, if the member is enrolled in Family Care, Family Care Partnership, or PACE, he or she may owe a cost share to the MCO if a cost share is determined following the change in living arrangement.

Exceptions:

- There is a patient liability if the reason the person did not reside in the institution for the entire month was due to death or being on therapeutic leave.
- There is a patient liability if the reason the person was not eligible for long-term care services for the entire month is because a divestment penalty period ended in that month. Members who are institutionalized for the entire month in which their divestment penalty period ends must pay the full patient liability for that month.

27.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month and the nursing home requests it, the patient liability can be adjusted to be equal to the nursing home charges for that month. See PH 11.2.2.3.

27.7.3.2 Community and Nursing Home

There is no patient liability in a month in which a member moves from one of the following:

- The community into a nursing home after the first of the month.

- From a nursing home to the community before the end of the month. This includes members moving from the nursing home to the community on the last day of the month.

27.7.4 Transfers Between Institutions

Effective December 1, 2008, when an institutionalized person transfers between institutions (nursing homes, hospitals, hospices) in the same month, do not prorate the patient liability between the various institutions that he or she resided in during that month. The member will pay his or her patient liability to the institution that he or she were residing in on the first day of the month. ForwardHealth will automatically deduct the appropriate patient liability amount from the **first** nursing home, hospice, or long term inpatient hospital claim received for the member. If the amount of the patient liability exceeds the reimbursement amount of the first claim, the remaining liability amount will be deducted from the next claim(s) received for services provided in the month that patient liability is owed. Patient liability amounts deducted from claims will appear in the provider's remittance information. Nursing home, hospice, and inpatient hospital providers may have to occasionally transfer a patient liability amount that they collected from a member on the first day of a month to the appropriate provider who ultimately had the claim adjusted to reflect the required patient liability amount.

27.7.5 Retroactive Cost of Care

Occasionally a nursing home or community waivers *applicant* becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively certify him or her and compute retroactive cost of care. The directions are the same as for current cost of care (see Section 27.7.1 Introduction).

27.7.6 Personal Needs Allowance

Deduct the personal needs allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) for all institutionalized members in both the eligibility test and the patient liability calculation.

An institutionalized person's personal needs allowance may accumulate to where he or she may lose eligibility due to excess assets. To prevent this, he or she can spend money on personal needs or make a refund to Medicaid (see Section 22.1.10 Voluntary Recovery [Not Estate Recovery Program]).

27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services

27.7.7.1 Introduction

Medicaid members in nursing homes are allowed to pay for some medically necessary noncovered services out of their patient liability. They are not required to use their personal needs allowance for these services.

Effective January 4, 2008, medical or remedial expenses an institutionalized applicant or member has incurred, is actually paying, and is legally obligated to pay are allowable expenses and are used as a need item when determining his or her eligibility for Medicaid. These actual payments are also allowed as an income deduction to reduce the cost share or patient liability amount. This includes payments for medical or remedial expenses that the institutionalized applicant or member is currently incurring as well as payments for certain previously incurred medical or remedial expenses.

Note: This does not include any medical or remedial expenses that another person has incurred.

In order to use the medical or remedial expense as a need item and as an income deduction in the cost share calculation, the expense must meet both the following criteria:

- The institutionalized person must be legally liable for payment of the incurred medical or remedial expense. Any portion that will be paid by a legally liable third party, such as private health insurance, Medicare, or Medicaid, cannot be allowed as a deduction.
- The institutionalized person must provide verification of the allowable expense (see Section 27.7.7.2 Disallowed Expenses).

Example 1: In February, Al had a root canal performed by a dentist who is not an Medicaid provider. He is responsible for paying $600 for the procedure. Al began making payments of $100 per month on this medical bill in March. On April 1, Al became institutionalized and eligible for Medicaid. The $100 payment that Al is making on a previously incurred medical expense should be used as a need item when determining Al's institutional Medicaid eligibility. The expense should also be used as in income deduction when calculating Al's cost share obligation. The $100 payment can be used as an income deduction in the cost share calculation until it is fully paid in August. Since Al will no longer be making payments in September, the expense should be decreased to zero prior to *adverse action* in August.

Example 2: In April, Edna applied for institutional Medicaid and requested a one month backdate. Her request for eligibility in March was denied because her assets exceeded program limits, but was approved effective April 1. Edna used her excess assets to make a partial payment to the nursing home for March costs, but still has an outstanding balance of $1,800. Edna agrees to make payments to the nursing home of $500 per month until the expense is paid in full. The $500 payment to the nursing home should be used as an

income deduction when calculating her cost share for the months of April through June. In July, she will only owe $300 to the nursing home so the deduction for July should be decreased to $300 prior to adverse action in June. Edna will no longer be making payments in August, so the expense should be decreased to zero prior to adverse action in July.

Example 3: Jack has been an institutionalized Medicaid member since January. In March, he had a tooth extracted. The procedure was performed by a dentist who is not an Medicaid provider, so it was a noncovered service. Jack contacts the agency in April to request a deduction from his cost share so that he can pay the expense. The cost of the extraction was $209. Since this was a one-time expense and his patient liability exceeds this amount, the agency enters the expense in *CWW* to reduce the May cost share by $209.

27.7.7.2 Disallowed Expenses

Do not allow payments that an institutionalized person is making, or requests to make, as a need item or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

- Remains unpaid but was previously used to meet a Medicaid deductible.
- Was incurred as the result of imposition of a divestment penalty period.
- A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.
- Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month.

Example 4: On September 17, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a $2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay $100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of $1,800 and was determined Medicaid-eligible from September through February.

In May, Alice was determined to be functionally eligible for *HCBW*s and was determined eligible for Medicaid under Group B waiver rules. Without a medical or remedial expense, Alice's cost share would be $100. Alice's care manager verified that Alice still owes $1,200, but only $200 of the expense is allowable because $1,800 was already used to satisfy a deductible. Her care manager will include the $100 payment in the medical or remedial expense amount submitted to the *IM* worker for determining her cost share, but will reevaluate Alice's medical or remedial expense amount in two months.

Example 5: On August 1, Alice moved to a nursing home. Her eligibility for HCBWs ended and she was determined eligible for Nursing Home Medicaid beginning August 1. She is still making the $100 payments to the hospital, and has an outstanding balance of $900. However, Alice used $1,800 to meet a deductible and already received a deduction of $200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.

Example 6: In January, Lyle was institutionalized and applied for Medicaid. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December. During this three-month period, Medicaid will not cover the cost of Lyle's institutional care, but will only cover his card services. In March, the divestment penalty period expired, and Lyle is eligible for Medicaid payment of his institutional cost share. He would like to use $2,000 of his monthly income to pay for the nursing home bills that he incurred in January and February and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior Medicaid divestment penalty period.

- The expense is unverified.

CARES Process

Enter allowable expenses on the Medical Expense Page for Institutional and Group B Waivers cases. See Process Help Section 18.2 Medical Expenses.

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27.8 Nursing Home Contracts

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (Medicaid).

In essence, this requires the prospective resident waive the right to apply for Medicaid for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for Medicaid before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the Medicaid program. The standards must be enforced as a condition of federal funding. They apply to all residents in a Medicaid certified nursing home, both Medicaid and private pay, as a condition of participation in the Medicaid program.

A resident can be involuntarily discharged or transferred essentially only for:

1. medical reasons,
2. his or her welfare or that of other patients, **or**
3. nonpayment.

Changing status from private pay to Medicaid and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for Medicaid by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHS has notified all Wisconsin nursing home providers that:

1. violations of private pay duration of stay contract provisions aren't grounds for discharge, **and**
2. they must notify all present and prospective residents of this.

27.9 Nursing Home Refunds

When an institutionalized person becomes eligible for Medicaid, he or she is certified with a begin date of the first of the month in which he or she became eligible. If he or she prepaid his or her patient liability for that month, the member may ask the nursing home to send the bill to Wisconsin Medicaid and ask that he or she be reimbursed for the month.

Treat the refund as a reimbursement in the month it is received. (15.3.19 Reimbursements) Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount he or she keeps as an available asset. He or she can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for fair market value for an exempt asset.
2. Transfer it to his or her spouse .
3. Refund it to the Medicaid program in an amount equal to what Medicaid has already paid for his or her care up to the date of the reimbursement.

27.10 Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- **Before** adverse action: Effective the first of the following month.
- **After** adverse action: Effective the first of the month after the following month.

Do not complete F-10110 (formerly DES 3070) for retroactive patient liability or cost share increases since the *member* must receive timely notice. This includes scenarios in which a member is switching from a patient liability to a cost share or from a cost share to a patient liability.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later.

Note: If an Administrative Law Judge or court orders a decreased liability or cost share, the agency must follow the court order and apply changes retroactively as stated in the court order.

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27.11 Institutions for Mental Disease

Brown
Bellin Psychiatric Center, Green Bay
Libertas Center, Green Bay (aka St. Joseph's)
Willow Creek Behavioral Health, Green Bay

Dane
Mendota Mental Health Institute, Madison

Fond du Lac
Fond du Lac County Health Care Center

Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Rogers Memorial Hospital Inc., Brown Deer
Rogers Memorial Hospital Inc., Milwaukee
Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Trempealeau
Trempealeau County Health Care Center IMD, Whitehall - license # 2961
Trempealeau County IMD, Whitehall - license # 5001

Waukesha
Rogers Memorial Hospital Inc., Oconomowoc
Waukesha County Mental Health Center, Waukesha

Winnebago
Winnebago Mental Health Institute, Winnebago

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid *applicant* /member resides.

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28 Home and Community-Based Waivers Long Term Care (HCBWLTC)

28.1 Adult Home and Community-Based Waivers Long-Term Care Introduction

Medicaid-eligible adults who meet the *LOC* requirements can receive their *LTC* services through enrollment in an *MCO* or through the *fee-for-service* program *IRIS*.

Managed LTC programs include:

- Family Care
- Family Care Partnership
- *PACE*

Medicaid Eligibility
Community waivers enable elderly , blind, or disabled people to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for services and supports permitting a person to remain in a community setting that normally are not covered by Medicaid. These programs include Family Care, Family Care Partnership, PACE, and IRIS.

IM workers are responsible for determining Medicaid eligibility as well as cost share amounts, if applicable. ADRC staff and IRIS consultants are responsible for determining the person's eligibility for enrollment in the specific community waiver program.

If a member disenrolls from the managed LTC program for any reason and does not enroll in IRIS or a managed LTC program, his or her Medicaid eligibility must be tested under non-HCBW rules. Eligibility for HCBW would end following adverse action logic once the IM worker has been notified by the *ADRC* that the member has disenrolled from the managed LTC program or IRIS.

Managed Long-Term Care of IRIS Enrollment
Enrollment in managed LTC or IRIS is completed by the ADRC. The ADRC will submit the following information to IM workers:

- ADRC Referral to Income Maintenance for Managed Long-Term Care Services, F-02053, which lists the anticipated program start date for HCBW
- Medicaid application, if the ADRC is assisting the applicant with the Medicaid application process or establishing a Medicaid filing date
- Functional Screen Eligibility Results page
- Medical and Remedial Expenses: checklist For Medicaid Long-Term Care Waiver Programs, F-00295, or other communication of the total expenses
- Housing expenses and any other verification items the ADRC has received from the applicant to support the Medicaid application
- Estate Recovery Program (ERP) Disclosure, F-13039, if completed by the ADRC

- Declaration Regarding Transfer of Resources Long-Term Care Medicaid Waiver Program and/or Community Options Program, F-20919D, if any potential divestment was reported to the ADRC
- Disenrollment from the managed LTC program or IRIS, if applicable

28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy

To be eligible for *EBD* Medicaid or LTC Medicaid, a person must be elderly, blind, or disabled.

Adults over age 18 and younger than 65 years old must have a disability determination unless the person is eligible for BadgerCare Plus, *WWWMA*, Foster Care, or Adoption Assistance. If a person later loses eligibility for that program and must be tested for EBD Medicaid or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care, Family Care Partnership, PACE, or IRIS.

A disability finding made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirements for managed LTC or IRIS until the first of the following:

- An adult disability determination can be completed
- The child disability determination was redetermined and the child was found to no longer be disabled.

Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

28.1.2 Family Care

Family Care is a managed long-term care program for adults with disabilities and frail elders.

To enroll in Family Care the individual must meet the following criteria:

- Be 18 years of age or older.
- Meet financial and non-financial eligibility criteria for:
    - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 Disability Policy),
    - BadgerCare Plus (BCP),
    - *WWWMA*,
    - Adoption Assistance (AA), or
    - Foster Care Medicaid; and
- Meet the nursing home or non-nursing home functional level of care.

28.1.3 Family Care Partnership

The Family Care Partnership program is a managed long-term care program integrating health and long-term support services for adults with disabilities and frail elders.

To participate in the Family Care Partnership program the individual must meet the following criteria:

- Be 18 years of age or older,
- Meet financial and non-financial eligibility criteria for:
  - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 Disability Policy),
  - BadgerCare Plus (BCP) Standard Plan,
  - *WWWMA*,
  - Adoption Assistance (AA), or
  - Foster Care Medicaid; and
- Meet the nursing home functional level of care.

28.1.4 PACE

PACE is a program that provides comprehensive community-based services, including both acute and chronic care for frail elderly individuals. Most services are provided in a day health center, and members must receive medical services from a PACE physician. PACE is only available in select counties.

To enroll in PACE, the individual must meet the following criteria:

- Be 55 years of age or older,
- Meet the nursing home functional level of care,
- Reside in a county that offers PACE.

PACE participants who are not eligible for Medicaid will pay a premium to the PACE organization. If the PACE Participant is eligible for Medicaid, the participant is subject to the requirements in this chapter, including cost sharing.

28.1.5 IRIS

IRIS (Include, Respect, I Self-Direct) is a fee-for-service long-term care support program available to individuals who meet the functional and financial eligibility requirements. IRIS participants receive a budget amount that is calculated based on the results of their long-term care functional screen that can be used to purchase long-term care supports and services related to the participant's needs.

To participate in the IRIS program, individuals must meet the following criteria:

- Be 18 years of age or older;
- Meet the nursing home level of care;
- Meet the financial and non-financial eligibility criteria for one of the following:
    - A full-benefit category of EBD Medicaid, including Long-Term Care Medicaid
    - BadgerCare Plus
    - *WWWMA*
    - Adoption Assistance
    - Foster Care Medicaid; and
- Reside in an IRIS eligible living setting:
    - Individual's own home or apartment;
    - 1-2 or 3-4 bed Adult Family Home (AFH);
    - Residential Apartment Care Complex (RCAC).

28.1.6 Changing Programs

Individuals who want to change long-term care programs must complete this request through their Aging and Disability Resource Center (ADRC).

28.1.7 Spousal Impoverishment

Spousal impoverishment policy applies to group B and B Plus waiver participants with a *community spouse* (see Section 26.3.7 Spousal Impoverishment).

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28.2 Home and Community-Based Waivers Long-Term Care Fiscal Test Group

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.
2. Married couple, when one *spouse* is applying for community waivers, and the other is a *community spouse*. This is a *spousal impoverishment* situation. Combine the assets (18.4.3 Calculate the Community Spouse Asset Share) and apply the spousal impoverishment asset test (18.4.4 Asset Test). The income limit is the same as for institutionalized persons who do not have a community spouse.
3. Married couple, both applying for HCBW, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example 1: Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.

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28.3 Adult Home and Community-Based Waivers Long-Term Care Divestment

IM determines divestment for adult home and community-based waivers applicants. For Group A applicants, the care manager completes F-20919D for IM to investigate and determine divestment. See 17.1 Divestment Introduction.

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28.5 Home and Community-Based Waivers Long-Term Care Effective Date

The begin date of waiver eligibility is the program start date submitted to the IM agency by the care manager or the *ADRC*.

28.5.1 Urgent Services

Applicants who have been determined functionally eligible for Family Care or Family Care Partnership may receive services from the MCO while Medicaid financial eligibility is being determined if they have been determined by the ADRC to be in need of urgent services. See Process Help Section 11.3.4 Urgent Services for more information on how to process these requests.

The effective date of enrollment into Family Care or Family Care Partnership shall be no earlier than the date the Urgent Services Agreement is signed and the Medicaid application is submitted.

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28.6 Home and Community-Based Waivers Long-Term Care Eligibility Groups and Cost Sharing

28.6.1 Home and Community-Based Waivers Long-Term Care Instructions Introduction

Financial eligibility for home and community-based waivers cases is determined in CARES.

Although Katie Beckett cases are Group A, these cases are processed manually outside of CARES by Katie Beckett staff.

28.6.2 Group A

Group A members are waiver functionally eligible and Medicaid eligible via any full-benefit Medicaid subprogram **other than HCBW Medicaid.**

- Group A members may be eligible for any of the full-benefit Medicaid programs, as listed in Section 21.2 Full-Benefit Medicaid, including those eligible for Special Status MA (see Section 25.0 Special Status Medicaid Introduction).
- Group A does not include someone solely eligible for any of the limited benefit Medicaid subprograms listed in Section 21.3 Limited Benefit Medicaid.

Group A members do not have a cost share.

Members who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share.

Group A members are financially eligible with no cost share. They are only subject to the asset limit and any premiums associated with the full-benefit Medicaid source, if applicable. For example, if the member's Medicaid source is MAPP, s/he would be subject to the MAPP asset limit and premium calculated. If the member's Medicaid source is BadgerCare Plus, the member would not have an asset limit, but may still have a premium calculated.

Note: Group A members do not have an asset limit if they are Group A eligible via BadgerCare Plus, Adoption Assistance Medicaid, Foster Care Medicaid, Katie Beckett Medicaid, or Wisconsin Well Woman Medicaid since these programs do not have an asset test. All Group A members, including those who are eligible for Group A through

BadgerCare Plus eligibility, are subject to the divestment policy described in Chapter 17 Divestment.

28.6.3 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

28.6.4 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (Section 25.0 Special Status Medicaid Introduction) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, he or she does not owe a cost share to the new MCO that month.

IRIS, Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.

Cost Share or Patient Liability Effective Dates
Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- Before adverse action: Effective the first of the following month.
- After adverse action: Effective the first of the month after the following month.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later.

28.6.4.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share. Do not give the special housing amount to waiver participants under age 18.

