

BadgerCare Plus Eligibility Handbook

20-03

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PROGRAM OVERVIEW (CHAPTER 1)

1.1 Introduction to BadgerCare Plus

1.1.1 Overview

BadgerCare Plus is a state and federal program that provides health coverage for low-income Wisconsin residents. To be eligible for BadgerCare Plus, a person must meet certain non-financial and financial requirements.

Depending on their age, income, and other criteria, BadgerCare Plus members have their benefits funded by either the Medicaid program or *CHIP*.

Note: BadgerCare Plus replaced *AFDC*-Medicaid, Healthy Start, and BadgerCare.

1.1.2 BadgerCare Plus Coverage Groups

Populations eligible for BadgerCare Plus include:

- Children younger than 19 years old
- Pregnant women
- Parents and caretakers of children younger than 18 years old and dependent 18-year-olds
- Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care
- Former Foster Care Youth younger than 26 years old who were in out-of-home care when they turned 18
- Adults ages 19–64 who are not receiving Medicare and do not have dependent children

For information on income limits, see Section 16.1 Income and Section 50.1 Federal Poverty Level Table.

All BadgerCare Plus members receive coverage under the Standard Plan. See Chapter 38 Covered Services for information on covered services.

BadgerCare Plus is funded by Medicaid and CHIP. CHIP, which is also known as *SCHIP* or Title 21, is primarily a program covering low-income children's health care needs. In Wisconsin, these low-income children include children with incomes above the Medicaid income limits up to 306 percent of the *FPL*. Children eligible for CHIP are covered under BadgerCare Plus. CHIP also covers pregnant women who are enrolled in the BadgerCare Plus Prenatal Program.

1.1.3 Limited Coverage Health Care Plans

BadgerCare Plus also has several limited coverage health care plans. These include:

- **Family Planning Only Services.** People of childbearing or reproductive age may be eligible for limited benefits under the Family Planning Only Services Program.
- **BadgerCare Plus Prenatal Program.** Documented and undocumented immigrants who are pregnant and ineligible for BadgerCare Plus solely due to their immigration status may be eligible for the BadgerCare Plus Prenatal Program.
- **BadgerCare Plus Emergency Services.** Documented and undocumented immigrants who are children, pregnant women, parents, or caretakers and who are ineligible for BadgerCare Plus solely due to their immigration status may be eligible for coverage for BadgerCare Plus Emergency Services.
- **Tuberculosis (TB)-Related Medicaid.** People infected with TB who are not eligible for any other category of full-benefit BadgerCare Plus or Medicaid may be eligible for limited benefits for the treatment of TB.

1.1.4 Wisconsin Medicaid

Medicaid is a state and federal program that provides health coverage for Wisconsin residents who are elderly, blind, or disabled. In addition to this, Medicaid funds the benefits of most adults and children enrolled in BadgerCare Plus.

Medicaid is also known as Medical Assistance, MA, and Title 19.

1.1.4.1 Medicaid Programs

The following are different subprograms of Medicaid:

- Home and Community Based Waivers Long-Term Care and *IRIS*
- Institutional Long-Term Care Medicaid
- Katie Beckett
- Managed long-term care programs (Family Care, Family Care Partnership, *PACE*)
- *MAPP*
- *SSI* Medicaid
- SSI-related Medicaid
- Wisconsin Well Woman Medicaid
- Emergency Services for Non-Qualifying Immigrants (limited benefit)
- Medicare Savings Programs (limited benefit): *QMB*, *SLMB*, *SLMB+*, *QDWI*
- SeniorCare (limited benefit)

1.1.5 Health Care Choice

It is possible for individuals to qualify for both BadgerCare Plus and EBD Medicaid based on financial and non-financial eligibility criteria. See Chapter 49 Health Care Choice for more information.

1.1.6 Ways to Apply

A person can apply for BadgerCare Plus:

- Online using ACCESS
- By phone by calling the local county or tribal agency
- In-person at the *IM* consortium or tribal agency
- By mail using a paper application

A person can also apply through the Federally Facilitated Marketplace.

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NON-FINANCIAL REQUIREMENTS (CHAPTERS 2-15)

2 BadgerCare Plus Group

Wisconsin residents in the following coverage groups may be non-financially eligible for BadgerCare Plus:

- Children younger than 19 years old
- Pregnant women
- Parents and caretakers of children younger than 18 years old and dependent 18-year-olds
 - Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care
- Former Foster Care Youth younger than 26 years old who were in out-of-home care when they turned 18
- Adults ages 19-64 who are not receiving Medicare and who do not have dependent children.

To be eligible for BadgerCare Plus, a person must meet the following criteria:

- Be a Wisconsin resident (see Chapter 3 Residence)
- Be a U.S. citizen or qualified immigrant (see Chapter 4 Citizen and Immigration Status)

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

- Provide documentation of citizenship and identity or of *immigration status* (see Section 4.1 U.S. Citizens and Nationals)
- Cooperate with establishing medical support and *TPL* (see Chapter 5 Medical Support and Third Party Liability)
- Sign over to the state his or her rights to payments from a third party for medical expenses (see Section 5.2 Medical Support/CSA Cooperation)
- Meet BadgerCare Plus *SSN* requirements (see Chapter 6 Social Security Requirements)
- Cooperate with verification requests when information is mandatory or deemed questionable (see Chapter 9 Verification)

- Meet health insurance access and coverage requirements (see Chapter 7 Health Insurance Access and Coverage Requirements)

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2.1 NonFinancial Program Requirements

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- Provide documentation of citizenship and identity or of *immigration status* (see Section 4.1 U.S. Citizens and Nationals)
- Cooperate with establishing medical support and *TPL* (see Chapter 5 Medical Support and Third Party Liability)
- Sign over to the state his or her rights to payments from a third party for medical expenses (see Section 5.2 Medical Support/CSA Cooperation)
- Meet BadgerCare Plus *SSN* requirements (see Chapter 6 Social Security Requirements)
- Cooperate with verification requests when information is mandatory or deemed questionable (see Chapter 9 Verification)
- Meet health insurance access and coverage requirements (see Chapter 7 Health Insurance Access and Coverage Requirements)

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2.2 Coverage Group Definitions

The following are the relationships and legal responsibility that determine who is in the BadgerCare Plus coverage groups:

2.2.1 Parents

A parent may be defined as the following:

- Natural, legally adoptive, or a step-parent.
- Of any age.

There can be more than one parent of a certain gender in a household.

To be considered a parent of a child younger than 19 years old for BadgerCare Plus purposes, the child must be under the care of that person at least 40 percent of the time. For example, in families where parents are divorced, if the child does not live with a parent at least 40 percent of the time, that parent would have his or her eligibility considered under the Childless Adults coverage group, rather than the Parents/Caretakers coverage group.

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

2.2.1.1 Paternity

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

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

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

1. Claimed father

A claimed father is someone claiming to be the father of a child but has not had his paternity established. **A claimed father is not the father for BadgerCare Plus eligibility purposes.** His child should be referred to the **CSA** so that steps to establish paternity can be taken.

2. Acknowledged father

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

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

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

3. Legal/adjudicated father

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

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

2.2.1.2 Joint Placement

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

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

If only one parent of a child is applying for BadgerCare Plus and he or she is stating that he or she has placement of the child for at least 40 percent of the time, accept the declaration unless it is questionable.

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

1. If both parents agree that they have a reasonably equivalent placement arrangement, ask under which parent's case they want the child to be receiving BadgerCare Plus benefits and determine eligibility for both parents' cases.
2. If either parent disputes that the placement arrangement is reasonably equivalent, the eligibility worker must determine the monthly percentage of the physical placement based on the court order. If the court order does not show reasonably equivalent placement, consider the child to be with the parent he or she is residing with during the month in question and deny the other parent's eligibility as a caretaker relative of this child.
3. If the parents cannot agree on which case the child will receive benefits, put the child on the case with the family whose income is at the lower *FPL* level.
4. Document your decision in the case record.

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

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

Example 1: Johnny, age 10, lives 50 percent of the time with his mom and 50 percent of the time with his dad. Both Johnny's dad and mom have applied for

BadgerCare Plus. Mom is employed, but does not have access to health insurance coverage through her employer. Dad is employed and does have access to a family health insurance where his employer pays 81 percent of the monthly premium. Johnny can remain eligible on his mom's case.

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

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

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

2.2.1.3 Dependent 18-Year-Old

When an adult is eligible as a parent or caretaker because he or she is caring for an 18-year-old child, and that child is the only child in the home, the child must meet both the following conditions in order for the parent or caretaker to be eligible for BadgerCare Plus as a parent or caretaker of a dependent 18-year-old:

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

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

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

2.2.2 Caretaker Relative

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

Qualifying relationships for caretaker relatives consist of the following:

1. Stepfather or stepmother (when the parent is deceased or divorced/separated from the stepparent).
2. Natural full brother or sister, legally adopted, half- or stepbrother or sister.
3. Grandmother or grandfather, aunt or uncle, first cousin, nephew or niece, or any preceding generation denoted by the prefix grand-, great-, or great-great, and including those through adoption.

Note: "First cousin" includes a first cousin from a different generation, such as a first cousin once removed (i.e. the relative is taking care of his or her first cousin's child).

4. Spouse of any of the above and the spouse of a child's parent, even after the marriage ends by death, divorce, or separation.

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

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

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

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

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

2.2.3 Child Welfare Parents/Caretakers

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

2.2.4 Pregnant Woman

A pregnant woman is nonfinancially eligible for BadgerCare Plus. Marital status has no effect on her nonfinancial eligibility. If she is a pregnant minor, she does not have to be under the care of or related to the caretaker to be eligible for BadgerCare Plus.

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add 1 to the group size.

2.2.5 Former Foster Care Youth (Formerly Known as Youth Exiting Out of Home Care)

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

BadgerCare Plus benefits are available to certain people who were in out-of-home care, including foster care, court-ordered Kinship Care, and subsidized guardianship, as of their 18th birthday. These people are categorically eligible for BadgerCare Plus. The person did not have to be in foster care in Wisconsin when he or she was 18 years old in order to be eligible for this coverage group. As of January 1, 2014, benefits are available to all Former Foster Care Youth younger than 26 years old. See Chapter 11 Foster Care Medicaid for additional eligibility criteria for Former Foster Care Youth.

Note: If the primary person is a Former Foster Care Youth and younger than 26 years old, then the BadgerCare Plus group includes the youth and his or her spouse if the spouse is also a Former Foster Care Youth.

2.2.6 Child

A child younger than 19 years old is nonfinancially eligible for BadgerCare Plus. Marital status and school enrollment status have no effect on his or her nonfinancial eligibility.

The child does not have to be under the care of or related to the caretaker to be eligible for BadgerCare Plus.

Note: A child younger than 19 years old residing with a caretaker relative may not apply as the primary person for the relative's benefits. For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BadgerCare Plus. A child younger than 19 years old residing with a parent may not apply separately from his or her parent. In addition, the parent must apply as the primary person for the case, unless the child filing the application is age 18. People older than 19 years old must always apply separately from their parents or caretakers, irrespective of their living arrangement or tax dependency.

2.2.7 Childless Adults

A childless adult is a person 19 to 64 years old who is not receiving Medicare and who does not have any dependent children younger than 19 years old who reside with him or her at least 40 percent of the time. Marital status has no effect on a person being a childless adult.

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2.3 Modified Adjusted Gross Income Test Group

BadgerCare Plus eligibility determinations use **MAGI** rules. MAGI rules are based on the concept of a person's tax household, not necessarily on the physical household or family relationships.

2.3.1 Forming the Test Group Using Modified Adjusted Gross Income Tax Filing Rules

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

2.3.1.1 Tax Filers

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

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add 1 to the group size.

In general, a person cannot be claimed as a tax dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico.

Note: **IM** agencies are not required to know tax rules and can accept self-attestation from applicants and members about their tax dependents, unless it is questionable.

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

Out-of-the-Home Tax Dependents

A tax filer is able to claim individuals who live outside of their home as their tax dependents. Common examples include college students and other adult children, elderly parents, or siblings who do not live with the filer(s). Tax filers can also claim a

deceased child as his or her tax dependent in the year that the child has died. In these instances, the deceased child would be included in the tax filer's group size, though the child would not be eligible for benefits on that application.

Deceased Co-Filers

It is possible for a person to file his or her taxes jointly with a deceased spouse for the taxable year in which the spouse died. As of February 1, 2014, the deceased co-filer should be added to assistance groups according to MAGI rules for adding the jointly filing spouse of a tax filer.

Household Members in the Military

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

Married Couples

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

2.3.1.2 Tax Dependents

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

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

1. The individual is being claimed as a dependent by a parent outside of the home (a non-custodial parent is defined as a parent who is living apart from the parent applying for benefits for the child),
2. The individual is being claimed as a dependent by someone who is not their parent; or
3. The individual lives with both parents and his or her parents are not married filing jointly.

2.3.2 Forming the Test Group Using Modified Adjusted Gross Income Relationship Rules

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

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

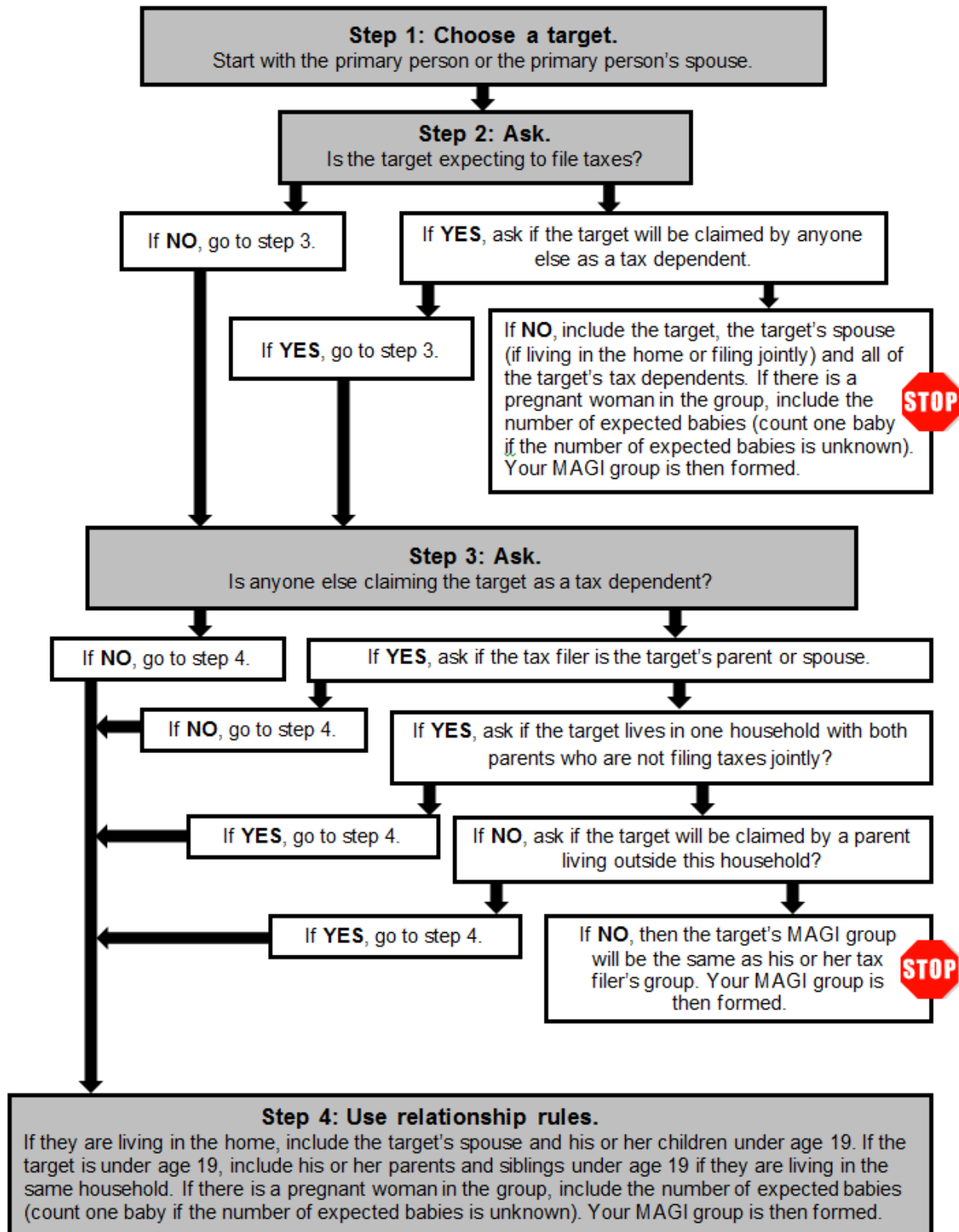
If the target individual is over age 19, the target's group includes the target's spouse and the target's children under age 19.

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add 1 to the group size.

2.3.3 Modified Adjusted Gross Income Flowchart

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

Four Steps to Forming a BadgerCare Plus MAGI Group



2.3.4 Former Foster Care Youth Test Group

If the primary person is a Former Foster Care Youth and younger than 26 years old, then the BadgerCare Plus test group will include the youth and his or her spouse if the spouse is also a Former Foster Care Youth. MAGI tax filing rules and relationship rules do not apply to Former Foster Care Youth when determining the youth's test group.

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2.4 BadgerCare Plus Household

"Living in the household" means all individuals residing in or temporarily absent (see Section 3.5.1 Temporary Absence) from the same residence. This includes:

1. People living in the home in a community residential confinement program. *DOC* electronically monitors them.
2. Huber law prisoners who are released from jail to attend to the needs of their families can become eligible for BadgerCare Plus. If the other parent is continuously absent, the Huber law prisoner may be the *caretaker relative* in the household if the prisoner:
 - a. Intends to return to the home, and
 - b. Continues to be involved in the planning of the support and care of the minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for BadgerCare Plus.

Consider them to be absent parents.

2.4.1 Not Living in the Household

Inmates of a public institution are not considered to be living in the household even if they are temporarily absent from the home. Exceptions to this include the following:

- A pregnant inmate is applying for the BadgerCare Plus Prenatal Program.
- An inmate has resided outside a public correctional institution for more than 24 hours at any one time. If this occurs, the inmate can qualify for BadgerCare Plus during that time period if he or she meets all other eligibility criteria. As an example, if an inmate is admitted as an inpatient to a non-prison hospital for 24 hours, that inmate could qualify for Medicaid for that day, if otherwise eligible.

2.4.2 Temporary Absence

A child and that child's parent or caretaker relative can be in the same BadgerCare Plus test group even when not living together if either is temporarily absent, provided:

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

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

and

2. The caretaker relative continues to exercise responsibility for the care and control of the child. See Chapter 10 Child Welfare Parents for more information about Child Welfare.

The following children are not considered temporarily absent:

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

2.4.3 Students

When a child younger than 19 years old who is a student living away from his or her parent's home applies for BadgerCare Plus, the child and his or her family can determine whether the student will be on his or her own case, or a temporarily absent individual included in his or her parent's case.

Students older than 19 years old will need to apply for BadgerCare Plus with their own application.

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2.5 Assistance Groups

Because of different BadgerCare Plus eligibility requirements, people within the BadgerCare Plus test group are placed into various BadgerCare Plus assistance groups.

Every BadgerCare Plus assistance group will have at least one potentially eligible member. Besides these potentially eligible members, other people may be designated as a person who is counted in the group and whose income may be counted when determining financial eligibility. Some people on the application will not be considered at all when determining eligibility. Placement in BadgerCare Plus assistance groups is dependent on age, tax filing relationships, and family relationships to the individual(s) whose eligibility is being determined.

The following are BadgerCare Plus assistance groups:

Assistance Group	Description
MAGY	Former Foster Care Youth
MAGP	Pregnant women, including those who are eligible for the BadgerCare Plus Prenatal Program and those who become eligible after meeting a deductible
MAGB	Continuously Eligible Newborns
MAGM	Adults in Earned Income and Spousal Support extensions
MAGN	Persons who are caretakers relatives, or the spouses of caretakers relatives in the home, including Child Welfare caretakers
MAGL	Children living with non-legally responsible relatives
MAGC	Children under age 19, living alone or with a parent or parents
MAGA	Persons age 19 or older who are parents, or stepparents of a child in the home, including Child Welfare parents
MAGD	Children who are eligible through meeting a deductible
MAGE	Children and Adults in Earned Income and Spousal Support extensions
MAGS	Childless adults

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2.6 Participation Status Codes

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

Status Code		Description	Include in the Group Size?
CA	Counted Adult	Ineligible for BadgerCare Plus in this AG	Yes
CC	Counted Child	Ineligible for BadgerCare Plus in this AG	Yes
EA	Eligible Adult	Non-financially eligible in this BadgerCare Plus AG	Yes
EC	Eligible Child	Non-financially eligible in this BadgerCare Plus AG	Yes
XA	Excluded Adult	Ineligible for BadgerCare Plus in this AG	No
XC	Excluded Child	Ineligible for BadgerCare Plus in this AG	No

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2.7 Group Examples

Example 1

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

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

Example 2

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

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

Example 3

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

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

Example 4

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

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

Example 5

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

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

Example 6:

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

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

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

Example 7

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

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

Example 8

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

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

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2.8 Modified Adjusted Gross Income Counting Rules

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

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

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

The following amounts are effective January 1, 2020:

- \$1,100 per year in taxable unearned income*
- \$12,400 per year in taxable earned income

*For expected unearned income, do not count Child Support, Social Security, **SSI**, Workers' Compensation, Veteran's Benefits, money from another person, or educational aid.

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

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

Example 1: Jack and Jill are married and will be filing a joint tax return. They have two children, Mickey (16) and Minnie (12), whom they will claim as tax dependents. Minnie has no income, but Mickey works at McDonald's earning approximately \$100 per month. Mickey's annual earned income is expected to be \$1,200; he is not expected to be required to file a tax return at the end of the year. Mickey's income is not counted.

Example 2: Daisy plans to file taxes this year. She has one tax dependent, her son Donald (16), who works part-time at a grocery store. He earns \$1,050 per month; with an annual income of \$12,600. Based on this income, Donald will be expected to be required to file a tax return. Donald's income is counted.

Example 3: Kelly and Zack are non-married co-parents and have two children, Jessie (17) and Albert (14). Albert mows lawns in the summer and makes around \$300 for the year. The only other income in the household is Zack's unemployment payment in the amount of \$400 per month (\$4,800 per year). Kelly and Zack do not plan to file taxes. Albert is not expected to be required to file taxes. The assistance groups for this case will be based on non-MAGI relationship rules since there is no tax filer in the household. Zack's UI payment will be counted, but Albert's self-employment income is not counted because he is not expected to be required to file.

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

Outcome for Barb

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

group.

Outcome for Michael and Janet

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

Example 5: Joe is married to Deanna, and they have a son Beau who is three years old. They file taxes jointly and claim Beau as a dependent. Deanna and Joe are both working and will be required to file taxes. Deanna is also in the military. Joe applies for BadgerCare Plus for himself and Beau while Deanna is deployed overseas. Even though Deanna will not be eligible, she will be a counted adult, and her income will be counted in the BadgerCare Plus determinations for Joe and Beau.

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3 Residence

3.1 Residence

A person must be a Wisconsin resident to be eligible for BadgerCare Plus. 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 3.5 Absence from Wisconsin), including students going to school in another state, do not have to be physically present to apply. However, individuals who are not Wisconsin residents and intend to move to Wisconsin must be physically present in Wisconsin to apply.

and

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

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

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

Example 3: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For BadgerCare Plus purposes, George is a Wisconsin resident.

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,

2. He or she is authorized to work in the US,
3. He or she is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crew leader"), and
4. He or she routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

See 12.3 for Special Migrant Laborer Processing Instructions.

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3.2 Intent To Reside

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

1. He or she is judged legally incompetent by a court of record; or
2. 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 Department of Health Services (DHS); or
3. Medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability supports a finding that he or she is incapable of indicating intent.

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

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3.3 Determining State Residency

3.3.1 Under Age 21

Not in an institution

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

- Age 18 through 20 or under age 18 and emancipated from his or her parents, or married, and is:
 1. Living in Wisconsin with the intent to remain living in Wisconsin, or
 2. Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.
- Under age 18 and not emancipated from his or her parents and not married, and is living in Wisconsin.

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

- Living in another state when Wisconsin or one of its county agencies has legal custody of him or her.
 - Living here and is eligible based on blindness or disability.
 - Living in another state when his or her parent is a resident of Wisconsin, has legal custody of him or her, and he or she intends to reside with this parent.

Example 1: Alicia resides in Wisconsin and intends to remain living in Wisconsin. She gives birth to her son, Max, at a hospital in Minnesota. Due to medical complications, Max is an inpatient in the hospital for three weeks immediately after his birth. Even though Max has not physically been in Wisconsin after his birth, he is a resident of Wisconsin because his parent, Alicia, has legal custody of Max and Max will reside with her in Wisconsin once he is discharged from the hospital.

In an institution

The residence of a person under age 21 living in a Wisconsin institution 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 located, and the person making the Medicaid *application* must reside in the same state.

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

3.3.2 Age 21 and Over

Not in an Institution

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

- Living in Wisconsin with the intent to remain living in Wisconsin, or
- Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

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

In an institution

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

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

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

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3.4 Special Situations

3.4.1 State Supplementary Payment

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

3.4.2 IV-E Children

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

It does not affect any maintenance payments for substitute care.

These cases are certified manually outside of **CARES**.

3.4.3 Non IV-E Foster Children

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

Non IV-E foster children are automatically eligible for BadgerCare Plus.

These cases are certified for BadgerCare Plus manually outside of CARES.

3.4.4 Homeless Persons

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

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3.5 Absence From Wisconsin

Once established, Wisconsin residency is retained until:

- The person notifies the *IM* 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.

3.5.1 Temporary Absence

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

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3.6 Inmates

An inmate is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to the person's needs is not considered an inmate. An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet, is not considered an inmate for the purposes of BadgerCare Plus. Individuals who are inmates of a public institution are not eligible for BadgerCare Plus unless they meet the Huber criteria or the following two exceptions:

- **Prenatal exception:** Pregnant women may apply for and enroll in the BadgerCare Plus Prenatal Program (see Chapter 41 BadgerCare Plus Prenatal Program) while they are inmates.
- **Inpatient exception:** If an inmate resides outside a public correctional institution for more than 24 hours at any one time, he or she can qualify for BadgerCare Plus during that time period if he or she meets all other eligibility criteria. For example, if an inmate of a public institution is admitted as an inpatient to a medical institution for 24 hours or more and is otherwise eligible, manually certify him or her for BadgerCare Plus from the admission date through the discharge date.

3.6.1 General BadgerCare Plus Application Process for Inmates of State Correctional Institutions

Use the following process for inmates of state correctional institutions:

1. **DOC** staff submits an ACCESS application, which will be systematically routed to **EM CAPO**. Superintendents of state correctional facilities (wardens) or their designee may sign the application for the inmate. Refer to the Medicaid Eligibility Handbook, Section 6.9.4 State Correctional Institutions for the list of state correctional facilities at which the warden may sign the application.
2. Process the inmate as a one-person household with a living arrangement of "01-Independent (Home/Apt/Trlr)" on the Current Demographics page.
3. If the individual is eligible, close the case in CARES by changing the Healthcare Request page to "N." Suppress CARES-generated notices for Medicaid and any program the individual has not requested. Manually certify the individual with the appropriate medical status code (see Process Help, Section 81.5 Med Stat Code Chart, for a list of medical status codes), from the hospital admission date

through the date of discharge. If the individual has not yet been discharged, certify the individual from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility. Also, if the individual had not been discharged when you sent the initial positive notice, send a manual negative notice with the eligibility end date as soon as that is known. If you issue the notice after the discharge date, the effective date of the termination and the notice should be the date you mail the notice. The reason for the termination should be shown as "Individual is incarcerated." The legal citation should read "DHS 103.03(6)." For situations in which an inmate has multiple inpatient admissions, see Section 3.6.2 BadgerCare Plus Application Process for Inmates with Multiple Inpatient Admissions.

Note: It is not necessary to provide a 10-day notice of termination for Medicaid when the reason for termination is the return of the individual to prison. The notice is considered timely if it is mailed no later than the termination effective date.

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

3.6.2 BadgerCare Plus Application Process for Inmates with Multiple Inpatient Admissions

Generally, a new application must be submitted for each inpatient admission for an inmate even if the inmate has already been verified as Medicaid-eligible for a previous inpatient admission.

Exception: If an application is pending and an inmate has multiple inpatient admissions prior to the application being approved, then all of those eligibility segments can be certified under one application.

Example 1: An inmate enters the hospital on April 5 and is discharged on April 7. An application is submitted on April 7. While the application is being processed, the inmate re-enters the hospital on April 10 and is discharged on April 15. The application is approved on April 16. Both the April 5–7 and April 10–15 inpatient hospital stays can be covered under the application submitted on April 7.

Example 2: A pregnant inmate has a pregnancy due date of December 15 and is enrolled in the BadgerCare Plus Prenatal Program with an end date of December 31. The pregnant inmate enters the hospital on December 10 and is discharged on

December 11. An application is submitted on December 14 because she was admitted for the delivery of the baby. The application is approved for the December 10 and 11 inpatient hospital stays.

For inmates who have already had their eligibility verified and who may have another hospital admission at a later point during the year, not all information will need to be verified (e.g., citizenship, identification). Income will always have to be verified. Any information that needs to be verified will be determined by EM CAPO as the application is being processed.

3.6.3 Huber Law

Huber Law prisoners who are childless adults are not eligible for BadgerCare Plus.

Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for BadgerCare Plus 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 the minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for BadgerCare Plus. They should be considered absent parents.

3.6.4 DOC Pre-Release Applications from Offenders

Upon release from prison, many offenders are eligible for BadgerCare Plus as parents/caretakers or as childless adults. In order to prevent a gap in medical or pharmacy coverage upon the offender's release, **DHS** requires consortia and tribal IM agencies to accept telephonic applications for health care from offenders nearing their date of release.

Inmates who have a definitive release date may apply for health care benefits by calling their **IM** agency on or after the 20th day of the month before the month of release. The application must be processed at the time of the initial call. The applicant must be allowed to sign the application telephonically.

Eligibility begins the first of the month in which the applicant is released, but providers are prohibited from billing BadgerCare Plus for any services while the applicant is still

incarcerated. The first day that a member can receive BadgerCare Plus-covered services is the day of release.