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is the total of the following:

1. Community Waivers Basic Needs Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).
2. Sixty-five dollars and ½ earned income deduction (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:
    - Rent.
    - Home or renters insurance.
    - Mortgage.
    - Property tax (including special assessments).
    - Utilities (heat, water, sewer, electricity).
    - "Room" amount for members in a CBRF, Residential Care Apartment Complex, or an Adult Family Home. The case manager determines and provides this amount.

If both spouses are applying and both have income, divide the special housing amount equally between them.

Example 1: Two spouses applying with income:
$600 rent
- 350
= 250/2 spouses = $125 that each can set aside

If only one *spouse* has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

When one spouse has income and both are applying:

1. And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.
3. And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a

deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.

Example 2: Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month. Emma does not have any income. The total housing costs are $650 for both of them. Allocate the full special housing amount to Herbert ($650-$350 = $300 special housing amount).

Example 3: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month. Ingrid does not have any income. The total rent amount is $650 for both of them. Allocate the full special housing amount to Bert ($650-$350 = $300 special housing amount).

Example 4: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1,000 per month. Maria does not have any income. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate Ned's special housing amount ($550-$350 = $200 special housing amount). Do not consider Maria's room and board amount when calculating Ned's special housing amount.

When both spouses have income and both are applying:

1. And they reside together in the same residence, divide the special housing amount equally between them.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between them.
3. And they reside in separate living arrangements (e.g., they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his or her own individual room and board contract) then calculate a separate special housing amount for each, based on their individual "rent" costs that are obtained from the care manager.

Example 5: Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month, and Emma has income of $500 per month. The total housing cost for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Emma and Herbert is $150 each).

Example 6: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month, and Ingrid has income of $500 per month. The total "rent" from the room and board amount for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Bert and Ingrid is $150 each).

Example 7: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1,000 per month, and Maria has income of $500 per month. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate the special housing amounts separately. Ned's is calculated as follows: $550-$350 = $200 special housing amount. Maria's is calculated as follows: $400- $350= $50 special housing amount.

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

28.6.4.2 Family Maintenance Allowance

A family maintenance allowance, an amount to be used for the support of the applicant's family members, should only be deducted from income when calculating cost share in certain cases. The family maintenance allowance may not be used for a deduction when *spousal impoverishment* policies apply or if the member is a disabled child. For spousal cases, the institutionalized person can allocate income to the community spouse and children in the home, see Section 18.6 Spousal Impoverishment Income Allocation.

28.6.4.2.1 Family Maintenance Allowance Calculation - Minor Child

When the waiver participant is the custodial parent of a *minor* child living in the home, and there's no spouse in the home, calculate the following:

1. Minor children's gross earned income.
2. -$65 and ½ of gross earned income (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. =_____.
4. + Minor Children's total unearned income.
5. = _____Add (3) and (4).
6. AFDC Related med needy income limit _____ (see Section 39.3 AFDC-Related Income Table). (Do not include the waiver *applicant* in the group size.)

If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

28.6.4.2.2 Family Maintenance Allowance Calculation - EBD-Related

If there are no minor children in the home, and spousal impoverishment policies do not apply, calculate the following:

1. Spouse's gross earned income.
2. -$65 and ½ of total gross earned income (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. =_____.
4. +Spouse's total unearned income.
5. =_____ (3)+(4).
6. -$20 disregard .
7. =_____(6)-(5).
8. _____Enter the SSI Payment Level Plus the E Supplement for one person (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

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

28.6.4.3 Special Exempt Income

Special exempt income (see Section 15.7.2 Special Exempt Income) must be deducted from income when calculating cost share.

28.6.4.4 Health Insurance

All health and dental insurance premiums covering the waiver person and for which he or she is responsible and pays a premium must be deducted from income when calculating cost share. This includes any Medicare Premium obligation including Medicare Part D. See Section 9.6.2 Policies Not To Report for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group but not responsible for the premium, find his or her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example 8: Sally pays a $600 premium quarterly for her Medicare supplement policy. Six hundred dollars divided by three equals $200. Enter $200 as her monthly health insurance premium payment on the Medical Coverage page.

28.6.4.5 Medical/Remedial Expenses

The dollar amount of the applicant's medical and remedial expenses, as reported by the MCO care manager, ICA, or ADRC, must be deducted from income when calculating cost share. See Section 15.7.3 Medical/Remedial Expenses and Section 20.3.6 Medical or Remedial Expenses.

Note: Care managers should refer to the limitations associated with allowable medical or remedial expenses that are described in Section 27.7.8 Medical/Remedial Expenses and Payments for Non-Covered Services.

28.6.5 Maximum Cost Share Amount

For Family Care, Family Care Partnership, and PACE, see Section 39.4.4 for maximum cost share amount.

28.6.6 Waiver or Reduction Cost Share

Family Care, Family Care Partnership, or PACE members may request a waiver or reduction of their cost share from the Department. Members indicating that they are having difficulty paying cost share should be informed of this right, directed to complete the Application for Reduction of Cost Share form (F-01827), and referred to the Bureau of Adult Programs and Policy (1-855-885-0287).

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28.7 Home and Community-Based Waivers Long-Term Care Medical Codes

See the Process Help Section 81.5 Med Stat Code Chart for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy Medicaid member could be eligible as a categorically needy waiver member (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

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28.8 Home and Community-Based Waivers Long-Term Care Care Review

IM reviews financial eligibility annually. The care manager reviews level of care eligibility annually. Eligibility should not be discontinued if the care manager has not yet made the level of care review.

The care manager informs the *IM* agency if the person is no longer level of care eligible. IM must notify the care manager if the person is no longer Medicaid eligible.

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28.9 Home and Community-Based Waivers Long-Term Care Community Spouse's Medicaid Application

When a community waivers person and his or her *community spouse* are both applying for Medicaid, they are one case, but separate AGs.

Both spouses are in the non-waiver spouse's fiscal test group (*FTG*). Since the waiver *spouse* is in the FTG, *disregard* any income that may have been allocated by the waiver spouse to the community spouse.

The waiver spouse is a FTG of one. CARES creates the separate FTG's and AG's.

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28.10 Reserved

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28.11 Reserved

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28.12 Reserved

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28.14 Reserved

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29 Katie Beckett

View History

29.1 Katie Beckett

The Katie Beckett Program tests qualified blind and/or disabled minors for Medicaid. It does not deem assets and income from the natural or adoptive parents.

To qualify under the Katie Beckett Program, a blind or disabled minor:

- Must require a level of care provided in a hospital, *SNF*, or *ICF*.
- Can appropriately receive this care in his or her home.
- Would be nonfinancially eligible for Medicaid if he or she were in a hospital, SNF, or ICF.
- Must have income below the Institutions Categorically Needy Income Limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.

Families may contact the Katie Beckett Program by:

- Calling 608-266-3236.
- Faxing information to 608-226-5420.
- Writing to the following address:

Katie Beckett Program
Division of Medicaid Services
Bureau of Children's Long Term Support Services
1 West Wilson Street, Room 418
Madison, WI 53707

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30 Tuberculosis

View History

30.1 Tuberculosis Medicaid

For information on Tuberculosis Medicaid, please see BadgerCare Plus Handbook, Chapter 43 Tuberculosis-Related Medicaid.

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30.2 Reserved

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31 Migrant Workers

View History

31.1 Introduction

A migrant worker is any person who temporarily leaves a principal place of residence outside Wisconsin and comes to Wisconsin for not more than 10 months in a year 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.

A migrant worker does not include any of the following:

- 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.
- 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.

A migrant family includes the adults, including non-marital co-parents, and their dependent children living in the migrant household.

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31.2 Simplified Application

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

- Have current Medicaid eligibility from another state ("Current Medicaid eligibility" means eligibility that includes at least months one and two of the application process.) or had Medicaid eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.
- Have the same members, or fewer, in the case as there were when the case had eligibility in the other state.

The simplified application procedure is as follows:

1. For members with current Medicaid eligibility from another state, verify the eligibility and the end date. Accomplish the verification by copying the out-of-state Medicaid card or by contacting the other state.
2. For members previously eligible in Wisconsin find the CARES Member Assistance for Re-employment & Economic Support closure code and review date.
3. Ask if the same members, or fewer, are in the case compared to when the group was eligible in the other state.
4. Collect all nonfinancial information.
5. Do not collect any financial information.
6. Certify Medicaid benefits for the migrant family.

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

The family has current Medicaid eligibility from Texas. That is, eligibility extends beyond application months one and two.

The household composition of five members is the same as listed on the Medicaid card.

The fulfillment of these two conditions indicates that the case should be processed with the simplified application procedure.

The IM worker enters nonfinancial information into CARES, and completes the

asset and income screens by answering “N” to all of the financial questions. He or she also makes sure to answer “Y” to the migrant question on ANDC for all family members.

CARES passes the case for MAOU eligibility with $0 assets and $0 income. The eligibility end date from Texas is November 30. The IM worker changes the review date on AGEC to November 30 to coincide with the end date from Texas.

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. Medicaid closes for failure to reside in the state. In 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.

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31.3 Regular Application

If migrant workers and their families have no current Medicaid eligibility or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular Medicaid application with the exception of using 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.

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31.4 Renewal Dates

Migrant families can do renewals:

- By mail.
- By phone.
- Through a face-to-face interview.

For more information, see Section 2.2 Application Types/Methods.

Income is always annualized.

31.4.1 Simplified Application

For migrant families who 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.

31.4.2 Regular Application

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

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32 Medicare Savings Programs

32.1 Medicare Savings Programs

32.1.1 Medicare Savings Programs Introduction

Medicare is the health insurance program administered by *CMS* for people 65 years old, people determined disabled for two years or more, or people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant). People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into four types of health coverage:

- Hospitalization insurance (Part A), which pays hospital bills and certain skilled nursing facility, home health care, and hospice expenses.
- Medical insurance (Part B), which pays doctor bills and certain other charges.
- Medicare Advantage (Part C), which allows private health insurance companies to provide Medicare benefits.
- Drug insurance (Part D), which pays for prescription drug charges.

Medicare charges monthly premiums, and Medicare beneficiaries are responsible for deductibles and coinsurance payments to providers. These out-of-pocket charges are generally referred to as Medicare cost-sharing.

Wisconsin Medicaid may pay some or all of the member's Medicare cost-sharing for certain Medicare beneficiaries participating in the following programs:

- *QMB*
- *SLMB*
- *SLMB+*
- *QDWI*

These programs are called Medicare Savings Programs (MSP). (They may also be referred to as Medicare Premium Assistance or Medicare Buy-In programs.)

When determining eligibility for MSP, IM workers should use the same rules for determining financial eligibility as are used for Medicaid with the exception of using the MSP asset limits in Section 32.6 Medicare Savings Programs Asset Limits and the MSP income limits in Section 39.5 Federal Poverty Level Table. Nonfinancial eligibility is available as follows:

- For QMB, see Section 32.2 Qualified Medicare Beneficiary.
- For SLMB, see Section 32.3 Specified Low-Income Medicare Beneficiary.

- For SLMB+, see Section 32.4 Specified Low-Income Medicare Beneficiary Plus.
- For QDWI, see Section 32.5 Qualified Disabled and Working Individual.

QMB members will receive a ForwardHealth card even if the member is not eligible for any other subprograms of Medicaid since Medicaid pays the Medicare copayments and deductibles for members enrolled in QMB.

32.1.2 Medicare Savings Programs Fiscal Test Group

The *FTG* size is two when a couple is living together in the community, unless one of the spouses is an *SSI* recipient. If one spouse is applying for MSP and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's FTG. If both spouses are living in the same nursing home, each person is an individual FTG.

32.1.3 Medicare Savings Programs Benefits

- QMB: Medicaid pays Medicare Part A and B premiums and Medicare deductibles, copayments, and coinsurance.
- SLMB: Medicaid pays Medicare Part B premiums.
- SLMB+: Medicaid pays Medicare Part B premiums.
- QDWI: Medicaid pays Medicare Part A premiums.

32.1.4 Low Income Subsidy Requests

See Section 2.6.4 Low Income Subsidy Program of Medicare Savings Programs for information on *LIS* Requests for *MSP*.

32.1.5 Part B Enrollment Via the Medicare Savings Programs Buy-In Program

Members who are receiving Medicare Part A coverage, but who previously chose not to enroll in Part B, may be eligible to enroll in Part B outside of their usual enrollment periods via the MSP process with the state. See Process Help Section 61.2.1.3 Part B Enrollment Via MSP.

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32.2 Qualified Medicare Beneficiary

32.2.1 Introduction

To be eligible for QMB the person must:

1. Meet non-financial Medicaid requirements
2. Be receiving Medicare Part A

The following Medicaid members are categorically eligible for *QMB* benefits:

- People who are receiving or are eligible to receive *SSI*.
- People who are eligible for categorically or medically needy SSI-related Medicaid as a:
    - 503 assistance group (as defined in Section 25.1 503 Eligibility).
    - *DAC* (as defined in Section 25.2 Disabled Adult Child).
    - Widow or widower (as defined in Section 25.3 Widows and Widowers).

Note: If a member is not eligible for categorically or medically needy SSI-related Medicaid through any of these four groups, he or she is not automatically eligible for QMB benefits.

Example 1: Kate receives an SSDC payment from Social Security. Due to other unearned income, however, Kate is not eligible for categorically or medically needy SSI-related Medicaid as a DAC. Even though she receives a “DAC” payment, she is not automatically eligible for QMB because she is not eligible for Medicaid through the receipt of SSI or through Special Status Medicaid.

A 503 assistance group, DAC, and widow or widower, as defined above, have the option of not taking the QMB benefit.

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A if he or she meets one of the following conditions:

1. He or she does not have to pay a premium for Medicare Part A and is enrolled in Medicare Part A as of the QMB determination.

Example 2: Mrs. Smith applies for QMB benefits August 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is "entitled" to Part A at the time of the QMB

determination.

2. He or she must pay a monthly premium to receive Medicare Part A and fits one of the following descriptions:

   a. He or she is a Medicaid member and has been enrolled in Medicare sometime in the past. In this case the State will attempt to enroll him or her in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 3: Eleanor's Part A lapsed because she did not work enough quarters for free enrollment, and she could no longer afford the premiums. When she becomes eligible for Medicaid, the state will begin paying her Medicare premiums.

   b. He or she is a Medicaid member or QMB or SLMB applicant and has never been enrolled in Medicare Part A. In this case he or she must apply at the local SSA office for Part A Medicare eligibility. He or she will receive a receipt which entitles him or her to enrollment in Part A on the condition that he or she is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB or SLMB eligibility cannot begin prior to the Part A begin date.

Example 4: Pearl was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She goes to the SSA office during the January-March enrollment period and is conditionally determined eligible for Part A effective July 1. She applies for QMB at the *IM* Agency on May 1. She becomes QMB eligible as of July 1.

32.2.3 Income Limit

The QMB income limit is 100% of the *FPL*. See 39.5 FPL Table.

The method of counting income is based on the SSI method, not on the *spousal impoverishment* method. (See 28.1 HCBWLTC Introduction). Calculate QMB net income as follows:

$ Earned income (See 15.5 Earned Income)
- $65 and ½ earned income deduction (15.7.5 $65 and ½ Earned Income Deduction)
+ Unearned income (Social Security income, etc.) (15.4 Unearned Income)

- Special exempt income (15.7.2 Special Exempt Income)
- $20 standard deduction
= Net income used to determine QMB eligibility

When counting Social Security income, use the gross Social Security income. Gross Social Security income:

1. Of a self-payer = the Social Security check amount + Medicare premiums he or she has paid.
2. Of someone for whom the state is paying the premiums = the Social Security check amount.

Disregard the *COLA* increase for the current year until the month after the new federal poverty limits become effective.

Example 5: Al is a QMB member. He has income of 99% of the FPL. In January, a COLA increase of $15.00 increases Al's income above 100% of the FPL. Disregard the COLA increase in any determination of Al's continuing QMB eligibility. On April 1, new QMB income limits are published. Redetermine Al's QMB eligibility in May using the new QMB income limits. At this redetermination, do not disregard the January COLA increase.

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32.3 Specified Low-Income Medicare Beneficiary

32.3.1 Introduction

To be eligible for *SLMB* the person must:

1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A.

32.3.2 Income Limit

The SLMB income limit is at least 100% of the *FPL*, but less than 120%. See 39.5 FPL Table.

Calculate SLMB net income in the same way as *QMB* net income including the temporary *disregard* of the annual *COLA* increase. (See 32.2.2 QMB Income Limit).

32.4 Specified Low-Income Medicare Beneficiary Plus

32.4.1 Introduction

To be eligible for *SLMB+*, the person must:

1. Meet nonfinancial Medicaid requirements.
2. Be receiving Medicare Part A.
3. Not be enrolled in full-benefit Medicaid (such as SSI Medicaid, Community Waivers, and BadgerCare Plus), Family Planning Only Services, or Tuberculosis Only Related Services. A person with an unmet deductible should be considered ineligible for Medicaid until he or she meets the deductible

32.4.2 Income Limit

SLMB+ income must be at least 120% of the *FPL*, but less than 135% (see Section 39.5 Federal Poverty Level Table).

Calculate SLMB+ net income in the same way as QMB net income including the temporary *disregard* of the annual *COLA* increase (see Section 32.2.2 Income Limit).

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32.5 Qualified Disabled and Working Individual

32.5.1 Introduction

A *QDWI* is a person who:

- Is under age 65 and has lost premium-free Medicare Part A as a result of returning to work.
- Is not otherwise eligible for Medicaid, including but not limited to EBD Medicaid programs, Community Waivers, and BadgerCare Plus. (Consider a person with an unmet deductible ineligible for Medicaid until he or she meets the deductible.)
- Continues to be disabled.
- Meets the QDWI income limit (see Section 32.5.2 Income Limit) and asset limit (see Section 32.6 Medicare Savings Programs Asset Limits).

32.5.2 Income Limit

The QDWI income limit is 200% of the *FPL*. See 39.5 FPL Table.

Calculate QDWI net income in the same way as *QMB* net income including the temporary *disregard* of the annual *COLA* increase.(See 32.2.2 QMB Income Limit).