Most verification can be obtained through current data exchanges, but if additional verification is needed, the applicant must be given 30 days to provide the verification.

When processing applications from applicants whose only source of income is through employment inside a prison in either DOC or Badger State Industries (BSI) jobs, the worker does not need to verify this income. DHS has already received verification that the maximum possible earnings in these positions are below program limits.

Applicants with sources of income in addition to DOC or BSI income are required to verify the income from employment within the prison, in addition to verifying the other income sources.

When processing an application, the worker will verify the reported discharge date using the appropriate resource before requesting verification from the applicant or a DOC staff member. Depending on the facility type, the worker may need to use different resources or websites. See Process Help, Section 9.8 Processing Telephonic HC Applications from Offenders for more information on processing these applications and how to verify release dates.

The inmate's release date may not be up to date. Consider the release date verified if the date reported is within seven calendar days of the applicant's reported release date.

Example 3: Clifford is an inmate near release calling to complete his BadgerCare Plus application on June 3. He states he is being released on Tuesday, June 11. The worker checks the WI DOC Offender Locator site to verify Clifford's release date. His Mandatory Release/Extended Supervision Date is listed as Saturday, June 15. Since his reported date release date is within seven days of what is listed on the WI DOC Offender Locator site, his release date is verified.

A prison or jail staff member may verbally verify the release date of the applicant but do not require a prison or jail staff member to verbally verify the release date or prevent the applicant from completing the telephonic application.

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4 Citizenship and Immigration Status

4.1 U.S. Citizens and Nationals

To qualify for BadgerCare Plus, 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:

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

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

4.1.1 Child Citizenship Act

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

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

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

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

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

- Adopted under the age of 16**, and has been in the legal custody of and has resided with the adopting parent or parents for at least two years.
- Adopted while under the age of 18**, and has been in the legal custody of and has resided with the adopting parent or parents for at least two years and is a sibling of another adopted child who is under 16.
- 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.
- Orphans adopted under the age of 18**, who have had their adoption and immigration status approved by the USCIS, and are siblings of another adopted child who is under the age of 16. These children need not have lived with the adoptive parents for two years.

4.1.2 Compact of Free Association States

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

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4.2 Citizenship Verification

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 4.2.2 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 4.2.3 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 4.2.4 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.

4.2.1 Covered Programs

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

- BadgerCare Plus (except for the Prenatal Program)
- Medicaid
- Katie Beckett
- Tuberculosis (TB)-related Medicaid
- Wisconsin Well Woman Medicaid

Note: Katie Beckett, TB and Wisconsin Well Woman Medicaid 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.

Presumptive Eligibility/Temporary Enrollment

Qualified providers who conduct BadgerCare Plus presumptive eligibility determinations may not verify the citizenship of persons seeking eligibility through presumptive eligibility. Persons determined eligible for BadgerCare Plus through presumptive eligibility are not subject to the citizenship verification requirement until they file an application online or with the Income Maintenance agency.

4.2.2 Exempt Populations

The following populations are exempt from the citizenship verification requirement:

- Anyone currently receiving Social Security Disability Insurance (SSDI).
- Anyone currently receiving Supplemental Security Income (SSI) benefits.
- Anyone currently receiving Medicare.
- Anyone currently receiving Foster Care (Title IV-E and non-Title 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.

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

Losing Exempt Status

Medicare, SSDI, SSI, Foster Care and Adoption Assistance recipients lose their exemption from the citizenship verification requirement when their enrollment in these programs ends. However, CENs continue to be exempt after their eligibility for CEN status ends. Their exemption from citizenship requirements is permanent.

4.2.3 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 Section 4.2.2 Exempt Populations
- Citizenship/nationality has not already been verified through other means

Non-exempt BadgerCare Plus 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 Section 4.2.4 Citizenship Verification through Documentation.

4.2.4 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 (Section 4.2.4.1 Stand-alone Documentation of Citizenship) or both documentation of citizenship (Section 4.2.4.2 Evidence of Citizenship) and identity (Section 4.2.4.3 Evidence of Identity). Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period for Verification of Citizenship section (Section 4.2.4.4 Reasonable Opportunity Period for Verification of Citizenship).

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 for obtaining documentation for an applicant/member. See Section 4.2.5 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 applicants and members 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.

4.2.4.1 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. Note: 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	<p>Documentary evidence issued by a federally recognized Indian tribe, which meets all the following criteria:</p> <ul style="list-style-type: none"> • 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 <p>Such Tribal identification documents include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 <p>A photograph is not required to be part of these documents.</p>

4.2.4.2 Evidence of Citizenship

If an applicant is unable to provide stand-alone documentation of citizenship, 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, Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation, for a list of acceptable Documentation of Citizenship Only.) 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 form, 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	<p>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, 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.</p> <p>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.</p>
Birth Query	A birth record query confirms a person's birth in Wisconsin.
U.S. birth record amended more than 5 yrs 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, 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 of 2000 (CCA)	An individual demonstrates that he or she has gained his or her U.S. citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	<p><u>U.S. Citizen ID Card</u></p> <p>The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S.</p>

	<p>citizens living near the Canadian or Mexican border who needed it for frequent border crossings.</p> <p><u>Northern Mariana Card</u> Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.</p>
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	<p>When the Wisconsin Medicaid program pays the costs associated with the birth of an infant who either:</p> <ul style="list-style-type: none"> • Did not qualify as a CEN, or • Was a CEN, but born before July 1, 2006, <p>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.</p>
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	The document must show a U.S. birthplace.

nursing care facility or other institution	
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, 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 <u>recorded</u> (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	<p>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 affidavit, the following rules apply:</p> <ul style="list-style-type: none"> • 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 affidavits must be signed under penalty of perjury. • The affidavit does not have to be notarized.

4.2.4.3 Evidence of Identity

If an applicant is unable to provide stand-alone documentation of citizenship, in addition to providing evidence of citizenship, 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 form, 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. Note: 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 two 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, (Form 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:

	<ul style="list-style-type: none"> • 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 affidavits must be signed under penalty of perjury. • The affidavit does not have to be notarized. <p>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.</p>
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4.2.4.4 Reasonable Opportunity Period for Verification of Citizenship

Applicants who are otherwise eligible for BadgerCare Plus 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 not 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 healthcare 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.

4.2.5 Agencies Paying for Documentation

The worker can authorize payment for a birth certificate from the state where the applicant was born and/or a Wisconsin State ID if an applicant/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/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/members, agencies need to follow the process outlined in Process Help, Section 68.2.5 Agency Documentation Requests.

4.2.6 Reserved

4.2.7 Situations Which Require Special Documentation Processing

4.2.7.1 Person Add

A person being added to a case is subject to the verification requirement at the time of his 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 BadgerCare Plus for that person only.

4.2.7.2 Presumptive Eligibility/Express Enrollment (EE)

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

4.2.7.3 Individuals Without Verification and Effect on Household Eligibility

IM workers should not delay an individual household member's eligibility when awaiting another household members' citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members. See Process Help, Section 68.1 Citizenship and Identity Verification, for processing instructions.

4.2.7.4 Child Citizenship Act

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA). Within the context of the BadgerCare Plus citizenship

verification requirement, this means that for any applicant or member claiming citizenship through the CCA, IM workers should not request documentation for that person. In these cases, IM workers need to acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

For persons who meet the citizenship verification requirement through the means allowed in the CCA, this is considered evidence of citizenship. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity.

See Section 4.1.1 Child Citizenship Act

4.2.7.5 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 identification 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." These individuals still need to provide proof of identity.

4.2.7.6 Individuals in Institutional Care Facilities

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

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4.3 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 BadgerCare Plus 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 4.3.1 Declaration of Satisfactory Immigration Status), and
 - Are "Qualified Immigrants" (see Section 4.3.3.1 Qualifying Immigrants), or
 - Are "Lawfully Present" (see Section 4.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant Women), 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 4.3.2 Verification). Prior to verification of immigration status, benefits may also be issued for a temporary period under a Reasonable Opportunity Period (see Section 4.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status).

4.3.1 Declaration of Satisfactory Immigration Status

To qualify for BadgerCare Plus, 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 Section 4.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status). 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.

4.3.2 Verification

Primary verification of immigration status is done through the Department of Homeland Security 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 through 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 Department of Homeland Security will research the alien's records and complete the response portion of the verification request.

See Process Help, Section 82 SAVE 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 4.3.2.1 Reverification of Immigration Status). 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.

4.3.2.1 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.

4.3.2.2 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 4.3.2.1 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 BadgerCare Plus, so the worker confirms BadgerCare Plus 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 BadgerCare Plus, 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.

4.3.3 Immigrants Eligible for BadgerCare Plus

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.

4.3.3.1 Qualifying Immigrants

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

1. A refugee admitted under *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 BadgerCare Plus even if his or her *immigration status* later changes.

2. An asylee admitted under *INA* Section 208. Similar to a refugee, an asylee 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 BadgerCare Plus 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 BadgerCare Plus 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 BadgerCare Plus even if his or her immigration status later changes.

Haitians paroled into the U.S. through the Haitian Family Reunification Parole Program are considered Cuban/Haitian entrants.

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). See Section 4.3.11 Victims of Trafficking.

7. An immigrant lawfully admitted for permanent residence under *INA* 8 USC 1101 et seq.*

8. An immigrant paroled into the U.S. under *INA* Section 212(d)(5).*

9. An immigrant 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:

- Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces (see Section 4.3.10 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 4.3.10 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
- Certain Amerasian immigrants 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 4.3.6 Continuous Presence)

4.3.3.2 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:

- Are lawfully admitted for permanent residence (see Registration Status Code #1 in the Immigration Status Chart in Section 4.3.8)
- Are lawfully present under Section 203(a)(7) (see Code #3 in the Immigration Status Chart in Section 4.3.8)
- Are lawfully present under Section 212(d)(5) (see Code #6 in the Immigration Status Chart in Section 4.3.8)
- Have suffered from domestic abuse and are considered to be a battered immigrant (See Code #16 in the Immigration Status Chart in Section 4.3.8)

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.

Example 2: Rose has an immigration status that requires a five-year waiting period before being eligible for BadgerCare Plus. Her date of entry to the U.S. was two years ago, so she is not eligible for BadgerCare Plus. In March, Rose reports that she is pregnant. She meets the other financial and nonfinancial requirements, so she is determined eligible for BadgerCare Plus as a pregnant woman. Rose's last day of pregnancy is September 5. The 60th day after her last day of pregnancy is November 4, so Rose's BadgerCare Plus coverage will end November 30. Starting in December, Rose is again subject to the five-year waiting period from her date of entry to the U.S.

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 if they are lawfully present in the U.S. under many of the immigrant and nonimmigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20 (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 (e.g., someone with a status of *DACA*) and who apply for BadgerCare Plus and meet all eligibility requirements except for citizenship and immigration status are entitled to receive BadgerCare Plus Emergency Services only (see Chapter 39 Emergency Services).

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

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

4.3.4 Public Charge

The receipt of BadgerCare Plus 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 BadgerCare Plus, 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.

4.3.5 Immigration and Naturalization Service Reporting

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

4.3.6 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 of 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

4.3.7 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 3: The legal status conferred on a non-citizen by immigration law— Toshi entered the U.S. February 2, 2004, with qualified immigrant status. She is applying for BadgerCare Plus in February 2008. The IM worker should first determine 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 BadgerCare Plus. She can be enrolled in BadgerCare Plus after February 2, 2009.

Example 4: 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 BadgerCare Plus if he meets other financial and non-financial criteria.

Example 5: Katrin entered the U.S. March 3, 1995, and gained qualified immigrant status June 20, 1995. She is applying for BadgerCare Plus in February 2008. She is a qualified immigrant who entered the U.S. prior to August 22, 1996. There is no need to apply the five-year ban. She is eligible for BadgerCare Plus if she meets other financial and non-financial criteria.

Example 6: Juan entered the U.S. as an undocumented immigrant on April 1, 1996. He applied for BadgerCare Plus on February 1, 2008. His immigration status changed to lawful permanent resident on March 3, 2005. He has signed a self-declaration stating he remained continuously present in the U.S. between April 1, 1996, and March 3, 2005. Additionally, Juan provided a copy of a lease showing a date prior to August 1996. He is eligible for BadgerCare Plus if he meets other financial and non-financial criteria.

Example 7: 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 BadgerCare Plus 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 BadgerCare Plus after October 31, 2009.

Example 8: 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.

4.3.8 Immigration Status Chart

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 age 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	Eligible	Eligible	Eligible	Eligible	Eligible

	Section 208					
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 Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective 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 4.3.11 Victims of Trafficking for more information.

4.3.9 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

4.3.9.1 Counting Refugee-Related Income

Refugee Cash Assistance Program payments are not counted as income for BadgerCare Plus. Refugee Cash Assistance is administered by **W-2** agencies and is made available for refugees who do not qualify for W-2.

Refugee "Reception and Placement" payments are not counted as income for BadgerCare Plus. Reception and Placement payments are 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.

4.3.9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for BadgerCare Plus, he or she may apply for Refugee Medical Assistance, which is not funded by BadgerCare Plus. Refugee Medical Assistance is a separate benefit from BadgerCare Plus 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 BadgerCare Plus subprograms is tested first.

More information about this program is in the 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.

4.3.10 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.

4.3.11 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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5 Medical Support and Third Party Liability

5.1 Medical Support

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

5.1.1 Recovery of Birth Costs

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

5.1.2 Referral to Child Support Agencies

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 BadgerCare Plus applications and person adds that include minors eligible under a Medicaid (T19) Medical Status Code, unless the referral field on the Absent Parent Page is answered 'No'. The information on the Absent Parent Page must be filled out accurately and to the best of the worker's ability, given that detailed questions about absent parents cannot be asked during the application process for health care-only applications. The referral will still be sent to the CSA, even if the absent parent's name is unknown.

Note: A Referral to Child Support form (DCF-F-DWSP3080) only needs to be completed when the Absent Parent page cannot be completed in **CWW**.

Note: While IM agencies are to continue referring the following individuals who are receiving BadgerCare Plus, the CSAs 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 BadgerCare Plus is requested or being received, must be referred to the local CSA unless an exception is noted:

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

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

Exception: Do not refer pregnant women receiving the BadgerCare Plus Prenatal Benefit to CSA.

2. **Child receiving SSI** only if the parent or caretaker relative requests child support services for the child. Do not sanction this parent or caretaker relative if 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 (IMM, Ch. I, Appendix 29g) has been completed,
- b. Both parents are in the home.

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

Note: If a father's name appears on a Wisconsin Birth Certificate for a child born after May 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 not legitimized after their marriage.

Do not refer the following:

- Former Foster Care Youth unless the youth is also the parent of an eligible child in the household.
- Pregnant women eligible under the BadgerCare Plus Prenatal Program.
- People residing in domestic abuse shelters. Once a person moves out of a domestic abuse shelter, complete the Absent Parent page in CWW so that the referral is sent to the CSA.

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5.2 Medical Support/Child Support Agency Cooperation

5.2.1 Introduction

Unless the person is exempt or has *good cause* for refusal to cooperate (see Section 5.2.2 Exemptions from Cooperation and Section 5.3 Claiming Good Cause), each applicant or member that is referred must, as a condition of eligibility, cooperate in both of the following:

- Establishing the paternity of any child born out of wedlock for whom BadgerCare Plus is requested or received
- Obtaining medical support for the applicant and for any child for whom BadgerCare Plus 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:

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

5.2.2 Exemptions from Cooperation

The caretaker relative is exempt from the requirement to cooperate and exempt from any sanction for non-cooperation if:

1. The child under his or her care is eligible for benefits funded under any source other than Title 19, such as Title 21 (Separate CHIP) or General Purpose Revenue (i.e., state funds). Check the BadgerCare Plus categories table in Section 51.1 BadgerCare Plus Categories to determine funding source. The CSA will monitor the child's BadgerCare Plus funding source.
2. The child under his or her care is on SSI.
3. The caretaker relative is:
 - a. Eligible for the BadgerCare Plus Extension,
 - b. A pregnant woman, until the end of the month in which the 60th day after the termination of pregnancy occurs.
 - c. Under 18 years old.
4. Both absent parents are now living in the home with the child.

5. Absent parent is deceased.
6. Paternity has been established and the father is living in the home with the mother and child.
7. The only parent absent from the home is absent because of military service.

5.2.3 Failure to Cooperate

The CSA determines if there is non-cooperation for people required to cooperate. The **IM** agency determines if good cause exists (see Section 5.3 Claiming Good Cause) and whether the applicant or member is exempt (See Section 5.2.2 Exemptions from Cooperation). If there is a dispute, the CSA makes the final determination of cooperation while the IM agency makes the final determination of exemptions or good cause. The member remains ineligible until he or she cooperates or establishes good cause or his or her cooperation is no longer required.

Note: If the local CSA determines that a parent is not cooperating because court-ordered birth costs are not paid, the parent or caretaker may not be sanctioned.

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

Mary is not eligible for EBD Medicaid or BadgerCare Plus 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 BadgerCare Plus.

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5.3 Claiming Good Cause

5.3.1 Claiming Good Cause Introduction

Any parent or other *caretaker relative* who is required to cooperate in establishing paternity and obtaining medical support may claim *good cause*. He or she must do the following:

- Specify the circumstance that is the basis for good cause.
- Corroborate the circumstance according to the evidence requirements in Section 5.3.5 Evidence.

5.3.2 Notice

The *IM* agency must provide a Good Cause Notice (DWSP 2018) to *applicants* and members whenever a child with an absent parent is part of the BadgerCare Plus application or case. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support.

Note: Good Cause Notices are provided automatically through ACCESS when people apply or complete renewals online, so the requirement for IM workers to furnish the notice directly to them does not apply in these situations. IM agencies must continue to mail a Good Cause Notice to people who apply or complete renewals by mail or by phone.

The IM worker and the parent or caretaker must sign and date the notice (except for when the notice is completed in ACCESS and automatically filed in the *ECF*). The IM worker must then file the original notice in the case record and give the *applicant* or member a copy. The *CSA* refers anyone who wants to claim good cause back to the IM agency for a determination of whether or not good cause exists.

5.3.3 Good Clause Claim

The Good Cause Claim form (DWSP 2019) must be provided to any BadgerCare Plus 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 or member's signature initiates the claim.

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

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

5.3.4 Circumstances

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

- The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to one of the following:
 - **Child.** This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected.
 - **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.
- 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:
 - The child was conceived as a result of incest or sexual assault.
 - A petition for the child's adoption has been filed with a court.
 - The parent or caretaker is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

5.3.5 Evidence

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

The following may be used as evidence:

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

- Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records that indicate the alleged father or absent parent might inflict physical or emotional harm on the member or the child.
- Medical records that give the emotional health history and present emotional health status of the member or the child.
- A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the member or the child.
- 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.
- A sworn statement from someone other than the member with knowledge of the circumstance on which the claim is based.
- Authorization card or other proof from Safe at Home confirming the person's status as a program participant in the Safe at Home program. Safe at Home can be contacted by calling 608-266-6613 or emailing safeathome@doj.state.wi.us.
- 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 all of the following:

- Person's present emotional state
- Person's emotional health history
- Intensity and probable duration of the emotional impairment
- Degree of cooperation required
- 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.
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 10 days from the notification date, good cause will not be found and that he or she may first:

- Withdraw the claim and cooperate, or
- Exclude allowable individuals, or
- Request a hearing, or
- Withdraw the application or request that the case be closed.

If no option above has been taken when the 10 days have expired, the IM worker will deny BadgerCare Plus to the applicant or disenroll the member from BadgerCare Plus. The sanctions remain in effect until there is cooperation or until it is no longer required.

5.3.6 Investigation

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

Good cause must be granted when both the member's statement and the investigation satisfies the worker that 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 the agency's intention. Once notified, the parent or caretaker has 10 days from the notification date to do one of the following:

- Present additional supporting or corroborative evidence of information so that contact is unnecessary.
- Exclude allowable individuals.
- Withdraw the application or request that the case be closed.
- Request a hearing.

If the 10 days have expired and no option has been taken, the IM agency will deny BadgerCare Plus to the applicant, and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

5.3.7 Determination

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

- The IM agency cannot obtain the information needed to verify the claim within the 45 days, or
- The parent or caretaker does not submit corroborative evidence within 20 days.

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

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

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

If a fair hearing is requested on a good cause determination, BadgerCare Plus 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 worker must notify the applicant or member in writing of the final determination and of the right to a fair hearing and send the CSA a copy. The CSA may also participate in any fair hearing.

5.3.8 Good Cause Found

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

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

1. First notify the person of the determination and the proposed directive to the CSA to proceed without his or her participation.
2. The person has 10 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 10 days, direct the CSA to proceed if no option was taken. The CSA may decide to not proceed based on its own assessment.

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

5.3.9 Good Cause Not Found

When good cause is not granted, the IM agency must notify the parent or caretaker. It must be stated in the notice that the parent or caretaker has 10 days from the notification date to do one of the following:

- Cooperate.
- Exclude allowable individuals.
- Request a hearing.
- Withdraw the application.
- Request that the case be closed.

If the 10 days have expired, no option has been taken, and the member is in non-cooperations status, the IM agency must terminate the member's BadgerCare Plus eligibility. Sanctions remain in effect until there is cooperation or it is no longer an issue. The IM agency will continue to refer the case to the CSA.

5.3.10 Review

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

The parent or caretaker must be notified when it is determined that good cause no longer exists. It must be stated in the notice that he or she has 10 days from the notification date to do one of the following:

- Cooperate.
- Exclude allowable individuals.
- Request that the case be closed.
- Request a hearing.

If the 10 days have expired and no option has been taken, the IM agency must deny the individual's BadgerCare Plus eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

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5.4 Cooperation Between IM & CSA

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

5.4.1 Information

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists them in providing medical support services. Therefore, the CSA may request information from the IM agency in addition to that included in the referral and as contained in the case record.

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

5.4.2 BadgerCare Plus Discontinued

The CSA is notified through CARES when BadgerCare Plus is discontinued.

5.4.3 Failure to Cooperate

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

5.4.4 Fraud

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

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5.5 Third Party Liability

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

5.5.1 TPL Cooperation

All BadgerCare Plus 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 BadgerCare Plus is received. In addition, BadgerCare Plus 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.

5.5.2 TPL Cooperation Requirements

The BadgerCare Plus 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 BadgerCare Plus, the adult is ineligible until he or she cooperates.

Do not sanction the following for non-cooperation:

1. Minors, including minor caretaker relatives.
2. A parent or caretaker relative requesting child support services for a child receiving SSI.
3. Pregnant woman - She may not be sanctioned during the pregnancy, or for two months after the pregnancy has ended, if the TPL source is the absent parent of her child(ren).

5.5.3 TPL Good Cause Claim

When good cause is claimed (see Section 5.3 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.

5.5.4 Assignment Process

At application, the IM agency must give a Notice of Assignment: Child Support, Family Support, Maintenance, and Medical Support (DCF-F-DWSP2477) (available in English, Hmong, and Spanish) to each **applicant**. If the applicant refuses to sign this form, the IM agency must complete the lower portion of the form and file it in the case record. This must be done no later than at the time of the interview. The applicant must be given a copy of the notice. Processing a BadgerCare Plus application must not be delayed while waiting for the form to be signed. The member should not be penalized for not signing this form. The original copy must be filed in the case record.

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5.6 Casualty Claim Process (Subrogation)

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

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

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

5.6.1 Reporting Accident or Injury Claims

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

More information can be found at www.wicasualty.com/wi/index.htm.

Note: 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 via phone their local agency and any HMO or MCO that may have provided services, before the case is settled. Members should include the date of the accident and any insurance/attorney information.

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5.7 Other Health Insurance

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

5.7.1 Policies Not to Report

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

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

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6 Social Security Requirements

6.1 Social Security Number Requirements

6.1.1 Overview of Social Security Number Requirements

BadgerCare Plus 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 9.9.1 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 9.9.1 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.

6.1.2 Social Security Number Exceptions

Do not require an SSN for:

- Continuously eligible newborns.
- Pre-adoptive infants living in a foster home.
- Non-qualifying immigrants applying for or receiving emergency services or BadgerCare Plus Prenatal benefits.
- Someone without an SSN who may only be issued one for a valid non-work reason.
- Tax dependents or tax filers living outside the home.
- 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 an SSN due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

6.1.3 Social Security Number 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 an 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 **SSA**. The applicant or member may request that 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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7 Health Insurance Access and Coverage Requirements

7.1 Health Insurance Conditions of Eligibility

To prevent the crowd out of private insurance, BadgerCare Plus benefits may be denied or terminated for people who have current health insurance coverage **or** have access (or have had access) to certain employer-sponsored health insurance policies when those people:

- Are children ages 1 through 5 with household incomes over 191 percent of the **FPL** and children ages 6 through 18 with household incomes over 156 percent of the FPL,
 - Are pregnant women eligible under the BadgerCare Plus Prenatal Program at any income level,
 - Are not in an exempt category (see list below) and,
 - Do not have a **good cause** reason for failure to enroll in an employer-sponsored health insurance plan

The following people are exempt from the policies related to employer-sponsored health insurance access and coverage:

- Infants younger than 1 year old
 - Children younger than 19 years old who have met a deductible (exempt only during the deductible period)
 - Children who are in an extension
 - Children ages 1 through 5 (up to age 6) with household income at or below 191 percent of the FPL
 - Children ages 6 to 18 with household income at or below 156 percent of the FPL
- Former Foster Care Youth
- Pregnant women and pregnant minors, other than those in the BadgerCare Plus Prenatal Program
- All adults 19 years old or older

BadgerCare Plus Prenatal Program members are subject to different policies related to health insurance coverage. Refer to Section 7.4. Current Health Insurance Coverage for the policies regarding the rules for current coverage under the BadgerCare Plus Prenatal Program.

Health insurance conditions that impact eligibility include:

- Past access (see Section 7.2 Past Access to Health Insurance)
- Current access (see Section 7.3 Current Access to Health Insurance)

- Coverage (see Section 7.4 Current Health Insurance Coverage)

IM workers are not responsible for determining current or past access to health insurance. The process will be done through the Employer Verification of Health Insurance database (see Section 9.9.6.1 Employer Verification of Health Insurance [EVHI] Database).

Childless adults are not eligible for BadgerCare Plus if they are enrolled in any part of Medicare.

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7.2 Past Access to Health Insurance

7.2.1 The Past Access Test

The Past Access Test policies apply to non-exempt children (see Section 7.1 Health Insurance Conditions of Eligibility). These children and any BadgerCare Plus Prenatal Program members who had access to health insurance, including access due to a qualifying event, in the 12 months prior to the application or renewal date are not eligible for BadgerCare Plus benefits if the access was through the current employer of an adult family member who is currently living in the household and,

1. The access was to a HIPAA health insurance plan through a current employer for which the employer paid at least 80 percent of the premium, or through the state of Wisconsin's health care plan (regardless of plan type or premium amount contributed by the employer); and
2. The applicant is a child under age 19 and child is not exempt; **and**
3. There is no good cause reason for not signing up for the coverage.

The child or BadgerCare Plus Prenatal Program member is ineligible for BadgerCare Plus for 12 calendar months from the date the health insurance would have begun.

Example 1: Marilyn applied for BadgerCare Plus in April 2016 for herself and her children, ages 10 and 8; they have family income that exceeds 156 percent of the FPL. She could have enrolled in a family health insurance plan through her current employer in October 2015, and her employer pays 80 percent of the premium for that plan. Marilyn did not sign up because she felt the premiums, copayments, and deductibles would be unaffordable. If she had signed up, coverage would have begun in December 2015.

Since Marilyn did not sign up for employer-provided coverage within the last 12 months when it was available and she does not have good cause, her children are ineligible for BadgerCare Plus through November 2016, 12 months from the date the coverage would have begun, unless they become exempt during that time. Marilyn is not eligible because her income is over the 100 percent FPL limit for the parent and caretaker coverage group.

7.2.2 Good Cause for the Past Access Test

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

1. Discontinuation of health insurance benefits by the employer;
2. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:
 - a. A private health insurance policy; **or**
 - b. Medicaid, or BadgerCare Plus;

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

- BadgerCare Plus with an assistance group income above 156 percent of the FPL,
 - BadgerCare Plus extension, **or**
 - BadgerCare Plus as a pregnant woman (not including the BadgerCare Plus Prenatal Program).
3. The employment through which the child is insured ended,
 4. The insurance only covers services provided in a service area that is beyond a reasonable driving distance from the person's residence, **or**
 5. Any other reason determined by DHS as a good cause reason. Local agencies must contact the DHS CARES Call Center for approval before granting good cause for any reason not stated above.

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7.3 Current Access to Health Insurance

7.3.1 The Current Access Test

The Current Access Test policies apply to non-exempt children (see Section 7.1 Health Insurance Conditions of Eligibility). These children and BadgerCare Plus Prenatal Program members with access to health insurance, including access due to a *qualifying event*, through an employed family member who is currently living in the household are not eligible for BadgerCare Plus benefits if:

1. The access is to a *HIPAA* health insurance plan through a current employer for which the employer pays at least 80 percent of the premium or the state of Wisconsin's health care plan (regardless of plan type, or premium amount contributed by state or local government); and
2. The *applicant* or member is a child under age 19 and the child is not exempt; and
3. The coverage would begin within three calendar months following:
 - a. The BadgerCare Plus application *filing date*; **or**
 - b. Annual review month; **or**
 - c. Employment start date

The child or BadgerCare Plus Prenatal Program member who could have been covered by the health insurance plan is ineligible for BadgerCare Plus benefits. Children under 19 years of age can become eligible by meeting a *deductible* (see Chapter 17 Deductibles)

Note: There are no good cause reasons for not enrolling in a health insurance plan when a person has current access.

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

Example 2: Bill applies for BadgerCare Plus in January for himself and his family. He can enroll in family health insurance through his employer and the employer pays 80 percent of the premium. Coverage would start in April. Bill chooses not to sign up because he thinks he will be eligible for BadgerCare Plus. His children are not eligible for BadgerCare Plus because Bill can sign up in this month and coverage would begin within the next three calendar months. Bill is not eligible because his income is over the limit for the parent and caretaker coverage group.

7.3.2 Good Cause for the Current Access Test

The only good cause reason for failing to enroll in a currently available employer-sponsored health insurance plan is that the insurance only covers services provided in a service area that is beyond a reasonable driving distance from a person's residence.

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7.4 Current Health Insurance Coverage

7.4.1 The Current Coverage Test for Children

The Current Coverage Test policy applies to non-exempt children (see Section 7.1 Health Insurance Conditions of Eligibility). These children who currently have individual or family health insurance coverage through an employed family member currently living in the household **and** who meets the following criteria are not eligible for BadgerCare Plus:

1. The child is not exempt from access and coverage policies (see Section 7.1 Health Insurance Conditions of Eligibility); **and**
2. Coverage is provided by an employer; and the employer pays at least 80% of the premium **or**
3. Coverage is available under the state of Wisconsin employee health plan (regardless of plan type or premium amount contributed by state or local government), **and**
4. The insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

Example 1: Dave applies for BadgerCare Plus in March for his family. The children's income exceeds 191 percent of the *FPL*. Dave is currently covered by family health insurance through his employer and the employer pays 80 percent of the premium. His children are not eligible for BadgerCare Plus because they are currently covered.

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

7.4.2 Current Coverage Test for BadgerCare Plus Prenatal Program

Pregnant women who are otherwise eligible only for the BadgerCare Plus Prenatal Program are not eligible for the BadgerCare Plus Prenatal Program if they are covered by any *HIPAA* health insurance policy. The plan does not have to be employer-sponsored, but the insurance must cover services provided in a service area that is within a reasonable driving distance from the woman's residence.

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7.5 Access and Coverage Overviews

7.5.1 Access and Coverage Overview for New Applicants

To determine whether or not an individual passes BadgerCare Plus insurance access and coverage requirements, answer the following questions for each individual within a BadgerCare Plus group.

1. Is the applicant or member a pregnant woman otherwise eligible for the BadgerCare Plus Prenatal Program?
 - If yes, go to Section 7.5.2 BadgerCare Plus Prenatal Program Insurance Access and Coverage Overview to determine whether she passes the insurance access and coverage requirements.
 - If no, continue to question 2.
3. Is the applicant or member:
 - a. Age 19 or older,
 - b. Pregnant,
 - c. Under age 1, or
 - d. A Former Foster Care Youth
 - If yes, the applicant or member is not subject to the access and coverage requirements.
 - If no, continue to question 3.
3. Is the member a child younger than 19 years old and currently eligible for BadgerCare Plus because a child's 150 percent deductible was met?
 - If yes, the member is not subject to the access and coverage requirements during the deductible period.
 - If no, continue to question 4.
4. Is the member in a BadgerCare Plus extension?
 - If yes, the applicant or member is not subject to the access and coverage requirements.
 - If no, continue to question 5.
6. Is the applicant or member one of the following:

- a. A child 1 through 5 years old with household income at or below 191 percent FPL
 - b. A child 6 through 18 years old with household income at or below 156 percent FPL
 - If yes, the applicant or member is not subject to the access and coverage requirements.
 - If no, continue to question 6.
6. Does he or she have access to or coverage under health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult member of the BadgerCare Plus test group?
 - If yes, continue to question 7.
 - If no, continue to question 11.
7. Does the employer pay 80 percent or more of the premium?
 - If yes, continue to question 9.
 - If no, continue to question 8.
8. Is the employer-provided insurance the Wisconsin state employee health plan (regardless of plan type or premium amount contributed by state or local government)?
 - If yes, continue to question 9.
 - If no, continue to question 11.
10. Is the coverage current or would the coverage begin in any of the three calendar months after one of the following:
 - a. The month of BadgerCare Plus application filing date
 - b. The annual review month
 - c. The employment start date
 - If yes, continue to question 10.
 - If no, continue to question 11.
10. Does the insurance cover services provided in a service area that is within a reasonable driving distance from the individual's residence?
 - If yes, the applicant or member is not eligible for BadgerCare Plus benefits.

- If no, continue to question 11.
11. Did the applicant or member have access to employer-provided health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult in the BadgerCare Plus test group in the twelve months prior to the application or review date?
- If yes, continue to question 12.
 - If no, the applicant or member passes the BadgerCare Plus insurance access and coverage requirements.
12. Would the employer have paid 80 percent or more of the premium (at any time in the last 12 months)?
- If yes, continue to question 14.
 - If no, continue to question 13.
13. Would the employer-provided insurance be under the Wisconsin state employee health plan (regardless of plan type or premium amount contributed by state or local government)?
- If yes, continue to question 14.
 - If no, the applicant or member passes the BadgerCare Plus insurance access and coverage requirements.
14. Did the applicant or member have "good cause" for failure to enroll in an employer-sponsored health insurance plan in the 12 months prior to the application (see Section 7.2.2 Good Cause for the Past Access Test)?
- If yes, the applicant or member passes the BadgerCare Plus insurance access and coverage requirements.
 - If no, the applicant or member is ineligible for BadgerCare Plus for 12 months from the date the coverage would have begun unless he or she becomes exempt from health insurance/access coverage requirements during that time.

7.5.2 BadgerCare Plus Prenatal Program Insurance Access and Coverage Overview

Use this overview **only** for the BadgerCare Plus Prenatal Program. The BadgerCare Plus Prenatal Program is for pregnant women who are not eligible for BadgerCare Plus solely due to immigration status or due to being an inmate.

1. Does she have access to health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult member of the BadgerCare Plus test group?
 - If yes, continue to question 2.
 - If no, continue to question 6.
2. Does the employer pay 80 percent or more of the premium?
 - If yes, continue to question 4.
 - If no, continue to question 3.
3. Is the employer-provided insurance the Wisconsin state employee health plan (regardless of plan type or premium amount contributed by state or local government)?
 - If yes, continue to question 4.
 - If no, continue to question 6.
5. Would the coverage begin in any of the three calendar months after one of the following:
 - a. The month of BadgerCare Plus Prenatal application filing date
 - b. The annual review month
 - c. The employment start date
 - If yes, continue to question 5.
 - If no, continue to question 6.
5. Does the insurance cover services provided in a service area that is within a reasonable driving distance from the individual's residence?
 - If yes, the applicant or member is not eligible for BadgerCare Plus benefits.
 - If no, continue to question 6.
6. Did she have access to employer-provided health insurance, including access due to a qualifying event, through a current employer or the current employer of an adult in the BadgerCare Plus test group in the twelve months prior to the application or review date?

- If yes, continue to question 7.
 - If no, continue to question 10.
7. Would the employer have paid 80 percent or more of the premium (at any time in the last 12 months)?
- If yes, continue to question 9.
 - If no, continue to question 8.
8. Would the employer-provided insurance be under the Wisconsin state employee health plan (regardless of plan type or premium amount contributed by state or local government)?
- If yes, continue to question 9.
 - If no, continue to question 10.
9. Did she have "good cause" for failure to enroll in an employer-sponsored health insurance plan in the 12 months prior to application (see Section 7.2.2 Good Cause for the Past Access Test)?
- If yes, continue to question 10.
 - If no, she is ineligible for the BadgerCare Plus Prenatal Program 12 months from the date the coverage would have begun unless she becomes exempt during that time.
10. Is the woman covered by any HIPAA health insurance policy (either private or employer provided)?
- If yes, continue to question 11.
 - If no, she passes BadgerCare Plus Prenatal insurance access and coverage requirements.
11. Does the insurance cover services provided in a service area that is within a reasonable driving distance from the individual's residence?
- If yes, the applicant or member is not eligible for BadgerCare Plus benefits.
 - If no, she passes BadgerCare Plus Prenatal insurance access and coverage requirements.

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7.6 Reserved

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7.7 Health Insurance Premium Payment

7.7.1 Introduction

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

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

In addition to families with employer sponsored health insurance plans, the following BadgerCare Plus families may also be considered for HIPP:

- Farm and other self-employed families
- Members with Self-funded insurance plans

Access to HIPP coverage will be allowed even if single or "plus one" coverage is the only coverage offered by an employer.

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

7.7.2 Cost Effectiveness

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

The HIPP Unit will identify the cost of wrapping around the Medicaid services with the employer-sponsored plan and then determine cost effectiveness of buy-in on that calculation of cost comparability.

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

7.7.3 Participation in HIPP

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

7.7.4 Cooperation

Parents may not be sanctioned for failing to cooperate with the HIPP program. This policy applies to both current members and new applicants.

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8 Pregnant Women and Continuously Eligible Newborns

8.1 Pregnant Women

Note: This chapter does not apply to pregnant women in the BadgerCare Plus Prenatal Program.

A pregnant woman who is enrolled in BadgerCare Plus stays eligible for:

- The balance of the pregnancy, and
- An additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs.

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

A pregnant woman with income over 306 percent of the *FPL* at the time of application when her eligibility is first determined can become eligible for BadgerCare Plus by meeting a *deductible* (see Section 17.2 Pregnant Women).

There are no premiums for pregnant women (see Section 19.1 BadgerCare Plus Premiums).

All pregnant women, except those eligible under the BadgerCare Plus Prenatal Program, may have their eligibility backdated to the first of the month up to three months prior to the month of application. If a woman is determined to be eligible as a pregnant woman for a backdated month, she remains eligible, even if she is over the income limit for any subsequent months, as long as she is still pregnant.

Example 1: Barb is pregnant and applied for BadgerCare Plus in December with a three-month backdate request. Barb is due in March. Her income was below 306 percent of the FPL for September, but over 306 percent for October, November, December, and ongoing. She met all of the other eligibility criteria. Since she was determined eligible as a pregnant woman for the month of September, the subsequent increase in her income is ignored and she remains eligible for BadgerCare Plus through the end of the month, which is 60 days after the pregnancy ends.

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8.2 Continuously Eligible Newborns

Newborn children are automatically eligible for BadgerCare Plus from the date of birth through the end of the month in which they turn 1 year old if both the following are true:

1. They are younger than 13 months old.
2. The natural mother was determined eligible in the state of Wisconsin for the month of the birth for one of the following programs:
 - a. BadgerCare Plus
 - b. Other full-benefit Medicaid (see Medicaid Eligibility Handbook Section 21.2 Full-Benefit Medicaid)
 - c. Emergency Services BadgerCare Plus
 - d. Emergency Services Medicaid (see Medicaid Eligibility Handbook Section 34.1 Emergency Services)
 - e. BadgerCare Plus Prenatal Program (as a nonqualifying immigrant)

There is no income or resource test for these children while they are eligible under this status; therefore, they are not required to provide any income tax filing information in order for their BadgerCare Plus eligibility to be determined.

Note: Children born to incarcerated mothers who are only eligible for the BadgerCare Plus Prenatal Program on the date of the child's birth will not be eligible as **CENs**.

A child whose natural mother's eligibility was determined either prior to the date of delivery or retroactively to cover the date of delivery qualifies as a CEN.

Example: Sasha gave birth on April 15. On June 15, she applied for BadgerCare Plus. Her eligibility was backdated to March 15. Her infant son is eligible as a CEN from April 15 through April 30 of the following year, the end of the month in which he turns 1 year old.

The newborn child does not receive this automatic eligibility as a CEN if the mother is temporarily enrolled in BadgerCare Plus (see Chapter 32 Presumptive Eligibility).

A newborn is not required to reside with his or her mother to be eligible as a CEN. This is true even if the newborn is being placed in foster care, adoption, or is residing with a **caretaker relative**. A CEN who no longer resides with his or her mother but still resides in Wisconsin should remain eligible as a CEN through the end of the month in which he or she turns 1 year old.

Anyone who has ever been eligible as a CEN under Wisconsin Medicaid or BadgerCare Plus is exempt from the citizenship and identity documentation requirements.

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

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9 Verification

9.1 Verification

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

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

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9.2 Application

The time period for processing an application for BadgerCare Plus is 30 days from the date the agency receives the application. For paper applications, this is the date a signed valid application is delivered to the agency or the next business day if it is delivered after the agency's regularly scheduled business hours. For phone applications, this is the date a valid signature is received by the agency. For electronic applications from ACCESS or the Marketplace, this is the next business day if the application is delivered after 4:30 p.m., on a weekend, or on a holiday.

Note: The date received may be different from the filing date. See Section 25.6 Filing Date for information on the filing date.

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

- 10th day after requesting verification, or the
- 30th day after the application filing date.

Advise the applicant of the specific verification required. Give the applicant a minimum of 10 calendar days to provide any necessary verification.

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

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9.3 Eligibility Renewals

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

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

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 BadgerCare Plus 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.

Requested verification turned in within three months of the renewal due date should be processed as timely (see Section 26.1.2 Three-Month Late Renewals).

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9.4 Changes

When a change is reported that requires verification, the member must be notified in writing of the specific verification required and allowed a minimum of 10 days to provide it.

9.4.1 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 will 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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9.5 Documentation

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

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

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

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

Document in the case comments:

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

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9.6 Collateral Contacts

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

While performing a collateral contact:

1. Do not disclose that an individual has applied for public assistance.
2. Do not disclose more information than is absolutely necessary to get the information being sought.
3. Do not disclose any information supplied by the applicant .
4. Do not suggest that the applicant is suspected of any wrongdoing.

9.6.1 Documenting Verbal Statements and Collateral Contacts

Documentation of collateral contacts must include:

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

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9.7 Release of Information

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

When a source requires a written release:

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

Benefits should be denied, discontinued or reduced only when:

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

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9.8 General Rules

1. Avoid over-verification (requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility). Do not require additional verification once the accuracy of a written or verbal statement has been established.
2. Do not verify information already verified unless there is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, determine if a referral for fraud or for front-end verification should be made (see Section 9.10.1).
3. Do not exclusively require one particular type of verification when various types are adequate and available.
4. Verification need not be presented in person. Verification may be submitted by mail, fax, e-mail, or through another electronic device or through an *authorized representative*.
5. Do not target special groups or persons on the basis of race, religion, national origin or migrant status for special verification requirements.
6. Do not require the member to sign a release form (either blanket or specialized) when the member provides required verification.
7. Do not require verification of information that is not used to determine eligibility.

Except for verification of access to employer-sponsored health insurance (see Section 9.9.6 Access to Employer-Sponsored Health Insurance), Child Welfare parent cooperation (see Section 10.1 Child Welfare Parent or Caretaker Relative), and former Foster Care status (see Section 11.2 Former Foster Care Youth), 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, unless the information from the data source is not reasonably compatible with what the applicant or member has reported (see Section 9.12 Reasonable Compatibility for Health Care).

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 or 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 or member when requesting verification.

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9.9 Mandatory Verification Items

The following items must be verified for BadgerCare Plus:

- **SSN**
- Citizenship and identity (see Section 4.2 Documenting Citizenship and Identity)
- Immigrant status
- Medical expenses (for deductibles only)
- Documentation for Power of Attorney and Guardianship
- Migrant worker's eligibility in another state (see Section 12.3 Simplified Application)
- Income
- Health insurance access
- Health insurance coverage (see Chapter 7 Health Insurance Access and Coverage Requirements)
- Family re-unification plan for child welfare parents (see Chapter 10 Child Welfare Parents)
- The placement status of a Former Foster Care Youth (Chapter 11 Foster Care Medicaid) on his or her 18th birthday
- Tribal membership or Native American descent
- Pre-tax deductions
- MAGI tax deductions

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

Do not request income verification from health care applicants and members unless the information cannot be obtained through an electronic data source, or information from the data source is not reasonably compatible with what the applicant or member has reported (see Section 9.12 Reasonable Compatibility).

9.9.1 Social Security Number

Social security numbers (SSNs) need to be furnished for household members requesting BadgerCare Plus unless they are exempt from the SSN requirement (see Section 6.1 Social Security Number Requirements). SSNs are not required from non-applicants, including outside of the home tax dependents and co-filers.

An **applicant** is not required to provide a document or Social Security card. 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 an 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 4.2.4.4 Reasonable Opportunity Period for Verification of Citizenship).

9.9.1.1 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:

1. Recommend further action be taken.

and/or

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

Verify the SSN only once.

9.9.1.2 Newborns

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

Do not require an SSN to be furnished or applied for on behalf of a newborn determined continuously eligible (see Section 8.2 Continuously Eligible Newborns) for BadgerCare Plus. Accept the parent's statement about the existence and residence of the newborn.

9.9.1.3 BadgerCare Plus Emergency Services

Do not require or verify SSNs of people applying for BadgerCare Plus Emergency Services only (see Chapter 39 Emergency Services).

9.9.1.4 BadgerCare Plus Prenatal Program

Do not require or verify SSNs of people applying for the BadgerCare Plus Prenatal Program (see Section 41.1 BadgerCare Plus Prenatal Program).

9.9.2 *Immigrant 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 Chapter 41 Badger Care Plus Prenatal Program) and people applying for Emergency Services (see Chapter 39 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 4.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status).

9.9.3 Pregnancy

Verification is not required for pregnancy unless the worker has information that contradicts the applicant or member's statement.

If pregnancy information is questionable, acceptable verification sources are:

- Physician's statement.
- Physician assistant's statement.
- Licensed nurse practitioner's statement.
- A written statement from a registered nurse working:
 - In a Healthy Birth Identification of Pregnancy Project (EDP).
 - In a Publicly funded family planning project.
 - As a Certified Nurse Midwife.

Note: If pregnancy must be verified, the BadgerCare Plus temporary enrollment card cannot be used as a source of verification, as pregnancy will not be verified for Temporary Enrollment for Pregnant Women (see Chapter 32 Presumptive Eligibility).

9.9.4 Medical Expenses

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

If verification is not provided, do not include the expense to determine when a deductible has been met. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.5 Power of Attorney and Guardianship

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

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 individual unless he or she is an authorized representative. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.6 Access to Employer-Sponsored Health Insurance

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

1. BadgerCare Plus Application and Renewal.
2. Person Add - if adult (age 18 or over) is employed and part of the BadgerCare Plus test group.
3. When an adult (age 18 or over) in the BadgerCare Plus test group gets a new job.
4. When a change is processed causing total household income to exceed the following FPL thresholds:
 - Children ages 1 through 5 (up to age 6), 191 percent of the FPL
 - Children ages 6 to 18, 156 percent of the FPL

9.9.6.1 Employer Verification of Health Insurance Database

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

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

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

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

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

BadgerCare Plus will not be terminated or denied due to an employer failure to respond to a request for verification of health insurance access. If BadgerCare Plus eligibility

begins and an employer later responds to the verification request indicating that health insurance access is available to the employee, BadgerCare Plus eligibility will be terminated with adequate notice of *adverse action*. There will be no overpayment liability for the applicant.

9.9.6.2 Other Forms of Health Insurance Access Verification

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

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

9.9.7 Tribal Membership, Descent, or Eligible to Receive Indian Health Services

The following people are exempt from paying BadgerCare Plus premiums and benefit copayments:

- Members of American Indian and Alaska Native tribes
- Children of members of American Indian and Alaska Native tribes
- Grandchildren of members of American Indian and Alaska Native tribes
- People eligible to receive *IHS*

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

- Tribal Enrollment Card.
- Written verification or a document issued by the tribe indicating tribal affiliation.
- Certificate of degree of Indian blood issue by Bureau of Indian Affairs.
- Tribal census document.
- Medical record card or similar documentation that specifies an individual is an Indian that is issued by an Indian health care provider.
- Statement of Tribal Affiliation, F-00685.

If verification is not provided, do not indicate in CARES that the person is a tribal member. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.8 Pretax Deductions

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

If verification is not provided, do not include the deductions when determining eligibility. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.9 MAGI Tax Deductions

People whose eligibility is determined using *MAGI* rules can claim certain tax deductions from the IRS 1040 Form, regardless of whether or not they file taxes (see Section 16.3.3 Tax Deductions). People who claim such deductions must provide verification that the expense is or was incurred. Verification could include:

- Receipts.
- Bank statements.
- Check stubs.
- Previous years' tax forms.

If verification is not provided, do not include the deductions when determining eligibility. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.10 Former Foster Care Youth

Verification of a person's status as a Former Foster Care Youth is required only at initial application. Verify the status of the youth, including a youth from another state, with the local Child Welfare agency by using the BadgerCare Plus Former Foster Care Youth form, F-10184.

Note: It is not the applicant's responsibility to verify his or her status.

If a Child Welfare agency does not provide verification within 30 days of the application filing date, confirm the person as a Former Foster Care Youth if he or she is otherwise eligible. Once the person is verified as a Former Foster Care Youth, additional verification of that status is not required even if the person becomes ineligible for BadgerCare Plus at some point and later reapplies.

9.9.11 Gross vs Taxable Portion of Pension

If the gross amount of pension and annuity income has been verified, but the taxable amount has not, the gross amount must be used in the BadgerCare Plus or FPOS budget calculation. The individual's benefits will not be terminated or denied due to failure to verify the taxable amount. If neither the gross nor the taxable amount is verified, the individual's benefits will be terminated or denied due to lack of verification.

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9.10 Questionable Items

Information is questionable for BadgerCare Plus 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 or BadgerCare Plus 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 Family Planning Services.
6. The information provided is unclear or vague.
7. **CWW** determines the case meets an automated **EPP**.

9.10.1 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).

9.10.2 Error Prone Profile

The EPP functionality in CWW (see Process Help, Chapter 70 Error Prone Profile) identifies error prone cases at application and renewal and tracks the resolution of identified potential errors. Once an EPP has been detected, affected programs cannot be confirmed until the EPP is resolved or deferred.

EPP identifies three types of potential errors:

- Questionable Income and/or Expenses
- Unresolved Discrepancies
- **IPV**/Overpayment History

9.10.2.1 Questionable Income and/or Expenses

Cases may be identified and tracked by EPP as having questionable income or expenses based on either of the following conditions:

- Expenses exceed income.

- Total income has remained the same for an extended period of time.

9.10.2.2 Unresolved Discrepancies

Cases may be identified and tracked by EPP as having unresolved discrepancies if they have inaccurate or unreported income based on the presence of unresolved **SWICA**, **UIB**, SOLQI, or Prisoner Match discrepancies.

9.10.2.3 Intentional Program Violation or Overpayment History

Cases may be identified and tracked by EPP if they include members who have a history of IPVs or overpayments.

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9.11 Processing Time frame

9.11.1 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 received.

9.11.2 Positive Actions

Begin or continue benefits when:

1. The member provides requested verification within the specified time limits and is otherwise eligible.
2. Requested verification is mandatory, but the member does not have the power to produce the verification and he or she is otherwise eligible. In this situation, the agency must also make an effort to obtain the verification (9.8).

9.11.3 Delay

Notify an applicant when the agency is not able to process the application within 30 days for any reason. The Notice of Decision needs to provide the reason for the delay when all of the following conditions apply:

- Verification is needed.
- The applicant has the power to produce the verification.
- The minimum time period allowed for producing the verification has not passed.
- Additional time is needed to produce the verification.

CARES will generate a notice to the applicant indicating the reason for the delay. If the reason is that verification is needed, the notice will indicate the specific verification or information required and the date the verification or information is due.

9.11.4 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.
- You need the requested verification to determine current eligibility. Do not deny current eligibility because an applicant or member does not verify some past circumstance not affecting current eligibility.

Note: Do not deny or terminate eligibility for failure to verify information that the member is not responsible to obtain, such as employer-sponsored health insurance (see Section 9.9.6 Access to Employer-Sponsored Health Insurance), Child Welfare parent cooperation (see Section 10.1 Child Welfare Parent or Caretaker Relative), and former Foster Care status (see Section 11.2 Former Foster Care Youth). Do not deny or terminate eligibility for failure to verify medical expenses (see Section 9.9.4 Medical Expenses) and deductions (see Section 9.9.8 Pretax Deductions and Section 9.9.9 MAGI Tax Deductions). The disallowance of unverified expenses and deductions is the only penalty to be imposed. Do not deny or terminate eligibility for failure to verify tribal member status (see Section 9.9.7 Tribal Membership, Descent, or Eligible to Receive Indian Health Services).

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9.12 Reasonable Compatibility for Health Care

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, 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 Chapter 16.5) will continue to be verified as outlined in this chapter and in PH 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 PH 16.4.4 and Section 16.2.

9.12.1 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 BadgerCare Plus:

- BadgerCare Plus based on MAGI rules, with the exception of deductibles
- Family Planning Only Services (FPOS) based on MAGI rules

Populations not subject to an income test (for example, Former Foster Care Youth) will not have a reasonable compatibility test.

9.12.2 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 thresholds, the following thresholds will be used by population to determine whether reported information is reasonably compatible. In some cases, the threshold will be a FPL percent, while in others it will be a fixed dollar amount.

Note: 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.

Population	Threshold(s)
Adults (MAGS, MAGA and MAGN)	100% FPL
Children – under age 1	306% FPL
Children – ages 1 through 5	191% FPL Premium thresholds (unless the child is exempt): 201, 231, 241, 251, 261, 271, 281, 291, and 301% FPL 306% FPL
Children – ages 6 through 18	133% FPL 156% FPL Premium thresholds (unless the child is exempt): 201, 231, 241, 251, 261, 271, 281, 291, and 301% FPL 306% FPL
Pregnant women	306% FPL

FPOS	306% FPL
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For populations with multiple thresholds, the lowest threshold that is higher than the reported income is used.

Example 1: Marty and Jen have two sons, Alex (age 9) and Warren (age 4). They apply for BadgerCare Plus and report that Marty has earnings of \$4,055/month. Equifax data is not available. SWICA reports that Marty has earnings of \$4,270/month. For a group size of 4, the reported household income is 189% FPL, while the household income based on SWICA data is 199% FPL. As parents, Marty and Jen are ineligible for BadgerCare Plus based on their reported income of 189% FPL. Each child is subject to a reasonable compatibility test based on the next highest relevant threshold for his age group.

For Alex, at age 9, the reasonable compatibility threshold is 201% FPL. The household's income based on both the reported income and SWICA are below this threshold, so the reasonable compatibility standard is met and no further verification is required for Alex.

For Warren, at age 4, the reasonable compatibility threshold is 191% FPL (the threshold for T19 vs. T21 funding of BadgerCare Plus benefits). The household's income based on reported income is below this threshold, while the household's income based on SWICA is above this threshold. As a result, the amounts are not reasonably compatible and verification must be provided in order for Warren to become eligible.

If the family provides paystubs that show actual monthly income of more than 200% FPL, both children would be subject to a premium based on the income verified by paystubs.

9.12.3 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.

Note: For simplicity, the examples below include households with earned income as the only source of income. It is important to remember that reasonable compatibility is based on the individual's total countable income, not just his or her earned income amount.

Example 2: Joe is a single childless adult with an income limit of \$1,040.83 for BadgerCare Plus. He reports that his earnings are \$500/month. Equifax is not available for his employment. SWICA reports that his quarterly earnings are \$2,700, for a monthly amount of \$830.77. Because his income is below the income threshold using either amount, his reported information is considered to be reasonably compatible with the SWICA reported income, and the agency must use the \$500 amount he reported without requesting additional verification.

Example 3: Lon is a single childless adult with an income limit of \$1,040.83 for BadgerCare Plus. He reports that his earnings are \$900/month. Equifax reports that he is paid twice a month at \$550.50 per month, for a monthly amount of \$1,101.00.

Because there is a difference in the eligibility outcome when applying the Equifax reported income, his reported information is not considered to be reasonably compatible, and the agency must request additional verification.

Example 4: Melanie is a single childless adult with an income limit of \$1,040.83 for BadgerCare Plus. She reports that her earnings are \$1,200/month. CARES will base the denial on this reported income amount, regardless of the income amount from SWICA or Equifax.

Example 5: Michelle applies for BadgerCare Plus for herself and her two children. She reports that she started a job last month and is earning \$1,400/month. Because the job is new, neither SWICA nor Equifax data is available. Since these data exchanges are not available, the reasonable compatibility test will not be performed, and Michelle will be required to verify her earnings using paystubs, an EVF-E form, or other documentation.

Example 6: Katie is a single childless adult with an income limit of \$1,040.83 for BadgerCare Plus. She applies for FS and BadgerCare Plus. She reports that her earnings are \$800/month. Equifax data is not available. SWICA reports that her quarterly earnings are \$2,550, for a monthly amount of \$784.62. Because she is eligible for BadgerCare Plus using either amount, her reported information is considered to be reasonably compatible. The agency must use her reported income for BadgerCare Plus, and based on this amount, she would be made eligible for BadgerCare Plus.

Her FoodShare eligibility, however, will pend for verification of her earnings. If she returns her paystubs and they show income of \$1,200/month, this information would replace the member-reported information and her health care benefits would be terminated. If she failed to provide the requested verification, her FoodShare benefits would be denied but she would continue to remain eligible for BadgerCare Plus.

9.12.4 Determining a Data Exchange-Based Income Amount for the Reasonable Compatibility Test

The following rules will be used to determine the data exchange information that will be used for the reasonable compatibility test:

- If Equifax data is available for a given employment, CWW will apply a reasonable compatibility test for health care using the member-reported information and the data available from Equifax.
- If data from both Equifax and SWICA are available, only Equifax data will be used in the reasonable compatibility test.
- If Equifax data is not available, the system will use SWICA data if it is available as the basis of the reasonable compatibility test.

If SWICA data is used, CARES will divide the most recent quarterly SWICA wages by 13 and multiply by four (4) to determine a monthly amount for use in the test.

If Equifax data is used, the following rules will determine the monthly amount for use in the test:

- For months for which the system is able to confirm that all paycheck information has been received from Equifax, the actual income amount reported by Equifax for that month will be used.
- For months for which the system cannot confirm that all paycheck information has been received, the system will base the monthly amount on the most recent paycheck.
 - If the member is paid weekly, the most recent paycheck will be multiplied by four.
 - If the member is paid biweekly or semi-monthly, the most recent paycheck will be multiplied by two.
 - If the member is paid monthly, the most recent paycheck amount will be used.

9.12.5 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 reported wage amount is the same as the Equifax wage amount, workers may consider the reported wage amount to be verified and use the verification code of “DE – Data Exchange”. If the worker is completing intake during a telephonic application for health care and/or an interview for FoodShare or Child Care, the worker should view the Equifax information during the interview and ask the member if the Equifax-reported

amount is correct. If the member agrees that the Equifax-reported amount is accurate, the worker should use the Equifax-reported amount and a verification code of “DE – Data Exchange.” Because the wage has already been verified, the reasonable compatibility test will not be triggered for this employment.

If the worker is completing intake outside of an interview, and there is a discrepancy between what the member has reported and what Equifax provides, the worker must enter the member-reported information with a verification code of either ? or Q?. For health care programs, this will trigger a reasonable compatibility test. For other programs, this will cause the case to pend for verification of the member-reported amount.