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32.6 Medicare Savings Programs Asset Limits

See 39.4 EBD Assets and Income Tables for MSP asset limits.

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility. Estate Recovery does not recover MSP benefits.

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32.7 Medicare Savings Programs Begin Dates

32.7.1 QMB Begin Dates

32.7.1.1 QMB Begin Date

For initial eligibility, *QMB* benefits begin on the first of the month after the month in which the person is determined to be eligible, and the case is confirmed in CARES.

Example 1: Henry has been in the same nursing home since 2013. He applied for Medicaid on January 23, 2017, and also requested QMB. His application was processed and confirmed for both programs on January 23, 2017, and he was determined eligible for both. His Medicaid begin date is January 1, 2017. His QMB begin date is February 1, 2017.

32.7.1.2 QMB Renewals

For renewals, QMB benefits begin on the first of the month following the renewal due month, regardless if the renewal was confirmed in the renewal due month or the month following the renewal due month.

Example 2: Diamond has been receiving Medicaid and QMB for five years. Her Medicaid and QMB was due for renewal in February. Her Medicaid and QMB renewal began February 20. The worker received verification for the renewal on February 28. The IM worker entered verification to complete the QMB renewal certification March 1. Her QMB renewal was confirmed eligible on March 1. QMB eligibility begins March 1 and not April 1. There is no gap in her QMB eligibility.

32.7.2 SLMB, SLMB+, QDWI Begin Dates

SLMB, *SLMB+*, and *QDWI* benefits begin the first day of the month in which the valid application is submitted and all eligibility requirements are met. Eligibility for these programs may be backdated to the first of the month, up to three calendar months prior to the month of application (see Section 32.8.2 SLMB, SLMB+, and QDWI Backdating).

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32.8 Medicare Savings Programs Backdating

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for *QMB* do not correctly begin on the first of the following month. This can occur if:

- The eligibility process was not completed within 30 days.
- Certification of eligibility was not completed.
- A fair hearing decision has ordered backdated QMB benefits.

See Process Help Section 61.2.2 for instructions for QMB backdating.

32.8.2 SLMB, SLMB+, QDWI Backdating

Benefits can be backdated for up to three months prior to the month of application. Use the backdating guidelines in Section 2.8.2 Backdated Eligibility.

A person cannot receive backdated *SLMB*, *SLMB+*, or *QDWI* benefits for months in which he or she would have been eligible for QMB.

Example 1: Henry applied for *MSP* on June 15. He also requested a three-month backdate. His income for June was under the QMB income limit (100% of the FPL). He was determined eligible for QMB for ongoing months. His backdated eligibility was denied because his income in each of the backdated months of March, April, and May was under the QMB income limit (100% of the FPL). Since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB or SLMB+ benefits.

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32.9 Medicare Savings Programs No Deductible

There is no deductible in *MSP* (see Section 24.2 Medicaid Deductible Introduction). If a person's income is above the appropriate income limit, he or she cannot qualify for an MSP.

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32.10 Medicare Savings Programs Renewals

MSP renewals are every 12 months.

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32.11 Potential Adverse Effect of Medicare Savings Program Participation

When a member is found eligible for one of the *MSP* programs and the state pays a person's Part B premium, his or her Social Security payment will increase by the same amount as the Medicare Part B premium. This increase in the Social Security payment may result in the person either losing Medicaid eligibility, or experiencing a reduction in benefits.

When a person would be adversely affected in this way, he or she is allowed to choose between either losing his or her Medicaid current benefits and keeping free Medicare enrollment, or giving up the free Medicare enrollment and keeping his or her Medicaid benefits. All but 503, DACs, and widow/widowers can opt out of the *QMB* buy-in through CARES. See Process Help Section 61.4 for processing instructions when a 503, DAC, or widower requests to opt out of MSP.

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33 SeniorCare

33.1 Introduction

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet the program's enrollment requirements.

SeniorCare is administered by *DHS*, through *EM CAPO*. IM consortia and tribal agencies are not responsible for determining eligibility for SeniorCare, but may need to coordinate with workers in the EM CAPO for mixed cases. Mixed cases include people eligible for SeniorCare and:

1. FoodShare, **or**
2. A Medicare Savings Program , **or**
3. An unmet Medicaid deductible, **or**
4. Child care assistance, **or**
5. Are participating in a Department of Workforce Development (DWD) employment program, such as *W-2*.

Although SeniorCare is a subprogram of Medicaid, only the portions of the handbook that are referenced in Chapter 33 SeniorCare apply to SeniorCare policy.

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33.2 Application

33.2.1 SeniorCare Application Introduction

An individual interested in participating in SeniorCare must complete a SeniorCare Application form (F-10076). Applications may be printed from the Department of Health Services' SeniorCare web site at: https://www.dhs.wisconsin.gov/seniorcare/apply.htm. Local Aging and Disability Resource Centers may also have copies of the SeniorCare application. If the *applicant* is unsure where to obtain an application or wants to have one mailed to him/her, he or she should call 1-800- 657-2038 (TTY and translation services are available).

A $30 enrollment fee per person is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See Section 33.3.2 Enrollment Fee).

SeniorCare applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: For benefit renewal requirements, see Section 33.15 Annual Eligibility Renewal.

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application form (F-10076) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (see 33.2.3 Signing the Application) in Section V. Applications that are not signed in Section V of F-10076) will be returned to the applicant.

However, non-financial (see Section 33.3 Nonfinancial Requirements) and income (33.6 Financial Requirements) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but cannot be used as a residence address.

The presence of a signature on a SeniorCare application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his or her intent.

The date a valid application is received by the SeniorCare program is the application filing date. Eligibility for SeniorCare will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his or her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, he or she should check the "New Application" box on the application form. "Reapplication" refers to current members who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.3 Signing the Application

The applicant must sign the application form in Section V of F-10076 (Section VI of the 07/02 version of F-10076) with his or her signature, a mark or an "X", unless one of the following signs for him or her:

1. A guardian of the estate, a guardian of the person and the estate, or a guardian in general.
2. An *authorized representative*.
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

33.2.3.1 Witnessing the Signature

If a SeniorCare applicant signs the application form in Section V of F-10076 with a mark or an "X", the signature must be witnessed by two individuals. (Section VI of the 07/02 version of F-10076).

33.2.4 Authorized Representative

An authorized representative may act on behalf of the SeniorCare member at application and/or renewals, and is authorized to provide information and any documentation that is necessary to establish SeniorCare eligibility.

A SeniorCare applicant or member may appoint an individual or an organization as an authorized representative by completing the SeniorCare Authorized Representative form (F-10080).

There can be only one authorized representative at a time for a SeniorCare. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. SeniorCare authorized representatives can only act on the individual's behalf for SeniorCare.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new SeniorCare Authorization of Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- Apply for or renew SeniorCare benefits
- Report changes in the SeniorCare applicant or member's circumstances or demographic information
- Receive copies of the applicant or member's notices and other communications from the SeniorCare program
- Work with the SeniorCare program on any benefit related matters
- File grievances or appeals regarding the applicant or member's SeniorCare eligibility

To change an authorized representative, the member must complete and submit the SeniorCare Authorization of Representative form to the SeniorCare program.

To remove an authorized representative, the member needs to let the SeniorCare program know of the removal in writing. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

33.2.5 Guardian and Power of Attorney

If a SeniorCare applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the SeniorCare applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the member or member would like the legal guardian of the person to act on his or her behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

Copies of guardianship or POA documentation must be submitted to the SeniorCare Program before information about the applicant or member can be released to the guardian or POA, unless the POA is the authorized representative. The SeniorCare Authorization of Representative form (F-10080) will be accepted in lieu of the POA papers.

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33.3 Nonfinancial Requirements

33.3.1 SeniorCare Nonfinancial Requirements Introduction

To be non-financially eligible for SeniorCare, an *applicant* must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident. A Wisconsin resident is an individual who meets at least one of the following criteria:
    - Has a permanent residence in Wisconsin
    - Is considered a Wisconsin resident for tax purposes
    - Is a registered voter in Wisconsin

    A SeniorCare member may temporarily live outside the state of Wisconsin, as long as he or she maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement. There is also not a specific period of time the applicant must be a Wisconsin resident before applying for SeniorCare.

3. Be a U.S. citizen or have qualifying immigrant status. (see Section 7.1 US Citizens and Nationals). An applicant who is a not a U.S. citizen will need to have a qualifying immigrant status to be eligible for SeniorCare (see Section 7.3 Immigrants). The applicant will need to provide his or her immigration registration number. Verification of the applicant's immigration status will be made through the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlements (SAVE) program. In some cases, the individual may need to provide an official government document. For example, if the applicant's immigration status cannot be verified through SAVE or there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant.

    If current SSDI, SSI, Medicare, Foster Care, or Adoption Assistance benefits have been verified, the applicant is exempt from documenting their citizenship (see Section 7.2 Documenting Citizenship and Identity).

4. Provide an SSN or be willing to apply for one, unless they are exempt from the SSN requirement (see Section 10.1.1 Social Security Number Requirements).

    SeniorCare applicants only need to provide a number, which is verified through the data exchange with Social Security. If the SSN validation process returns a mismatch record, then the applicant must provide the Social Security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, he or she must be willing to apply for one.

If an applicant requires assistance in obtaining a SSN, the SeniorCare Program will assist him or her in applying for one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

SeniorCare applications without the SSN or with an incorrect SSN will not be returned. Applicants will be contacted and given an opportunity to provide a valid SSN or apply for one. The SeniorCare program will honor the original application date for individuals who initially provide an incorrect SSN or who need assistance in applying.

If the individual is not willing to provide or apply for an SSN or the proof of application is not received within 30 days of application for the SeniorCare application date, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they are willing to provide or apply for an SSN. The eligibility begin date will be based on the new application receipt date.

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 cannot 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:

- Recommend further action be taken
  and/or
- 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.

5. Not be a full-benefit Medicaid member (see Section 21.2 Full-Benefit Medicaid). This includes members who are covered by BadgerCare Plus (see the BadgerCare Plus Handbook).
   Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (see Section 24.2 Medicaid Deductible Introduction) or receive one of the following:

   - Medicare Savings Program (see Section 32.1 Medicare Savings Programs).
   - TB-related Medicaid (see Chapter 30 Tuberculosis)

6. Not be an inmate of a public institution (6.9.3 General Medicaid Application Process for Inmates of State Correctional Institutions).

7. Cooperate with providing information and/or verification necessary to determine eligibility (see Chapter 20 Verification) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SeniorCare program will assist him or her.

   If a person is not able to produce the required verification and the SeniorCare program is not able to produce the required verification, the SeniorCare program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a member reapplies for a new benefit period, a new enrollment fee is required.

When a SeniorCare enrollment fee check is returned for non-sufficient funds, the applicant or member is mailed a letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a letter giving another 10 days to replace the fee is sent. If the check is still not replaced, then eligibility is denied or terminated.

33.3.2.1 Refunds

No Application Received
If *EM CAPO* receives an enrollment fee without an application, a manual notice and application will be sent, if possible, to the individual from whom the enrollment fee was received. If a SeniorCare application is not received by EM CAPO within 45 days of the receipt of the enrollment fee, a refund will be processed at the request of the person who submitted the enrollment fee.

Application Denied
Anytime an application for SeniorCare is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt Out
In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

- Ten days following issuance of the eligibility notice, or
- 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

Refunds are based on individual participation. A SeniorCare member may receive an enrollment fee refund if he or she received an initial eligibility notification, but has not received any SeniorCare prescription drug benefits or services and requests to withdraw from the program (see Section 33.12.2 Withdrawal).

SeniorCare prescription drug benefits include use of the SeniorCare card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SeniorCare card at Level 3 where a spenddown has not been met constitutes receipt of SeniorCare prescription drug services. A refund of the enrollment fee may be issued if such claims are reversed by the pharmacy.

Example 1: Julie is a SeniorCare member at Level 2b. Julie's SeniorCare application filing date was October 26th, and her benefit period began November 1st. On November 15th, Julie calls the SeniorCare Customer Service hotline to withdraw from the SeniorCare program and request a refund of her $30 enrollment fee. Julie used her SeniorCare card on November 10th, when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using her SeniorCare card.

Example 2: Mike is a Level 3 SeniorCare member. Mike's SeniorCare application filing date was October 28th and his benefit period began November 1st. On November 20th, Mike requests to withdraw from the SeniorCare program and that his $30 enrollment fee be refunded to him. Mike used his SeniorCare card on November 18th, when he purchased a prescription; however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

33.3.2.2 Refunds to Deceased Members

A refund may also be requested by the family *member* of a deceased member when all the following criteria are met:

1. He or she received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SeniorCare benefit period, and
3. The request is made within 45 days of the date of death; and
4. He or she had not received any SeniorCare prescription drug benefits or services.

Example 3: Henry was a SeniorCare member at Level 1 whose benefit period began December 1st. Henry passed away on December 4th. His daughter reported Henry's death to the SeniorCare program on December 10th, and requested a refund of his $30 enrollment fee. Henry's SeniorCare card had been used on December 1st to purchase a prescription; however, the pharmacy had reversed those charges on December 5th, since Henry's prescription had not been picked up. The $30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.

Note: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

33.3.2.3 Opt-In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the EM CAPO if he or she chooses to "opt in" to the program. He or she would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A participant who decides after the 30-day period that he or she wants to rejoin the program will need to complete a new application and submit the enrollment fee.

33.3.3 Age Limitation

A single applicant should apply for SeniorCare no sooner than the calendar month of his or her 65th birthday.

When a couple applies where one *spouse* is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SeniorCare unless he or she is turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-month enrollment period, he or she will receive a notice pending his or her eligibility for the enrollment fee approximately one month prior to his or her 65th birthday.

33.3.4 Other Insurance

Except for people enrolled in full-benefit Medicaid, applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts B and D, may enroll in SeniorCare. SeniorCare is the payer of last resort except for state-funded-only programs, such as *WCDP*.

SeniorCare will coordinate benefit coverage with all other health insurance coverage. SeniorCare may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517

33.3.5 Creditable Coverage

Wisconsin's SeniorCare prescription drug assistance program is considered to be creditable prescription drug coverage. This means SeniorCare meets or exceeds the standard Medicare Part D plan. If an individual chooses to enroll in SeniorCare instead of Medicare Part D, they will not have a penalty.

If an individual is enrolled in SeniorCare, they can keep SeniorCare and not pay extra if they decide to enroll in Medicare Part D later. However, if their SeniorCare coverage ends and he or she does not enroll in a Medicare Part D plan right away, they may have to pay more to enroll in Medicare Part D at a later date.

If an individual goes without creditable prescription drug coverage for 63 days or longer, their monthly premium for Medicare Part D will go up at least one percent for each month they did not have creditable coverage. For example, if they go nine months without coverage, their premium will always be at least nine percent higher that if they had enrolled in Medicare Part D right away.

If individuals enroll in a Medicare Part D plan, their coverage will typically begin about a month after they enroll. If they need help paying for their prescription drugs and they are enrolled in SeniorCare, they may choose to remain enrolled in SeniorCare until their Medicare Part D coverage begins.

If an individual does not enroll in a Medicare Part D plan when they are eligible, they may have to wait until the next enrollment period before they can enroll. The enrollment period is from October 15 through December 7 each year, and coverage begins January 1.

Individuals with limited resources may be able to get extra help paying premiums, deductibles, and copayments for Medicare Part D. They can apply or get more

information about Extra Help, also called the Low Income Subsidy, by calling the Social Security Administration at 800-722-1213 or visiting www.socialsecurity.gov/extrahelp.

If applicants have questions about SeniorCare and Medicare Part D, or need help choosing which prescription drug plan is best for them, they should be referred to a benefits specialist at their local aging and disability resource center (ADRC) or the Wisconsin Medigap Part D and Prescription Drug Helpline at 1-855-677-2783 for questions about Medicare Part D and other prescription drug coverage options.

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33.4 Fiscal Test Group

The *FTG* consists solely of an *applicant* , unless the applicant is married and resides with his or her *spouse*.

If the applicant is married and resides with his or her spouse, the FTG consists of both the applicant and his or her spouse. An applicant is considered to be residing with his or her spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
2. The applicant's spouse is a SSI recipient, **or**
3. The applicants are married but are living separately, **or**
4. Both spouses are living in a nursing home.

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33.5 Benefit Period

33.5.1 SeniorCare Benefit Period Introduction

The benefit period for SeniorCare is 12 consecutive months. The benefit period and eligibility remain intact unless the member:

1. Moves out of state,
2. Reapplies (33.11 Re-Application),
3. Requests to withdraw from the program (33.12 Early Termination), **or**
4. Dies.

Once eligibility has been established, any changes in income will not be considered until the next renewal, unless the individual reapplies for a new benefit period.

33.5.2 ID Cards

When an *applicant* is found eligible for SeniorCare, he or she is mailed a plastic SeniorCare ID card and information about how to use it. SeniorCare members who renew their eligibility will continue to use their original card.

SeniorCare members must present their SeniorCare card to their pharmacy provider. The card does not show enrollment dates. The pharmacy provider will verify the member's enrollment at each visit.

If SeniorCare members have questions regarding their eligibility status or need a replacement SeniorCare card, they should call the SeniorCare Customer Service hotline at 1-800-657-2038.

33.5.3 Eligibility Begin Date

SeniorCare eligibility begins on the first day of the month following the month in which all eligibility requirements have been met. This includes receipt of a completed application and enrollment fee.

Exception: SeniorCare eligibility begins the day after Medicaid eligibility ends if a SeniorCare application is submitted prior to the Medicaid termination date and all eligibility requirements are met.

Example 1: Carol applies for SeniorCare on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2: William applied for SeniorCare on September 19th but did not submit the enrollment fee with his application. His eligibility pends and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3: Mary is notified that Medicaid eligibility will end on November 30th because her assets exceed the program limit. She applied for SeniorCare on November 29th and will meet all SeniorCare eligibility requirements on December 1st (when she is no longer a full-benefit Medicaid member). Mary's benefit period is from December 1st through November 30th.