If the member fails to provide verification and does not contact the agency, FoodShare, Child Care and/or W-2 will fail for lack of verification. Health care will fail for any member whose reported income is not reasonably compatible and who failed to provide requested verification.

However, 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 Chapter 9.8). 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.

Example 7: Ryan applies online for himself, his wife, and their child, with a request for health care, Child Care and FoodShare. He reports earnings of \$9.55/hour at 30 hours/week from his job at Walmart on the application. The agency does not process the application until the interview for Child Care and FoodShare. During the interview, FDSH is queried for Equifax data and the worker sees that the most recent weekly paycheck amount was for an hourly rate of \$9.55/hour but for 33 hours/week, for a paycheck of \$315.15. The worker then confirms with Ryan that this amount is correct, enters this amount on the employment page and uses DE as the verification code. Because this information has been reported by the member and verified using Equifax data from the FDSH, it is considered verified for all programs and the reasonable compatibility test is not invoked.

Example 8: Mindy applies online for herself and her 2-year-old twins, with a request for health care, Child Care and FoodShare. She reports \$400/week in earnings from her job at Subway. When the worker processes the application for health care (prior to completing the interview for FoodShare and Child Care), the worker finds that Equifax data is available from the FDSH and that her most recent weekly paycheck is \$490. Because the member-reported and the FDSH-reported amount are different, the worker enters a Q? on the Employment page and runs eligibility. FoodShare and Child Care both pend for interview.

Because the employment amount has not yet been verified, a reasonable compatibility test is invoked for health care. For a group size of three (3), the reported household income is \$1,600/month, or 90% FPL, while the household income based on FDSH data is \$1,960/month, or 110% FPL.

- For Mindy's eligibility as a parent, the reasonable compatibility threshold is 100% FPL. The household's income based on reported income is below this threshold, while the household's income based on FDSH is above this threshold. As a result, the amounts are not reasonably compatible. Verification must be provided in order for Mindy to become eligible.
- For the twins, at age 2, the reasonable compatibility threshold is 191% FPL and no verification is needed. The household's income based on both the reported income and FDSH are below this threshold, so the reasonable compatibility standard is met and no further verification is required for the twins.

When the worker completes the Food Share / Child Care interview, the worker asks Mindy whether the information provided by Equifax is correct. Mindy confirms that it is. The worker can then use the amount provided by Equifax on the employment page and changes the verification to DE. When eligibility is re-run for all programs, the employment is considered verified and no further verification is needed.

Example 9: Same as example 8, except that during the interview, Mindy tells the worker that her hours have changed and that her weekly pay is \$400 and not \$490. The worker should leave the Q? as the verification code for the employment and issue a verification checklist.

- If Mindy provides verification, the worker should use this to verify the income per current process.
- If Mindy fails to provide verification and does not contact the agency, the employment record will be marked as NV, and she will be denied for health care for lack of verification, although her children will continue to remain open because they were reasonably compatible. Both FoodShare and Child Care will fail due to failure to provide requested verification.
- If Mindy contacts the agency to say that she has not been able to obtain verification, the agency must assist with obtaining verification. If verification cannot be obtained, the worker should determine her income based on the "best available" information and document how this was determined in case comments.

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10 Child Welfare Parents

10.1 Child Welfare Parent or Caretaker Relative

Qualifying parents and *caretaker relatives* of children who have been temporarily removed from the home and are in the care of the child welfare system may be eligible for BadgerCare Plus benefits under the parent/caretaker relative category if they meet all the following requirements:

- Their child was living with them at the time the child welfare agency removed the child and placed him or her in:
 - Foster care (both IV-E and non IV-E).
 - Court-ordered Kinship Care.
 - Another living arrangement.

Note: If child welfare is involved and the child welfare agency has established a permanency plan for the child under authority of Wis. Stat. § 48.38 or 938.38, other living arrangements for the children meet this criteria. For example, a child may be placed with grandparents who are not eligible for Kinship Care or a child may be placed with the other parent.

- The parent or caretaker relative is cooperating with a permanency plan, the goal of which is family reunification. Cooperation is always presumed unless the court has determined that reunification will no longer be the permanency goal.
- The caretaker relative meets all other BadgerCare Plus financial and non-financial requirements.

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

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

See Process Help, Chapter 14 Processing a Child Welfare Parents and Caretaker Relative (CWPC) Case, for information on processing the child welfare parent or caretaker relative cases.

The parent or caretaker relative who meets the above requirements is considered caring for a child who is temporarily absent as long as the child lived with the parent or caretaker at the time of removal from the home. For this reason, the parent will continue to be considered a parent or caretaker for purposes of BadgerCare Plus eligibility. However, the child may not always be included in the parent's MAGI group (see Chapter 2 BadgerCare Plus Group).

If the child welfare system places a child with a Kinship Care relative, the Kinship Care relative is no longer considered a caretaker relative (if the parent is enrolled in BadgerCare Plus as a child welfare parent under the policy described above). Instead, the Kinship Care relative may qualify for BadgerCare Plus under the childless adult category. If the parent is not enrolled as a child welfare parent, the Kinship Care relative may enroll in BadgerCare Plus as a caretaker relative.

Example 1: Stacy's child, Jared, was placed in Kinship Care with Stacy's mom Laura, who is 55 years old. Stacy files taxes but will not be claiming Jared as her tax dependent. Laura will claim Jared as her tax dependent. There are no other children, tax filers, or tax dependents in either Stacy's or Laura's households. If they both apply for BadgerCare Plus and meet all financial and non-financial requirements, Stacy will be eligible for BadgerCare Plus as a parent with a group size of one and Laura as a childless adult with a group size of two.

Example 2: Ben's daughter, Megan, was placed in Kinship Care with her grandfather James, who is 60 years old. Ben does not file taxes. James does file taxes and will claim Megan as his dependent that year. There are no other children, tax filers, or tax dependents in either Ben's or James's households. If they both apply for BadgerCare Plus and meet all financial and non-financial requirements, Ben will be eligible for BadgerCare Plus as a parent with a group size of two and James as a childless adult with a group size of two.

Example 3: Consider the details of Example 2, except James is now 66 years old. Under this example, James would not be eligible for BadgerCare Plus because he is a childless adult over 65 years old. He may, however, be eligible for **EBD** Medicaid.

Example 4: Christopher's son, Braden, was placed in Kinship Care with Christopher's sister, Vicki. Christopher is claiming Braden as a tax dependent but is not applying for BadgerCare Plus. If Vicki meets all financial and non-financial

requirements, Vicki would be eligible for BadgerCare Plus as a caretaker relative with a group size of one.

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11 Foster Care Medicaid

11.1 Out-of-Home Care (Foster Care)

Children or youth placed into any of the following placements are categorically eligible for Foster Care Medicaid:

- Foster Care (either IV-E or non-IV-E)
- Subsidized guardianship
- Court-ordered Kinship Care

Eligibility determinations for Foster Care Medicaid are not the responsibility of the *IM* agency. Child welfare agencies determine eligibility for Foster Care Medicaid when a child has been removed from the home and enters an out-of-home care placement, often referred to as Foster Care.

11.1.1 Foster Care Medicaid Certification

Eligibility for Foster Care Medicaid begins on the date the child or youth enters out-of-home care. Paper documentation is not required when certifying children placed in out-of-home care.

Foster Care Medicaid must be certified for no longer than 12 months. Children or youth certified for Foster Care Medicaid through *eWiSACWIS* who remain in placement during the 12th month of eligibility will have their Foster Care Medicaid administratively renewed based on their placement. Children or youth certified for Foster Care Medicaid through other means should be certified for no longer than 12 months and re-certified if the child or youth is still eligible.

11.1.2 Foster Care Medicaid Disenrollment

When a child or adult is discharged from out-of-home care, Foster Care Medicaid eligibility must be maintained until one of the following occurs:

- The person is determined eligible for another category of Medicaid or BadgerCare Plus.
- The child is determined ineligible for all categories of Medicaid and BadgerCare Plus.

- The child or family failed to provide the required information to complete an eligibility determination or chooses not to pursue other Medicaid benefits.
- The child dies or leaves Wisconsin.

When the child or youth is discharged from out-of-home care, the child welfare agency will extend Foster Care Medicaid eligibility under the Foster Care medical status code for an additional three months. During this time, IM agencies are expected to redetermine the child or youth's health care eligibility with assistance from the child welfare agencies, when needed. Child welfare agencies and IM agencies should set up a formal communication process to ensure IM agencies are made aware of all children leaving the Foster Care system, and provided with information necessary to redetermine eligibility.

To help facilitate communication between child welfare and IM agencies, *EM CAPO* will review a biweekly report of children or youth discharged from out-of-home care. EM CAPO will then research the child or youth's eligibility history in CARES.

If the child is returning to a household with an open health care benefit in CARES, EM CAPO will complete the Child or Youth Discharge from Out-of-Home Care Change Report (F-01665) and scan the form to the CARES case to alert workers of a household change.

If the IM agency does not have sufficient information to redetermine Medicaid eligibility, the agency must request needed information from the individual or family. Once the IM agency has enough information, it must determine eligibility for the youth or child as of the date the child returned to the home. If the youth or child is determined eligible, a Notice of Decision must be sent.

If the individual or family does not comply with a request for information after 30 days or if the youth or child is determined ineligible, a Notice of Decision must be sent denying BadgerCare Plus or Medicaid eligibility for the appropriate reasons. In addition, the IM agency must send a manual negative Notice of Decision specifically terminating eligibility for Foster Care Medicaid. The manual notice must be mailed at least 10 days before the Foster Care Medicaid end date. The end date can be found on the Child or Youth Discharge from Out-of-Home Care Change Report.

If the child is not returning to a household with an open health care benefit in CARES, EM CAPO will send the Important Information About Foster Care Medicaid letter (F-01661 or F-01661A) and a copy of the BadgerCare Plus Application (F-10182). The family or youth will need to apply for health care benefits. If no application is submitted, Foster Care Medicaid will end after the three-month extension period. The IM agency

will not have to take any further action concerning health care benefits for the child or youth.

If an application is submitted before Foster Care Medicaid ends, the IM agency must process the application like any other health care application. If the agency is unable to make an eligibility decision prior to the end date of the Foster Care Medicaid, the IM agency needs to manually extend the Foster Care Medicaid eligibility an additional month and issue a manual positive Notice of Decision.

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11.2 Former Foster Care Youth

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

1. The youth was receiving foster care (either IV-E or non-IV-E), subsidized guardianship, or court-ordered Kinship Care on the date that he or she turned 18 years old. It does not matter what state he or she was residing in when he or she turned 18 years old.
2. The youth is younger than 26 years old.
3. The youth meets the following BadgerCare Plus eligibility criteria:
 - a. Is no longer receiving foster care benefits (which includes subsidized guardianships and court-ordered Kinship Care) but was receiving the benefits on his or her 18th birthday. Verification of the placement status on his or her 18th birthday is required.
 - b. Provides a **SSN** or cooperates in applying for one.
 - c. Is a U.S. citizen or national or is a qualifying immigrant.
 - d. Provides verification of U.S. citizenship and identity or qualifying **immigration status** or makes a good faith effort to obtain it.
 - e. Cooperates with child support enforcement agencies in obtaining medical support (if a parent).
 - f. Cooperates with **TPL** requirements.
 - g. Physically resides in Wisconsin and intends to reside in the state.
 - h. Is not an inmate.

There is no income or resource test for these youths while they are eligible under this status; therefore, they are not required to provide any income tax filing information in order for their BadgerCare Plus eligibility to be determined.

Note: If a FFCY is included in another household member's **AG**, his or her tax filing information may be needed to determine eligibility for those household members.

In addition, they are not subject to the BadgerCare Plus insurance access or coverage policies and are not required to pay any premiums for themselves. Regardless of income, they are eligible for the BadgerCare Plus Standard Plan unless they are found otherwise ineligible or until the end of the month in which they turn 26 years old.

A 12-month recertification renewal is required to continue eligibility.

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12 Migrant Workers

12.1 Migrant Workers

When determining a migrant family's eligibility for BadgerCare Plus, use the appropriate rules as outlined in Chapter 2 BadgerCare Plus Group.

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12.2 Migrant Worker Definition

A "Migrant worker" is a person who:

1. Temporarily leaves his or her principal place of residence (outside of Wisconsin) and
2. Comes to Wisconsin for not more than ten months per year in order to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading or storing of any agricultural or horticultural commodity in its unmanufactured state.

"Migrant worker" does not include the following:

1. A person who is employed only by a state resident if the resident or the resident's spouse is related to the person as the child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, nephew, or the spouse of any such relative.
2. A student who is enrolled in or, during the past six months has been enrolled, in any school, college or university unless the student is a member of a family or household which contains a migrant worker.

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12.3 Simplified Application

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

1. 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/BadgerCare Plus eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.
2. And have the same members or fewer in the case as there were when the case had coverage in the other state.

The simplified application procedure is as follows:

1. For applicants with current Medicaid eligibility from another state, verify the eligibility and the end date. Verify with a copy of the out-of-state Medicaid card or by contacting the other state.
2. For applicants previously eligible in Wisconsin, determine the closure code and renewal date.
3. Determine if the same members, or fewer, are in the case compared to when the group was eligible in the other state.
4. Collect all non-financial information.
5. Do not collect any financial information.
6. Certify BadgerCare Plus benefits for the migrant family.

Example 1: A migrant family consisting of Dad, Mom, and their three children come to Wisconsin. On July 3, Dad applies for BadgerCare Plus in Wisconsin for his family.

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

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

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

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

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

12.3.1 Renewal Dates for Simplified Application

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

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

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12.4 Regular Application

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

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

Renewal dates for regular applications

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

12.4.1 Renewals

Offer the following three renewal choices for migrant families:

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

See Chapter 26 for information on renewals.

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13 - 15 Reserved

Reserved

FINANCIAL REQUIREMENTS (CHAPTERS 16-24)

16 Income

16.1 Income

16.1.1 Income Limits

Population	Income Limits for All Members
Pregnant women	306% <i>FPL</i>
Children under 19*	306% FPL
Parents/Caretaker relatives	100% FPL
Childless adults	100% FPL
Family Planning Only Services	306% FPL

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

See Section 50.1 Federal Poverty Level Table for the most recent FPL limits.

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

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

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

16.1.2 Income Under Modified Adjusted Gross Income Rules

All taxable income is counted when determining BadgerCare Plus eligibility. Social Security income is also counted. See Section 16.2 Income Types Not Counted for the list of income that is not counted. These rules apply to families that are filing taxes and those who are not.

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

All MAGI group members' income is counted with one exception: If a group member is the child or tax dependent of another group member, his or her income is only counted if he or she is "expected to be required" to file a tax return for the current year. See Section 2.8 MAGI Income Counting Rules for more information.

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

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

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

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

Example 1: Ms. M. is entitled to unemployment compensation benefits of \$430. However, she declined a \$100 increase offered by unemployment compensation, and the amount of her check remains at \$430. Since the full entitlement amount is known, the available income is \$530.

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16.2 Income Types Not Counted

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

1. Adoption Assistance

2. Agent Orange Settlement Fund

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

3. Combat Pay

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

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

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

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

4. Other Military Pay

Do not count income received for the following purposes:

- Living allowances
 - Basic Allowance for Housing

- Basic Allowance for Subsistence
- Housing and cost-of-living allowances abroad paid by the U.S. government or by a foreign government
- Overseas Housing Allowance
- Death allowances
- Family allowances
- Moving allowances
- Travel allowances
- Professional education allowances
- ROTC educational and subsistence closure benefit allowances
- Uniform allowances

Note: Military pay can be verified using the Leave and Earnings Statement received by active duty personnel.

5. Crime Victim Restitution Program

Payments received from a state-established fund to aid victims of a crime.

6. Disaster and Emergency Assistance

Payments made by federal, state, county, and local agencies and other disaster assistance organizations.

7. Income of People Younger than 18 Years Old

See Section 2.8 Modified Adjusted Gross Income Counting Rules for information about counting income for people younger than 18 years old.

8. Foster Care

9. Individual Development Account

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

10. Jury Duty Payments

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

11. Kinship Care

12. Life Insurance Policy Dividends

13. Nutrition Benefits

Received from the following:

- Emergency Food and Shelter National Board.
- Federal Emergency Management Assistance.
- FoodShare allotment.
- Home produce for household consumption.
- National School Lunch Act.
- Supplemental food assistance under the Child Nutrition Act of 1966.
- Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965.
- **USDA** Child Care Food Program.
- USDA-donated food and other emergency food.
- **WIC**—the supplemental food program for women, infants, and children.

14. Payments to Native Americans

- a. Distributions from Alaska Native Corporations and Settlement Trusts, including:
 - Menominee Indian Bond interest payments.
 - All judgment payments to tribes through the Indian Claims Commission or Court of Claims.
 - Payments under the Alaskan Native Claims Settlement Act.
 - Payments under the Maine Indian Claims Settlement Fund.
 - Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except under non-MAGI rules, individual shares over \$2,000.
 - Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except under non-MAGI rules, individual shares over \$2,000.
 - Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge Munsee Indian Community of Mohicans.
 - Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.
 - Payments under PL 96-420 to the Houlton Band of Maliseet Indians, the Passamoquoddy, and Penobscot.
 - 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.

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

b. Other Exempt Tribal Payments

Disregard non-gaming tribal income from the following sources:

- Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
 - Rights of ownership or possession in any lands held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior; or
 - Federally-protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources
- Distributions resulting from real property ownership interests related to natural resources and improvements:
 - Located on or near a reservation or within the most recent boundaries of a prior
 - federal reservation; or
 - Resulting from the exercise of federally-protected rights relating to such real property ownership interests

c. Tribal general welfare payment received under the Tribal General Welfare Exclusion Act. (Note: This exemption applies only to MAGI budgeting rules.)

15. Payments to Nazi Victims

Made under PL 103-286 to victims of Nazi persecution.

16. Radiation Exposure Compensation Act (PL 101-426)

Payments to persons to compensate injury or death due to exposure to radiation from nuclear testing (\$50,000) and uranium mining (\$100,000). The federal Department of Justice reviews the claims and makes the payments. If the affected person is dead, payments are made to his or her surviving spouse, children, parents, or grandparents.

This is retroactive to October 15, 1990. Do not count these payments for as long as they are identified separately.

17. Refugee Cash Assistance Program Payments

The Refugee Cash Assistance program is administered by **W-2** agencies and is made available for refugees who do not qualify for W-2.

18. Refugee "Reception and Placement" Payments

Refugee "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/family or to a vendor.

19. Reimbursements

Reimbursements for out-of-pocket expenses that an assistance group member has incurred and/or paid. However, reimbursements for normal household living expenses (rent, clothing, or food eaten at home) are counted.

Examples of reimbursements that are not counted:

- Reimbursements 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.
- Reimbursements 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 (for example, transportation, chore services, and child care services).

The reimbursement payment should not be more than the person's actual out-of-pocket expenses. If it is more, count the excess amount as unearned income.

20. Relocation Payments

Under 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 and replacement housing and property transfer expenses. Do not count the amounts paid by any governmental agency or organization listed in Wis. Stat. § 32.02. Do not count 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.

Do not count Experimental Housing Allowance Program payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

21. Repayments

Repayments of money the member has received from an economic support 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.

Do not count 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 to equal \$300. If the VA overpays Richard by \$200, he can only pay back the \$50 a month he receives from the VA. If he repays more, for instance, \$75 a month, only \$50 should be disregarded.

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

22. Special Programs

Income received from any of the following:

- Active Corp. 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 16.4.1 #5), except wages or salaries, which are counted as earned income.
- Retired Senior Volunteer Program (RSVP).
- Service Corp. of Retired Executives (SCORE).
- University Year for Action Program.
- 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.
- AmeriCorps Volunteers in Service to America (VISTA).

23. Spina Bifida Child

(PL 104-204) Payments to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

24. Susan Walker Payments

Susan Walker Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products.

25. Student Financial Aids

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

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

The following types of grants, scholarships, and fellowships are counted as income:

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

The following educational aid types are not counted as income:

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

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

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

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

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

- Room

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

26. Stipends from the University of Wisconsin Upward Bound Program

Paid to high school students to encourage low income students to further their education.

27. Tax Refunds (Income and *EITC*)

28. Unpredictable Income

Income that is unpredictable, irregular, and has no appreciable effect on ongoing need.

29. Veterans Benefits

Do not count any veterans' benefits paid under any law, regulation, or administrative practice administered by the VA. The following amounts paid to veterans or their families are not countable:

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

Do not count VA allowances for unusual medical expenses that are received by a veteran, their surviving spouse, or dependent. Do not count aid and attendance and housebound allowances received by veterans, spouses of disabled veterans, and

surviving spouses. For institutionalized and community waiver cases, do not count these allowances in eligibility and post-eligibility determinations, except for residents of the State Veterans Home at King.

30. Wartime Relocation of Citizens

(PL 100-383) restitution payments made to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during World War II.

31. Workforce Investment Act Unearned Income

Income paid to any adult or minor participating in the Workforce Investment Act, including:

- "Need-based payments" paid to persons as allowances to enable them to participate in a training program.
- "Compensation in lieu of wages" paid to persons in "tryout employment." This is arranged when private for-profit opportunities are not available and is generally limited to persons younger than 22 years old. Ask any applicant younger than 23 years old, or the local Workforce Investment Act 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 persons in training programs who are not able to pay for training-related expenses (e.g., transportation, health care, child care, meals).

32. W-2 Payments

Payments for W-2 Transition, *Custodial Parent* of an Infant, At Risk Pregnancy, Case Management Follow-up Plus (CMF+) and Community Service Jobs. Do not disregard payments for Trial Employment Match Program or Transform Milwaukee Jobs.

33. General Relief and Charity

34. SSI

SSI is not counted income for BadgerCare Plus. The following is a brief list of the potential codes for SSI.

- SI - SSI/Supplemental Security Income
- SISE - SSI-E/Supplemental Security Income - Expenditure
- SISS - State Supplemental Security Income

35. Lump Sums Payments

Count lump sum payments (if the payment is otherwise a countable income type) in the month received. Lump sum payments are not counted outside of the month received.

36. Property Settlement

Money received as a property settlement is always an asset, regardless of whether it is paid in one payment or installments. It is never income.

37. Subsidized Guardianship Payments

Subsidized guardianship payments are not counted for BadgerCare Plus.

38. Child Support

Child Support payments are not taxable and are not counted under MAGI rules. See Process Help, Section 62.2.6 Entering Child Support Income on an Unearned Income Page. However, some spousal support payments are taxable and must be counted. If a household is receiving family support, divide the payment by the number of members in the household. The amount of the payment allocated to the child(ren) is considered child support and is disregarded. Count the amount of the payment allocated to the adult(s) as alimony/spousal support if the payment meets one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 that does not designate the payments as non-taxable, OR
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 but modified on or after January 1, 2019 that does not designate the payments as non-taxable and does not reference Section 11051 of Pub. L. 115-97 that makes alimony non-taxable.

Payments received under a separation or divorce agreement finalized on or after January 1, 2019 are not taxable and not counted as income under MAGI rules.

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

39. Gifts

A gift is something a person receives, 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).

Do not count the value of a gift as income. This includes funds received through crowdfunding accounts, such as GoFundMe and Kickstarter. Funds received through a crowdfunding account would be considered a gift. These funds are not taxable and are not counted.

Example 5: Marco's grandmother gave him \$1,600 to help pay for his classes at a local technical college. Do not count this \$1,600 as income.

40. Money from Another Person

Money 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. Money from another person is not a loan.

Do not count money from another person as income (see #41 for policies regarding money received from another person through an inheritance, bequest, or devise).

Example 6: Mimi receives \$500 each month from her parents. She is not expected to pay back this money. The \$500 is not counted as income for BadgerCare Plus eligibility.

Note: If money received from another person is in exchange for goods or services (such as an informal arrangement in which someone rents a room in his or her house) and if the payment is regular and predictable, it should be counted. See Section 16.4.3.1 Income Sources for information on counting rental income.

Example 7: Jeremy pays Micah \$300 each month to live in a room in Micah's house. Micah and Jeremy do not have a formal lease agreement, but the payment is regular and predictable. Count the \$300/month as income for BadgerCare Plus eligibility.

41. Inheritances, Bequests, and Devises

An inheritance is property received from someone who is deceased without a valid will. A bequest is personal property received from someone who is deceased, as directed by

that decedent's will. A devise is real property received from someone who is deceased, as directed by that decedent's will.

Inheritances, bequests, and devises are generally not taxable, and, as a result, the value of the inheritance, bequest, or devise is generally not counted as income.

However, there are a few forms of inheritances or bequests that may be taxable. For example, distributions from an inherited pension are usually taxable to the beneficiary if the distributions would have been taxable if the deceased were still living.

In addition, income generated from an inheritance, bequest, or devise is usually taxable.

For inheritances, bequests, and devises that are taxable, the income should be counted only in the month it was received if it was received as a lump sum. If the payments are regular and predictable, they should be prorated (unless they are received monthly) and counted accordingly.

Example 8: Roger's aunt passed away, and Roger inherited her rental house. It is worth \$100,000. The house is occupied by tenants who pay \$800/month in rent. At the time of the deed transfer, the tenants owed \$3,200 in back rent. The value of the \$100,000 property is not taxable, but if the tenants pay Roger the \$3,200 in back rent, that income is taxable and would be counted in the month it was received. If they pay Roger \$800/month on an ongoing basis, this income would also be taxable and would be counted based on rules regarding rental income.

Note: Income from the sale of inherited property is taxable if the property is sold for more than the fair market value on either the date of the decedent's death or on the alternate valuation date. In Example 9, if Roger were to sell the rental house for \$150,000, the \$50,000 gain would be taxable. If Roger receives income from the sale in a lump sum, this income would only be counted in the month it was received.

Example 9: Darcy inherited her husband's \$150,000 life insurance policy. In most cases, life insurance policies are not taxable when they are inherited, so the \$150,000 should not be counted as income. However, Darcy receives an ongoing interest payment of \$1,200/month from the policy. This amount is taxable and would be counted as unearned income.

Income generated by an inheritance, bequest, or devise includes situations in which someone is the beneficiary of a trust or estate, and the trust or estate holds assets that

are generating income. If the trust or estate distributes income to the beneficiary, the beneficiary is responsible for paying taxes on that income.

Example 10: Keisha is the beneficiary of a trust. Land was given to the trust, and it generates interest that is distributed to Keisha as the beneficiary. Count this interest as unearned income.

42. Workers' Compensation

Do not count workers' compensation benefits. This includes workers' compensation benefits received as a settlement.

43. 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. Do not count this income.

44. Loans

If a BadgerCare Plus applicant or member receives a loan and it is available for current living expenses, do not count it as income, even if there is a repayment agreement.

45. Live-In Care Providers

Certain payments received by live-in care providers who provide care to someone enrolled in an **HCBW** program are not counted for BadgerCare Plus under **MAGI** budgeting rules. Live-in care providers are typically paid as employees, but some may be self-employed. They may be related to or not related to the person receiving care. In order to not be counted, payments to live-in care providers must meet all of the following criteria:

- The payments are for HCBW services provided to a member enrolled in one of the following HCBW programs:
 - **CLTS** waiver programs
 - Community Integration Program I (CIP 1A and CIP 1B)
 - Community Integration Program II (CIP II)
 - Community Options Program Waiver (COP-W)
 - Family Care
 - Family Care Partnership
 - **IRIS**
 - **PACE**

- The payments are made to a live-in care provider for services provided to an HCBW member under the member's written HCBW plan of care. Payments made for skilled services that only a nurse or other health professional may perform are not eligible for this exemption.
- The payments are made to a live-in care provider for services provided while the care provider and the HCBW member are living in the same home. The live-in care provider may be related to or not be related to the HCBW member.
- The live-in care provider is not providing care to more than 10 people younger than age 19 at the same time or five people age 19 or older at the same time.

If the payments received by the live-in care provider meet all of these criteria, they are not counted when determining eligibility for BadgerCare Plus. If the payments received by the live-in care provider do not meet all of these criteria, the payments must be treated like other countable earnings or self-employment income.

46. ABLE 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:

- Do not count contributions to the account, any interest or dividends earned, or other appreciation in value as income.
- 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 person reports that a distribution was used for nonqualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.

ABLE account funds remaining after a 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.

47. Income Allocated to a Community Spouse

When spouses are filing taxes separately and one spouse enrolled in Institutional Medicaid and allocates income to the spouse still living in the community, do not count this income when determining BadgerCare Plus eligibility for the spouse living in the community.

Example 11: Jenny resides in a nursing home and is enrolled in Institutional Medicaid. Her husband, Kevin, lives in the community and is applying for BadgerCare Plus. Jenny and Kevin file taxes separately. Jenny has income from Social Security and a pension. She allocates \$1,100 of her monthly income to Kevin as the community spouse. Do not count this allocation when determining Kevin's BadgerCare Plus eligibility.

48. Spousal Support/Alimony

Do not count alimony/spousal support if it meets one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 that designates the payments as non-taxable.
- The payment was received under a separation or divorce agreement finalized on or after January 1, 2019.
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 but modified on or after January 1, 2019 and provides that Section 11051 of Pub. L. 115-97 applies to the modification which makes the alimony/spousal support non-taxable.

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16.3 Income Deductions

16.3.1 Child Support Payments

Child support payments are not allowed as an income deduction.

Spousal support, alimony, or maintenance can be claimed as a BadgerCare Plus tax deduction (see Section 16.3.3 Tax Deductions).

16.3.2 Pretax Deductions

Pre-tax deductions are allowed if the payments are taken out of the individual's paycheck on a pre-tax basis. Examples include but are not limited to:

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

16.3.3 Tax Deductions

Monthly expenses related to tax deductions from page one of the IRS Schedule 1 (Form 1040) are allowed as income deductions for the current year, even if the individual does not plan on filing taxes. If the expense is not incurred on a monthly basis, it will be prorated and counted as a monthly expense.

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

A net loss carryover from previous periods, known as an **NOL** on IRS tax forms, is allowed as an income deduction. An NOL should be considered as an ongoing tax deduction, but should be reviewed each tax year. If claimed, it would be found on Line 21 of the IRS Schedule 1 (Form 1040).

See #15 Capital and Ordinary Gains and Losses in Section 16.5 Other Income for information on counting capital losses.