Note: If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example 4: Harold's Renewal Application was mailed to him on December 13th to be completed for his new benefit period that would begin February 1st. The Renewal Application was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the IM worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SeniorCare program. Due to the incorrect address, Harold did not receive the Renewal Application form to complete until late in January. The completed Renewal Application was received by the SeniorCare program on February 10th, along with a letter explaining why it was late. Harold's new SeniorCare benefit period is February 1st through January 31st, since the one month gap in coverage was due to an agency error.

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33.6 Financial Requirements

33.6.1 Assets

There is no asset test for SeniorCare. In general, cash that is received as a result of converting an asset from one form to another is not income. This includes withdrawals from savings and/or checking accounts, *CD*s, or money market accounts. However, special provisions apply to retirement benefits (see Section 33.6.7 Gross Retirement Income) and Cobell buy-out payments (see Section 16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case). Income generated from any assets that the SeniorCare participant may have is considered budgetable income and must be reported on the application or renewal application.

Example 1: Eric has a savings account with $5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income.

Eric anticipates withdrawing $1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset and are not counted as income.

33.6.2 Income

Income for SeniorCare is based on what the FTG expects to receive in the next 12 month period, beginning with the month of application. The incomes for the applicant and his or her spouse are counted together if they live together. Applicants can use the previous year's information from tax returns or other sources as a guide when estimating what to report on their application. Applicants are asked to round income amounts to the nearest whole dollar when entering their good faith estimates on their SeniorCare application or renewal application.

Social Security income will always be verified. For all other income types, if reported amounts seem unreasonable or questionable, further verification may be obtained from the applicant or other available sources, such as a data exchange.

The income of a *spouse* who is in the SeniorCare *FTG* is included in the estimate of the annual, budgetable income even if he or she does not apply or is nonfinancially ineligible. However, the spouse's income is not counted if one of the exceptions noted in Section 33.4 Fiscal Test Group applies.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SeniorCare (see Section 15.3 Exempt and Disregarded Income), including *EITC* and income tax refunds (see Section 15.5.7 Income Tax Refunds).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income (see Section 33.6.6 Self-Employment Earnings).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application form, F-10076. All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, add any deductions for Medicare Part B or D and court-ordered guardianship fees, alimony, and/or child support must be added to the net payment amount.

Exception: If a SeniorCare applicant is receiving Medicare premium assistance (see Section 32.1 Medicare Savings Programs), his or her monthly payment already includes the Medicare Part B premium.

The applicant should contact the *SSA* at 1-800-772-1213 if he or she does not know his or her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his or her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

Social Security income is verified through the Social Security Administration data exchange.

33.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (see Section 33.6.6 Self-Employment Earnings). Gross earnings include the following:

- AmeriCorps (see Section 15.5.9 AmeriCorps)
- Contractual income (see Section 15.5.2 Contractual Income)
- Income in-kind (see Section 15.5.1 Income In-Kind)
- Income received by members of a religious order (see Section 15.4.16 Income Received by Members of a Religious Order and Section 15.5.12 Income Received by Members of a Religious Order)

- Jury duty payments (see Section 15.5.4 Jury Duty Payments)
- Salary
- Severance pay (see Section 15.5.11 Severance Pay)
- Wage advances (see Section 15.5.5 Wage Advances)
- Wages
- Wages and salaries received from a program funded under Title V—Older Americans Act of 1965 (see Section 15.5.13 Title V—Older Americans Act of 1965)
- Worker's compensation (see Section 15.5.6 Worker's Compensation)
- Respite care payment for services

33.6.5 Interest and Dividends

The SeniorCare applicant must report the estimated gross amount of all interest and dividends that he or she expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to, the following:

- Bonds
- CDs
- Checking accounts
- Money market accounts
- Savings accounts
- Stocks
- Capital gains (see Section 33.6.5.1 Capital Gains)
- Trusts (see Section 33.6.5.2 Trusts)
- *IRA*s (see Section 15.4.4 Retirement Benefits)
- Annuities
- Land contracts (see Section 15.4.7 Land Contract)
- Loans (see Section 15.4.8 Loans, Promissory Notes, and Mortgages)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, income that is received irregularly and infrequently and is under $20 per month should be reported as budgetable income for SeniorCare applicants.

33.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported

if it is greater than zero. Negative amounts should not be reported and will not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when he or she sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

33.6.5.2 Trusts

All anticipated payments (including interest, dividends, and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, withdrawals from principal are counted for SeniorCare as income in the month received.

33.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant or applicant's spouse should report only his or her share of the interest.

If the applicant and his or her spouse are not living together and hold a joint savings account, the applicant should only report his or her share of the interest

33.6.6 Self-Employment Earnings

SeniorCare will budget net self-employment income, which is calculated by deducting allowable business expenses, losses, and depreciation from gross self-employment income (see Section 15.6 Self-Employment Income).

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported. Any reported losses will be budgeted as zero and will not be used to offset other income.

33.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income. Refer to Section 15.6.4 Self-Employed Income Sources for more information about rental income for self-employed members.

Refer to Section 33.6.8.3 Rental Income if rental income is not reported as self-employment income.

33.6.7 Gross Retirement Income

Examples of retirement income that should be counted for SeniorCare include:

- Veterans retirement benefits
- Railroad Retirement Board benefits
- The taxable portion of IRAs, annuities, work-related retirement plans, and pensions

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 are funds held in an IRA and plans for self-employed individuals, sometimes referred to as Keogh plans.

The funds in retirement accounts, including IRAs, Keogh plans, etc., are assets and are therefore not counted for SeniorCare. However, periodic payments, withdrawals, and distributions the individual expects to receive from their retirement account or annuity in the next 12 months are counted as income. The only exception is when the individual has never previously made withdrawals from the account and he or she withdraws the full amount at one time. This is not considered a periodic payment and is not countable income.

Note: Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SeniorCare.

Example 2: Mike owns a $2,000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one-time withdrawal of $1,000 from the $2,000 IRA in the next 12 months, the $1,000 would be considered income. He should report this income on his SeniorCare application and it should be budgeted.

If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income. He should report this income on his SeniorCare application and it should be budgeted.

33.6.8 Other Income

Examples of other income are:

- Allocated income from a spouse who is a Medicaid member (see Section 33.6.8.1 Allocated Income From a Medicaid Member Spouse)
- Child support (see Section 15.4.14 Child Support)
- Federal farm subsidy (see Section 33.6.8.2 Farm Subsidy)
- Gifts (see Section 15.4.6 Gifts)
- Profit sharing (see Section 15.4.15 Profit Sharing),
- Sick/disability benefits (see Section 15.4.2 Sick Benefits)
- Rental income (see Section 33.6.8.3 Rental Income)
- Unemployment compensation (see Section 15.4.3 Unemployment Compensation)
- Veterans disability payments (see Section 33.6.8.4 Veterans Disability)

33.6.8.1 Allocated Income From a Medicaid Member Spouse

A SeniorCare applicant whose spouse is a Medicaid member living outside the home (e.g., in a nursing home) must report the spousal income allocation amount (see Section 18.6 Spousal Impoverishment Income Allocation) as income.

Example 3: Betty is a Medicaid member and in a nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that, $45 is set aside as her personal needs allowance. The $605 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,260 as “Other Income” on his SeniorCare application.

A SeniorCare applicant whose spouse is a Medicaid member living in the home (e.g., a community waivers participant) should not report income that is allocated to him or her. The allocated amount must be included in the income estimate for the Medicaid member spouse because he or she is living in the home.

33.6.8.2 Farm Subsidy

A SeniorCare applicant must report anticipated farm subsidy payments. A SeniorCare applicant must also report payments from *CREP*, a program where the landowner is paid to install conservation practices for a period of 10–15 years.

33.6.8.3 Rental Income

All expected rental income will be budgeted for SeniorCare. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses, such as insurance, utilities, taxes,

advertising for tenants, and repairs. Repairs include expenses, such as repainting, fixing gutters or floors, plastering, and replacing broken windows.

Refer to Section 33.6.6.1 Rental Income if rental income is reported to the IRS as self-employment income.

33.6.8.4 Veterans Disability

Veterans disability payments should be reported as income.

Do not count as income the portion of a veterans disability payment that is for unusual medical expenses, aid and attendance, or a housebound allowance.

An applicant should check with the Veterans Administration at 1-800-827-1000 to determine if any portion of the payment is considered an allowance for unusual medical expenses, aid and attendance, or housebound allowance.

Reimbursement from the *VA* for medical costs does not count as income.

33.6.9 Disregarded Income

The applicant should not report income anticipated from any of the following:

- Active Corps of Executives (see Section 15.3.22 Special Programs)
- Adoption assistance payments (see Section 15.3.1 Adoption Assistance)
- Agent Orange Settlement Fund payments (see Section 15.3.2 Agent Orange Settlement Fund)
- Disaster and emergency assistance payments made by federal, state, county, and local agencies or other disaster assistance agencies (see Section 15.3.5 Disaster and Emergency Assistance)
- Earned Income Tax Credit (see Section 16.7.8 Earned Income Tax Credit)
- Earnings of a census enumerator (see Section 15.3.22 Special Programs)
- Emergency Fuel Assistance payments (see Section 15.3.22 Special Programs)
- Foster care payments (see Section 15.3.7 Foster Care)
- Foster Grandparents Program (see Section 15.3.22 Special Programs)
- Governmental rent or housing subsidies (see Section 15.3.22 Special Programs)
- Homestead Tax Credit (see Section 15.3.22 Special Programs)
- Income tax refunds (both state and federal) (see Section 16.7.7 Income Tax Refunds)
- Individual Development Account payments (see Section 15.3.9 Individual Development Account Payments)
- Kinship Care payments (see Section 15.3.11 Kinship Care)
- Low-Income Energy Assistance Program (see Section 15.3.22 Special Programs)
- Older American Community Service Program (except for wages or salaries that are counted) (see Section 15.3.22 Special Programs)

- Payments made to individuals because of their status as victims of Nazi persecution (see Section 15.3.15 Payments to Nazi Victims)
- 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 (see Section 15.3.24 Susan Walker Payments).
- Penalty payments made when the state does not correctly process child support refunds
- Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining (see Section 15.3.16 Radiation Exposure Compensation Act)
- Reimbursement from private insurance company for medical, *LTC*, or dependent care expenses (see Section 15.3.19 Reimbursements)
- Restitution payments to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during World War II (see Section 15.3.27 Wartime Relocation of Citizens).
- Retired Senior Volunteer Program (see Section 15.3.22 Special Programs)
- Reverse mortgage payments (see Section 16.7.2.1 Reverse Mortgage)
- Service Corps of Retired Executives (see Section 15.3.22 Special Programs)
- University Year for Action Program (see Section 15.3.22 Special Programs)
- Volunteers in Service to America (see Section 15.3.22 Special Programs)
- *W-2* payments for transitional jobs and community service jobs (see Section 15.3.28 Wisconsin Works Payments)
- Wisconsin's Family Support Program (see Section 15.3.22 Special Programs)
- Payments from Indian Health Services (**Note:** Payments to Native Americans listed in Section 15.3.14 Payments to Native Americans must be counted.)

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33.7 Participation Levels

See 39.11 SeniorCare Income Limits.

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33.8 Countable Costs

33.8.1 SeniorCare Countable Costs Introduction

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible SeniorCare member,
2. Purchased during the benefit period, and
3. Covered by the SeniorCare program (see Section 33.6 Financial Requirements).

All covered prescription drug costs the member incurs will be tracked, and the SeniorCare Program will coordinate coverage with other insurance companies if the member has other coverage. If the prescription is covered by other insurance, only the portion not paid by other insurance is applied toward the spenddown or deductible.

When a member's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.8.2 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, within a benefit period, when carryover covered prescription amounts are applied.

1. When the covered prescription cost exceeds the remaining deductible amount, SeniorCare pays the difference.

Example 1: Jeff earns between 160% and 200% of the *FPL* for a *FTG* size of one (39.11 SeniorCare Income Limits and Participation Levels). He is eligible for SeniorCare and has a $500 deductible. In three months, Jeff has a remaining deductible amount of $30.

During the fourth month of his benefit period, with a $30 remaining deductible, Jeff purchases a covered prescription drug that costs $100. The pharmacist informs him that he owes $30 of the $100 prescription drug cost. He has met his deductible. The remaining $70 will be paid by SeniorCare.

For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

2. When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

Example 2: Rachel's income is $1,800 more than 240% of the FPL for a FTG of one (see Section 39.11 SeniorCare Income Limits and Participation Levels). Her spenddown amount for the 12-month benefit period is $1,800. In four months, Rachel has incurred all but $50 of her spenddown amount by purchasing covered prescription drugs at retail price.

During the fifth month of her benefit period when she has $50 of her spenddown left, Rachel purchases a covered prescription drug that costs $100. Rachel pays the full $100. Of the $100, $50 is applied to her spenddown, and $50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is $800.

33.8.3 Date of Purchase

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

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33.9 Addition of a Spouse

33.9.1 SeniorCare Addition of a Spouse Introduction

The following exceptions apply when one *spouse* (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless he or she chooses to reapply (see Section 33.11 Re-Application).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (see Section 33.9.2 Adding a Spouse No Change in FTG).

    a. If Spouse 1's eligibility was determined at level 2a or 2b, then refer to 33.9.2 Adding a Spouse No Change in FTG.
    b. If Spouse 1's eligibility was determined at level 3 then refer to Section 33.9.2.2 Adding a Spouse, No FTG Change, At level 3. Refer to the applicable policy depending on whether or not the spenddown has been met as follows:

        - Met spenddown (see Section 33.9.2.2.1 Unmet Spenddown)
        - Unmet spend (see Section 33.9.2.2.2 Met Spenddown)

Or

2. Spouse 2 was not included in the *FTG* (e.g., single or not living with Spouse 1) at the time of Spouse 1's application. (see Section 33.9.3 FTG Changes), but they are now residing together.

1.

a. If spouse 1's eligibility was determined at level at level 2a or 2b, refer to Section 33.9.3.1 FTG Changes at Level 2a and 2b)

b. If spouse 1's eligibility was determined at level 3, refer to Section 33.9.3.2 FTG Changes At Level 3

See 33.9.4 Addition of a Spouse Summary Table

33.9.2 Adding a Spouse No Change in FTG

If Spouse 2' s participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual income information provided on Spouse 1's application.

Example 1: Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for SeniorCare. Anne takes no prescription drugs and does not request SeniorCare when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st.

In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SeniorCare on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income.

Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SeniorCare eligibility is reviewed in March.

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the *FPL*, and Spouse 2 becomes SeniorCare eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500 or $850) by the number of months in Spouse 2's benefit period and divide by 12.

Example 2: Mary and Jim apply for SeniorCare in January. They have an annual income between 160% and 200% of the FPL for a FTG of two (see Section 39.11 SeniorCare Income Limits and Participation Levels). Their income places them in Level 2a with a $500 deductible.

Jim is determined eligible for SeniorCare, but Mary's eligibility for SeniorCare is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible.

In June, Mary will turn 65. At *adverse action* in the month of May, *CARES* will process this case through batch. At that time, the application status is updated if the *applicant* who is turning 65 is:

1. In an open SeniorCare case, **and**

2. The individual has requested SeniorCare.

A letter is sent to Mary notifying her that if she still wishes to participate in SeniorCare, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st.

Because Mary paid her enrollment fee on July 5th, Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12.

$500 x 6=$3,000/12=$250

Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

33.9.2.2 Adding A Spouse, No FTG Change, At level 3

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

33.9.2.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is $850. The deductible for Spouse 2 is prorated (33.9.3.1 FTG Changes at Level 2a and 2b).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 3: Reginald and Elizabeth's joint income is $3,000 more than 240% of

the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SeniorCare effective January 1. Only Elizabeth's covered prescription drug costs are applied toward the spenddown.

In March, Reginald turns 65 and is determined eligible for SeniorCare beginning April 1. His benefit period ends December 31, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1.

In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a $850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, $850 is multiplied by nine and the total is divided by 12.

$850 x 9 = $7,650/12 = $638

Reginald's deductible is $638. Once Reginald meets the $638 deductible, he purchases covered prescription drugs at the copayment amounts through the remainder of his benefit period. Once Elizabeth meets her $850 deductible, she purchases covered prescription drugs at the copayment amounts through the remainder of the benefit period.

33.9.2.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 4: Bob and Bernice's joint income is $1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SeniorCare effective January 1. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of $1,000.

Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her $850 deductible. In June, she has

$100 left before she will meet her deductible.

In May, Bob turns 65 and is determined eligible for SeniorCare. His eligibility begin date is June 1. His benefit period ends December 31, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, $850 is multiplied by seven and the total is divided by 12.

$850 x 7 = $5,950/12 = $496

Bob's deductible is $496. After he meets the $496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at copayment amounts for the remainder of his benefit period.

Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another $100 in covered prescription drugs, she purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

33.9.3 FTG Changes

When a married SeniorCare participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**

2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**

3. The eligibility and benefit period for Spouse 1 is not affected, unless he or she chooses to reapply.

Example 5: Jim is a SeniorCare participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one.

In January, Jim marries Helen. Helen applies for SeniorCare in February. Jim's eligibility is not redetermined when Helen applies.

Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February.

Helen's benefit period begins in March, if she met all eligibility requirements in

February. Helen's benefit period ends in August, when Jim's benefit period ends.

33.9.3.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated (33.9.3.1 FTG Changes at Level 2a and 2b) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

Example 6: Will is married, but he and his wife Grace were separated at the time he applied for SeniorCare.

Will applies for SeniorCare in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is less than 160% of the FPL for a FTG of one.

Will is determined to be SeniorCare eligible at Level 1 beginning November 1. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the copayment amounts.

Grace returns home in January. She applies for SeniorCare in February and is determined eligible beginning March 1. Grace's benefit level is determined based on a FTG of two. Their joint income is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends.

Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of $850 is multiplied by eight and then divided by 12.

$850 x 8=$6,800/12=$567

Grace's deductible amount is $567. After she has met her deductible, she purchases covered prescription drugs at the copayment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

33.9.3.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**

1. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**

2. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.3.1 FTG Changes at Level 2a and 2b). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, he or she purchases covered remainder of the benefit period.

Example 7: Tim is married, but his wife Marsha was institutionalized at the time he applied for SeniorCare. Marsha was expected to be out of the home for five months.

Tim applies for SeniorCare in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is less than 160% of the FPL for a FTG of one.