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

1. Student loan interest

Interest on a loan taken to pay for school expenses for the following people at the time the loan was taken out:

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

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

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

2. Higher education expenses

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

3. Self-employment tax deduction

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

4. Spousal support, alimony, or maintenance

The amount paid for court ordered spousal support, alimony or maintenance or payments under Section 71 for a current or prior spouse as a result of a legal separation or divorce. Do not deduct more than the court ordered amount. Do not allow any deduction if the court order designates the payments as being non-taxable.

5. Teachers' tax-deductible expenses

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

6. Self-employed Simplified Employee Pension (SEP) and simple or qualified plan contributions

Examples of these plans include:

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

7. Penalties for early withdrawal of funds

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

8. Performing artists tax-deductible expenses

Applies to performing artists who have out-of-pocket business expenses not paid by the employer and meet all of the following criteria:

- Worked for at least two employers who each paid at least \$200
- Did not earn more than \$16,000 for their work in the current year
- Had out-of-pocket expenses that were more than 10% of their earnings

9. Military reserve members' tax-deductible expenses

Applies to travel expenses for members of the Armed Forces Reserve who travel more than 100 miles away from home to perform work for the Armed Forces Reserve.

10. Moving expenses for military members

Applies to individuals who paid out-of-pocket expenses for a job-related move and who meet both the following criteria:

- The move must be for a job-related reason, such as starting a new job.
- The new job must be at least 50 miles farther from the individual's old home than the old home was from the individual's old job or must be at least 50 miles from the old home if the individual did not have a job before.

11. Loss from sale of business property

Applies to self-employed individuals that had a loss from the sale or exchange of property that they owned for their business.

12. Individual Retirement Account (IRA) contributions

Applies to individuals who had income from a job and made contributions to an IRA. Also applies to self-employed individuals who made contributions to an IRA they set up themselves.

13. Fee-based official tax-deductible expenses

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

14. Domestic production activities deduction

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

15. Health Savings Account deduction

Applies to contributions made to a health savings account for someone enrolled in a high-deductible health plan, as specified on Form 8889. Contributions made by employers, through roll-overs, or through distributions from Individual Retirement Accounts are not deductible

16. Self-employed health insurance deduction

Applies to self-employed people who are paying premiums for a medical, dental, or long-term care plan established under their business that covers them, their spouse, and/or their dependents.

17. Allowable write-in expenses

These deductions include:

- Contributions to Archer MSAs.
- Deductions attributable to rents and royalties.
- Certain deductions of life tenants and income beneficiaries of property.
- Jury duty pay given to the employer because the juror was paid a salary during duty.
- Reforestation expenses.
- Costs involving discrimination suits.
- Attorney fees relating to awards to whistleblowers.
- Contributions to section 501(c)(18)(D) pension plans.

- Contributions by certain chaplains to section 403(b) plans.

18. Live-in care providers

The IRS requires live-in care providers to include the income paid to their self-employment business when it is reported on a 1099 form. When that income meets the conditions listed in #45 Live-In Care Providers in Section 16.2 Income Types Not Counted, the providers are allowed to list all of that 1099 income as an expense in Part V of their Schedule C. Likewise, the self-employment income of the care provider has to be counted for EBD Medicaid and other IM programs. To disregard the self-employment income for BadgerCare Plus, the case should receive a tax deduction amount equal to the income.

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16.4 Earned Income

Earned income is income from gainful employment.

Earned income after pre-tax deductions is counted. See Section 16.3.2 Pre-Tax Deductions for more information on pre-tax deductions.

1. Contractual Income.

This provision applies primarily to teachers and other school employees.

When an employed BadgerCare Plus group member is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, the income is prorated over the period of the contract. For example, if the contract is for 18 months, the income is prorated over 18 months no matter the number of installments made in paying the income. The income is prorated even if one of the following is true:

- a. There are predetermined vacation periods
- b. He or she will only be paid during work periods

- c. He or she will be paid only at the end of the work period, season, semester, or school year

2. Income In-Kind.

Count in-kind benefits as earned income if they are all of the following:

- a. Regular
- b. Predictable
- c. Received in return for a service or product

Do not count the following:

- a. Meals and lodging for armed services members
- b. In-kind services that do not meet all three of the above criteria

b. In-kind room and board for employees may be considered not countable income in situations where it is provided as a convenience to the employer and when it is provided on the employer's premises. Do not include the value of room or board if the following conditions are met:

- a. Board. All of the following must be met:
 - The meals are furnished on the business premises of the employer.
 - The meals are furnished for the convenience of the employer.
- b. Room. All of the following must be met:
 - The lodging is furnished on the business premises of the employer.
 - The lodging is furnished for the convenience of your employer.
 - The lodging is a condition of your employment. The employee must accept the lodging in order to be able to properly perform the job duties.

c.

Example 1: Alicia is working as a resident assistant at the college she attends. In exchange for working, she receives lodging in a residence hall and a meal plan at the college during the semesters she works. The

college requires her to live in the residence hall and use the meal plan as part of her job as a resident assistant. Do not count Alicia's room and board as in-kind income.

a.

b. To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits.

3. Wage Advances.

Count advances on wages as earned income in the month received.

4. Severance Pay.

Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee's request or through a mutual agreement with his or her employer as earned income when he or she would have received the amount had it not been deferred.

5. Workers' Compensation.

Do not count workers' compensation as earned income.

16.4.1 Specially Treated Wages

1. Income Received by Members of a Religious Order.

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

2. Housing Allowances for Members of the Clergy.

Do not count any housing or housing utility allowances that are received as compensation for services as an ordained, licensed, or commissioned minister as income.

3. **Jury Duty Payments.**

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

4. **AmeriCorps.**

Earnings or cash benefits received through AmeriCorps will be counted as earned income. Educational awards received from AmeriCorps are not counted as income.

Note: This does not include earnings or cash benefits received through **VISTA** (see #22 Special Programs) in Section 16.2 Income Types Not Counted.

5. **Title V—Older Americans Act of 1965.**

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to the following:

- a. Green Thumb.
- b. Experience Works.
- c. The National Urban League.
- d. National Senior Citizens Education and Research Center (Senior Aides).
- e. National Indian Council on Aging.
- f. U.S.D.A. Forest Service.
- g. **WISE.**
- h. Community service employment programs, such as the Older Americans Community Service Program.

Identify programs funded under 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 16.2 #19 Reimbursements).

6. Live-in care providers

Do not count any wages of a live-in care provider if those wages meet the conditions listed in #45 Live-In Care Providers in Section 16.2 Income Types Not Counted. See Section 16.4.4.2 Live-In Care Providers for more information about verifying whether the wages should be counted.

16.4.2 Room and Board Income

There are no special deductions if the income is reported as room and board income. If room and board income is reported as self-employment income, see Section 16.4.3 Self-Employment Income for more information on counting self-employment income.

16.4.3 Self-Employment Income

16.4.3.1 Definitions

16.4.3.1.1 Income

Self-employment income is income derived directly from one's own business rather than as an employee with a specified salary or wages from an employer.

16.4.3.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

16.4.3.1.3 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 16.4.3.3.4 Anticipated 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, and there is no one else to carry out the duties of the business, he or she may claim his or her business was not in operation for those months.

16.4.3.1.4 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

16.4.3.1.5 Non-real Property

Non-real property means all property other than real property. Non-real property is personal or business property that typically is movable rather than attached to land.

16.4.3.2 Identifying Farms and Other Businesses

A farm or other business should be identified according to the following criteria:

16.4.3.2.1 By Organization

A farm or other business is organized in one of the following ways:

- A sole proprietorship, which is an unincorporated business owned by one person.
- A partnership, which exists when two 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.
- 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:
 - Is taxed as a separate entity rather than the owners being taxed as individuals, and
 - Provides only limited liability. Each owner's loss is limited to their investment in the corporation while the owners of unincorporated business are also personally liable.
- 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.

16.4.3.2.2. By IRS Tax Forms

A self-employed person who earns more than \$400 net income must file an end-of-year return. A person who will owe more than \$400 in taxes at the end of the year must file quarterly estimates.

IRS tax forms for reporting self-employment income are listed below.

- Form 1065—Partnership

Schedule K-1 (Form 1065)—Partner's Share of Income, Deductions, Credits, etc.

- Form 1120—Corporation
- Form 1120S—S Corporation

Schedule K-1 (Form 1120S)—Shareholder's Share of Income, Deduction, Credits, etc.

- Form 4562—*Depreciation* and Amortization
- Form 4797—Sales of Business Property
- Form 1040—Sole Proprietorship or single member LLC
 - Schedule C (Form 1040)—Business (non-farm)
 - Schedule D (Form 1040)—Capital Gains and Losses
 - Schedule E (Form 1040)—Rental and Royalty
 - Schedule F (Form 1040)—Farm Income
 - Schedule SE (Form 1040)—Social Security Self-Employment

16.4.3.2.3 By 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:

- 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.

- Does not complete a W-4 for an employer.
- Is not covered by employer liability insurance or workers' compensation.
- Is responsible for his or her own work schedule.

Examples of self-employment include:

- Businesses that receive income regularly (for example, daily, weekly, or monthly):
 - Merchants

- Small businesses
 - Commercial boarding house owners or operators
 - Owners of rental property
- Service businesses that receive income frequently and possibly sporadically:
 - Craft persons
 - Repair persons
 - Franchise holders
 - Subcontractors
 - Sellers of blood and plasma
 - Commission sales persons (such as door-to-door delivery)
- Businesses that receive income seasonally:
 - Summer or tourist-oriented businesses
 - Seasonal farmers (custom machine operators)
 - Migrant farm worker crew leaders
 - Fishers, trappers, or hunters
 - Roofers
- Farming: Farming includes income from cultivating the soil or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time, or hobby farming.

16.4.3.3 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 the IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, the worker must judge whether or not it is self-employment income.

Self-employment income sources are:

- **Business.** Income from operating a business.
- **Capital Gains.** Business income from selling securities and other property is counted. Personal capital gains and ordinary gains or losses are counted as unearned income. See Section 16.5 Other Income for more information.
- **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.

- **Rental.** Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income. Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.
 - When a Medicaid group member reports rental income to the IRS as self-employment income, see 3A Reported to IRS as Self-Employment Income.
 - If he or she does not report it as self-employment income, add "net rent" to any other unearned income. Determine "net rent" as detailed in 3B Rental Income Not Reported as Self-Employment Income.

3A Reported to IRS as Self-Employment Income

When the owner is not an occupant, net rental income is the rent payment received minus the interest portion of the mortgage payment and other verified operational costs.

When a *life estate* holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

When the owner lives in one of the units of a multiple unit dwelling and does not file taxes for the rental income, compute net rental income as follows:

1. Add the annual interest portion of the mortgage payment and other operational costs common to the entire operation.
2. Divide the result in step 1 by the total number of units to get the proportionate share.
3. Multiply the amount in step 2 (the proportionate share) by the number of rental units.
4. Add the proportionate share to any operational costs paid that are unique to any rental unit. This equals total expenses.
5. Subtract total expenses from the total rent payments to get net rent.

Example 2: George owns a four-unit apartment building and lives in unit one. His annual interest paid on his mortgage for the most recent tax year is \$9,765. His operational expenses, including taxes on the house, 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
<u>- \$16,593</u>
\$12,207

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

3B Rental Income Not Reported as Self-Employment Income

When a BadgerCare Plus group member reports rental income to the IRS as self-employment income, see 3A_Reported_to_IRS_as_Self_Employment_Income.

If he or she does not report it as self-employment income, add "net rent" to any other unearned income. Determine "net rent" as follows:

1. When the owner is not an occupant, "net rent" is the rent payment received minus the interest portion of the mortgage payment and other verifiable operational costs. Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.

Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement; adding a room; putting up a fence; putting in new plumbing, wiring, or cabinets; 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. The carryover should only be done until the end of the year in which the expenses were incurred.

When a life estate holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. Net rental

income is the gross rental income minus taxes, insurance, and other operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

2. When he or she receives income from a duplex, triplex, etc. and lives in one of the units, determine "net rent" as follows:

- a. Add the annual interest portion of the mortgage payment and other annual verifiable operational costs common to the entire operation.
- b. Divide the result in "a" by the total number of units to get the proportionate share.
- c. Multiply the amount in "b" (the proportionate share) by the number of rental units.

Note: Rental units mean the total number of units minus the unit the owner lives in.

- d. Add the proportionate share, "c," to any operational costs paid by the member that are unique to any rental unit. The result is the total member expense.
- e. Subtract the total member expense, "d," from the total annual rent payments to get annual net rental income. Budget this amount.

16.4.3.4 Calculating BadgerCare Plus Self-Employment Income

Calculate BadgerCare Plus income in one of the following ways:

- Using IRS tax forms (Section 16.4.3.4.1 IRS Tax Forms) completed for the previous year
- Anticipating earnings (Section 16.4.3.4.4 Anticipated Earnings)

16.4.3.4.1 IRS Tax Forms and Worksheets

IM workers do not fill out 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 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 change in circumstances since the previous year.

If all three conditions are not met or if IRS tax forms were not filed and are not available, use anticipated earnings (Section 16.4.3.4.3 Anticipated Earnings).

If you decide to use IRS tax forms, use them together with the chart 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

There is no worksheet for Sole Proprietor. See Process Help, Section 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

CWW will calculate the monthly countable income for each self-employment business, which will be added to the fiscal test group's other earned and unearned income. If monthly income is a loss, the loss will be subtracted from the non-self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Losses from self-employment can be used to offset other income types. In situations where an individual is planning to file a joint tax return with his or her spouse, losses from self-employment may offset the spouse's income.

Each self-employment operation (Sole Proprietor, Partnership, S Corporation) requires its own Self-Employment page in CWW.

Remember that while a salary or wage paid to a test group member is an allowable business expense, you must count it as earned income to the payee. Similarly, dividends or other types of passive income (as defined by the IRS) must be counted as unearned income.

Even though IRS Schedule D (Form 1040) – Personal Capital Gains and Losses is associated with sole proprietorships, it is not considered self-employment income. If someone reports personal capital gains or losses, it is counted as unearned income (see Section 16.5 Other Income).

16.4.3.4.2 Depreciation, Depletion, and Disallowed Expenses

Countable self-employment income will be the same as the net self-employment taxable income.

Depreciation and depletion expenses are allowable expenses.

The following expenses are disallowed expenses for BadgerCare Plus:

- Charitable donations
 - Work-related personal expenses, such as transportation to and from work
 - Employer work-related personal expenses, such as pensions, employee benefit and retirement programs, and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not.)
 - Principal payments on loans for the purchase price of income-producing real estate, capital assets and equipment, and durable goods. (An example is the

principal portion of mortgage payments. Only the interest portion of business loan payments is an allowable expense.)

Note: Disallowed expenses are added back into an individual's gross income on the BadgerCare Plus Budget page.

16.4.3.4.3 Anticipated Earnings

If past circumstances do not represent present circumstances, workers should calculate self-employment income based on anticipated earnings. Anticipated earnings should 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 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 (nor will anyone else be able 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 on date.

16.4.3.4.3.1 Reporting Anticipated Earnings

The Self-Employment Income Report form, F-00107, (also called a SEIRF) and the Self-Employment Income Report: Farm Business form, F-00219, simplify reporting income and expenses when earnings must be anticipated. Self-Employment Income Report forms 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 Self-Employment Income Report form 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 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 Self-Employment Income Report form for each month or combine the months on one Self-Employment Income Report form.

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 not more than 12 months) income.

Example 3: James applies for BadgerCare Plus on November 1, 2017. He reports that he was self-employed starting in April 2017. The agency asks James to complete Self-Employment Income Report forms for April, May, June, July, August, September, and October so that his prospective self-employment income can be determined for his BadgerCare Plus 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 4: Bonnie applies for Child Care and BadgerCare Plus on April 5, 2016. She reports that she was self-employed starting in January 2016. The agency asks Bonnie to complete a Self-Employment Income Report form for January, February, and March so that her prospective self-employment income can be determined for her Child Care and BadgerCare Plus 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 5: Ricardo applies for FoodShare and BadgerCare Plus on February 5. He was self-employed starting December 15. The agency asks Ricardo to complete a Self-Employment Income Report form for December, January, and February so that his prospective self-employment income can be calculated. The completed Self-Employment Income Report form 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 6: Jenny is a BadgerCare Plus member who has been self-employed as a hairdresser since 2012. Jenny's BadgerCare Plus 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 Self-Employment Income Report form 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, until the person completes an IRS tax form, or until a significant change in circumstances is reported between renewals.

16.4.3.4.4 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 7: Maggie applied for BadgerCare Plus 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 BadgerCare Plus for the backdated months of March, April, and May.

Example 8: Glenn applied for BadgerCare Plus 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 BadgerCare Plus for the backdated months of June, July, and August.

Example 9: Hershel applied for BadgerCare Plus 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 BadgerCare Plus 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 BadgerCare Plus for the backdated month of March.

16.4.4 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see Section 9.10 Questionable Items).

Completed IRS tax forms (see Section 16.4.3.4.1 IRS Tax Forms and Worksheets) are sufficient verification of farm and self-employment income. If tax forms are not available or cannot be used because of a significant change in circumstances, a completed and signed Self-Employment Income Report form(s) is also sufficient verification.

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 9.10 Questionable Items). If requesting verification, workers must document the reason for the request in case comments.

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.

16.4.4.1 Self-Employment Hours

Count the time a self-employed person spends on business-related activities involving planning, selling, advertising, and management, along with time spent on the production of goods and services provided as hours of work.

16.4.4.2 Live-In Care Providers

Because contract agencies may or may not treat payments to a live-in care provider as exempt from federal taxation, workers must not rely on 1099 forms to verify whether the payments are tax exempt. Instead, if an applicant or member claims to be a live-in care provider with tax-exempt income, workers must provide the applicant or member with a Verifying Tax-Exempt Income for Live-in Care Providers form, F-02193, and ask him or her to complete it to attest to meeting the criteria that makes this income exempt. If there is a reason to question some or all of the information provided on the form, workers may seek additional verification.

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16.5 Other Income

Other income is any payment that a member receives from sources other than employment that are counted as taxable income. Count the gross payment in the person's income total.

1. Unemployment Compensation

Count unemployment compensation income, including the amount of unemployment compensation that is intercepted to collect child support.

2. Spousal Support

Spousal support payments are countable income if the payments meet one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 that does not designate the payments as non-taxable.
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 but modified on or after January 1, 2019 that does not designate the payments as non-taxable and does not reference Section 11051 of Pub. L. 115-97 that makes alimony/spousal support non-taxable.

Spousal support payments are not counted as income if they are non-taxable or they are made under a separation or divorce agreement finalized on or after January 1, 2019.

3. Family Support

If a household is receiving family support, divide the payment by the number of members in the household. The amount of the payment allocated to the child(ren) is considered child support and is disregarded. Count the amount of the payment allocated to the adult(s) as alimony or spousal support if the payment meets one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 that does not designate the payments as non-taxable.

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018 but modified on or after January 1, 2019 that does not designate the payments as non-taxable and does not reference Section 11051 of Pub. L. 115-97 that makes alimony/spousal support non-taxable.

Spousal support and alimony payments are not counted as income if they are non-taxable or they are made under a separation or divorce agreement finalized on or after January 1, 2019.

4. Social Security Benefits

Although Social Security benefits are not taxable, they must be counted as unearned income. Count Social Security benefits as unearned income in the month received.

The following is a list of some of the codes that should be used in coding Social Security income types:

- SSDC - Social Security Disabled Child
- SSDI - Social Security Disability/Wage Earner
- SSDW - Social Security Disability/Wife
- SSRE - Social Security Retirement
- SSSC - Social Security Surviving Child
- SSSS - Social Security Surviving Spouse
- SSWW - Social Security Disabled Widow(er)

Note: Social Security benefits are not considered when determining if a person is “expected to be required” to file a tax return for the current year (see Section 2.8 MAGI Income Counting Rules).

5. Income From a Bequest, Devise, or Inheritance

Count income from a bequest, devise, or inheritance in the month it is received.

6. Income Generated From Property Given to a Trust

Count income generated from property given to a trust if the income is paid, credited, or distributed to the person.

Example 1: Keisha is the beneficiary of a trust. Land was given to the trust, and it generates interest that is distributed to Keisha as the beneficiary. Count the interest as unearned income, but do not count the value of the land or the trust.

7. Land Contract

Count only the portion of monthly payments received that are considered interest from a land contract as unearned income. Deduct from the gross countable interest any expenses the person is required to pay by the terms of the contract. Do not count the principal as income (because it is the conversion of one asset form to another).

If the income is received monthly, budget it monthly. 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 \$5000 payment in March and another \$5000 payment in September. Ten percent of that payment is interest.

When Bob applies for BadgerCare Plus in February, prorate the interest portion of the land contract payments Bob receives after he becomes eligible. In March, when Bob receives a \$5000 land contract payment, divide the total countable income (\$5000 multiplied by 10 percent equals \$500 of countable interest income) by the frequency of the payments (six months) to get the budgeted income amount of \$83.33 per month. Begin budgeting this amount in March.

8. Loans

If a BadgerCare Plus applicant or member makes a loan (except a land contract), count only the portion of the repayment to that applicant or member that is interest. Count the interest as income in the month received.

9. Profit Sharing

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

10. 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 *IRAs* and plans for self-employed individuals, sometimes referred to as KEOGH plans.

Count the taxable portion of any retirement distribution as income.

11. Sick Benefits

Count sick benefits received from an insurance policy if the person's employer contributed or paid for the benefit. Do not count the following:

- Reimbursement for medical care
- Payments for loss of a member or bodily function or permanent disfigurement
- Amounts computed with reference to the injury but not with respect to the person's absence from work

12. Trusts

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

The term "trust" includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee, and the grantor's intention is that the trustee holds, manages, or administers the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

- The BadgerCare Plus member.
- The spouse of the BadgerCare Plus 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 regular payments, including dividends and interest, made under the terms of the trust from a trust to the beneficiary are unearned income to the beneficiary. Dividends and interest income are counted even if they are tax exempt.

13. Gambling Winnings

Count gambling winnings that are regular and predictable as income. Gambling losses cannot be used to offset other types of income.

14. Royalties

See Section 16.4.3 Self-Employment Income.

15. Capital and Ordinary Gains and Losses

Capital gains are profits from the sale of assets as bonds or real estate. If personal capital gains are regular and predictable, count as unearned income. Personal capital losses can be used to offset the person's other income types. In situations where a person is planning to file a joint tax return with his or her spouse, personal capital losses may offset the spouse's income.

16. Student Financial Aids

Work study income and any income from an internship or assistantship should be counted as earned income.

Grants, scholarships, fellowships, and any additional financial assistance provided by public or private organizations that exceed the cost of tuition, books, and mandatory fees are counted as unearned income and should be prorated over the period of time they are intended to cover.

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

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

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

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

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

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

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

The following educational aid types are not counted as income and cannot be considered when determining if grants, scholarships, and fellowships exceed the cost of tuition, books, and mandatory fees:

- Loans, including Stafford Loans and Perkins Loans (Student loans are not counted as income irrespective of what the loan is used to pay for.)
- AmeriCorps or HealthCorps grant
- Bureau of Indian Affairs grant
- GI Bill/Veterans benefits
- ROTC benefits

Note: When an applicant or member is enrolled in job-related classes or training and the tuition is reimbursed by the applicant's or member's employer, this may be considered reimbursement for job- or training-related expenses (as defined in Section

16.2 Income Types Not Counted). As long as the reimbursement is not more than the cost of the class or training, it does not need to be budgeted as educational aid.

17. Jury Duty Payments

Count all jury duty payments as earned income for the month in which they are received if the payments are not turned over to the person's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

18. Interest and Dividend Income

Interest and dividend income is counted as unearned income.

19. Lump Sums Payments

Count lump sum payments (if the payment is otherwise a countable income type) in the month received. Lump sum payments are not counted outside the month received.

20. Reimbursements for Normal Household Living Expenses Are Counted as Income

Examples of reimbursements that are counted as income:

- Rent
- Clothing
- Food eaten at home

For examples of reimbursements that are not counted as income, see Section 16.2 Income Types Not Counted #19 Reimbursements.

21. Tribal Per Capita Payments from Gaming Revenue

All of the income from Tribal Per Capita payments from gaming revenue is counted income.

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16.6 Fluctuating Income

If the amount or frequency of regularly received income is known, average the income over the period between payments. If neither the amount nor the frequency is predictable, do not average; count income only for the month in which it is received.

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16.7 Prorating Income

Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, must be converted to a monthly amount or prorated.

Prorate means "to distribute proportionately."

Example 1: Sally receives a \$1,500 royalty payment quarterly. This payment should be prorated for the months between payments. \$1,500 is distributed over three months by dividing the amount of money by the number of months between payments. The prorated amount is $\$1,500/3 = \500 a month.

Prorating is applied to a member's income when the income is received less often than monthly. By prorating, income is distributed evenly over the number of months between payments

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

Example 2: Joe receives semi-annual land contract installments of \$900. This equals a monthly income of \$150 (\$900 prorated over six months). He becomes eligible in May. He receives payments in January and July each year. Do not budget any prorated income until July, the first month of receipt after Joe becomes eligible.

If the group becomes ineligible and reapplies before they receive the next installment, use the same prorated amount as before.

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16.8 Migrant Worker's Income

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

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16.9 Gap Filling

Due to differences between the eligibility rules used by the Federally Facilitated Marketplace and the eligibility rules used when counting income for BadgerCare Plus, the Marketplace may find someone to be at or below 100 percent of the FPL based on his or her annual income, while BadgerCare Plus may find someone to be above 100 percent of the FPL based on his or her current monthly income. Because of this difference in eligibility rules, the person is eligible for neither BadgerCare Plus nor *APTCs*. If people were left in this eligibility "gap," then the only option available to them is to pay for the full cost of private health insurance through the Marketplace. To prevent this from happening, these people must have eligibility for BadgerCare Plus determined based on their expected annual income under a process called "gap filling."

16.9.1 Processing Gap Filling Referrals and Requests

Gap filling referrals and requests may be received through any of the following:

- The Marketplace will transfer an application as a gap filling referral if it determines that the applicant's annual income is at or below 100 percent of the FPL but monthly income is above 100 percent of the FPL.
- The applicant's monthly income is above 100 percent of the FPL, but he or she provides a copy of his or her Marketplace denial letter stating he or she may be eligible for BadgerCare Plus.
- The applicant or member is denied or terminated due to excess monthly income and requests a gap filling eligibility determination.
- The worker initiates a gap filling eligibility determination because it is apparent that the person is ineligible for BadgerCare Plus based on current monthly income but would be eligible under gap filling rules.

The IM agency must assess the referral or request to determine the following for each person in the household:

- If a person meets the BadgerCare Plus nonfinancial and financial eligibility rules based on his or her monthly prospective income, BadgerCare Plus should be certified with a 12-month certification period beginning from the first of the month of the Marketplace application date. There is no need to determine the person's eligibility under gap filling rules.
- If a person is found ineligible due to a nonfinancial reason, BadgerCare Plus should be denied for the nonfinancial reason for that person. There is no need to determine the person's eligibility under gap filling rules.
- If a person has a gap filling referral or request and is found ineligible for BadgerCare Plus solely due to excess monthly income, BadgerCare Plus

eligibility must be assessed under gap filling rules (see Section 16.9.2 Determining Annual Income for Gap Filling Referrals). This includes eligibility determinations for backdated months.

16.9.1.1 People Found Eligible Under Gap Filling Rules

When a person is found eligible under gap filling rules, the IM agency must document in case comments the income used to make the determination and how that amount was calculated. The worker must also clearly document the following information in the case comment:

- Name of the eligible person(s)
- Assistance group size
- Monthly income on which the original BadgerCare Plus denial was based
- Annual income
- Eligibility begin and end months (The end month will always be December of the calendar year in which the application was filed with the Marketplace.)
- Med stat code (The current med stat codes for adults with income between 0 and 100 percent of the FPL are "BL" for parents/caretakers and "9P" for childless adults.)

Note: Because their eligibility is manually certified, childless adults determined eligible under gap filling rules cannot be subject to the premium or treatment needs question requirements described in Sections 44.2 Premiums for Childless Adults and 44.3 Treatment Needs Question for Childless Adults.

IM workers should work with their CARES coordinator who will email EM CAPO to indicate when a person has been found eligible as a gap filling referral. The email must include the following items:

- Case number
- Assistance group size
- Monthly income on which the original BadgerCare Plus denial was based
- Annual income
- Eligibility begin and end months
- Med stat code

EM CAPO will manually certify the person for BadgerCare Plus and send a notice of decision informing the person of his or her eligibility and change reporting rules.

16.9.1.2 People Found Ineligible Under Gap Filling Rules

When an applicant is determined ineligible under the gap filling rules, IM workers should document in case comments the income used to make the determination, how that income was calculated, and confirm the denial in **CWW** to send the notice of decision. IM workers must also send one of the following manual letters, which provide more information about the denial under gap filling rules and next steps:

- The Member Request Gap Filling Eligibility Determinations Supplemental letter, F-01915A, must be used if **both** of the following conditions apply:
 - The applicant or member has requested a gap filling eligibility determination.
 - The applicant or member does **not** have a gap filling indicator or a denial letter from the Marketplace.
- The Marketplace or Indicator Gap Filling Eligibility Determinations Supplemental letter, F-01915, must be used for gap filling denials when **either** of the following conditions applies:
 - The agency processes an application for someone with a gap filling indicator.
 - The applicant has received a denial letter from the Marketplace.

A copy of the letter must be scanned into the ECF.

If the applicant contacts his or her agency about the denial, the IM agency may need to clarify the reason for denial, which should be documented in case comments, and help explain the next steps for the applicant to follow up with the Marketplace in order to get health care coverage. For gap filling referrals from the Marketplace, certain income may not have been reported or may have been inaccurately reported during the Marketplace application process. The applicant can either apply at the Marketplace and report all expected annual income or file an appeal at the Marketplace within the allowable 90-day timeframe if he or she has applied and been denied for coverage at the Marketplace.

16.9.2 Determining Annual Income for Gap Filling Referrals and Requests

When determining annual income under gap filling rules, use the income reported on the application, income discovered or verified through data exchanges, and other income to determine annual income. This includes, but is not limited to, using wages earned for previous quarters verified through **SWICA**, wages verified through the **FDSH** wage match, wages verified through an Employer Verifications of Earnings form (EVFE), or other verification and data exchanges verifying unemployment and Social Security income. If the information reported on the application is not clear or the sources

of income cannot be verified through available data exchanges, the IM agency must send a verification request.

This method should be also used when determining eligibility under gap filling rules for backdated months (see Section 25.8.1 Backdated Eligibility) and when determining whether someone would have qualified under gap filling rules as part of reviewing a potential overpayment (see Section 28.3 Unrecoverable Overpayments).

When budgeting expected annual income for eligibility in the same calendar year, consider the person's employment history and pattern of employment to determine if he or she is reasonably expected to have a change in income that would impact eligibility. For example, if an applicant has been working a seasonal job, such as construction or farming, with wages in the second and third quarters and unemployment in the first and fourth quarters of the past several years, it would be reasonable to expect the person to continue that pattern of employment and unemployment unless the person reports a change that indicates he or she is not returning to that employment.

Example 1: Megan's application has an August 1 filing date and is sent with the Gap Filling Indicator. She reports that she is currently on unemployment and receives \$1,452 per month. When the worker is processing the application, there are wages earned for the first quarter in the amount of \$5,800, and the unemployment query shows that she was fired in February and that she started receiving unemployment compensation on March 1. Based on income she has already received this year (\$5,800 in wages plus \$7,260 in unemployment from March to July), she has already received \$13,060 this year, which is over 100 percent of the FPL for a group of one, so she does not meet gap filling rules. Megan is not eligible for BadgerCare Plus. The worker confirms the denial in CWW and sends the Marketplace or Indicator Gap Filling Eligibility Determinations Supplemental letter (F-01915).

Example 2: Greg's application has a November 15 filing date and is sent with the Gap Filling Indicator. He reports that he is currently on unemployment and receives \$1,000 per month. When the worker is processing the application, there are wages earned in the second and third quarters of the last three years at a local roofing company. Wages earned so far in the current year total \$5,200. Unemployment received so far includes \$2,400 received from January through March, \$1,000 received in October, and \$500 so far in November, for a total of \$3,900. He is still filing unemployment and has more than \$3,000 available to be paid. To determine the anticipated income for the remainder of the year, the worker would continue to budget \$1,000 for unemployment per month for November and December. Greg's total income expected for the year is \$10,600 (\$5,200 in wages, \$2,400 in

unemployment from January through March, and \$3,000 in unemployment from October through December). Because his annual income is expected to be under 100 percent of the FPL, Greg is eligible for BadgerCare Plus under gap filling rules.

Example 3: Erin's application has an August 1 filing date and is sent with the Gap Filling Indicator. She reports that she is currently working and earns \$1,400 per month (paid biweekly with earnings of \$700 per pay period) with no other income. Her job started July 1 and she received one paycheck in July. Her anticipated annual income is \$7,700 (\$1,400 per month from August through December and \$700 for July). Because her annual income is expected to be under 100 percent of the FPL, Erin is eligible for BadgerCare Plus under gap filling rules.

Example 4: Amber and Ryan are married and reside together. Their application has a February 15 filing date and is sent with the Gap Filling Indicator. Amber is currently on unemployment and receives \$1,452 per month and reports that they have no other income. When the worker is processing the application on February 28, SWICA shows earnings between \$15,000 and \$20,000 per quarter for the first, second, and third quarters of each year for the past four years. The unemployment query shows that Amber is currently receiving \$1,452 per month, which started October 1 and she has \$9,500 remaining to be paid; the query also shows that she received unemployment from October through December for the past four years when laid off from her job. However, the most recent claim shows that Amber was not laid off, she was fired. The worker contacts Amber to clarify that she will not be returning to that job and Amber confirms that in the past, she had been laid off at the end of the season, but she was fired on October 1, and has been on unemployment since then. Because she is not expected to return to that job, their anticipated annual income is \$12,404 (\$2,904 in unemployment from January through February and \$9,500 in unemployment anticipated from March through September). Because their annual income is expected to be under 100 percent of the FPL, Amber and Ryan are eligible for BadgerCare Plus under gap filling rules.

Example 5: Monica submits a BadgerCare Plus application on July 23. She reports that she started a seasonal job in June and that it will end in September. Monica earns \$1,500 per month and has no other source of income. Monica believes her income might be over the monthly limit, but will likely be below the annual limit. She contacts the IM agency to request a gap filling eligibility determination.

Based on her monthly income, Monica is over the limit for BadgerCare Plus. However, her expected annual income is \$6,000 (employment wages from June to September). Because her annual income is expected to be at or below 100 percent of the FPL, Monica is eligible for BadgerCare Plus under gap filling rules.

Example 6: Byron has been enrolled in BadgerCare Plus as a childless adult since October. At the time of his enrollment, Byron had no income. In March, Byron began receiving SSDI income in the amount of \$1,400. Since he is over the monthly income limit, his BadgerCare Plus eligibility ends on April 30, and he is sent a notice of decision. Byron contacts the IM agency on May 3, to request a gap filling eligibility determination. Byron's anticipated income is \$14,000 (SSDI income in the amount of \$1,400 per month for the 10 months from March to December). Since his annual income is expected to exceed 100 percent of the FPL, Byron is not eligible for BadgerCare Plus under gap filling rules. The worker confirms the denial in CWW and sends the Member Request Gap Filling Eligibility Determinations Supplemental letter, F-01915A.

Example 7: Samantha applies for BadgerCare Plus on August 20 and reports she will begin receiving SSDI payments in the amount of \$1,400 per month beginning in September. Employment queries show that Samantha has not earned any wages for the year. Samantha will be eligible for BadgerCare Plus for August but will be ineligible for September due to her monthly income exceeding 100 percent of the FPL. Since Samantha had no other annual income, the worker believes that Samantha may be eligible for BadgerCare Plus under gap filling rules. Her expected annual income is \$5,600 (SSDI income in the amount of \$1,400 per month from September to December). Her annual income is expected to be at or below 100 percent of the FPL, so Samantha is eligible for BadgerCare Plus under gap filling rules.

Example 8: Kyle has been enrolled in BadgerCare Plus since April. At the time of his enrollment, he reported his employment ended last February and he filed for unemployment, but he has not yet heard if he qualifies. When processing the application, the IM worker noted in case comments that Kyle had consistent wages from a job he had in the previous year, but his wages for the first quarter were \$2,200, which was significantly lower than his wages from the third and fourth quarters of the previous year.

On July 25, Kyle contacts the IM agency to report that he started receiving unemployment in the amount of \$1,300 per month. The unemployment query confirms that Kyle received unemployment compensation beginning July 1, in the amount of \$1,300 per month. He will receive \$7,800 for the months of July through December. Based on his monthly income, Kyle would be over the limit for BadgerCare Plus. However, the worker believes that Kyle may still be eligible under gap filling rules based on his expected annual income, which is \$10,000 (\$2,200 in wages from the first quarter and \$7,800 from anticipated unemployment benefits from July to December). His annual income is expected to be at or below 100 percent of the FPL, so Kyle would be eligible for BadgerCare Plus under gap filling rules.

16.9.3 Change Reporting for People Eligible Under Gap Filling Rules

People are still subject to change reporting requirements while enrolled in BadgerCare Plus under gap filling rules. A person can lose eligibility during the certification period if:

- He or she is no longer eligible for any nonfinancial reason such as moving out of the state.
- He or she experiences an increase in income that will make annual income greater than 100 percent of the FPL.

When a person is no longer eligible for the reasons noted above, the IM agency should inform EM CAPO to end eligibility and send the termination notice. If the person has exceeded the annual income limit during the gap filling certification period, include the person's new reported annual income amount in any communication with EM CAPO when requesting the person's eligibility be terminated.

16.9.4 Certification End Date Under Gap Filling Rules

Because the Marketplace considers annual income on a calendar-year basis, the manual gap filling certification will last until the end of the calendar year. Approximately 45 days prior to the end of the year, members will receive a notice from EM CAPO advising them that their eligibility is ending and directing them to return to the Marketplace (or, if appropriate, to reapply for BadgerCare Plus).

16.9.5 Eligibility Under Another Category of BadgerCare Plus or Medicaid

If the member becomes eligible in another category of BadgerCare Plus or Medicaid, the gap filling certification will end. EM CAPO does not send a notice of termination to

the member if the gap filling certification ended due to the member becoming eligible in another category of BadgerCare Plus or Medicaid.

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17 Deductibles

17.1 Deductibles

Children (younger than 19 years old) with income over 306 percent of the *FPL* may become eligible for BadgerCare Plus by meeting a deductible. Children with income over 156 percent of the FPL who are denied BadgerCare Plus solely due to access to health insurance may also become eligible for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150 percent of the FPL.

Pregnant women with incomes above 306 percent of the FPL can qualify for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 300 percent of the FPL for pregnant women. The deductible is met by incurring medical expenses that equal the deductible amount. Pregnant women who could only qualify for the BadgerCare Plus Prenatal Program may not become eligible for the Prenatal Program by meeting a deductible.

Note: When determining the deductible amount, only the income of the applicant, the applicant's spouse, and, if the applicant is younger than 19 years old, the applicant's parents, should be considered. If a sibling or other tax dependent has been counted as part of the applicant's regular MAGI assistance group, the sibling's or tax dependent's income should be excluded for purposes of calculating the deductible; however, he or she should still be included in the assistance group size.

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17.2 Pregnant Women

17.2.1 Introduction

For a pregnant woman with countable MAGI income above 306 percent of the FPL, the **deductible** amount is the amount of countable income above 300 percent of the **FPL** for a six-month period. To meet the deductible, the pregnant woman or other family members included in the BadgerCare Plus group must incur medical bills equal to the pregnant woman's deductible amount.

Note: If there is more than one pregnant woman in the BadgerCare Plus group, all of them become eligible when a deductible is met.

A pregnant woman with assistance group income over 306 percent of the FPL must meet a deductible to become eligible for BadgerCare Plus, even if she is a parent or caretaker of born children.

If the pregnant woman applies after the birth of her baby and becomes eligible by meeting a deductible in backdated months, she is only eligible as a pregnant woman until the end of the month she gives birth.

(For eligibility regarding the BadgerCare Plus Prenatal Program for inmates of a public institution or non-qualifying immigrants, see Section 41.2 BadgerCare Plus Prenatal Program Eligibility Requirements).

Example 1: Janet applies for BadgerCare Plus in July and requests a BadgerCare Plus deductible period from April through September. She gave birth on June 30. Janet paid the full deductible amount, so is certified from April 1 through June 30. She should be tested as a caretaker relative effective July 1 if she is living with the newborn or any other child under her care.

17.2.2 Deductible Period

The pregnant woman can choose to begin the BadgerCare Plus deductible period as early as three months prior to the month of **application**, and as late as the month after the month of application.

A pregnant woman can choose a BadgerCare Plus deductible period which includes a month in which she would have been ineligible for a non-financial reason, with one exception. A deductible period may not begin with a month in which the pregnant woman is non-financially ineligible. Although excess income is still calculated over a six

month period, the individual may only be certified for BadgerCare Plus during the dates when she was non-financially eligible.

Example 2: Luanne applied for BadgerCare Plus on June 1st and requests a BadgerCare Plus deductible period from April through September. She gave birth on June 2nd and gave the baby up for adoption. Luanne paid the full deductible amount, so is certified from April 1st through June 30th.

A new deductible period can be established at any time before the current deductible has been met.

Example 3: Julie is pregnant and due November 15. She applied for BadgerCare Plus April 1 and a deductible period was set up for April through September. She did not incur enough expenses to meet the deductible. In July, Julie's income decreased and she requested a new deductible period from July through November. Because she had not met the original deductible, the new deductible period could be established.

A pregnant woman who is ineligible due to excess income in some backdated months, but has no excess income in others, does not have to choose to have a BadgerCare Plus deductible. She can choose to be certified in the months she is eligible and to accept the ineligibility of the other months when she had excess income.

Example 4: Rachel is pregnant and applied for BadgerCare Plus in July. She had no income and did not expect any income in the future. She was eligible in July. She also requested BadgerCare Plus eligibility for April to cover some medical expenses she had in April. In April and May, she had income in excess of 300 percent of the FPL. In June, she would have been eligible because she had no income.

In April and May, her income was over 300 percent of the FPL by \$200 a month. She has two choices:

1. Choose a BadgerCare Plus deductible period of April through September. After meeting the BadgerCare Plus deductible of \$400, she would be certified for BadgerCare Plus from April through September or 60 days past the birth of her baby, with no premium.
2. Not choose a BadgerCare Plus deductible period. She would not have to meet a BadgerCare Plus deductible. She could be certified immediately for June through 60 days past the birth of her baby but would have to forego

BadgerCare Plus for April and May because of the excess income in April and May.

17.2.3 Calculating the Deductible Amount

To calculate the dollar amount of the BadgerCare Plus deductible for a pregnant woman:

1. Determine the BadgerCare Plus deductible period.
2. Find the BadgerCare Plus group's total countable income for each month in the deductible period.
3. If the assistance group's total countable income includes the income of someone other than the pregnant woman, her spouse, or, if she is younger than 19 years old, her parents, subtract the income of that person(s), but do not change the size of the assistance group.
4. Compare the total income of each month with 300 percent of the FPL. If any month's income is less than or equal to 300 percent of the FPL, ignore it. If any month's income is more than the income limit, find the excess income by subtracting the income limit from the income of that month.
5. Add together the excess income of the months in the deductible period. The result is the pregnant woman's BadgerCare Plus deductible amount.

When calculating a deductible amount for backdated months, use the actual, not prospective, income received in the backdated months.

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17.3 Children Under 19

Children (younger than 19 years old) with income over 306 percent of the FPL may become eligible for BadgerCare Plus by meeting a deductible. Children with income over 156 percent of the FPL who are denied BadgerCare Plus solely due to access to health insurance may also become eligible for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150 percent of the FPL.

To meet the deductible, the child or his or her parents included in the child's BadgerCare Plus group must incur medical bills equal to the deductible amount. Deductible-based eligibility is **not** extended to other children or members of the original assistance group. The parents' medical expenses may be used for meeting the deductible of more than one child at a time. Medical expenses of siblings may not be used for a child's deductible.

17.3.1 Deductible Period

The child under 19 can choose to begin the BadgerCare Plus deductible period as early as three months prior to the month of application and as late as the month following the month of *application*.

Example 1: On November 1, John's mother and stepfather apply for BadgerCare Plus for themselves, John, and John's two stepbrothers. The family's countable income is 225 percent of the FPL. John's mother has employer-sponsored insurance that covers her and John. John is ineligible for BadgerCare Plus due to the insurance access. John's stepbrothers are eligible for BadgerCare Plus with a premium. Because the health insurance does not cover all of John's medical expenses, in December, John's mother requests a deductible for John. The deductible period is December through May. John has medical bills that will meet the deductible as of January 1. John will be covered under BadgerCare Plus with no premium from January through May.

The BadgerCare Plus deductible period for a child can include a month in which he or she would have been ineligible for a non-financial reason other than health insurance access or coverage, with one exception. A deductible period may not begin with a month in which the child is non-financially ineligible for a reason other than health insurance access or coverage. Although excess income is still calculated over a six month period, the child may only be certified for BadgerCare Plus during the dates

when he or she met all non-financial criteria other than health insurance access or coverage.

A new deductible period can be established at any time before the current deductible has been met.

17.3.2 Calculating the Deductible Amount

To calculate the dollar amount of the BadgerCare Plus deductible for a child:

1. Determine the BadgerCare Plus deductible period.
2. Find the child's assistance group's total countable income for each month in the deductible period.
3. If the assistance group's total countable income includes the income of someone other than the child, the child's parents, or, if married, the child's spouse, subtract the income of that person, but do not change the group size of the AG.
4. Compare the total income of each month with 150 percent of the FPL. If a month's income is less than or equal to 150 percent of the FPL, ignore it. If a month's income is more than the income limit (150 percent of the FPL), find the excess income by subtracting the income limit from the income of that month. The child could choose to drop the deductible for months his or her income decreases so that the child is eligible to enroll in BadgerCare Plus.
5. Add together the excess income of the months in the deductible period. The result is the child's BadgerCare Plus deductible amount.

Example 2: Kyle is 14 years old, and his assistance group's income is over 156 percent of the FPL. Because of his age and assistance group's income amount, he is subject to health insurance access policies. He is ineligible for BadgerCare Plus because he is covered under his mother's employer-sponsored health insurance plan. The household's size is five. Their income is \$366.25 over the 150 percent FPL for a group size of five. Kyle's six-month deductible amount is \$2,197.50.
($366.25 \times 6 = \$2,197.50$)

Example 3: Mark, who is 5 years old, is ineligible for BadgerCare Plus because his assistance group's income is over 306% of the FPL. The household is made up of Mark's mother and 17-year-old brother whose income is counted because he is expected to be required to file taxes. Mark's assistance group's income is \$3,026 over the 150 percent FPL for a group size of three. However, because Mark's brother is not his parent or spouse, his income must be excluded from the deductible

calculation. This reduces the excess income to \$1,526. John's six-month deductible amount is \$9,156 ($\$1,526 \times 6 = \$9,156$).

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17.4 Meeting The Deductible

The BadgerCare Plus member or group meets the *deductible* by incurring medical or remedial costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the pregnant woman or child under 19 can be certified for BadgerCare Plus through the end of the deductible period.

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

If an expense was applied to a prior deductible but did not result in BadgerCare Plus certification, it can be applied to a later deductible, as long as it still meets the criteria listed in Section 17.4.1.

17.4.1 When Expenses Can Be Counted Toward a Deductible

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions:

1. Be incurred by the member, his or her spouse (if applicable), or, if the member is younger than 19 years old, his or her parents.

Expenses may also be counted if incurred for someone the member is legally responsible for if that person's bills could be counted toward the member's deductible. The medical bill may be used even if the person is no longer living or no longer in the current BadgerCare Plus group.

Example 1: Sally's spouse, Michael, died in April. In September, Sally requests that a medical bill incurred for Michael be used toward her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long as it did not result in a BadgerCare Plus certification in an earlier period.

Example 2: Jenny's children, Sam and Olivia, each have a \$1000 deductible. Jenny has a medical bill for \$1000. This bill can be used to meet both Sam's \$1000 deductible and Olivia's \$1000 deductible at the same time.

2. Meet the Definition of Medical or Remedial expense described in 17.4.2.
3. Meet one of the following four conditions:

- a. Still be owed to the medical service provider sometime during the current deductible period.

Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a BadgerCare Plus deductible.

- The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
- If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
- Because many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 3: In May, Helen resided in an Institute for Mental Disease (IMD) and incurred a \$14,000 bill. In October, Helen becomes pregnant and applies for BadgerCare Plus.

Helen turned in the bill for the stay in the IMD which shows the amount as 'deferred charges' which means the member would never be billed for the charges, but if 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's parent applies for BadgerCare Plus in July 2008. A BadgerCare Plus deductible of \$700 is calculated for him. In

January 2003, he had a blood transfusion. The bill for the transfusion was \$800. The bill was never paid. Lestat can use the unpaid bill to meet his BadgerCare Plus 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.

c. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 5: Estelle applies for BadgerCare Plus in March. A deductible period is set up for March through August. In April, she had a two-year-old medical bill of \$300 written off. She can apply the \$300 toward the March - August deductible because it was written off during the deductible period.

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, 2007. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February 2006. He may not apply this toward his current deductible.

d. Paid or written off some time during the three months prior to the start of the first deductible period. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 8: Norah is in her second deductible period which began in September. In June, Norah met her deductible and was certified for BadgerCare Plus. After certification, and before the prior deductible period ended in August, Norah paid for medical services that were not BadgerCare Plus covered services. Norah can apply these paid bills to the deductible period that began in September.

Example 9: Julie applies for BadgerCare Plus in August. Her deductible for the period from August through January is \$1,500. On May 10 she paid off a \$2,000 outstanding medical bill. She can use that expense to meet her deductible because it was paid in the three months prior to the date of her application. The remaining \$500 cannot be applied to future deductible periods.

Example 10: Maria's son Joseph is open for BadgerCare Plus as a child (MAGC). Maria reports an income increase. Starting in October, Joseph must meet a deductible in order to be eligible for BadgerCare Plus. The deductible for the period from October through March is \$1,500. Joseph had a medical bill for \$2,000 for services not covered by BadgerCare Plus that was written off in September. Maria can apply this written-off bill to Joseph's deductible period that begins in October. The remaining \$500 cannot be applied to future deductible periods.

17.4.2 Countable Expenses

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by BadgerCare Plus. Medical expenses for services or prescriptions acquired outside of the U.S. may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

Some examples of medical expenses are deductibles, copayments and premiums for BadgerCare Plus, Medicare, private health insurance; and bills for medical services that are not covered by the Wisconsin BadgerCare Plus program. When determining the countable medical expenses under MAGI rules, health insurance premiums that are counted as pre-tax deductions from income cannot also be counted toward a deductible as a medical expense.

Note: MMIS data may be used to calculate BadgerCare Plus copayments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying or reducing a medical or health condition. Some examples of remedial expenses are:

- a. Case management
- b. Day care
- c. Housing modifications for accessibility
- d. Respite care
- e. Supportive home care

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- Assistance with activities of daily living
- Attendant care
- Supervision
- Reporting changes in the member's condition,
- Assistance with medication and medical procedures which are normally self-administered, or
- The extension of therapy services, ambulation and exercise.
- Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the member's safety, well being and care at home.

- f. Transportation.
- g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

3. Remedial expenses do not include housing or room and board expenses.

4.

5. Ambulance service and other medical transportation including attendant services

6. Medical insurance premiums paid by a member of the BadgerCare Plus Group. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period.

7. 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).

8. The cost of medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.

9. 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.

10. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in # 1 through 7 above.

Examples include:

7.

- General Assistance
- Community Options Program
- AIDS Drug Assistance Program (ADAP)

Example 11: Jenna receives a medical service which will be paid by ADAP. When Jenna becomes pregnant and applies for BadgerCare Plus she has a deductible to meet. This medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 12: 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 BadgerCare Plus for herself and her son,

James. Sally has access to health insurance so James must meet a deductible. Since the medical bill was paid by COP within three months of Sally's BadgerCare Plus application it can be used to meet James' BadgerCare Plus deductible.

8. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in (17.4.2)

Example 13: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for BadgerCare Plus 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 14: Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February Charlie's mother applies for BadgerCare Plus. Charlie has to meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's BadgerCare Plus application, it can be used to meet Charlie's BadgerCare Plus deductible.

17.4.3 Expenses That Cannot Be Counted Toward a Deductible

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by BadgerCare Plus, Medicare or other Insurance.

Example 15: The costs of medical services provided to an incarcerated person are not allowed as expenses to meet a deductible. The incarcerating authority is the legally liable third party.

3. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in (17.4.1).

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17.5 Order of Bill Deduction

When applying medical bills to the *deductible* , start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

17.5.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is sometimes difficult to know when the patient met the deductible.

For this reason, if the patient's hospital bill for one continuous stay in the hospital is equal to or above the deductible amount on the date of admission, the first day of admission is the date of service for the entire bill. The hospital bill is applied to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example: Linda submits a \$2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for \$2,500 with a date of service of July 12th. Apply the \$2,000 hospital bill to the deductible first.

17.5.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

The entire "global" pregnancy fee is counted as an expense as of the date an agreement was signed.

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17.6 Prepaying a Deductible

Anyone can prepay a BadgerCare Plus *deductible* for him or herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment prior to the begin date of the corresponding deductible period.

Instruct the member to make the payment payable to the local Income Maintenance Agency. Report the receipt on the Community Aids Reporting System (CARS) labeled as a Medical Refund.

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and BadgerCare Plus ID number.

17.6.1 *Insufficient Funds*

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

17.6.2 *Payment of Entire Deductible Amount*

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 1: 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 BadgerCare Plus eligibility begins on March 1st.

17.6.3 *Combination of Payment and Incurred Expenses*

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 2: Gloria's deductible period is from March 1st through August 31st. The total BadgerCare Plus deductible amount is \$1,800. Gloria submits a medical bill with a March 8th date of service for \$800. On July 15th, she submits payment of \$1,000. Gloria's BadgerCare Plus eligibility begins March 8th. A BadgerCare Plus Remaining Deductible Update (F-10109) must be submitted to identify the provider of service on March 8th and the \$800 member share amount.

17.6.4 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 3: Roberta's deductible period is from March 1st through August 31st. The total BadgerCare Plus 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 BadgerCare Plus eligibility begins March 1st

Enter the first date of the deductible period on AGTM as the date the payment was received.

17.6.5 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS. If the error was caused by an *applicant* /member error, see Section 28.2 Recoverable Overpayments for determining the overpayment amount.

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17.7 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 BadgerCare Plus. However, he or she is still responsible for the part of the bill that equals the deductible. BadgerCare Plus will consider the remainder of the bill for payment. See (Process Help, Chapter 19 Medicaid Deductible).

To make sure that BadgerCare Plus does not pay what the member still owes on the deductible, send a BadgerCare Plus Remaining Deductible Update (F-10109) to the fiscal agency indicating the amount of the bill that the member owes. The *Fiscal Agent* subtracts this amount from the bill and BadgerCare Plus pays the rest.

Fill out the BadgerCare Plus Remaining Deductible Update (F-10109) only if:

1. A BadgerCare Plus certified provider has provided the billed services.
2. The person, having met the deductible, is being certified. If he or she is not being certified, BadgerCare Plus 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 the BadgerCare Plus Remaining Deductible Update (F-10109) for any other bills for which the member would be responsible.

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17.8 Changes In Income

Once the *deductible* has been met, changes in income do not affect the group's eligibility for the remainder of the deductible period.

If there are income changes reported during the BadgerCare Plus deductible period but prior to meeting the deductible, recalculate the BadgerCare Plus 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, or when the group size decreases. 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 income, deductions, or group size. To determine the amount of a decreased deductible:

1. Add together the monthly excess income of the months of the BadgerCare Plus deductible period that have already gone by.
2. Subtract the 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, a pregnant woman with income over 300% FPL, applied for BadgerCare Plus in July. She had excess income of \$20 a month. Her BadgerCare Plus deductible was \$120. On October 8th, she reports a pay decrease of \$10 a month. The change is effective for November. The BadgerCare Plus deductible amount is recalculated by:

1. Adding together the excess income of months July through October. The result is \$80.
2. Calculating her November excess income. The result is excess income of \$10.
3. Prospective excess income for December is \$10.
4. Cicely's new BadgerCare Plus deductible amount is: $\$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 current BadgerCare Plus deductible, or

2. Create a new deductible period.

Example 2: Mary, a pregnant woman, goes from full time to part time employment in the fourth month of her BadgerCare Plus deductible period. She still has excess income, but it is lower than in the previous three months. She can choose either to recalculate her BadgerCare Plus deductible to a lower amount or to start a new deductible period.

If she chooses to start a new deductible period, she will forfeit any eligibility she might have acquired in the previous deductible period if she had met the previous deductible.

If the income change results in no excess income the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. Begin eligibility immediately.

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17.9 Non-financial Changes

17.9.1 Non-Financial Changes Introduction

If there is a change in non-financial eligibility during the *deductible* period, discontinue BadgerCare Plus eligibility for those persons who have become non-financially ineligible.

Every child in a BadgerCare Plus household must have his or her eligibility for a deductible determined separately. If a child enters the BadgerCare Plus group after a deductible for another child in the group has been set, the new child must have his or her eligibility for a deductible determined separately.

If an adult caretaker relative who is EBD, or is pregnant, enters the BadgerCare Plus group, his or her eligibility for a deductible must be determined separately.

If a member loses non-financial eligibility and regains it during the same deductible period, the member may choose:

- To continue with the current deductible period.
- OR**
- To reapply and establish a new deductible period if his or her income still exceeds the appropriate BadgerCare Plus income limit.

17.9.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, and the deductible is not met, the deductible must be recalculated. Compare the new group's countable monthly income with the new group's FPL limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes. Beginning July 1, 2020, the deductible amount will no longer be increased when an unmet deductible assistance group has a decrease in the 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 income, deductions or group size.

17.9.3 Death

If the member dies during the deductible period, and is not already certified, look at all countable expenses prior to death. If those countable expenses meet the deductible, certify the person. The time period for the deductible remains six months. All months that remain of the six-month deductible period from the point the member dies, are considered to have \$0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

If the member prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the member prepays and dies before the deductible period starts, the deductible pre-payment is refundable.

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17.10 Late Reports of Changes

If the member turns in late reports on income changes or medical costs, recalculate the *deductible* as of the date the change took place or the medical cost was incurred. See what would have been the deductible had 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 BadgerCare Plus certification on that date.

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18 BadgerCare Plus Extensions

18.1 Extensions

18.1.1 Introduction

A BadgerCare Plus extension is a period of eligibility given to a person when the assistance group's income increases above 100 percent FPL either due to an increase in earned income and/or spousal support and otherwise meets the BadgerCare Plus eligibility criteria for people with incomes below 100 percent FPL.

A parent/caretaker relative or pregnant woman can enter an extension due to an increase above 100 percent FPL in the assistance group's earned income, spousal support, or both. The children, stepchildren, and NLRR children of the parent/caretaker will also enter the extension at this time, provided they are under age 19, living with the parent/caretakers, and meet the income requirements outlined in Section 18.1.3 Children.

BadgerCare Plus members eligible as childless adults are not eligible for an extension.

If a family is moving out of the State of Wisconsin at the time of the income increase, they would not be eligible for the extension.

In late renewal situations, the renewal must have been submitted in the month the renewal is due in order for the family to be eligible for the extension.

If all members of the household are eligible for an extension, verification of income is not required. If a member of the household is eligible for BadgerCare Plus but not in an extension, the household may be required to provide verification of income for determining that person's BadgerCare Plus eligibility. If verification is not provided timely, it will not impact the other members' eligibility in a BadgerCare Plus extension.

Example 1: The Brown family's health care renewal is due July 31. The renewal is submitted to the agency on July 31. The agency processes the renewal on August 7. The agency determines that the Brown family's income is now over 100 percent of the FPL and no financial verification is required since all members of the family meet the criteria to be eligible under a BadgerCare Plus extension. The Brown family enters into an extension starting August 1.

Example 2: The Brown family's health care renewal is due July 31. The renewal is submitted on August 9. They are not eligible for an extension.

Example 3: Janine and her son, Zachary, are open for BadgerCare Plus under an extension, and her daughter, Amy, is open for regular BadgerCare Plus (not an extension). Janine reports an increase in income. She will be required to verify her new income since her income is counted when determining Amy's BadgerCare Plus eligibility.