Tim is determined to be SeniorCare eligible beginning June 1. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the copayment amounts.

Tim's wife Marsha returns home in November. She applies for SeniorCare in November and is determined eligible beginning December 1. Marsha's participation level is determined based on a FTG of two. Their joint income is $1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31, when Tim's benefit period ends.

Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of $1,000 is multiplied by six and then divided by 12.

$1,000 x 6=$6,000/12=$500

Marsha's spenddown amount is $500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, $850 is multiplied by six and then divided by 12.

$850x 6=$5,100/12=$425

Marsha pays for covered prescription drugs until she has met the $425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the copayment amounts for the remainder of benefit period.

Tim's eligibility and benefit period are not affected.

33.9.4 Addition of a Spouse Summary Table

The following table assumes that Spouse 1 and Spouse 2 do not apply for SeniorCare at the same time.

	SPOUSE 1's Eligibility	**SPOUSE 2's Eligibility**
Benefit Period: **Begin Date**	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: End Date	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: Married at time of Spouse 1's application	FTG of two. Participation Level determined based on annual income of both spouses.	FTG of two. Participation Level determined based on annual income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level: Single or not living together at time of Spouse 1's application.	Gross annual income test based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless he or she chooses to do so.	Gross annual income test based on a FTG of two. Participation Level determined based on annual income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time he or she applies. Spouse 1's income remains the same.
Deductible:	Has a $500/$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: Unmet	Covered prescription drugs	Projected income from

Original FTG of 2	of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of $850.	Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: Met Original FTG of 2	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse 2 has a prorated deductible.
Spenddown: Unmet Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: Met Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note: If Spouse 1's eligibility is terminated prior to Spouse 2's request, a new application is required for a new 12-month benefit period.

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33.10 Changes

33.10.1 SeniorCare Changes Introduction

The following changes must be reported to the SeniorCare program within 10 days:

1. Address (including a change in mailing address or permanent residency outside of Wisconsin).
2. Household Composition (including marriage, divorce, separation, or someone moving to a nursing home or other medical facility).
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service hotline at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Members are asked to include an *SSN* or case number on any written correspondence.

If an individual reports any changes before the case has been confirmed in CARES, the new information will be used in his or her SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the member's SeniorCare benefits as follows:

1. Address change:
    a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
    b. Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. The member will be provided with at least 10 days notice before the effective date of an *adverse action*.

    Note: Reporting an out-of-state address does not necessarily signify that an *applicant* is not a Wisconsin resident (see Section 33.3 SeniorCare Nonfinancial Requirements).

2. Death

    A member's death ends SeniorCare eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the member should be equal to the member's date of death.

If a member's *spouse* dies, the member will remain eligible at the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a member experiences a change in household composition, the SeniorCare benefit level will not change through the remainder of the SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a *Public Institution* (See General Medicaid Application Process for Inmates of State Correctional Institutions).

An inmate of a public institution is ineligible for SeniorCare on the date incarceration begins. The member will be provided adequate notice before the effective date of the adverse action. The "early termination date" is equal to the notice mailing date.

If a member's spouse is an inmate of a public institution the member benefit level will remain eligible as the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

If an applicant needs to correct their application, or has a change in circumstances during the application processing period, he or she may need to report this information before their eligibility is determined in order to have the change impact their SeniorCare eligibility and participation level.

Depending on the nature of a client-reported error or agency-discovered error, a member's eligibility will be redetermined (see Section 33.10.2 Correction of Errors). The member will be provided with at least 10 days notice before the effective date of an adverse action.

If the case has already been confirmed in CARES, and the individual reports a change in circumstances since they applied (for example, a job loss), eligibility will not be redetermined. The applicant may opt out and reapply if he or she so desires.

Example 1: Sally and Fred are husband and wife and applied for SeniorCare in July. Both Sally and Fred were found eligible at Level 2a with a deductible for

August. In September, Fred loses his job. He reports the change to the SeniorCare program. This change will not affect Sally or Fred's SeniorCare benefits, because Fred reported the change after his case had been confirmed in CARES.

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (see Section 33.11 Re-Application) and submit enrollment fees to have their eligibility redetermined and change their benefit level. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

33.10.2 Correction of Errors

All errors made on the SeniorCare Application (F -10076) must be reported by the member or his or her *Authorized Representative*, POA, or Guardian to the SeniorCare Customer Services hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (for example, totaling income on the application incorrectly).
2. Incorrect entries (for example, income amounts are off by a factor of 100 due to the lack of decimal point).
3. Application processing errors.

An applicant who wishes to report a change in circumstances from what was on his or her submitted application may do so, but to impact eligibility, this change should be reported prior to eligibility being confirmed in CARES (see Section 33.10.1 #5 Change in Circumstance).

If a member has been found eligible for either an incorrect SeniorCare benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be due to agency error or *Applicant*/Member error, as follows.

33.10.2.1 Agency Error

Agency errors for SeniorCare will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an

underpayment, corrected benefits will be restored back to initial eligibility date of the current benefit period.

33.10.2.2 Applicant or Member Error

If an applicant or member error resulted in an overpayment, benefit recovery will be pursued, and the correction is processed with an effective date based on adverse action notice. The member will be provided with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and he or she reported the error within 45 days of the mail date of the notice of decision, corrected benefits should be restored back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 2: In August, Charlie lost this job at the Burger Palace. In September, Charlie applied for SeniorCare. In his application, Charlie erroneously reported income of $1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown.

Depending on when Charlie reports this error, his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported (see Section 33.10.2 Correction of Errors).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 3: Eric applied for SeniorCare in July and was determined eligible at level 1 effective August 1. Prior to applying for SeniorCare, Eric got a part-time job that had begun in June. When Eric applied for SeniorCare, he neglected to report his anticipated part-time earnings on the SeniorCare application.

Eric receives his notice of decision, dated August 8. The notice informs him that he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice and realizes that he forgot to report the earnings from his part-time job. He calls the SeniorCare Customer Service hotline on August 21 to report his error.

Eric indicates that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5,200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income move him from level 1 to level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

Prior to reporting this mistake, Eric had purchased several prescriptions at the copayment levels with his SeniorCare card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 (the end of his 12-month benefit period). SeniorCare will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

33.10.3 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which he or she is not entitled. Penalties for fraud include a fine of up to $10,000, imprisonment up to one year, or both, and suspension from the SeniorCare program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SeniorCare application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SeniorCare;
3. Applying for SeniorCare on behalf of another person and use of any part of the benefit for oneself;
4. Allowing another person to use someone else's card to get prescription drugs.

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33.11 Re-Application

SeniorCare participants may request to establish a new SeniorCare benefit period at any time. However, it is not beneficial for a SeniorCare participant to reapply unless he or she will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SeniorCare eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

Such a change may result from divorce, marriage, institutionalization or death of a *spouse* , or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a $30 enrollment fee per person. Eligibility will be redetermined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and he or she is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

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33.12 Early Termination

33.12.1 SeniorCare Early Termination

SeniorCare eligibility is terminated prior to the end of the established benefit period if:

1. A member no longer meets non-financial eligibility requirements, or
2. S/he requests to withdraw from the program, or
3. S/he requests to establish a new benefit period and eligibility for the new benefit period is confirmed (see Section 33.11 Re-Application).

When SeniorCare eligibility has been terminated prior to the end of the established benefit period and the SeniorCare Program is notified that all eligibility requirements are again satisfied, within one calendar month of SeniorCare eligibility termination, the benefit period is restored.

Exception: SeniorCare members who lose SeniorCare eligibility solely due to receipt of Medicaid benefits do not have their benefit period terminated; however, they are not eligible for SeniorCare benefits or services for the calendar months that they receive Medicaid benefits.

If Medicaid eligibility ends prior to the end of the SeniorCare benefit period, and the member is still SeniorCare eligible, SeniorCare eligibility automatically resumes.

Example 1: Amy applies for SeniorCare on October 4th and is determined eligible effective November 1st. In December she applies for Medicaid and is determined eligible, effective December 1st. Amy is not eligible for SeniorCare benefits or services while she is receiving Medicaid.

In January, Amy inherits $5,000 and is notified that her Medicaid eligibility ends January 31st, because her assets exceed the limit. Amy still meets SeniorCare eligibility requirements, so SeniorCare eligibility will resume from February 1st through October 31st.

See Section 33.15 Annual Eligibility Review for termination as it applies to the need for an annual review.

33.12.2 Withdrawal

Applicants or participants may withdraw from the SeniorCare Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SeniorCare participant is eligible for an enrollment fee refund only if he or she meets the requirements listed in 33.3.2.1 Refunds.

If an *applicant* chooses to withdraw his or her application prior to eligibility confirmation, he or she will get a refund. If he or she later wishes to "opt in", he or she will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to "opt-out" and SeniorCare receives the request to withdraw within the timeframe for obtaining a refund, he or she will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, he or she would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his or her benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that he or she meets eligibility requirements. If within thirty calendar days of opting out he or she does not contact SeniorCare and SeniorCare does not receive the enrollment fee, he or she will have to submit a new application and another $30 enrollment fee if he or she wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, he or she will not get a refund. Customer Service should counsel the participant that he or she will not be getting a refund, and he or she can keep his or her case open in the event his or her circumstances change and he or she wants to use the SeniorCare benefit in the next 12 months.

If the participant still opts out, but contacts SeniorCare within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. He or she will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another $30 enrollment fee to be credited for CARES to process correctly.

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33.13 Notice of Decision

A written notice is sent to the *applicant* indicating SeniorCare certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining the participation level. It will also provide the member with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials, or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare members will be notified of an *adverse action* at least 10 days prior to the effective date of the adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A member chooses to withdraw from the program.
3. A member requests to establish a new benefit period and eligibility for the previous benefit period is terminated (see Section 33.11 Re-Application).
4. A person is an inmate.
5. A member passes away.

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33.14 Appeals

33.14.1 SeniorCare Appeals Introduction

SeniorCare applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.
2. An application is not acted upon within thirty calendar days.
3. A participant believes that the benefits he or she received, or the initial eligibility date of program benefits were not properly determined.
4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

33.14.2 Requesting a Hearing

The SeniorCare *applicant* or participant, or his or her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the *adverse action* .

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

33.14.3 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
2. Reasonably accessible to the petitioner.
3. Held on department or agency premises, subject to the judgement of the administrative law judge.
4. Accessible to those in need of accommodations for a *disability* or translation. For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096.

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33.15 Annual Eligibility Renewal

An annual eligibility review is required for each participant by the end of the current 12 month benefit period to prevent a gap in coverage.

Members are mailed a preprinted Renewal Application and instructions approximately six weeks prior to the end of their current benefit period. The Renewal Application is preprinted with the information currently on file for the member. Members are required to review the information for accuracy, make any necessary changes, answer any questions, and return the signed form with their enrollment fee.

Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed Renewal Application or new application form (F-10076) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the $30 annual enrollment fee per person.

Note: For the definition of “valid,” see Section 3.2.2 Application Processing.

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33.16 Benefits

33.16.1 SeniorCare Benefits Introduction

For all of the participation levels, SeniorCare allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Most prescriptions are limited to a 34-day supply of medication. There are a few classes of medications that are allowed to be filled as a three-month supply. Members should work with their pharmacist and prescriber to determine whether it is clinically appropriate to dispense a three-month supply. The co-payment amount is not affected by the number of days in the supply.

Note: Some drugs require prior approval from the SeniorCare program, called prior authorization.

Note: The member should contact his or her provider to verify that SeniorCare covers a specific drug.

SeniorCare does not cover the following:

1. Prescription drugs administered in a physician’s office
2. Prescription drugs that are experimental or are for cosmetic; not a medical, purpose
3. Over-the-counter drugs such as vitamins and aspirin, even with a prescription
4. Prescription drugs for which authorization has been denied.
5. Prescription drugs from manufacturers who have not signed the appropriate rebate agreement

    - Prescription drugs for members in levels 1 and 2a are limited to drugs from manufacturers who have signed a federal rebate agreement.
    - Prescription drugs for members in levels 2b and 3 are limited to drugs from manufacturers who have signed a SeniorCare rebate agreement with the state of Wisconsin.

6. Drugs that have not been dispensed from a pharmacy.

Note: Immunizations and vaccines (for example, flu shots, pneumonia vaccines, etc.) are not covered under the SeniorCare program.

If a member chooses to purchase a prescription that is not covered under SeniorCare, they are responsible for the cost at the pharmacy's retail price and it will not count towards their spenddown and/or deductible.

SeniorCare provides medication therapy management (MTM) services. The MTM services are provided by the pharmacist to answer the member's questions about the drugs they get. The goal of MTM services is to help the member understand more about the drugs they take, make sure they are taking their drugs properly, and make sure they are only taking drugs they need.

33.16.2 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SeniorCare allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SeniorCare allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SeniorCare spenddown and/or deductible.

33.16.3 Early Refills

When the participant is temporarily leaving the state and the supply on his or her prescriptions is insufficient, he or she will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SeniorCare, nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

33.16.4 Out-of-State Pharmacies

In an emergency, a participant can get a prescription filled out of state and have it count toward SeniorCare as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

34 Emergency Services

34.1 Emergency Services

34.1.1 Emergency Services Eligibility Introduction

Documented and undocumented non-citizens ineligible under regular Medicaid due to alien status can be eligible for Emergency Services, if he or she meets all other eligibility requirements except having or applying for an *SSN*. Non-citizens may have an SSN and may still qualify for Emergency Services. If a non-citizen would otherwise be eligible for any type of EBD Medicaid, he or she would qualify for Emergency Services.

An inmate who is a non-qualifying immigrant may be eligible for Emergency Services for the dates they are hospitalized as an inpatient for emergency treatment as long as they meet the rest of the eligibility criteria for Emergency Services.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

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 Medicaid 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.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying aliens.

The *IM* agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to the fiscal agent. It determines if a condition is an emergency medical condition covered by Emergency Services.

A citizen is not eligible for Medicaid Emergency Services even when he or she cannot produce citizenship and/or identity verification.

Example 1: Jill applies for Medicaid, 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 Medicaid 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 Emergency Services Medicaid eligibility for persons declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency. Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying alien meets all other eligibility requirements during the dates of service and to certify if he or she is eligible for Emergency Services.

If a non-qualifying alien provides a "Certification of Emergency for Non-U.S. Citizens" (F-01162) at the time of application, determine his or her eligibility for Emergency Services for the dates of the emergency indicated on the form. If a non-qualifying alien does not have the form at the time of application, ask him/her for the dates that he or she received emergency services. The F-01162 is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. He or she must meet the eligibility requirements for his or her type of Medicaid, such as being *elderly* blind or disabled*, and provide required verifications. He or she is also entitled to all notice rights and must receive a manual positive or negative notice regarding his or her eligibility. Positive Notices must provide the dates of eligibility for Emergency Services. Negative Notices must provide the reasons for the denial or termination.

*If a non-qualifying alien would only qualify for Medicaid if he or she was disabled, follow *disability* determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

34.1.2.1 Medicaid Deductible

Aliens who apply for emergency services may become eligible by way of the Medicaid deductible. If, on the date he or she applies, he or she is eligible in all respects except income, apply the same deductible policies (24.2 Medicaid Deductible Introduction) to him or her as any other client.

34.1.3 Certification of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. When an alien is determined eligible for Emergency Services, complete and

submit a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) (formerly DES 3070). Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to an organ transplant procedure are not covered by Emergency Services. The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

The Medicaid/BadgerCare Plus Eligibility Certification form may be submitted to the fiscal agent by fax to 608-221-8815 or by mail to:

ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

A person eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility ends when the emergency ends.

34.1.4 BadgerCare Plus Emergency Services

For Emergency Services for children, parents, caretakers, and pregnant women, see the BadgerCare Plus Handbook Chapters 39.1 Emergency Services and 41.1 BadgerCare Plus Prenatal.

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35 Long Term Care Insurance Partnership (LTCIP)

View History

35.1 Long Term Care Insurance Partnership

35.1.1 LTCIP Introduction

The Wisconsin Long-Term Care Insurance Partnership (LTCIP) is a joint effort between the federal Medicaid Program, long-term care insurers, and the Wisconsin Department of Health Services (*DHS*) and Office of the Commissioner of Insurance (OCI). The program's main purpose is to provide an incentive for people to plan for meeting their future long-term care needs, whether in a community-based setting such as their own home, or in a nursing home.

35.1.2 LTCIP Asset Disregard

The LTCIP allows a person with a qualified long-term care insurance policy to have assets disregarded in the Medicaid eligibility determination, while at the same time protecting those assets from Medicaid estate recovery. Under the LTCIP, assets are disregarded when determining eligibility for EBD Medicaid programs, or any of the programs for Medicare beneficiaries (i.e., *QMB*, *SLMB*, SLMB+, *QDWI*), up to the total amount of long-term care services paid by the qualified WI LTCIP policy on or after January 1, 2009. The amount paid out by the qualified LTCIP policy on or after January 1, 2009 is not counted toward the WI Medicaid asset limit, nor is it recoverable under the estate recovery program.

Maximum Disregard
The maximum amount that can be disregarded for the purpose of Medicaid eligibility, or protected from estate recovery, is the verified amount of benefits paid out by the qualified WI LTCIP policy on or after January 1, 2009.

The disregarded asset amount is still counted in the Asset Assessment when determining the Community *Spouse* Asset Share (CSAS) in a *Spousal Impoverishment* case. However, the disregarded asset amount is not counted in the individual's eligibility determination.

The disregarded amount is exempt from divestment policies, i.e., transferring assets for less than *fair market value* up to the LTCIP payout amount will not result in a divestment penalty. However, a divestment may result in a reduction or elimination of the Medicaid eligibility and estate recovery protections under the LTCIP. See 35.1.3.3 for more information regarding the disregard.

35.1.3 Verification

Verify the following items as described.

35.1.3.1 Verification of the Qualified LTCIP Policy

A "qualified LTCIP policy" must meet all relevant requirements of federal and state law. Qualified LTCIP policies are certified by the Wisconsin Office of the Commissioner of Insurance (OCI).

OCI certification of the policy must be verified by assuring that the policy is in the "Long-Term Care Insurance Partnership Program (LTCIP)" section of the Long-Term Care page on the OCI website.