While on the extension, children are not subject to the insurance access and coverage requirements. For example, having access to employer health insurance when the family income increases from 80 percent to 175 percent FPL will not make them ineligible for the extension.

18.1.2 Pregnant Women

A pregnant woman is able to enter an extension if she was eligible for BadgerCare Plus as a pregnant woman or a parent or caretaker relative at any time during the pregnancy with income at or below 100 percent of the FPL in three of the past six months. In most cases, her continuous eligibility as a pregnant woman will take precedence over the extension, but the extension will be maintained and will result in eligibility if the pregnancy and postpartum period end prior to the end of the extension. The pregnant woman will remain exempt from the premium requirements through the end of the extension certification period.

18.1.3 Children

Under most circumstances, the end of an extension will apply to all of the members of the BadgerCare Plus Test group. However, when the household income decreases to 100 percent FPL or less, the extension will end for the parent(s), but any children would remain in the extension. All dependent children, stepchildren, and **NLRR** children whose parent or caretaker becomes eligible for an extension will be eligible for the same extension provided that they are eligible for BadgerCare Plus in the month prior to the start of the extension and:

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

Conditions:

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

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

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18.2 Increase in Earnings

18.2.1 Earned Income Extensions

To receive a 12-month BadgerCare Plus extension due to an increase in earnings, a parent, caretaker, or pregnant woman must meet all of the following requirements:

1. The income increase which caused the countable income for his or her BadgerCare Plus **AG** to exceed 100 percent FPL must be due solely to one of the following:
 - a. Increased earnings (of anyone in the same AG)
 - b. Increased earnings along with other income (changed or unchanged)
2. He or she must be a BadgerCare Plus member with income at or below 100 percent FPL at the time the income increased to over 100 percent FPL.
3. He or she must have been enrolled in BadgerCare Plus with income that was at or below 100 percent FPL for at least three of the six months immediately preceding the month in which the income went above 100 percent FPL.
4. He or she must otherwise meet the BadgerCare Plus eligibility criteria for persons with income below 100 percent FPL.
5. He or she must not be eligible as a Former Foster Care Youth.

Note: These requirements do not apply to children (see Section 18.1.3 Children).

Example 1: Jane lives with her two teenage children and Dave, the non-marital co-parent of the two children. Jane is claiming both children on her taxes and her income for her MAGA AG of three is 90 percent FPL. Dave's MAGA AG consists only of himself, and he is eligible for BadgerCare Plus with income of 95 percent FPL. The children-in-common are eligible in a MAGC AG group of four, with both parents as counted adults in their AG and their group's income is 121 percent FPL. Jane was enrolled in BadgerCare Plus with income below 100 percent FPL for three of the prior six months. In June, her earned income increased to 120 percent FPL. She is eligible for a 12-month BadgerCare Plus extension. Dave is not included in the extension because he was not a counted member of Jane's AG. The children are eligible for a 12-month extension because they were eligible in June when Jane's income rose above 100 percent and their own AG's income was below 156 percent FPL at the time.

18.2.2 Supplemental Security Income Exception

A person who was eligible for **SSI** benefits may be eligible for a 12-month BadgerCare Plus extension if he or she loses SSI and would have been eligible for BadgerCare Plus

with countable income at or below 100 percent if he or she had not been an SSI recipient.

Example 2: Mary is receiving SSI. Her two children are enrolled in BadgerCare Plus with countable income at or below 100 percent FPL. Mary started a job and her earnings put her above the SSI income limit. Her earned income also caused the BadgerCare Plus countable income to exceed 100 percent FPL. Both Mary and her two children are eligible for a 12-month BadgerCare Plus extension.

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18.3 Increase in Spousal Support or Family Support Income Extensions

18.3.1 Support Extensions

If a parent, caretaker, or pregnant woman's countable income increases above 100% FPL and all or part of the excess income consists of spousal support income, grant an extension of either four months or 12 months depending on the case circumstances.

Note: For cases that receive family support, only the spousal support or alimony portion of the family support is considered for support extensions. See Section 16.5 Other Income for more information on counting spousal support and family support.

18.3.1.1 Four-Month Extensions

The four-month BadgerCare Plus extension only applies if:

1. The income increase which caused the countable income to exceed 100% FPL must be due solely to:
 - a. Increased spousal support income, or
 - b. Increased spousal support income along with other unearned income (changed or unchanged).
2. There has been no increase in earned income.
3. He or she is an eligible BadgerCare Plus member with income at or below 100% FPL, at the time the income increased to over 100% FPL.
4. He or she must have been enrolled in BadgerCare Plus with income that was at or below 100% FPL for at least 3 of the 6 months immediately preceding the month in which the income went above 100% FPL.
5. He or she otherwise meets the BadgerCare Plus eligibility criteria for persons with income below 100% FPL

18.3.1.2 Twelve-Month Extensions

The 12-month BadgerCare Plus extension applies only if:

1. Earned income increased but spousal support income remained the same or both earned income and spousal support income increased.
2. He or she is a BadgerCare Plus member with income at or below 100% FPL, at the time the income increased to over 100% FPL.
3. He or she must have been enrolled in BadgerCare Plus with income that was at or below 100% FPL for at least 3 of the 6 months immediately preceding the month in which the income went above 100% FPL, and

4. He or she otherwise meets the BadgerCare Plus eligibility criteria for persons with income below 100% FPL.

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18.4 Income Changes During the Extension

During an extension, a group or individual's income may decrease to an amount at or below 100% FPL for the group size and then increase again to exceed the 100% FPL. When the income decreases, the individual will be removed from the extension and placed in regular BadgerCare Plus. The remaining months of the extension will continue to run in the background. Verification of the income decrease to at or below 100% FPL is required in order to make the individual eligible in regular BadgerCare Plus. If income verification is not provided, the individual will remain in the extension for the remaining months.

If the individual's countable income again increases above the 100% FPL, he or she would be eligible under the previous extension for any remaining months. If the individual is eligible for a new extension when the income again increases, because he or she meets all of the criteria above, choose the extension which gives the longest coverage, and cancel the other.

Example 1: A BadgerCare Plus group with a 12-month extension from January through December has a decrease in income in February that puts them back below 100% FPL. The group provides pay stubs to verify the decrease in income. The extension continues to run while the group is on regular BadgerCare Plus. In October the group's countable income again increases to above 100% FPL, this time due to an increase in spousal support income. They are now eligible for a four-month spousal support extension, which would run from November through February. Since the four-month extension would be longer than the current extension, apply the new four-month extension.

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18.5 Losing an Extension

18.5.1 Introduction

A BadgerCare Plus member loses an extension if one or more of following happens:

1. He or she fails to cooperate in providing third party health insurance coverage (*TPL*). Children younger than 19 are exempt from any penalty for not cooperating with this requirement.
2. All children under the parent's or caretaker relative's care have either left the household or turned 19, or the parent is no longer cooperating with a reunification plan, and the extension was based on an increase in earned income.
3. A child in an earned income extension turns 19.

Note: Children in a support extension who turn 19 years old do not lose the extension just for turning 19. Similarly a parent or caretaker relative in a support extension does not lose the extension just because all of the children under his or her care either left the home or turned 19. Members may continue to be eligible through the end of the extension period unless they meet any of the criteria listed above.

Note: An assistance group does not need to maintain employment in order to maintain an earned income extension.

18.5.2 Regaining Extensions

If a condition necessary for an extension is lost and the extension is closed for a full calendar month, the extension is not regained solely by recovering the lost condition.

If an extension is terminated for failure to verify information, eligibility for the unexpired extension cannot be regained by later providing the verification if it is more than a month after closure.

If an earned income extension ends because all children have turned 19 years old or left the household, but the child(ren) return to the household within the calendar month after the closure, the child and any people who qualify again as a parent or caretaker of that child(ren) may reopen under an unexpired earned income extension.

Example 1: Bob, his wife Betty, and their only child Ben are open for an earned income extension until May 31. Their eligibility ended on January 31 because Ben

left the household. It was reported that Ben returned to the household on February 13. Because it was reported that the child returned to the home within a calendar month, they may regain eligibility for their earned income extension until May 31.

However, people would be able to regain eligibility for an unexpired extension, even after being closed for more than a calendar month, in the following scenarios:

- They move out of the state and return before the extension ends (see Section 18.5.2.1 Leaving Wisconsin and Regaining Extensions).
- They de-request BadgerCare Plus after their extension has started (that is, the extension has been built and confirmed) and later request to reinstate for the remaining months of an unexpired extension.

Example 2: Bobby and his two children, Maria and David, are open for BadgerCare Plus (not in an extension). Bobby reports an increase in income on May 2. His increased earnings push the household income from 80% FPL to 160% FPL. The worker processes the change and confirms eligibility on May 8. Bobby and his family are determined eligible under a BadgerCare Plus extension starting June 1. However, Bobby changes his mind and de-requests BadgerCare Plus on May 12. Because it is before adverse action, their BadgerCare Plus will close effective May 31. Bobby contacts the agency on June 20, saying that he does want the coverage for his family under the extension. Even though he de-requested before June, the extension was built and confirmed, so Bobby's family can reinstate for the remainder of the unexpired extension.

18.5.2.1 Leaving Wisconsin and Regaining Extensions

If a BadgerCare Plus member is eligible for an extension and moves out of Wisconsin, he or she loses the extension. He or she can regain the extension if he or she returns and becomes a Wisconsin resident again during any month in the original extension period.

Example 3: Earl, a Wisconsin resident, received a 12-month extension beginning January 1, 2015. He moved out of state, thus losing his extension. On May 1, 2015, he moved back to Wisconsin and became a Wisconsin resident again. He regained the extension at the time he moved back to Wisconsin and became a Wisconsin resident.

If the time period of the extension expires while the person is out of state, he or she does not regain the extension.

Example 4: Gloria, a Wisconsin resident received a 12-month extension beginning January 1, 2015. She moved out of state, thus losing her extension. In February 2016, she moved back to Wisconsin and became a Wisconsin resident again. She does not regain the extension because the time period has expired.

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19 Premiums

19.1 BadgerCare Plus Premiums for Children

Children in families with income over 201 percent of the *FPL* must pay a premium to become or remain eligible for BadgerCare Plus unless exempt. This includes children who are open for regular BadgerCare Plus (not an extension) but whose parents, caretakers, or siblings are in a BadgerCare Plus extension.

Example 1: Roger lives with his son, Sam, and they are open for BadgerCare Plus under an extension. Neither of them have a premium since they are both in an extension. In October, Roger's other son, Justin, moves into the household. Justin is determined eligible for regular BadgerCare Plus as a child because he does not meet the requirements to be eligible under the extension with Roger and Sam. Roger and Sam continue to be eligible under the extension and do not have a premium. The household income is 230% of the FPL. Justin has a premium of \$10.

If Justin's premium is not paid, he will go into an RRP. Roger and Sam continue to be eligible under the extension.

The following children are exempt from the requirement to pay a premium for BadgerCare Plus:

1. Pregnant minors,
2. Former Foster Care Youth (see Chapter 11 Foster Care Medicaid)
3. Children who have met a BadgerCare Plus deductible, during the remainder of the deductible period,
4. Children in a BadgerCare Plus extension,
5. All children under age 1 including Continuously Eligible Newborns (see Section 8.2 Continuously Eligible Newborns),
6. American Indian or Alaskan Native Tribal members, the son or daughter of a tribal member, the grandson or granddaughter of a tribal member, or anyone otherwise eligible to receive Indian Health Services.

Note: Persons who are members of families receiving BadgerCare Plus benefits, but who are individually certified for EBD Medicaid, Well Woman Care, Family Planning Only Services or Emergency Services, are not charged a BadgerCare Plus premium.

Information about premiums and restrictive re-enrollment periods (RRP) for childless adults can be found in Section 44.2 Premiums for Childless Adults.

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19.2 Premium Calculations

19.2.1 Premium Calculations

Premiums are initially calculated on an individual basis and then a total for the case is determined. The general rules for calculating the premium amounts are explained below.

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

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19.3 Premium Limits

Children with assistance group income above 201% of the FPL will be required to pay premiums. The total premium amount for the household is the total of the individually calculated premiums, not to exceed a 5% cap. The cap will be 5% of the income of the assistance group with the highest income (in terms of dollar amount) in the case.

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

Example: Susan and Alan are non-marital co-parents caring for four children: Susan's son, Aaron (15); Alan's daughters Rachel (12) and Hannah (11); and Susan and Alan's son Jacob (9). Alan claims Rachel and Hannah as his two tax dependents, while Susan claims Aaron and Jacob. Susan earns \$2,500/month as a waitress, and Alan earns \$4,500/month as a computer analyst. None of the children have income. All four children are eligible for BadgerCare Plus.

Child	MAGI Group Formation	Assistance Group Income Amount	FPL	Premium Amount
Aaron	Susan, Aaron, and Jacob	\$2,500	138%	\$0
Rachel	Alan, Rachel, and Hannah	\$4,500	249%	\$23
Hannah	Alan, Rachel, and Hannah	\$4,500	249%	\$23
Jacob	Susan, Alan, Aaron, Rachel, Hannah, and Jacob	\$7,000	239%	\$15

Aaron does not have a premium, Rachel and Hannah have \$23 premiums, and Jacob has a premium of \$15. In this example, 5% of the income of the assistance group with the highest income is 5% of Jacob's MAGI group, or 5% of \$7,000/month, or \$350. Altogether, the household's monthly premiums are \$61. The household will pay \$61 in premiums for their children's coverage.

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19.4 Premium Payment Methods

Upon request from the member, the *fiscal agent* (1-888-907-4455) will provide members with instructions for choosing their preferred payment method from the list below.

Approved payment methods include:

1. Direct payment by check or money order.
2. Electronic Funds Transfer (EFT).
3. Wage withholding from each paycheck received.

Agencies are responsible to provide members with the Wage Withholding (F-13025) and EFT (F-13026) forms upon request, to facilitate the choice of payment method other than direct payment. Instruct the member to mail the completed forms to the address listed on the forms once he or she has chosen a payment method. Direct premium payments must be made until the fiscal agent informs the family the EFT and wage withholding has been set up.

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19.5 Initial Payments

Payment of the BadgerCare Plus premium is a non-financial condition of eligibility. Initial premium payments must be made before eligibility is confirmed and the members are enrolled. The first month is free if no one in the BadgerCare Plus group was eligible for BadgerCare Plus or Medicaid in the previous month, and the BadgerCare Plus **AG** has not received a free month in the previous 12 months. Consider someone with an unmet **deductible** as not being eligible for BadgerCare Plus. Free months occur at application and when members reopen after serving an RRP (and not reinstating during the RRP) and no one was on BadgerCare Plus in the previous month or received a free month in the last 12 months.

The eligibility policy and time frame procedures for premium payments are as follows:

1. Initial eligibility date and confirmation occur in the month of application.

When an application is processed in the same month it was received, and a premium for the initial month of eligibility is not due because they are eligible for a free month, the premium for the second month of eligibility must be paid in advance before a family can be enrolled in BadgerCare Plus.

Example 1: Lisa and her family applied for BadgerCare Plus on January 25. On January 31, the worker determined that the family met eligibility requirements effective January 1. Since the family had not been previously eligible for BadgerCare Plus, a premium for January was not assessed since they were eligible for the free month. However, Lisa had to pay the February premium for her family before their eligibility could be confirmed.

2. Eligibility begins in the month of application - confirmation occurs in a future month.

When an application is not processed within the 30-day application processing period and the family is eligible for a free month, the family must pay both the second and third months' premium before enrollment. CARES requires that premiums for both the second and third months be paid before confirmation when eligibility is processed any time in the third month.

Example 2: Cheryl and her family applied for BadgerCare Plus on March 25. No one in her family was eligible for BadgerCare Plus in the previous month. At Cheryl's request, the IM worker extended the 30-day processing

time period by ten days for additional verification. The application for BadgerCare Plus was processed on May 2, but the family was determined eligible effective March 1. A premium is not due for March because it is a free month. However, Cheryl had to pay the premium amount for April and May before BadgerCare Plus eligibility could be confirmed.

3. Eligibility begins in a future month, but application is processed in the month of application.

When an application is processed within 30 days but eligibility does not begin until a future month, the free month is the first future month of eligibility. The family will receive an invoice for the premium amount through the mail. He or she must pay the premium due for the second month by the tenth of the benefit month to remain eligible for BadgerCare Plus.

Example 3: Arnie and his family applied for BadgerCare Plus on April 12. He and his family were determined to be eligible for BadgerCare Plus beginning May 1. A premium is not assessed for May. A coupon for Arnie's June premium was mailed on May 20 with payment due by June 10.

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19.6 Ongoing Payment

BadgerCare Plus premiums are due on the 10th of the benefit month, regardless of which payment method is chosen.

Premium payments may not be paid in advance.

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19.7 Refunds

A refund must be issued if the premium was paid and is for a month in which one of the following situations occurs:

1. The individual or family was ineligible for BadgerCare Plus.
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 or \$0 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 27.2 Nonfinancial Change Reporting Requirements and Section 27.3 Income Change Reporting Requirements 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.

Example 1: David and Jenny are married and have a child, Megan. Their household income is 285% of the FPL. Megan is enrolled in BadgerCare Plus with a \$68 monthly premium. In June, David had a decrease in work hours. At the end of June, David and Jenny found that this reduction in work hours resulted in the household income decreasing to 235% of the FPL in the month of June. David reports this income change to the agency on July 7. Since this change was reported within 10 days of the household monthly income changing, the lower premium is effective the month in which the change occurs (June). Starting in June, Megan's monthly premium is \$15. David had already paid \$68 each for Megan's June and July premiums, so a refund must be issued. See Process Help 23.6.

Example 2: Morgan and Taylor are married and have a child, Kelly. Their household income is 285% of the FPL. Kelly is enrolled in BadgerCare Plus with a \$68 monthly premium. In June, Morgan has a decrease in work hours. At the end of June, Morgan and Taylor found that this reduction in work hours resulted in the household income decreasing to 235% of the FPL in the month of June. Morgan reports this income change to the agency on July 18. Since this change was reported more than 10 days after the household monthly income changed, the lower premium amount is effective during the month in which it was reported (July). Starting in July, Kelly's monthly

premium is \$15. Morgan already paid \$68 for Kelly's July premium, so a refund must be issued. See Process Help 23.6.

Example 3: Aaron has a child, Emily. Their household income for a group of 2 is 285% of the FPL. Emily is enrolled in BadgerCare Plus with a \$68 monthly premium. On September 4, Aaron marries Kathy. Aaron contacts his agency on September 13 to report his marriage to Kathy and adding her to his household. Their household income for a group of 3 is 225% of the FPL. Starting in September, Emily's monthly premium is \$10. Aaron had already paid \$68 for Emily's September premium, so a refund must be issued. See Process Help 23.6.

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19.8 Non-Payment

19.8.1 Non-Payment Introduction

The failure to pay a premium does not affect the eligibility of any person in the household who does not have a premium obligation. If an individual or family with a premium obligation fails to pay the premium by *adverse action* of the benefit month, BadgerCare Plus will close for those individuals who owed a premium. They will not be eligible for BadgerCare Plus for three calendar months, called an *RRP*, unless there is good cause (see Section 19.8.3 Good Cause for Non-Payment) or they pay the late premiums (see Section 19.11 BadgerCare Plus Restrictive Re-enrollment Period).

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

19.8.2 Insufficient Funds

If a BadgerCare Plus member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds it is considered a non-payment and the BadgerCare Plus eligibility will terminate. A restrictive re-enrollment (see 19.11) will be applied unless there is good cause (19.8.2). The RRP begins with the first month after closure. If an overpayment occurred, a benefit recovery claim should be established.

19.8.3 Good Cause for Non-Payment

Do not apply an RRP for non-payment if good cause exists. Good cause reasons for not paying the BadgerCare Plus premium are:

1. Problems with the financial institution.
2. CARES problem.
3. Local agency problem.
4. Wage withholding problem.
5. Fair hearing decision.

The member must still pay the arrears before eligibility will begin again.

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19.9 Late Payments

The case will remain open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by *adverse action* in the benefit month.

If the member pays between adverse action of the benefit month and the last day of the benefit month, eligibility can be restored.

Example: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He pays on September 26th. The case closed effective September 30th. Eligibility for October will be restored. He is not required to pay the October premium until October 10th.

Note: An individual's BadgerCare Plus eligibility can be reinstated during an RRP if the individual pays the owed premiums before the end of the RRP. For information about payments made during the RRP, see Section 19.11 BadgerCare Plus Restrictive Re-enrollment Period.

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19.10 Premium Changes

19.10.1 Decreased 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 or \$0 premium amount is effective during the month in which it was reported. The *fiscal agent* will refund any excess premium that was paid.

19.10.2 Increased Premium Amount

A 10-day notice must be given to the member when the group is required to pay a premium for the first time or is required to pay a higher premium. The increase is effective the following month if BadgerCare Plus eligibility is confirmed before *adverse action*. If the change is confirmed after adverse action, the increase is not effective until the month after the following month.

Example 1: Jessica has BadgerCare Plus with a premium for her and her family. She reports a change in income to her worker on April 23rd that results in a higher premium amount. Jessica's premium amount will increase effective June 1st. She will receive the coupon for the new premium amount at the end of May.

19.10.2.1 Person Adds

If the person add will cause an increase in the premium, *CARES* will not allow eligibility confirmation if the notice requirement cannot be met.

See also Process Help, Chapter 81.

19.10.2.2 Effective Dates of Premium Increase (Person Add)

1. If the person was added to the case before adverse action, the increase is effective the next month.
2. If the person was added to the case after adverse action, the increase is not effective until the second month.

Example 2: Rachel's husband Mike moved back into the home on June 1. She reported the change on June 6 and the agency processed the change on June 10 (before adverse action). Inclusion of Mike's income resulted in a premium increase. The increase is effective July 1. Mike's BadgerCare Plus eligibility must be manually certified for the dates between June 6th and June 30.

Example 3: Ann moved back to her parent's home on December 12 and reported it on December 22 (after adverse action). The agency acted to process the change on the same day. Inclusion of Ann's income resulted in a premium increase. The premium increase is not effective until February 1. Ann's BadgerCare Plus eligibility must be manually certified for the dates between December 22 and January 31.

19.10.2.3 Effective Dates of Premium Increase (Other Than Person Adds)

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

The following situations qualify for this treatment:

- A person is added to a case that has not paid the premium for another member.
- A person becomes eligible for BadgerCare Plus for any non-financial reason except late payment of the previous month's premium, failure to verify a reported change that resulted in the premium increase, or failure to complete a renewal.
 - A case reports a decrease in income from above 306% to below 306% and the child(ren) are now eligible with a premium.

Example 4: Mary and Tom apply for BadgerCare Plus on May 1 for their son, Sam, and Mary's daughter, Sara. Mary and Tom are not married and both plan to file taxes. Mary claims Sara as a dependent and Tom claims Sam. Sara's AG income is 208%, so she has a \$10 premium. Sam's AG income is at 310%, so he is not eligible for BadgerCare Plus. The case is confirmed on May 15 with Sara's eligibility beginning May 1. On June 1, Tom reports his income decreased in late March,

resulting in Sam's AG income to decrease to 265%. Sam would now be eligible with a \$44 premium. Because CWW will not allow the worker to confirm the increase in premium for June, Sam will not be required to pay a premium until July 1, although he will be eligible as of June 1. Sara is still required to pay her \$10 June premium, and the combined premium of \$54 will be effective July 1.

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19.11 BadgerCare Plus Restrictive Re-enrollment Period

19.11.1 Restrictive Re-Enrollment Period Introduction

A member for whom a premium is owed for the current month who leaves BadgerCare Plus by not paying a premium may be subject to a restrictive re-enrollment period. An **RRP** means the member cannot re-enroll in BadgerCare Plus for a certain number of months from the termination date while their income remains high enough to owe a premium, unless they pay the premiums owed, meet a good cause exemption or the RRP is lifted. Members can make late premium payments at any time during their three-month RRP.

Members must pay the overdue payment(s) that resulted in case closure, but do not have to pay the premium owed for the following month, unless the late payment is made after the benefit month.

Example 1: If a premium was owed for September, but is not paid until November, the premiums for September, October and November must be paid in order for eligibility to be restored for those months.

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

Example 2: Jim's son, Chad, is open for BadgerCare Plus with a premium. Adverse action is September 16. Jim has not paid his son's September premium by September 16. He pays on October 26. Chad's BadgerCare Plus closed on September 30 due to not paying the premium. Jim must pay both of Chad's premiums for September and October before Chad's eligibility can be restored. The November premium is not due until November 10 and does not have to be paid in advance.

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

19.11.2 Reinstatement

RRPs are set for three months.

The child can become eligible for BadgerCare Plus again at any time during the three-month RRP if all owed premiums are paid by the last day of the RRP. The child's eligibility will be restored back to the beginning of the RRP. If the person serves the full three-month penalty period, he or she may be eligible to re-enroll for the remainder of the BadgerCare Plus certification again (without paying any owed premiums) on the first of the following month after the RRP ends, if he or she continues to meet the program eligibility criteria.

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

Exception: If a child becomes a member of a different case during an RRP, discontinue the RRP for that child.

Example 4: Josh was on his mom's case in November when she failed to pay the premium. His RRP started December 1. In January, Josh's grandmother applied for BadgerCare Plus for Josh, reporting that Josh is now living with her as of January 5. Josh's RRP from his mother's case does not extend to his grandmother's case, so Josh is eligible for BadgerCare Plus beginning with the month of January.

19.11.3 Reapplying

A child included on an application for BadgerCare Plus before the end of the RRP and whose assistance group's income is still above the premium threshold may be eligible for BadgerCare Plus if his or her owed premiums are paid.

If the individual's assistance group's income is now below the premium threshold, he or she can become eligible for BadgerCare Plus without paying owed premiums.

19.11.4 De-requesting BadgerCare Plus

If a member de-requests BadgerCare Plus prior to adverse action, the member's BadgerCare Plus enrollment ends at the end of that month.

Example 5: Ben, age 9, is open for BadgerCare Plus. Due to an increase in his parent's income, Ben will owe a premium starting in October. On September 9, his

parent contacts the IM agency to de-request BadgerCare for Ben. The IM agency processes this de-request and ends Ben's BadgerCare Plus as of September 30. Ben will not enter an RRP due to not paying the October premium since he is not enrolled in BadgerCare Plus in October.

If a member de-requests BadgerCare Plus after adverse action, the member's BadgerCare Plus enrollment ends the end of the following month in order to provide timely negative notice. If a premium is owed for the month and is not paid, the member will enter into an RRP.

Example 6: Susan, age 14, is open for BadgerCare Plus. Due to an increase in her parent's income, Susan will owe a premium starting in October. On September 25, her parent contacts the IM agency to de-request BadgerCare for Susan. The IM agency processes this de-request and ends Susan's BadgerCare Plus as of October 31. If Susan's premium for October is not paid, she will enter into an RRP starting November 1. She will not be able to re-enroll in BadgerCare Plus prior to February 1 unless she pays her owed premiums.

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20 Assets

20.1 Assets

There is no asset limit for BadgerCare Plus.

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21 - 24 Reserved

Reserved

PROGRAM ADMINISTRATION (CHAPTERS 25-37)

25 Application

25.1 Application

Anyone has the right to apply for BadgerCare Plus; however, people younger than 18 years old must have a parent, caretaker relative, or a legal guardian apply for BadgerCare Plus on his or her behalf unless he or she is living independently. In situations where a legal guardian, parent, or caretaker is absent, an adult acting responsibly may apply on behalf of a person who is younger than 18 years old. Individuals younger than 18 years of age have the right to apply for Family Planning Only Services on their own behalf even if not living independently.

The *applicant* 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: <https://access.wisconsin.gov/access/>; or
2. Mail the paper application form; or
3. Schedule a telephone or face-to-face interview.

Provide any information, instruction and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP-2477) and *Good Cause* Claim form (DWSP-2019) to each applicant with children applying for BadgerCare Plus, with the exception of applicants who apply via ACCESS or to anyone who requests either of these.

Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to: <http://www.dhs.wisconsin.gov/em/customerhelp/>

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the 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 4 months after the date of death, he or she is not eligible.

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25.2 Application Types/Methods

BadgerCare Plus applicants have the choice of one of the following *application* methods:

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

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25.3 Where to Apply

25.3.1 Where to Apply Introduction

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

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

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

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

25.3.2 Intercounty Placements

When a county 51.42 board, 51.437 board, human services department or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the applicant's BadgerCare Plus eligibility. A congregate care facility is a:

1. Child care institution.
2. Group home.
3. Foster home.
4. Nursing home.
5. Adult Family Home (AFH).
6. Community Based Residential Facility (CBRF).
7. Any other like facility.

The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in BadgerCare Plus and renewals for BadgerCare Plus members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility. If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

1. The applicant's name, age, and SSN.
2. The date of placement.
3. The applicant's current BadgerCare Plus status.
4. The name and address of the congregate care facility in which the applicant has been placed.
5. The name of the county and agency making the placement.

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

25.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when 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 (25.1), by the public welfare agency in the other state. The forms should be forwarded to the welfare agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.

25.3.4 Applications Received From the Federal Marketplace

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

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

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25.4 Valid Application

A valid *application* for BadgerCare Plus must include the applicant's:

- Name
- Address
- Signature in the Rights and Responsibilities section of one of the following forms:
 - Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet, F-10101
 - Wisconsin Medicaid, BadgerCare Plus and Family Planning Services Registration Application, F-10129
 - BadgerCare Plus Application Packet, F-10182
 - BadgerCare Plus Supplement to FoodShare Wisconsin Application, F-10138
 - Application for Health Coverage & Help Paying Costs from the *FFM*
 - Telephonic signature in CWW
 - Electronic signature in ACCESS
 - Electronic signature in an account transfer from the FFM.

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25.5 Valid Signature

25.5.1 Valid Signature Introduction

The *applicant* or the applicant's caretaker relative must sign (using his or her own signature):

1. The paper *application* form,
2. The signature page of the application (telephone or face to face) or
3. The ACCESS application form with an electronic signature.
4. The online or paper Application for Health Coverage & Help Paying Costs from the Federally-facilitated Marketplace.

25.5.1.1 Signatures from Representatives

The following people can sign the application with their own name on behalf of the applicant:

1. 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 individual 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.