35.1.3.2 Reciprocity Standards

Participation in Wisconsin's LTCIP program is allowed for individuals who purchased qualified policies in any state that is subject to the LTCIP reciprocity standards as documented in that state's Medicaid State Plan. Such states are referred to as "Participating States." Information regarding reciprocity states can be found at:

http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved

If the policy was issued by a Participating Reciprocity State:

1. Apply the policies specified at 35.1.2 LTCIP Asset Disregard.
2. Apply the policies specified in this subsection, 35.1.3 Verification.

If the policy was not issued by a Participating State, the individual is not eligible to participate in Wisconsin's LTCIP program. The LTCIP asset disregards and estate recovery offsets do not apply to such individuals.

35.1.3.3 Verification of Benefits Paid

In addition, the amount paid out by a qualified LTCIP policy must be verified before it can be disregarded for Medicaid eligibility or estate recovery purposes. The qualified LTCIP policy carrier must document the amount paid for benefits on or after January 1, 2009 using the appropriate OCI approved form (OCI 26-114) and provide verification of the payout amount upon request. Only benefits paid on or after January 1, 2009 may be disregarded when determining eligibility for Medicaid programs.

35.1.4 Examples

Example 1: Ruth is a resident of a medical care facility. She has no spouse . Her qualified $90,000 LTCIP policy has been paying for her care. When Ruth applies for WI Medicaid payment of long-term care services, she verifies that her qualified

LTCIP policy has paid out $80,000 in policy benefits since January 1, 2009. Ruth owns the following non-exempt assets:

- $5,000 savings account
- $6,000 checking account
- $70,000 equity value in non- homestead property

The worker determines that Ruth's total non-exempt assets equal $81,000 ($5,000 + $6,000 + $70,000). Her WI Medicaid asset limit is $2,000; however, because $80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional $80,000 in non-exempt assets is disregarded. Ruth passes the asset test for WI Medicaid because we disregard $80,000 of her assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away at this point, $80,000 of her assets would be protected from estate recovery.

Example 2: A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full $90,000 since January 1, 2009. Ruth owns the following non-exempt assets:

- $4,000 savings account
- $7,000 checking account
- $80,000 equity value in non-homestead property

The worker determines that Ruth's total non-exempt assets equal $91,000 ($4,000 + $7,000 + $80,000). Her WI Medicaid asset limit is $2,000; however, because $90,000 has been paid out by Ruth's qualified LTCIP policy, an additional $90,000 in non-exempt assets is disregarded. Ruth continues to qualify for WI Medicaid because we disregard $90,000 of her assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away, $90,000 of her assets would be protected from estate recovery.

Example 3: Edith is applying for Family Care. She and her spouse reside in their home and have $100,000 in non-exempt assets. Her qualified $80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Edith applies for Family Care, she verifies that her LTCIP policy has paid out $80,000 in benefits since January 1, 2009. Because this is a Spousal Impoverishment case, an Asset Assessment (AA) must be done to establish the Community Spouse Asset Share. The total $100,000 is used in the AA and the CSAS is set at $50,000. Edith's asset limit of $2,000 is added to the CSAS when determining her eligibility. Since $80,000 of her assets can be disregarded, the remaining non-exempt assets are $20,000 which is less than the $52,000 limit. Prior to her first review (12 months) Edith must transfer, to her spouse, any of her assets that exceed $82,000 (the LTCIP policy pay out amount plus the regular WI Medicaid asset limit of $2,000) to remain eligible.

Example 4: Emma had been residing in a nursing home and had been eligible for Institutional Medicaid for the past 2 years. Her qualified $90,000 LTCIP policy had been paying for a portion of her care. As of her last WI Medicaid review, the policy had paid out $70,000 since January 1, 2009, an amount disregarded in determining her continued Medicaid eligibility. Ten months after her last review, Emma died. Emma's representatives verify that, during those ten months, her qualified LTCIP policy paid out an additional $10,000 toward her long-term care. Emma's estate can protect a total of $80,000 (i.e., the total amount paid out by the qualified policy) from estate recovery.

Example 5: Joe has a $100,000 home and $100,000 in non-exempt liquid assets. He needs home care and his qualified LTCIP policy begins paying out. By the time Joe applies for Medicaid, his LTCIP policy has paid out $100,000. Joe can have up to $102,000 in assets ($2,000 limit plus $100,000 disregarded) and still be eligible for Medicaid. His home is an exempt asset and his non exempt assets are less than $102,000 so he qualifies for Family Care.

Over the next few months, Joe decides to give $100,000 to his son. At his annual review, he reports that he has done so, but because he has given away no more than the LTCIP protected asset amount (i.e., the LTCIP payout amount of $100,000), there is no divestment penalty. However, because he has divested the entire payout amount, he can no longer take advantage of the LTCIP protections with regard to his Medicaid eligibility. That means, when he's tested for Family Care, he must have assets below $2,000 to remain eligible (instead of $102,000). Also, because he already gave away the entire LTCIP protected amount during his lifetime, that amount will not be protected from estate recovery.

35.1.5 Process Help

Until CARES can be updated to accommodate this policy change, the amount of assets that are disregarded under this policy should be designated as 'unavailable' in CARES. When processing an Asset Assessment (AA) the whole asset amount should be counted as available. Once the AA is completed, update the availability question to indicate the amount paid out by the LTCIP is unavailable. Be sure to document in Case Comments why the asset is being treated as unavailable. The documentation provided for verification of the LTCIP policy and pay out should be scanned into the ECF under the Asset Information subfolder.

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36 Wisconsin Well Woman Medicaid

36.1 Introduction

WWWMA is administered by the *DHS DMS* and provides eligible women with access to full-benefit Medicaid through non-HMO providers.

Wisconsin Well Woman Medicaid Eligibility
WWWMA enrollment is limited to the following groups. A woman must be enrolled in one of the following ForwardHealth programs before she can initially enroll in WWWMA:

- *WWWP*
- *FPOS*
- BadgerCare Plus

As long as the woman is enrolled in WWWMA, she does not have to reapply for any of the above programs. She will have full-benefit *fee-for-service* Medicaid health care coverage through WWWMA.

Effective October 2009, all WWWMA enrollments and renewals are administered by *EM CAPO*. The local certifying agencies have no role in recertifications or new WWWMA enrollments (see Section 36.2 Wisconsin Well Woman Medicaid Enrollment).

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36.2 Enrollment

36.2.1 EM CAPO Administrating Enrollment for Wisconsin Well Woman Medicaid

All initial enrollments and renewals for continuous *WWWMA* are now processed by EM *CAPO*. Temporary Enrollment/Presumptive Eligibility enrollment is still processed by the fiscal agent.

Any applications received in local *IM* or tribal agencies should be faxed to the EM CAPO at (608) 267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the *applicant*.

CONTACTS:
EM CAPO: DHSEMCAPO@dhs.wisconsin.gov
Fax: (608) 267-3381
Phone: 1-877-246-2276
Customer line: (608) 266-1720

36.2.2 Enrollment through the Wisconsin Well Woman Program

The *WWWP* is administered by the *DHS* Division of Public Health (DPH). WWWP provides eligible women with various health screenings (including breast and cervical cancer screening), referrals, education and outreach.

The WWWP performs the financial and initial non-financial screening for WWWMA for WWWP enrollees. A WWWP enrollee must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer to be considered for WWWMA.

WWWP *LCA*s enroll women in WWWP and perform some of the basic non-financial and all financial data gathering, and verification for WWWMA. They also coordinate the WWWP member's referral to a health care provider for breast and cervical cancer screening.

1. The WWWP LCA will complete the F-44818 (formerly DPH-4818) with the assistance of the applicant prior to the applicant's health care screening. The F-44818 enrolls the woman in WWWP. Her WWWP eligibility will be recorded in interChange as "Med Stat CS".
2. The WWWP member will receive a breast and cervical cancer screening from a WWWP provider. If the WWWP member is diagnosed with breast or cervical cancer, her provider will complete the F-10075 recording the diagnosis and indicating that treatment is required. The provider will sign and date the F-10075. The WWWP member will also sign and date the F-10075. The signature dates do not have to be the same date.

3. The provider will fill in the beginning and end dates of the temporary enrollment/presumptive eligibility for WWWMA on the F-10075
4. The provider will forward a copy of the F-10075 to the WWWP LCA.
5. The WWWP LCA will provide the member with a copy of the signed F-10075 and F-44818 forms.
6. The WWWP LCA will check to be sure correct temporary eligibility dates (if appropriate) are entered on the F-10075 and explain that the member's temporary enrollment for WWWMA will end on the last day of the following calendar month.

36.2.2.1 Temporary Enrollment / Presumptive Eligibility (TE) Available Only to Women Enrolling through WWWP

Temporary Enrollment (TE) for WWWMA is available for women to assure immediate access to cancer treatment. The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the F-10075. The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.

The WWWP LCA should then fax a copy of the completed F-10075 to the fiscal agent at (608) 221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of CB) and send the member a ForwardHealth card with the temporary enrollment dates activated on the card. (If the member had a previous ForwardHealth card, it will be reactivated.)

Until the ForwardHealth card arrives or is reactivated, the new WWWMA *member* may receive services by presenting both of the following completed forms to any Medicaid provider:

1. WWWP Enrollment Form F-44818
2. WWWMA Determination Form (F-10075).

To continue receiving WWWMA, the member or the WWWP LCA must submit an F-10075 to the EM CAPO. If the member does not apply, her WWWMA benefits will terminate at the end of the month following the month of diagnosis.

The TE period extends from the date of diagnosis on the F-10075 through the following month. A new TE period would only occur if a new cancer diagnosis was established for the same member.

Note: If the member applies during her TE certification period and the EM CAPO is not able to process her application, within the 30-day processing time frame, the EM CAPO will extend the members' eligibility for an additional 30 days from the last day of her Wisconsin Well Woman Medicaid TE with a medical status of "CB". Submit an F-10110

(formerly DES 3070) to extend the Well Woman Medicaid TE for an additional calendar month.

36.2.3 WWWP Members Enrolling for Continuous WWWMA

36.2.3.1 Applications for Wisconsin Well Woman Medicaid through the Wisconsin Well Woman Program

To apply for WWWMA through the WWWP, the applicant or the WWWP LCA must send or fax the completed F-44818 and F-10075 forms to the EM CAPO. The applicant may apply for WWWMA at any time after the WWWP screening and diagnosis. Eligibility may only be backdated to the first of the month up to three months prior to the application date or from the date of diagnosis, whichever is most recent. (For requests to back date farther than three months, refer to the *BEPS* policy analyst.)

Use the F-44818 and F-10075 in place of the standard application forms. This program requires manual determination. Do not enter the woman's information into CARES as an application.

The date of receipt of the F-10075 is the filing date. Use the verification policy listed in Chapter 20 for any items requiring verification.

Complete the following steps to certify the member for WWWMA:

1. Review the F-44818. There should be a ”No” answer to the following questions:

    a. Does the applicant have any health insurance? (Item #32 on F-4818) If the applicant answers "Yes", determine if the insurance is one of those listed in 36.3.3 that covers treatment for her breast or cervical cancer. If she has coverage for the treatment, she is ineligible for WWWMA.

    b. Does the applicant have Medicare Part B? (Item #33 on F-44818)

    c. Does the applicant have Medicare Part A.

If the applicant answered ”Yes” to any of these questions in a-c, the applicant is ineligible for WWWMA. The EM CAPO will refer her back to the Well Woman Program and send a manual negative notice.

2. Review the F-44818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, and 27-45.

    If the form is incomplete, the EM CAPO will request that the applicant provide any missing information. If the applicant does not provide all necessary information, there may be a delay in eligibility determination and benefits.

3. Review F-10075 for an *SSN*. If the SSN is missing from the F-10075 and is not present on the F-44818 (# 6a); the CAPO will ask the applicant to provide her SSN. Providing an SSN for the Well Woman Program is voluntary, but providing an SSN, or applying for one, is required for WWWMA

   If the applicant fails to provide an SSN, or fails to apply for an SSN within the 30-day application processing time or within ten days (whichever is later), the CAPO will send a manual negative notice to the applicant indicating that the she is not eligible for WWWMA because she did not provide an SSN.

4. Ask the applicant if she is a citizen.

   If the applicant is not a citizen, ask her what her immigration status is and to provide her immigrant registration card. Verify that the applicant is in a qualified immigration status using the SAVE system.

   Note: Some applicants with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services.If a non-qualifying immigrant has been screened by Well Woman Program, determine her eligibility for emergency services using the criteria in 7.1 US Citizens and Nationals.

5. If there are any questionable items, contact the Well Woman Program Local Coordinating Agency.

6. EM CAPO will update interChange with the WWWMA eligibility information using a medical status code of "CB" to certify any member who has met the criteria listed above. Submit the completed Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) to the fiscal agent by fax to 608-221-8815, through interChange, or by mail to:

   ForwardHealth
   Attn: Eligibility Lead Worker WWWMA
   313 Blettner Blvd
   Madison WI
   53714-2405

7. Certify the member for 12 months from the filing date and backdate to whichever is more recent:

   a. Up to three months prior to the filing date, **or**
   b. To the date of the diagnosis (F-10075),

   Never certify a woman for Well Woman Medicaid prior to her date of diagnosis.

Example 1: Gina applies for Well Woman Medicaid (WWWMA) at the Local

Coordinating Agency (LCA) on September 20th 2009. The LCA submits the F-44818 and F 10075 to CAPO. The F-10075 indicates that Gina is enrolled in Well Woman Program (WWWP). The LCA provides a copy of the F-4818 documenting Gina's enrollment in the WWWP. Gina's date of diagnosis on the F-10075 is August 6th 2009. Gina meets the following non-financial requirements: citizenship/ID documentation, provides a valid SSN and has no public or private insurance that will cover her cancer treatment and she is under 65 years of age.

CAPO will certify Gina in interChange (iC) effective August 6th, 2009 through July 31 2010 with a CB medical status code. CAPO will send Gina a notice indicating her eligibility dates. About one month from the end of Gina's eligibility period, CAPO will send Gina a recertification notice indicating she needs to recertify for WWWMA.

For initial WWWMA certifications, if the applicant applies during her WWWMA TE certification period and EM CAPO is not able to process her application within the 30 day processing time frame, EM CAPO will extend the applicant's eligibility for an additional 30 days from the last day of her WWWMA TE in iC with a medical status of "CB." Note this extension in the CARES Comments section if appropriate.

To contact the WWWP LCA, refer to #27 of F-44818.

36.2.4 Enrollment for Family Planning Only Services Members

Women enrolled in *FPOS* who meet **one** of the following criteria (regardless of age), will be eligible for WWWMA:

- Are screened for, and diagnosed with, cervical cancer or a precancerous condition of the cervix
- Receive a clinical breast exam through a FPOS provider and through follow up medical testing (independent of the FPOS) and
    - Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition **and**
    - Do not have other insurance that would cover their cancer treatment.

36.2.4.1 Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services

A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a FPOS member or her representative is a request to enroll in WWWMA and disenroll from FPOS. Women 15 through 44 years of age, enrolled in FPOS in CARES who meet the criteria 36.2.4 Enrollment for Family Planning Only Services Members above, will be eligible for Well Woman Medicaid.

A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a FPOS member or her representative is a request to enroll in WWWMA and disenroll from

FPOS. Women who are enrolled in FPOS in CARES and meet the criteria in the 36.2.4 above may be eligible for WWWMA.

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36.3 Nonfinancial Requirements

36.3.1 Introduction

The following are *WWWMA* specific non-financial requirements:

1. Live in Wisconsin,
2. Meet general EBD citizenship and ID requirements.
3. Be under age 65.
4. Have been screened for breast or cervical cancer by the Well Woman Program, or enrolled in Family Planning Only Services.
5. Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the clinical screener.
6. Require treatment for the breast or cervical cancer, or pre-cancerous conditions of the cervix, as identified by the clinical screener.
7. Not be eligible for BadgerCare Plus or EBD Medicaid.
8. Meet the insurance coverage requirements listed below in 36.3.2 Disqualifying Insurance Coverage

36.3.2 Disqualifying Insurance Coverage

A woman is ineligible for WWWMA if she is currently covered by *any* one of the following:

- Group health plans that cover treatment for her breast or cervical cancer
- Full benefit health insurance that covers treatment for her breast or cervical cancer
- Medicare Part A
- Medicare Part B
- BadgerCare Plus without a premium or any other category of full benefit Medicaid that covers her treatment for breast or cervical cancer (**Note:** An unmet deductible is not full-benefit Medicaid.)
- Veteran's benefits/TRICARE that cover treatment for her breast or cervical cancer
- Federal employee health plans
- Peace Corps health plans
- Other full-benefit private or public health care plans that provide cancer treatment as determined by her health care team

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits *do not* disqualify an applicant or member from WWWMA:

a. Coverage only for accident or disability income insurance, or any combination thereof,
b. Liability insurance including general liability insurance and automobile liability insurance,
c. Workers' compensation or similar insurance, credit-only insurance,
d. Coverage for on-site medical clinics,
e. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits,
f. Indian Health Services,
g. Non-coverage of cancer treatment due to waiting period, **or**
h. Non-coverage of breast or cervical cancer treatment due to exclusion (max out) of cancer treatment in the policy.

2. Separate health insurance benefits that are not considered health insurance if offered separately are:

   a. Limited scope dental or vision benefits, **or**
   b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.

3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (for example,, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance).

4. Separate insurance policies are not considered health insurance if offered as a separate insurance (Wrap Around) policy:

   a. Coverage supplemental to military insurance (ex., TRICARE wrap around), **or**
   b. Similar "wrap around" supplemental coverage under a group health plan.

5. Creditable coverage plans that do not cover treatment for the breast or cervical cancer due to a waiting period, exclusion or carve out restrictions.

Note: Current coverage under Medicare Parts A or B will disqualify an applicant or member from WWWMA eligibility.

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View History

36.4 financial Requirements

Because enrollment in *WWWMA* is dependent on financial eligibility for a gatepost program, there are no financial requirements for WWWMA.

Do not test for assets or income. Financial requirements are addressed through the *WWWP*, *FPOS*, or BadgerCare Plus enrollment process. See the BadgerCare Plus Handbook Chs.16-20 for BadgerCare Plus and Ch. 40 for FPOS.

Once a woman is enrolled in WWWMA, she may not be financially tested as a condition of her continuing eligibility in WWWMA.

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36.5 Changes and Transfers

36.5.1 Member Loses Eligibility

WWWMA members are required to report changes that would affect eligibility. Reported changes that result in the WWWMA case closing are:

1. Reaching the age of 65 years,
2. Moving out of state,
3. Reporting that she no longer needs treatment for breast or cervical cancer,
4. Obtaining health insurance that covers her treatment for breast or cervical cancer, **or**
5. Obtaining Medicare Part A, Part B, or both.

If a case closes, the *CAPO* will send a manual negative notice to the *member* if one of these changes is reported, indicating that she is no longer eligible for WWWMA. In situations 1, 3, 4, and 5 above, offer her a BadgerCare Plus / Medicaid Application, F-10182, to test eligibility for other programs.

36.5.2 WWWMA Interagency Case Transfers

All WWWMA cases are processed through the EM CAPO. There should be no interagency transfers.

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36.6 Reviews/Recertifications

Reviews/recertifications are required every 12 months after the initial eligibility determination at the member's *WWWMA* enrollment date. A review for WWWMA only consists of receiving an updated F-10075 WWMA Determination form. There is no financial test.

Notices identifying the WWWMA members needing recertification are sent to the *EM CAPO* monthly. The EM CAPO notifies the member 45 days before a review is due, and indicates what materials or information the *member* needs to return. The EM CAPO includes a blank F-10075 with the notice. In most cases the member will only need to supply the EM CAPO with an updated F-10075.

Note: In order to eliminate unnecessary reviews, a best practice is to check interChange to be sure that the member has not become certified for BadgerCare Plus or another type of full benefit MA (for example *SSI* MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare Part(s) A, B or both, prior to notifying the member that a review is due.

The member or her representative must send or fax the F-10075. to the EM CAPO via:

1. **Email**: DHSEMCAPO@dhs.wisconsin.gov,
2. **Fax**: (608) 267-3381, **or**
3. **Mail** :
   WI *DHS* - EM CAPO
   1 West Wilson St.
   P.O. Box 309
   Madison, WI 53701- 0309

At review, the member must provide a newly completed WWWMA Determination form F-10075 indicating she is still in need of treatment for breast or cervical cancer, as certified by a physician or nurse practitioner.

Members formerly enrolled in *WWWP* do not need to provide a new DPH 4818 at recertification.

The EM CAPO sends a manual positive notice if all requirements are met.

The EM CAPO will send a manual negative notice at least ten days prior to the case closing if the member does not provide an updated F-10075 or if the member reports one of the changes listed in 36.5 Changes.

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37 Home and Community-Based Services: Children's Long-Term Support Waiver Program

View History

37.1 Children's Long-term support (clts) waiver Program Introduction

37.1.1 Program Purpose

CLTS is a Medicaid Home and Community-Based Waiver Program that enables children and youth with disabilities to live at home and participate in family and community life rather than reside in an institution or nursing home. The waiver program allows Medicaid to pay for supports and services that normally are not covered by Medicaid.

The CLTS Waiver Program serves eligible children and youth in the following three target groups:

- Developmental disabilities
- Physical disabilities
- Severe emotional disturbance or mental health disabilities

37.1.2 Eligibility Requirements

To be eligible for the CLTS Waiver Program, an individual must meet all of the following:

- Be under 22 years old
- Meet an institutional level of care, as determined by the CLTS Functional Screen
- Meet nonfinancial and financial eligibility criteria for a full-benefit category of Medicaid (see Section 21.2 Full-Benefit Medicaid)
- Reside in a setting allowed by CLTS Waiver policy

A disability determination is not required for the CLTS Waiver Program.

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37.2 Agency Roles and Responsibilities

County waiver agencies (CWAs) complete the level of care assessment and determine eligibility for the CLTS Waiver Program. Being enrolled in any form of full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid) is a prerequisite for participation in the CLTS Waiver Program. If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, SSI Medicaid, or Katie Beckett Medicaid, the child is not referred to IM.

CLTS Waiver Program applicants and participants who are not open for a type of non-CARES Medicaid must complete a health care application, and they must first be tested for eligibility using HCBW rules (see Section 37.3 HCBW CARES Processing for the Children's Long-Term Support Waiver Program). If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

When a CLTS waiver applicant or participant is determined to be ineligible for a CARES form of Medicaid, the IM agency sends notice of Medicaid ineligibility to the member. Additionally, IM must notify the CLTS case manager if an applicant or member is not eligible for a CARES Medicaid source.

When an applicant or participant is determined to be ineligible for the CLTS Waiver Program, the CWA sends notice regarding the waiver program to the family. The CWA must also inform the IM agency if an HCBW member is no longer functionally eligible (that is, they no longer meet an institutional level of care).

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37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program

When a child who is functionally eligible for the CLTS program is referred to IM, he or she must first be tested for eligibility using *HCBW* rules. To be eligible for HCBW Medicaid, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW, only the child's income is counted. Effective 10/01/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

If the CLTS applicant is the only household member applying for healthcare, the packet provided by the CWA is all that is required to be submitted. When the CWA submits the signed F-10129 to the IM agency, the primary person is required to provide a second signature. The primary person can choose to call the IM agency to provide a telephonic signature or mail a signed Application Summary (see 2.5.1 Valid Signature Introduction).

Individuals can be eligible for the CLTS Waiver Program and HCBW Medicaid through age 21. When a CLTS Waiver Program applicant or member reaches 18 years old and their source of Medicaid is HCBW, they must apply for HCBW Medicaid as the primary person. Federal and state privacy and confidentiality protections prevent the parents of adults from automatically having access to protected information; therefore, these young adults must apply separately from their parents.

See Process Help Section 11.4 Home and Community-Based Waiver Medicaid for Children's Long-Term Support for processing instructions.

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View History

37.4 Cost Sharing

37.4.1 Group A

Group A members are Medicaid eligible via *SSI* (including *SSI-E* Supplement and *1619a* and *1619b*) or a full-benefit Medicaid subprogram (see Section 21.2 Full-Benefit Medicaid) other than HCBW Medicaid.

Members who have met a deductible are eligible for community waivers as Group A. The member remains eligible as Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as Group B or B Plus with a potential cost share.

Individuals eligible as Group A have no CARES cost share obligation, although BadgerCare Plus participants may be required to pay a premium and other cost sharing based on income.

37.4.2 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B and B Plus members do have a cost share, including CLTS participants who are enrolled in HCBW Medicaid.

37.4.3 Calculating a Cost Share for HCBW Members

Cost sharing is the monthly amount a HCBW member may have to contribute to the cost of their waiver services. Only the income of the member is counted when calculating the cost share.

CWA staff submits the Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919 to IM at application or review when an individual needs a CARES source of

Medicaid. The cost share amount for HCBW Medicaid is calculated in CARES following the process outlined in Section 28.6.4 Cost Share Amount.

Note: Not all deductions apply to CLTS participants who are under age 18. Do not apply the special housing amount or the family maintenance allowance to minors. If the CLTS participant is married, spousal impoverishment policies do apply.

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37.5 CLTS Parental Payment

Following the procedures of the Uniform Fee System (Wis. Admin. Code ch. DHS 1), CWA staff determines if the parent(s) must contribute toward the CLTS supports and services their child receives. The Parental Payment Fee is calculated separately from an HCBW cost share by the CLTS case manager.

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38 Reserved

View History

38.1 Reserved

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38.3 Reserved

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38.4 Reserved

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38.5 Reserved

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APPENDIX (CHS. 39-40)

39 Tables

39.1 Life Estate and Remainder Interest

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	42	.90457	.09543
1	.98988	.01012	43	.89855	.10145
2	.99017	.00983	44	.89221	.10779
3	.99008	.00992	45	.88558	.11442
4	.98981	.01019	46	.87863	.12137
5	.98938	.01062	47	.87137	.12863
6	.98884	.01116	48	.86374	.13626
7	.98822	.01178	49	.85578	.14422
8	.98748	.01252	50	.84743	.15257
9	.98663	.01337	51	.83674	.16126
10	.98565	.01435	52	.82969	.17031
11	.98453	.01547	53	.82028	.17972
12	.98329	.01671	54	.81054	.18946
13	.98198	.01802	55	.80046	.19954
14	.98066	.01934	56	.79006	.20994
15	.97937	.02063	57	.77931	.22068
16	.97815	.02185	58	.76822	.23178
17	.97700	.02300	59	.75675	.24325
18	.97590	.02410	60	.74491	.25509
19	.97480	.02520	61	.73267	.26733
20	.97365	.02635	62	.72002	.27998
21	.97245	.02755	63	.70696	.29304
22	.97120	.02880	64	.69352	.30648
23	.96986	.03014	65	.67970	.32030
24	.96841	.03159	66	.66551	.33449
25	.96678	.03322	67	.65098	.34902
26	.96495	.03505	68	.63610	.36390
27	.96290	.03710	69	.62086	.37914
28	.96062	.03938	70	.60522	.39478
29	.95813	.04187	71	.58914	.41086
30	.95543	.04457	72	.57261	.42739
31	.95254	.04746	73	.55571	.44429

32	.94942	.05058	74	.53862	.46138
33	.94608	.05392	75	.52149	.47851
34	.94250	.05750	76	.50441	.49559
35	.93868	.06132	77	.48742	.51258
36	.93460	.06540	78	.47049	.52951
37	.93026	.06974	79	.45357	.54643
38	.92567	.07433	80	.43659	.56341
39	.92083	.07917	81	.41967	.58033
40	.91571	.08429	82	.40295	.59705
41	.91030	.08970	83	.38642	.61358

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
84	.36998	.63002	99	.20486	.79514
85	.35359	.64641	100	.19975	.80025
86	.33764	.66236	101	.19532	.80468
87	.32262	.67738	102	.19054	.80946
88	.30859	.69141	103	.18437	.81563
89	.29526	.70474	104	.17856	.82144
90	.28221	.71779	105	.16962	.83038
91	.26955	.73045	106	.15488	.84512
92	.25771	.74229	107	.13409	.86591
93	.24692	.75308	108	.10068	.89932
94	.23728	.76272	109	.04545	.95455
95	.22887	.77113			
96	.22181	.77819			
97	.21550	.78450			
98	.21000	.79000			

The source of the Life Estate & Remainder Interest Table is 26 CFR 20.2031 (49 Federal Register, Vol. 49, No. 93, May 11, 1984). The version of the table published here is from the Social Security Administration's Policy & Operations Manual Series (POMS), Section 01140.120.

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39.2 County & Tribe Area

Use this list to determine which column to use in the AFDC-related categorically needy income test. If a municipality is in 2 counties, use the area for the county in which the Medicaid fiscal group resides. If a pregnant woman is in a maternity home, use the area in which the home is located, even though the county of residence making the payment is in the other area. For example, if her county of residence is Vilas (Area 2) and she is in a maternity home in Milwaukee (Area 1), Vilas county pays at the Area 1 rate.

39.2.1 Area 1

Brown	Kenosha	Outagamie	Sheboygan
Dane	La Crosse	Ozaukee	Washington
Dodge	Marathon	Racine	Waukesha
Dunn	Manitowoc	Rock	Winnebago
Eau Claire	Milwaukee	St. Croix	Winnebago Tribe*
Fond du Lac			

39.2.2 Area 2

Adams
Ashland
Bad River
Barron
Bayfield
Buffalo
Calumet
Chippewa
Clark
Columbia
Crawford
Door
Douglas
Florence
Forest
Green
Green Lake
Grant
Iowa
Iron
Jackson
Jefferson

Juneau
Kewaunee
Lafayette
Langlade
Lincoln
Marinette
Marquette
Menominee
Monroe
Oconto
Oneida
Pepin
Pierce
Polk
Portage
Price
Richland
Rusk
Sauk
Sawyer
Shawano
Taylor
Trempeleau
Vernon
Vilas
Walworth
Washburn
Waupaca
Waushara

Lac Courte Oreilles
Lac du Flambeau
Menominee Tribe
Mole Lake
Potawatomi
Red Cliff
St.Croix Tribe
Stockbridge -Munsee
Winnebago Tribe

*Only if residing on tax-free land in La Crosse or Marathon County. All other locations are Area 2.

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39.3 AFDC-Related Income Table

Group Size	Categorically Needy		Medically Needy
	Area I	Area II	
1	$ 311	$ 301	$ 591.67
2	$ 550	$ 533	$ 591.67
3	$ 647	$ 626	$ 689.33
4	$ 772	$ 749	$ 822.67
5	$ 886	$ 861	$ 944.00
6	$ 958	$ 929	$1,021.33
7	$ 1,037	$ 1,007	$1,105.33
8	$ 1,099	$ 1,068	$1,172.00
9	$ 1,151	$ 1,117	$1,226.67
10	$ 1,179	$ 1,143	$1,257.33
11	$ 1,204	$1,168	$1,284.00
12	$1,229	$1,193	$1,310.67
13	$1,254	$1,218	$1,337.33
14	$1,279	$1,243	$1,364.00
15	$1,304	$1,268	$1,390.67
16	$1,329	$1,293	$1,417.33
17	$1,354	$1,318	$1,444.00

18	$1,379	$1,343	$1,470.67
+	+25 each person above 18	+25 each person above 18	+26.67 each person above 18

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39.4 Elderly, Blind, Or Disabled Assets and Income Tables

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

The values in the following table were effective January 1, 2021.

Group Size				
Category		**1**		**2**
SSI-Related Categorically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$877.78	Income	$1,323.05
SSI-Related Medically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$1,073.33 (effective 2/1/2021)	Income	$1,451.67 (effective 2/1/2021)
***SSI* Payment Level**				
Federal SSI Payment Level	Income	$794.00	Income	$1,191.00
SSP	Income	$83.78	Income	$132.05
Total	Income	$877.78	Income	$1,323.05
SSI Payment Level + E Supplement	Income	$973.77 (Home Maintenance Maximum Allowance)		$1,668.41
SSI E Supplement	Income	$95.99		$345.36
Community Waivers Special Income Limit	Income	$2,382.00		

Institutions Categorically Needy Income Limit	Income	$2,382.00		
Substantial Gainful Activity Limit (non-blind individuals)	Income	$1,310.00		
Substantial Gainful Activity Limit (blind individuals)	Income	$2,190.00		
Medicaid Savings Programs				
QMB	Income	At or below 100% FPL		
SLMB	Income	At least 100% FPL but less than 120% FPL		
SLMB+	Income	At least 120% FPL but less than 135% FPL		
QMB, SLMB, SLMB+	Assets	$7,970		$11,960
QDWI	Income	At or below 200%		
	Assets	$4,000		$6,000

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2021.

Description	**Amount**

Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,382.00
EBD Deeming Amount to an Ineligible Minor		$397.00
Community Waivers Basic Needs Allowance		$974.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$794.00 $1,191.00

The spousal impoverishment values in the following table were effective July 1, 2020.

Description	**Amount**
Community Spouse Lower Income Allocation Limit	$2,873.34
Community Spouse Excess Shelter Cost Limit	$862.00
Community Spouse Maximum Income Allocation (monthly)	The lesser of $3,259.50 (as of 1/2021) or the Lower Income Allocation Limit plus excess shelter expenses
Family Member Income Allowance	$718.34
Community Spouse asset share (CSAS) maximum	$130,380.00 as of 1/2021

39.4.3 Institutional Cost of Care Values

The values in the following table were effective January 1, 2021.

Description	Amount
Daily Average Private Pay Nursing Home Rate	$303.38
Monthly Average Private Pay Nursing Home Rate	$9,227.81
Monthly Rate for State Centers for Persons with Developmental Disabilities	$25,709.69

39.4.4 Maximum Cost Share Amount for Family Care, Family Care Partnership, or PACE

The values in the following table were effective February 1, 2021.

Description	Amount
Maximum Cost Share Amount for an individual in Group B+ for Family Care, Family Care Partnership, or PACE	$2,903.45

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39.5 Federal Poverty Level Table

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL
1	$12,880	$1,073.33	$1,288.00	$1,427.53	$1,449.00	$1,610.00	$1,674.39
2	$17,420	$1,451.67	$1,742.00	$1,930.72	$1,959.75	$2,177.51	$2,264.61
3	$21,960	$1,830.00	$2,196.00	$2,433.90	$2,470.50	$2,745.00	$2,854.80
4	$26,500	$2,208.33	$2,650.00	$2,937.08	$2,981.25	$3,312.50	$3,444.99
5	$31,040	$2,586.67	$3,104.00	$3,440.27	$3,492.00	$3,880.01	$4,035.21
6	$35,580	$2,965.00	$3,558.00	$3,943.45	$4,002.75	$4,447.50	$4,625.40
7	$40,120	$3,343.33	$4,012.00	$4,446.63	$4,513.50	$5,015.00	$5,215.59
8	$44,660	$3,721.67	$4,466.00	$4,949.82	$5,024.25	$5,582.51	$5,805.81
9	$49,200	$4,100.00	$4,920.00	$5,453.00	$5,535.00	$6,150.00	$6,396.00
10	$53,740	$4,478.33	$5,374.00	$5,956.18	$6,045.75	$6,717.50	$6,986.19
11	$58,280	$4,856.67	$5,828.00	$6,459.37	$6,556.50	$7,285.01	$7,576.41

12	$62,820	$5,235.00	$6,282.00	$6,962.55	$7,067.25	$7,852.50	$8,166.60
13	$67,360	$5,613.33	$6,736.00	$7,465.73	$7,578.00	$8,420.00	$8,756.79
14	$71,900	$5,991.67	$7,190.00	$7,968.92	$8,088.75	$8,987.51	$9,347.01
15	$76,440	$6,370.00	$7,644.00	$8,472.10	$8,599.50	$9,555.00	$9,937.20
16	$80,980	$6,748.33	$8,098.00	$8,975.28	$9,110.25	$10,122.50	$10,527.3
17	$85,520	$7,126.67	$8,552.00	$9,478.47	$9,621.00	$10,690.01	$11,117.6
18	$90,060	$7,505.00	$9,006.00	$9,981.65	$10,131.75	$11,257.50	$11,707.8
19	$94,600	$7,883.33	$9,460.00	$10,484.83	$10,642.50	$11,825.00	$12,297.9
20	$99,140	$8,261.67	$9,914.00	$10,988.02	$11,153.25	$12,392.51	$12,888.2
21	$103,680	$8,640.00	$10,368.00	$11,491.20	$11,664.00	$12,960.00	$13,478.4
22	$108,220	$9,018.33	$10,822.00	$11,994.38	$12,174.75	$13,527.50	$14,068.5
23	$112,760	$9,396.67	$11,276.00	$12,497.57	$12,685.50	$14,095.01	$14,658.8
24	$117,300	$9,775.00	$11,730.00	$13,000.75	$13,196.25	$14,662.50	$15,249.00

each additional person	$4,540	$378.33	$454.00	$503.18	$510.75	$567.50	$590.19
		QMB BC+ Extensions trigger limit BC+ Adults limit MAPP premium limit	SLMB	BC+ adult premium limit	QI-1 (SLMB+)		MAGI/BC+ Limit for kids 6-18 subject to access / backdate / EE

		Annual figures for SeniorCare	

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39.6 Cost-of-Living Adjustment

To calculate the *COLA disregard* amount, do the following:

1. Find the *AG*'s current gross *OASDI* Benefits income. The gross OASDI income is the sum of the following:

    - OASDI check.
    - Any amount that has been withheld for a Medicare premium.
    - Any amount withheld to repay an earlier overpayment.

    Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.

2. On the COLA Disregard Amount Table below, find the last month in which the person was eligible for and received a check for both OASDI and *SSI*.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount	
January to December 2020	0.012833
January to December 2019	0.028379
January to December 2018	0.054843
January to December 2017	0.073376
January to December 2016	0.076148
January to December 2015	0.076148
January to December 2014	0.091590
January to December 2013	0.105015
January to December 2012	0.119976

January to December 2011	0.150556
January to December 2010	0.150556
January to December 2009	0.150556
January to December 2008	0.197123
January to December 2007	0.215174
January to December 2006	0.240245
January to December 2005	0.270169
January to December 2004	0.289356
January to December 2003	0.303973
January to December 2002	0.313582
January to December 2001	0.330977
January to December 2000	0.353601
January to December 1999	0.368751
January to December 1998	0.376852
January to December 1997	0.389669
January to December 1996	0.406870
January to December 1995	0.421900
January to December 1994	0.437646
January to December 1993	0.451897
January to December 1992	0.467861
January to December 1991	0.486848
January to December 1990	0.513138

January to December 1989	0.534993
January to December 1988	0.552878
January to December 1987	0.570900
January to December 1986	0.576407
January to December 1985	0.589144
January to December 1984	0.603037
July 1983 to December 1983	0.616461
July 1982 to June 1983	0.642888
July 1981 to June 1982	0.678856
July 1980 to June 1981	0.719034
July 1979 to June 1980	0.744344
July 1978 to June 1979	0.759947
July 1977 to June 1978	0.773321
July 1976 to June 1977	0.786956
July 1975 to June 1976	0.802737

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39.7 Hospital Daily Rates

City	Hospital Name	Average IP Daily Charge Based on Gross Inpatient Revenue*
Amery	Amery Regional Medical Center	2,089.80
Antigo	Langlade Memorial Hospital	2,138.75
Appleton	Appleton Medical Center	2,619.86
Appleton	St. Elizabeth Hospital	2,116.37
Arcadia	Franciscan Skemp Healthcare-Arcadia	3,092.15
Ashland	Memorial Medical Center, Inc.	1,482.73
Baldwin	Baldwin Area Medical Center, Inc.	2,533.16
Baraboo	St. Clare Hospital and Health Services	2,179.26
Barron	Barron Medical Center, Mayo Health System	1,954.05
Beaver Dam	Beaver Dam Community Hospitals, Inc.	2,668.64
Beloit	Beloit Memorial Hospital, Inc.	2,372.91
Berlin	Berlin Memorial Hospital	2,281.50
Black River Falls	Black River Memorial Hospital	2,008.27
Bloomer	Bloomer Medical Center, Mayo Health System, Inc.	2,650.71
Boscobel	Boscobel Area Health Care	2,223.16
Brookfield	Elmbrook Memorial Hospital	2,939.91
Burlington	Memorial Hospital Corporation of Burlington	3,388.85
Chilton	Calumet Medical Center, Inc.	2,275.09
Chippewa Falls	St. Joseph's Hospital	1,328.26
Columbus	Columbus Community Hospital, Inc.	2,189.11
Cumberland	Cumberland Memorial Hospital and ECU	1,401.31
Darlington	Memorial Hospital of Lafayette County	2,176.27
Dodgeville	Upland Hills Health	2,319.07
Durand	Chippewa Valley Hospital	4,079.93
Eagle River	Eagle River Memorial Hospital, Inc.	2,089.94

Eau Claire	Luther Hospital	2,856.90
Eau Claire	Sacred Heart Hospital	2,048.11
Edgerton	Memorial Community Hospital	4,277.41
Elkhorn	Lakeland Medical Center, Inc.	2,818.54
Fond du Lac	Agnesian HealthCare, Inc.	2,038.43
Fond Du Lac	Fond du Lac County Department of Com. Prog.	542.75
Fort Atkinson	Fort Atkinson Memorial Health Services	1,611.49
Friendship	Adams County Memorial Hospital	2,122.78
Grantsburg	Burnett Medical Center, Inc.	2,463.85
Green Bay	Bellin Memorial Hospital	3,203.79
Green Bay	Bellin Psychiatric Center	1,127.78
Green Bay	Brown County Mental Health Center	604.30
Green Bay	Libertas Treatment Center	599.69
Green Bay	St. Mary's Hospital Medical Center	2,150.08
Green Bay	St. Vincent Hospital	2,181.42
Greenfield	Kindred Hospital-Milwaukee	2,863.08
Hartford	Aurora Medical Center	1,951.60
Hayward	Hayward Area Memorial Hospital	2,499.17
Hillsboro	St. Joseph's Comm. Health Services, Inc.	3,214.87
Hudson	Hudson Hospital	3,123.36
Janesville	Mercy Health System Corporation	2,959.12
Janesville	Rock County Psychiatric Hospital	627.07
Kenosha	Aurora Medical Center - Kenosha	3,394.71
Kenosha	Children's Hospital of WI, Inc. - Kenosha	1,583.90
Kenosha	Kenosha Hospital and Medical Center	3,002.25
La Crosse	Franciscan Skemp Healthcare - La Crosse	2,472.35
La Crosse	Gundersen Lutheran Medical Center, Inc.	3,399.28
Ladysmith	Rusk Co. Memorial Hospital and Nursing Home	1,713.81
Lancaster	Grant Regional Health Center, Inc.	2,827.16
Madison	Mendota Mental Health Institute	577.84
Madison	Meriter Hospital, Inc.	2,740.11
Madison	St. Mary’s Hospital Medical Center	2,785.67

Madison	University of WI Hospital and Clinics Authority	3,171.65
Manitowoc	Holy Family Memorial Medical Center	2,349.37
Marinette	Bay Area Medical Center	1,985.82
Marshfield	Norwood Health Center	662.10
Marshfield	Saint Joseph's Hospital	2,693.24
Mauston	Hess Memorial Hospital	2,500.85
Medford	Memorial Health Center, Inc.	2,079.43
Menomonee Falls	Community Memorial Hospital	2,527.08
Menomonie	Myrtle Werth Hospital-Mayo Health System	2,020.15
Mequon	St. Mary's Hospital-Ozaukee	2,626.39
Merrill	Good Samaritan Health Center	1,862.32
Milwaukee	Aurora Sinai Medical Center	3,504.31
Milwaukee	Children's Hospital of Wisconsin	4,109.72
Milwaukee	Columbia Hospital, Inc.	3,142.63
Milwaukee	Froedtert Memorial Lutheran Hospital	3,763.75
Milwaukee	Milwaukee County Mental Health Complex	658.69
Milwaukee	Sacred Heart Rehabilitation Institute	1,590.18
Milwaukee	St. Joseph's Hospital	2,870.63
Milwaukee	St. Luke's Medical Center	4,194.60
Milwaukee	St. Mary's Hospital-Milwaukee	3,038.61
Milwaukee	St. Michael Hospital	3,041.39
Monroe	The Monroe Clinic	2,821.34
Neenah	Theda Clark Medical Center	2,123.14
Neillsville	Memorial Hospital, Inc	2,546.27
New London	New London Family Medical Center	2,048.86
New Richmond	Holy Family Hospital	2,331.20
Oconomowoc	Oconomowoc Memorial Hospital	2,756.58
Oconomowoc	Rogers Memorial Hospital	845.81
Oconto	Oconto Memorial Hospital, Inc.	2,419.99
Oconto Falls	Community Memorial Hospital	2,436.47
Osceola	Osceola Medical Center	2,533.79

Oshkosh	Mercy Medical Center of Oshkosh	2,204.91
Osseo	Osseo Area Hospital and Nursing Home, Inc.	8,485.86
Park Falls	Flambeau Hospital, Inc.	2,149.84
Platteville	Southwest Health Center, Inc.	2,053.36
Portage	Divine Savior Healthcare	2,096.57
Prairie Du Chien	Prairie du Chien Memorial Hospital	2,986.91
Prairie Du Sac	Sauk Prairie Memorial Hospital	2,575.36
Racine	All Saints-St. Luke's Hospital, Inc.	1,500.18
Racine	All Saints-St. Mary's Medical Center, Inc.	2,203.06
Reedsburg	Reedsburg Area Medical Center	2,252.02
Rhinelander	Saint Mary's Hospital, Inc.	2,601.07
Rice Lake	Lakeview Medical Center	1,649.24
Richland Center	The Richland Hospital, Inc.	2,376.05
Ripon	Ripon Medical Center	2,345.92
River Falls	River Falls Area Hospital	2,771.15
Shawano	Shawano Medical Center	1,945.56
Sheboygan	Sheboygan Memorial/Valley View Medical Center	2,414.85
Sheboygan	St. Nicholas Hospital	1,870.69
Shell Lake	Indianhead Medical Center Shell Lake, Inc.	1,889.70
Sparta	Franciscan Skemp Healthcare-Sparta	2,503.34
Spooner	Spooner Health System	2,063.49
St. Croix Falls	St. Croix Regional Medical Center, Inc.	2,738.80
Stanley	Victory Medical Center	2,768.09
Stevens Point	Saint Michael's Hospital	2,016.21
Stoughton	Stoughton Hospital Association	1,945.35
Sturgeon Bay	Door County Memorial Hospital	3,027.83
Superior	St. Mary's Hospital of Superior	1,959.67
Tomah	Tomah Memorial Hospital, Inc.	1,660.85
Tomahawk	Sacred Heart Hospital, Inc.	1,350.84
Two Rivers	Aurora Medical Center of Manitowoc City, Inc.	2,441.01

Viroqua	Vernon Memorial Hospital	2,196.89
Waterford	Lakeview NeuroRehab Center Midwest	1,655.79
Watertown	Watertown Memorial Hospital	2,476.15
Waukesha	Waukesha County Mental Health Center	694.85
Waukesha	Waukesha Memorial Hospital, Inc.	2,691.44
Waupaca	Riverside Medical Center	1,958.61
Waupun	Waupun Memorial Hospital	1,903.18
Wausau	North Central Health Care Facilities	694.88
Wausau	Wausau Hospital	2,602.82
Wauwatosa	Aurora Psychiatric Hospital	1,075.72
West Allis	Rogers Memorial Hospital - Milwaukee	1,674.72
West Allis	Select Specialty Hospital	2,372.35
West Allis	West Allis Memorial Hospital	3,282.94
West Bend	St. Joseph's Community Hospital	1,758.48
Whitehall	Tri-County Memorial Hospital, Inc.	2,472.95
Wild Rose	Wild Rose Community Memorial Hospital Inc.	2,077.47
Winnebago	Winnebago Mental Health Institute	457.54
Wisconsin Rapids	Riverview Hospital Association	1,934.27
Woodruff	Howard Young Medical Center, Inc.	2,509.65

Data Source: Gross Inpatient Revenue and Total Discharge Days, 2001 Wisconsin Hospital Fiscal Survey

* Average Daily Charge is the sum of Gross Inpatient Revenue and Gross Inpatient Ancillary Revenue divided by Total Discharge Days.

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39.8 Life Expectancy Table

See the Life Expectancy Table at Social Security Administration site.

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39.9 BadgerCare Premiums

See the BadgerCare + handbook Section 48 for BadgerCare Plus premiums

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39.10 Medicaid Purchase Plan Premiums before August 1, 2020 only

The following are *MAPP* premiums for months of eligibility **up to and including July 2020** for members whose gross monthly income equals or exceeds 150 percent of the *FPL* for the appropriate fiscal test group size.

For MAPP premiums for months of eligibility starting August 1, 2020 please reference Section 26.5 MAPP Premiums.

MAPP PREMIUM SCHEDULE prior to August 1, 2020					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
$0	$25.00	$0.00	500.01	525.00	500.00
25.01	50.00	25.00	525.01	550.00	525.00
50.01	75.00	50.00	550.01	575.00	550.00
75.01	100.00	75.00	575.01	600.00	575.00
100.01	125.00	100.00	600.01	625.00	600.00
125.01	150.00	125.00	625.01	650.00	625.00
150.01	175.00	150.00	650.01	675.00	650.00
175.01	200.00	175.00	675.01	700.00	675.00
200.01	225.00	200.00	700.01	725.00	700.00
225.01	250.00	225.00	725.01	750.00	725.00
250.01	275.00	250.00	750.01	775.00	750.00
275.01	300.00	275.00	775.01	800.00	775.00

300.01	325.00	300.00	800.01	825.00	800.00
325.01	350.00	325.00	825.01	850.00	825.00
350.01	375.00	350.00	850.01	875.00	850.00
375.01	400.00	375.00	875.01	900.00	875.00
400.01	425.00	400.00	900.01	925.00	900.00
425.01	450.00	425.00	925.01	950.00	925.00
450.01	475.00	450.00	950.01	975.00	950.00
475.01	500.00	475.00	975.01	1000.00	975.00
			1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than $1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

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39.11 SeniorCare Income Limits and Participation Levels

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs, depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his or her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1:** Co-Payment (Annual income is at or below 160% of the *FPL*.)
- **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b**: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL may be adjusted annually. See 39.5 Federal Poverty Level Table for current FPLs. If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $20,608 per individual or $27,872 per couple annually.*	▪ No deductible or spenddown. ▪ $5 co-pay for each covered generic prescription drug. ▪ $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL** $20,609 to $25,760 per individual and $27,873 to $34,840 per couple annually.*	▪ $500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the $500 deductible is met. ▪ After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

Level 2b **Income above 200% and at or below 240% of FPL** $25,761 to $30,912 per individual and $34,841 to $41,808 per couple annually.	▪ $850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $30,913 or higher per individual and $41,809 or higher per couple annually.*	▪ Pay retail price for drugs equal to the difference between the member's and $30,913 per individual or $41,809 per couple. This is called “spenddown.” ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an $850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2021 federal poverty guidelines, which typically increase by a small amount each year.

39.11.2 Level 1: Copayment

SeniorCare will pay for covered prescription drugs purchased from participating pharmacies except for participant copayments.

Level 1 participants are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

If a participant has private insurance with a higher copayment per prescription than SeniorCare, the SeniorCare copayment rules will apply and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services at 1-800-947-9627.

Residents of nursing homes and community based residential facilities will have to pay the usual SeniorCare copayment even when they are required to purchase drugs on less than a monthly basis.

39.11.3 Level 2a: Deductible

Participant has an annual deductible of $500. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 copayment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

39.11.4 Level 2b: Deductible

Participant has an annual deductible of $850. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Note: If married persons in the same *FTG* with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the *spouse* who applies later. (See 33.9.3.1 FTG Changes at Level 2a and 2b)

39.11.5 Level 3: Spenddown

Level 3 participants must meet a spenddown. The amount of spenddown is the difference between the FTG annual income and 240% of the FPL corresponding to the size of the FTG. The SeniorCare program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spenddown.

39.11.5.1 Level 3: Fiscal Test Group of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copayment.

Example 1: Dorothy's annual income is $31,624. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period

39.11.5.2 Level 3: Fiscal Test Group of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 2: Bob and Alice's annual income is $43,376, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his or her costs count toward the spenddown. He or she pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 3: Tracy and Dave's annual income is $43,376, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period.

View History

39.12 Five Percent Copay Limit Tiers

2020 Per-Member Copay Limits											
Status	Assistance Group Income Tier as Percentage of the Federal Poverty Level										
	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	$0	$26	$53	$79	$106	$132	$159	$186	$212	$239	$265
Prorated (split between counted spouses)	$0	$13	$26.50	$39.50	$53	$66	$79.50	$93	$106	$119.50	$132.50

40 Worksheets

40.1 Worksheets table of contents

The following is a list of Medicaid worksheets. Workers should come here each time a worksheet is needed to insure they are using the most up to date worksheets.

WORKSHEETS	
NUMBER	NAME
Wkst 01	Medicaid Non-Financial
Wkst 02	Dependent Care
Wkst 03	Medicaid Deductible
Wkst 04	Medicaid Institution Determination
Wkst 05	Medicaid Extensions (obsolete)

Wkst 06	Supplemental Security Income-Related Determination Worksheet
Wkst 07	Spousal Impoverishment Income Allocation
Wkst 08	Medicaid Purchase Plan (MAPP) Eligibility as of 8/1/2020 Medicaid Purchase Plan (MAPP) Eligibility prior to 8/1/2020
Wkst 09	Medicaid Purchase Plan (MAPP) Premium Calculation as of 8/1/2020 Medicaid Purchase Plan (MAPP) Premium Calculation prior to 8/1/2020
Wkst 10	Medicaid Purchase Plan (MAPP) Work Expenses
Wkst 11	Medicaid Purchase Plan (MAPP) Medicaid/Remedial Expenses
Wkst 12	Family Care Eligibility – Non-MA Financial Determination (obsolete)
Wkst 13	FFU Income (obsolete)
Wkst 14	AFDC-Related Determination Worksheet

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