2. *Authorized Representative*: The applicant may authorize someone to represent him or her. An authorized representative can be an individual or an organization. See 34.1 Authorized 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 Authorization of Representative form (F-10126).

3. 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, workers must do both of the following:

- 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 BadgerCare Plus application, if authorized on the power of attorney form. The Durable Power of Attorney form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent an individual from filing his or her own application for BadgerCare Plus, nor does it prevent the individual from granting authority to someone else to apply for public assistance on his or her behalf.

4. 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 BadgerCare Plus on Carl's behalf.

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

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

7. The director of a county social or human services department delegates, in writing (retain a copy of this written authorization), to the superintendent of the county psychiatric institution the authority to sign and witness an application for residents of the institution.

The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.

25.5.2 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 mail-in, online or telephone application.

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

25.5.3 Telephone Signature Requirements

Telephonic signatures are valid forms of signatures for BadgerCare Plus. 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:
 - Rights and responsibilities
 - Attestation to the accuracy and completeness of information provided
 - Attestation to the identity of individual signing the application
 - 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 ten 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 Marketplace are signed electronically, so an additional signature (telephone or physical) is not needed.

25.5.4 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 BadgerCare Plus-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.

Example 2: Victoria and Timothy are married and filing taxes jointly. They are claiming Casey, their 24 year-old son, as a tax dependent. Victoria signs and submits an application to the FFM for health care for herself, Timothy, and Casey. The FFM assesses that they are potentially eligible for BadgerCare Plus and transfers the application to the agency.

Although Casey is included in the health care request, his BadgerCare Plus eligibility cannot be determined on his parents' CARES case. The worker must set up a separate case for Casey. No additional signature or application is required for Casey's health care request.

Example 3: Darrell is filing taxes and claiming Carmen, his 22 year-old niece, as a tax dependent. Darrell signs and submits an application to the FFM for health care for Carmen. The FFM assesses that she is potentially eligible for BadgerCare Plus and transfers the application to the agency.

The worker must set up a separate CARES case for Carmen. No additional signature or application is required for Carmen's health care request.

Tax dependents living outside the home will not be included in the health care request for their tax filer's household. A separate application is required to determine eligibility for the tax depending living outside the home.

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25.6 Filing Date

For health care applications submitted to a local agency, the *filing date* is the day a signed, valid *application* or registration form is delivered to the *IM* agency.

The filing date on an ACCESS application for health care is the date that the application is submitted electronically, regardless of the time of day it was submitted. The filing date on an application received from the Marketplace is the application date listed on the Marketplace application.

When an application is submitted by mail or fax, record the date that the IM agency received the valid application form or the next business day if the application is received after the agency's regularly scheduled business hours.

When a request for assistance is made by phone, the filing date is not set until a valid signature is received by the agency.

Note: The filing date may be different from the date received for application processing purposes. See Section 9.2 Application for information on the application processing timeline.

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25.7 Time frames

25.7.1 Time Frames Introduction

All applications received by an agency must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from:

- The filing date for applications submitted directly to the local tribal or consortium agency,

OR

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

This includes issuing a notice of decision.

IM workers should not delay eligibility for an individual in a household when waiting for another household member's citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members. (See 2.2)

Extend the 30-day processing time up to an additional 10 days, if you are waiting for the *applicant* to provide additional information. **CARES** will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due Page.

Deny the *application* for failure to provide information or verification, if:

1. Requested information or verification is required by program policy to determine eligibility (Chapter 9), and
2. The applicant had the power to produce the information or verification, within the period, but failed to do so, and
3. The applicant had a minimum of 10 days to produce the verification.

Example 1: A signed application was received on March 15th. The worker processed the application on April 7th and requested verification. Verification was due April 17th, but was not received by that date. Even though the end of the 30-day

application processing period was April 13th, the application should not have been denied until April 18th to allow at least 10 days to provide verification.

If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, determine eligibility using the original filing date.

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

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

25.7.2 Changes

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For changes that occur after the confirmation date, follow the adequate and timely notice requirements outlined in the Income Maintenance Manual, Section 3.2 Adverse Action and Appeal Rights.

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25.8 Begin Dates

BadgerCare Plus eligibility begins the first day of the month in which the valid *application* is submitted and all eligibility requirements are met, with the following exceptions. For these exceptions, begin dates are the date a valid application is submitted, all eligibility requirements are met, and:

1. Deductible—The date the deductible was met.
2. Inmates—The date the member is no longer an inmate of a public institution. See Section 3.6 Inmates for more information on exceptions.
3. Newborn—The date the child was born.
4. Person adds—The date the person moved into the household.
5. BadgerCare Plus Prenatal Program—The first of the month in which a valid application is received.
6. Recent moves—The date the member moved to Wisconsin.
7. Insurance coverage ends—The begin date for BadgerCare Plus is the date following the coverage end date.

25.8.1 Backdated Eligibility

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

All former foster care youth that meet the criteria in Chapter 11 Foster Care Medicaid may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application.

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

- Infants less than 1 year old may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 306% FPL,
- Children ages 1 through 5 may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 191% FPL, and
- Children ages 6 through 18 may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 156% FPL.

All non-pregnant, non-disabled parents and caretakers may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 100% FPL.

Childless adults with assistance group income under 100% FPL are eligible for backdating.

See Section 16.4.3.4.4 Backdated Months for information on counting self-employment income for backdated months.

When backdating BadgerCare Plus, do not go back further than the first of the month, three months prior to the application month. Certify the person for any backdate month in which he or she would have been eligible had he or she applied in that month. In the case of children, certify the person for any backdate month in which he or she would have been eligible had he or she applied in that month and in which their assistance group income was at or below the appropriate FPL level for their age group.

When determining backdated eligibility, use actual nonfinancial information (e.g., household composition) and actual income in the backdated months. When determining backdated eligibility under gap filling rules for months in a past calendar year, use actual income. When determining backdated eligibility under gap filling rules for months in the current calendar year, assess expected annual income using the same process for non-backdated months.

A backdate request can be made at any time, except in the case where the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

Note: Applicants are not eligible for backdated health care benefits while pending for citizenship and/or identity. Applicants who are otherwise eligible must be certified for health care benefits for the 95 day good-faith period within the normal application processing timeframe. Once verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested. See Section 4.2 Documenting Citizenship and Identity for more information.

If a member has incurred a bill from a BadgerCare Plus certified provider during a backdate period, instruct the member to contact the provider to inform them to bill BadgerCare Plus. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example 1: Mary, who is pregnant with an August due date, applied for BadgerCare Plus 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 nonfinancial and financial eligibility criteria in the months of February and March. Her worker certifies her for BadgerCare Plus for both months.

Example 2: Crystal applied for and was determined eligible for BadgerCare Plus effective February 1, 2018. She contacts her IM agency in April 2018 to see if she is eligible for coverage back to December 1, 2017. Crystal had previously reported no income for the month of January 2018. The worker finds no information contrary to what Crystal reported. She is determined eligible for backdated benefits for the month of January 2018.

However, Crystal reported that she received unemployment benefits in 2017 and had a seasonal job from November 1, 2017, through December 31, 2017, with her last paycheck received on December 31, 2017. Crystal reports she earned \$2,000 from the seasonal job and received a lump sum payment of \$500 for December. Based on her monthly income (\$2,500), she is not eligible for BadgerCare Plus for December 2017.

The worker checks Crystal's annual income for 2017 to see if she may be eligible based on annual income. A SWICA match shows that she earned a total of \$3,995 during the fourth quarter of 2017. The unemployment compensation query shows that Crystal received a total of \$3,200 in unemployment benefits during 2017. Her annual income for 2017 is \$7,695 (\$3,995 from wages earned, \$3,200 from unemployment benefits, and a \$500 lump sum payment). Her annual income for 2017 is below 100% of the FPL. Crystal is eligible for backdated benefits under gap filling rules for the month of December 2017.

25.8.1.1 BadgerCare Plus Family Planning Services

Eligibility for **FPOS** begins on the first of the month of application, if all nonfinancial (Section 40.4 Nonfinancial Requirements) and financial (Section 40.5 Financial Requirements) eligibility requirements are met. FPOS may be backdated up to three months prior to the month of application.

25.8.1.2 Pregnant Women

Except for those women eligible only under the BadgerCare Plus Prenatal Program, backdate a pregnant woman to whichever is more recent:

1. The first of the month in which the pregnancy began.
2. The first of the month, three months prior to the month of application. If a woman was pregnant before the date of her application, backdate her BadgerCare Plus even though she is not pregnant on the date of application. Do not, however, continue her eligibility as a pregnant woman beyond the end of the pregnancy. Before backdating her BadgerCare Plus, verify that she has met all the eligibility requirements during the backdated period.

See Section 41.5 BadgerCare Plus Prenatal Program Eligibility Begin Date for BadgerCare Plus Prenatal Program *eligibility begin date* policy.

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25.9 Denials and Terminations

25.9.1 Termination

During the calendar month after a member's enrollment has been terminated, BadgerCare Plus can be reopened without requiring a new application. The person may need to provide verification if required to complete the eligibility determination.

If more than a calendar month has passed since a member's enrollment was terminated, the person must file a new application to reopen his or her BadgerCare Plus.

If a case is closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the person's case can be reopened for BadgerCare Plus without filing a new application if he or she provides the necessary information within three months of the renewal date (see Section 26.1.2 Three-Month Late Renewals).

If the person re-requests BadgerCare Plus after enrollment was terminated and the case is open for any other program of assistance, do not require him or her to re-sign his or her application or sign a new application.

25.9.2 Denial

If less than 30 days has passed since the applicant's eligibility was denied, allow the applicant or his or her representative to re-sign and date the original application, the signature page of the application summary, or page one of the application or to call the agency to submit a telephonic signature to set a new filing date.

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

The person may need to provide verification if required to complete the eligibility determination.

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26 Renewal

26.1 Renewals

26.1.1 Renewals Introduction

A renewal is the process during which all eligibility factors subject to change are reexamined and it is determined if eligibility continues. The group's continued eligibility depends on its timely completion of a renewal and verification of required information. Each renewal results in a determination to continue or discontinue eligibility.

The first required eligibility renewal for a BadgerCare Plus case is 12 months from the certification month, except for the following:

- **CENs.** The renewal date is 12 months from the date of birth.
- **Pregnant women.** The renewal date is two calendar months after the date the pregnancy ends.

Note: Women in the BadgerCare Plus Prenatal Program lose eligibility on the date the pregnancy ends. However, they are automatically eligible for emergency services for two months after eligibility for BadgerCare Plus Prenatal Program ends (see Section 41.6 BadgerCare Plus Prenatal Eligibility End Date).

- **Deductibles.** A renewal is not scheduled for a case that did not meet its deductible, unless someone in the case was open for BadgerCare Plus. For cases that did meet the deductible, the renewal date is six months from the start of the deductible period.

Note: For manually certified BadgerCare Plus cases, make sure the member receives a timely notice of when the renewal is due.

Review Dates for Time-Limited Benefits

BadgerCare Plus members are required to complete a renewal no earlier and no later than 12 months from their certification period. People whose benefits are time-limited (CENs, pregnant women, people who have met a deductible, or people in an extension) are required to complete a renewal at the end of their time-limited benefit unless they are on a case with other open BadgerCare Plus assistance groups. In this situation:

- If the regular BadgerCare Plus assistance group has a renewal date after the end of the time-limited benefit certification period, the person enrolled in time-

limited benefits will have his or her eligibility redetermined at the end of his or her certification period, but a full renewal is not required at that time.

- If the regular BadgerCare Plus assistance group has a renewal date prior to the end of the time-limited benefit certification period, the time-limited benefit will remain open even if there is no renewal completed for the regular BadgerCare Plus assistance group. If a renewal is completed for the BadgerCare Plus assistance group, the length of the time-limited benefit certification period does not change.

Workers can complete an early renewal only if the member requests an early renewal. Once the member requests an early renewal, the renewal must be completed.

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

26.1.2 Three-Month Late Renewals

Most health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. This policy applies to the following subprograms:

- BadgerCare Plus
- *FPOS*
- *EBD* Medicaid
- *HCBW*
- Institutional Medicaid
- *MAPP*
- Medicare Savings Programs (*QMB*, *SLMB*, *SLMB+*, *QDWI*)

The policy applies to members receiving health care benefits based on a met deductible, but not to members with an unmet deductible.

Late renewals are only permitted for people 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.

Agencies should consider late submission of an online or paper renewal form or a late renewal request by phone or in person to be a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verification is required during the completion of a late renewal, the member has 10 days to provide it.

Example 1: Jenny's renewal is due on January 31, 2016. She submits an online renewal via ACCESS on March 15, 2016. If the renewal is processed on the same day and verification is requested, the verification would be due on March 25, 2016. If she provides verification on or before this due date and meets all other eligibility criteria for BadgerCare Plus, her eligibility and certification period would start on March 1, 2016. Her next renewal would be due February 28, 2017.

Note: The three-month period starts after the month the renewal was due. It does not restart when a late renewal has been submitted. If Jenny submits her renewal on March 15 but does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date.

26.1.2.1 Verification Requirements for Late Renewals

If the BadgerCare Plus renewal was completed timely, but requested verifications were not provided as part of the renewal, BadgerCare Plus can reopen without a new application if these verifications are submitted within three months of the renewal month. The submission of the renewal-related verifications is considered a request for health care. Only the missing verifications must be provided. However, the verifications must include information for the current month of eligibility. If verification is submitted for a past month, a new Verification Checklist must be generated to request the current verification, allowing 10 days to submit the verification.

Example 2: Jenny's renewal is due on January 31, 2016. She completes her renewal on January 20, 2016, and a Verification Checklist 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, 2016. On April 27, 2016, 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, 2016, and her next renewal will be due March 31, 2017. If she had submitted the verification of her income for January, a new Verification Checklist should be generated asking for verification of her current income for April.

26.1.2.2 Gaps in Coverage

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. Backdated coverage under the late renewal policy is available to all BadgerCare Plus members who meet program rules, including children who would not otherwise qualify for backdated

coverage because their income is too high (see Section 25.8.1 Backdated Eligibility). However, this does not change the rules for backdating at application.

If a member requests coverage for past months during a late renewal, he or she must provide all necessary information and verifications for those months (including verification of income for all months requested) and must pay any required premiums to be covered for those months.

26.1.3 Administrative Renewals

26.1.3.1 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 the administrative renewal process.

If information from electronic data exchanges validated information about a member's income as currently recorded in **CARES**, additional information about income cannot be requested from the member at renewal. This includes member-reported information about earned income that is found to be reasonably compatible with earned income information obtained from **SWICA** and **FDSH** data exchanges, 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 and tax filing status have not changed.

Note: Information on administrative renewals that is specific to childless adults is described in Section 44.3.4 Real Time Eligibility and Administrative Renewals.

26.1.3.2 Administrative Renewal Selection Criteria

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.

Cases may be excluded from the administrative renewal process for a number of reasons.

26.1.3.2.1 Exclusions During the Administrative Renewal Process

A BadgerCare Plus or FPOS case is excluded from being administratively renewed if:

- Any person on the case has or is any of the following:
 - An unverified or missing **SSN**
 - An unresolved Prisoner, UIB, or **SOLQ-I** discrepancy
 - A new discrepancy found through a data exchange during the administrative renewal process
 - 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
 - A Former Foster Care Youth turning 26 (this is because the person's income information has not been previously collected)
 - A pregnant woman whose due date is in or before the renewal month (this is because there is an anticipated change in household composition)
 - A **CEN** turning 13 months old (this is because the child is aging out of his or her current assistance group and may either lose eligibility or become eligible under a new assistance group)
 - Turning 19 or 65 years old
- The case has or is any of the following:
 - Income that cannot be verified or is not found reasonably compatible through a data exchange (such as self-employment or room and meals income)
 - Tax deductions on file
 - A calendar year tax dependent for a past year
 - A pending health care assistance group (i.e., health care eligibility has not been confirmed for all people on the case)
 - Related unprocessed ACCESS items, including applications, program adds, renewals, change reports, and **SMRFs**
 - Related unprocessed **PPRF** or SMRF documents
 - An unresolved **EPP**
 - A met deductible
 - A BadgerCare Plus extension assistance group due for renewal
(**Note:** BadgerCare Plus extension assistance groups will not be administratively renewed, but other eligible health care categories on the same case may be selected for an administrative renewal as long as the extension is not due for renewal.)
 - A reason for exclusion from batch eligibility processes (for example, an eligibility override)
 - In review mode

A BadgerCare Plus or FPOS case is excluded from being administratively renewed if any of the following occur when CARES is running eligibility for the renewal:

- A new EPP is generated as a result of a data exchange.
- Health care or FPOS benefits pend.
- Health care or FPOS benefits would be terminated for any person on the case.
- A premium is now required, or the premium amount increased.

26.1.3.3 Administrative Renewal Process

During the administrative renewal process, **CWW** will automatically do the following:

- Select cases subject to administrative renewal
- Verify and update information using data exchanges
- Determine the new 12-month certification period for health care
- Notify the member of the administrative renewal
- Notify the member of his or her eligibility determination

The administrative renewal process will occur in the 11th month of a member's certification period, prior to a 45-day renewal letter being sent. On the first Saturday of the 11th month, CARES will determine who qualifies for an administrative renewal and initiate a batch request through the **RRV** service through the FDSH to request Equifax data.

On the second Saturday of the 11th month, the following will occur:

- CARES will determine who qualifies for an administrative renewal.
- Data exchange updates will occur for SWICA, New Hire, and **EVHI**.
- The existing batch process will update SSA and UIB data.
- The RRV response with Equifax data will be processed.
- Reasonable compatibility will be tested as applicable.
- The administrative renewal process will run through a batch eligibility cycle to determine if the administrative renewal is successful or unsuccessful.

26.1.3.3.1 Administrative Renewal Data Exchange Results

If new income information is identified from SSA or UIB during the administrative renewal process, the case will be updated with the new information. Income information obtained from SWICA or FDSH will be tested for reasonable compatibility (see Section 9.12 Reasonable Compatibility for Health Care).

For health care- and/or FPOS-only cases where a person in the household has current employment, the Begin Month on the Employment page will be updated to the current month. In addition, the wage verification code on the Employment page will be set to "Q?" if the existing verification code is not "?," "QV," "NV," "Q?," "?O," "WN," or "SP."

These verification codes will allow CARES to test wages for reasonable compatibility. The income types and amounts will not be systematically updated. For cases that include programs other than health care and/or FPOS or for cases for which the administrative renewal is unsuccessful, the original wage verification code will be retained. Keeping the original verification code will ensure that other programs only have to verify wages when appropriate for their program rules.

26.1.3.3.2 Successful Administrative Renewals

Cases that pass the administrative renewal criteria after the eligibility batch run will go through the administrative renewal confirmation process. During the confirmation process the following will occur:

- Case level review dates will be set.
- A case comment will be added by CARES that states "Administrative Renewal completed."
- The Interview Details page will display "Admin Renewal" as the interview type for health care and/or FPOS.
- The Generate Summary Page will display "Admin Renewal" as the signature type.
- The appropriate administrative renewal letter, with or without a case summary, will be generated and mailed. The letter will be stored in the *ECF*.
- The Enrollment and Benefits Handbook will be sent to the member.

Most categories of health care will be renewed during the administrative renewal. For example, if a case is open for both BadgerCare Plus and MAPP without a premium and the programs have different renewal dates, both programs would be renewed and their renewal dates would be synced to the later of the two renewal dates. This does not apply to time-limited health care benefits (such as pregnancy-related BadgerCare Plus) because these benefits are not renewed for additional months. In addition, FPOS benefits will be renewed separately from other categories of health care, and the renewal date will not be synced, unless it is due for renewal at the same time as the other health care program(s).

If BadgerCare Plus and/or FPOS is successfully recertified through an administrative renewal, the member will be sent an administrative renewal letter with an attached case summary. 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 on the letter. The member has the option to make changes on the summary and mail or fax it to his or her agency or to call his or her agency to report changes. When changes are applied to the case, a Notice of Decision will be sent and will include the message "Your health care renewal has been completed." If all of the information on the case summary is correct, the member will not need to take any other action.

Cases will go through a batch run on the second Saturday of the 12th month of the certification period, approximately 30 days after the administrative renewal. This batch run will generate a Notice of Decision, unless one has already been sent following the processing of a change or a renewal for another program(s).

26.1.3.3.3 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.

If the administrative renewal process was initiated, but not completed, any updates made to the case, with the exclusion of data exchange updates, will be undone, and the case will be returned to its original status. The member will be sent a 45-day renewal letter and a PPRF. The PPRF will include any SSA or UIB updates.

Members have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS. Failure to complete a renewal by the end of the certification period will result in the termination of benefits.

26.1.3.3.4 Change Reporting After Administrative Renewal

Cases that have a successful administrative renewal remain subject to 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 is 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. The other program may require the person to verify his or her information. Once verification is received for the other program, the information should also be used for ongoing health care eligibility.

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26.2 Choice of Renewal

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

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

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26.3 Renewal Processing

A BadgerCare Plus eligibility renewal notice is generated in the second week of the 11th month of the *certification period*. Do not schedule a renewal until after *adverse action* in the month prior to the month of renewal.

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

Do not require a new *Authorized Representative* form at renewal, if the person signing the renewal is the authorized representative on file. If the renewal is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES, at adverse action in the renewal month.

26.3.1 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

With the exception of renewals completed through the administrative renewal process, the signature requirements for renewals are the same as those for applications (see Section 25.5 Valid Signature).

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27 Change Reporting

27.1 Changes Reported During the Application Processing Period

For applications, changes that occur between the *filing date* and confirmation date must be reported and considered in the eligibility determination. Changes that are reported after certification must be acted on in the same manner as any other reported change.

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27.2 Nonfinancial Change Reporting Requirements

BadgerCare Plus members must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy and changes to the pregnancy of a BadgerCare Plus member
- Living arrangement (e.g., institutionalization, incarceration)
- Change in marital status
- Change in insurance coverage
- Change in expected tax filing status
- Change in tax dependents
- No longer receiving a tax-related deduction

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27.3 Income Change Reporting Requirements

BadgerCare Plus members must report income changes when the total monthly income of the assistance group with the highest monthly income amount exceeds the following FPL percentages for their assistance group size:

- 50% FPL
- 100% FPL
- 133% FPL
- 156% FPL
- 191% FPL
- 200% FPL
- 250% FPL
- 306% FPL
- 350% FPL
- 400% FPL

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

The **CARES** notice will indicate the dollar amount associated with each FPL level, for the BadgerCare Plus group size.

Example 1: Sally's countable family income has been at 80% of the FPL since she applied in January. In June her income increased to 107%, so she must report the change by July 10.

Example 2: Heidi's countable family income is 128% of the FPL. In September it increased to 164% of the FPL. Heidi must report this change by October 10.

Example 3: Steve's countable family income is 265% of the FPL. In December it increased to 411% of the FPL. Steve must report this change by January 10.

27.4 Other Reported Changes

Any other change that is reported or becomes known to the agency (i.e., through data exchange) must be acted upon.

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27.5 Change Reporting Requirements for BadgerCare Plus Family Planning Only Services Members:

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

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

These changes must be reported within ten days of occurrence.

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27.6 Change Reporting Methods

Members can report changes using one of the following methods:

- ACCESS
- Mail or fax the Information Change Report, F-10183
- Call their agency
- Go to their agency

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28 Corrective Action

28.1 Overpayments

An overpayment occurs when BadgerCare Plus benefits are paid for someone who was not eligible for them or when BadgerCare Plus payments are made in an incorrect amount (for example, incorrect premium calculations). The amount of recovery may not exceed the amount of the BadgerCare Plus benefits incorrectly provided. Some examples of how overpayments occur are:

- Concealing or not reporting income.
- Failure to report a change in income.
- Providing misinformation at the time of *application* or renewal regarding any information that would affect eligibility.

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

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28.2 Recoverable Overpayments

Initiate recovery for a BadgerCare Plus overpayment, if the incorrect payment resulted from one of the following:

1. **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 one of the following:

- 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 BadgerCare Plus 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 (see Section 27.3 Income Change Reporting Requirements) (income, expenses, etc.) or nonfinancial (Section 27.2 Nonfinancial Change Reporting) information that affects eligibility, premium, patient liability or cost share amounts.

An overpayment occurs if the change would have adversely affected eligibility, the benefit plan or the premium amount.

Example 1: Joe and his daughter Olivia are on a case. Olivia is open for BadgerCare Plus with a monthly premium of \$10. Joe is not open for BadgerCare Plus. In November, Joe's worker learned that Joe had received a raise September 1 that Joe was required to report by October 10. Because of the new family income, Olivia's monthly premium increased to \$55.00. The worker entered the new income in CARES and confirmed the increase in the premium amount for December.

What can be recovered?

Because Joe did not report the increase in income, the premium amount for November is incorrect. The overpayment amount would be whichever is less of the following:

- The difference between the correct premium for November and the premium amount that was paid
- The amount of claims and any HMO capitation payments the state paid for each month in question

Example 2: John and his family were determined eligible for BadgerCare Plus in June. John accepted a new job in South Carolina, and he and his family moved there on July 20. Since John and his family were no longer residents of Wisconsin, they were no longer eligible for BadgerCare Plus. However, because their move to South Carolina was not reported, capitation payments continued to be made for John and his family until the worker closed the case effective December 31.

What: can be 'recovered?

''

Giving 10 days to report and following adverse action logic, the case would have closed August 31. Fee-for-service claims and any HMO capitation payments for September, October, November, and December are recoverable.

Example 3: Susan was determined eligible for BadgerCare Plus in January. She was pregnant with a due date of August 15. On February 3, she miscarried but did not report this change to her worker. Her BadgerCare Plus eligibility continued until the worker closed the case effective October 31. Once she was no longer pregnant, she would only have remained eligible for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. Susan was not eligible May through October.

What can be recovered?

The change should have been reported in February. Allowing for the two-month extension, BadgerCare Plus should have closed April 30. The overpayment amount is the amount of the fee-for-service claims and the capitation payments made for her from May through October.

2. Fraud

Fraud exists when an applicant, member, or any other person responsible for giving information on the applicant's or 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.

If there is a suspicion that fraud has occurred, see Section 28.6 Refer to District Attorney for information about referral to the District Attorney (DA).

3. Member loss of an appeal

Benefits a member receives as a result of a fair hearing request order can be recovered if the member loses the appeal.

A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount or the amount of claims and any 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.

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28.3 Unrecoverable Overpayments

Do not initiate recovery for a BadgerCare Plus overpayment if it resulted from a non-member error, including the following situations:

- The member reported the change timely, but the case could not be closed or the benefit reduced due to the 10-day notice requirement.
- Agency error (keying error, math error, failure to act on a reported change, etc).
- Normal prospective budgeting projections based on best available information.
- The member's tax filing status is different from what he or she reported as his or her expected tax filing status for that year.

Example 1: Susan and her daughter Kathy are open for BadgerCare Plus. Susan reported a change in income on April 1. The worker did not process the change until April 28, so it was not effective until June 1. There is no overpayment for May since the change was reported timely, but not acted on by the worker until after *adverse action*.

28.3.1 Gap Filling Eligibility Considerations

For any potential overpayments for BadgerCare Plus on or after February 1, 2014, a member should not be subject to an overpayment if he or she could have been eligible under gap filling rules for the overpayment period even if he or she failed to report a change in monthly income or other household circumstances. A denial letter from the *FFM*, gap filling indicator, or specific gap filling request by the member is not required to determine eligibility during the overpayment period under gap filling rules.

For any past overpayments in which *MAGI* rules for BadgerCare Plus were in effect and the member believes he or she would have been eligible for BadgerCare Plus based on annual income, the *IM* agency must review the past overpayment at the member's request. To determine annual income, refer to Section 16.9 Gap Filling.

When researching a potential overpayment due to excess monthly income for the current calendar year, an IM agency must determine that the person surpassed 100 percent of the *FPL* based on his or her annual income limit before an overpayment can be established. If the person's annual income has not yet surpassed 100 percent of the FPL, do not establish an overpayment until there is evidence that the person has surpassed 100 percent of the FPL. Establishing the overpayment may require waiting until the end of the calendar year for actual income to become available to determine if the person surpassed 100 percent of the FPL.

Example 2: Richard became eligible for BadgerCare Plus as a childless adult in March of last year and had no countable income. At his renewal in February, Richard reports that he has been working since April of last year. Verification shows that Richard's salary of \$2,500 per month came to a countable income total of \$22,500. Although Richard exceeded his reporting limit in April, the worker must look at what would have happened had he reported the change timely when determining whether an overpayment occurred.

The worker finds that Richard was required to report his change in income no later than May 10. Since verification of his actual income for last year shows that he was over the annual income limit for gap filling, there is an overpayment for June 1–December 31.

The worker then evaluates the overpayment for January and February of the current year. So far, Richard has only received \$5,000 in countable income. Because the IM agency does not have any information to indicate that Richard's job will not continue for the rest of the year, he would not be found eligible under gap filling rules. However, for benefit recovery purposes, he has not yet exceeded the 100 percent of the FPL annual income limit, so the IM agency cannot say definitively that he would not have been eligible under gap filling rules. The worker may not establish an overpayment for his eligibility in the current year until Richard's income has been found to be over the annual limit for gap filling coverage. The worker must manually track the case to review the case in January of the next year.

In January of the next year, the worker reviews Richard's case for a potential overpayment from January 1–February 28, of last year, and determines his annual income. His earned wages were \$6,700 for the first quarter, \$5,100 for second quarter, and \$4,250 for the third quarter. His fourth quarter wages have not been updated yet. Based on the information available, Richard has surpassed the annual income limit for last year. His total wages through the third quarter total \$16,050. There is an overpayment for the period of January 1–February 28.

Example 3: Kimmy was eligible for BadgerCare Plus as a childless adult beginning in October of last year. In August of this year, the worker is processing a discrepancy created in July showing that Kimmy has unreported wages from the first quarter of this year. The worker requests verification from Kimmy, which shows that she works 32 hours per week and earns \$15 per hour for a total of \$1,920 per month. Had Kimmy reported her income timely by February 10, she would have been over the

monthly income limit for BadgerCare Plus. SWICA shows that Kimmy has already earned \$13,700 this year.

Since the worker has evidence that Kimmy has surpassed the annual income limit for this year, the worker can proceed with establishing an overpayment for March 1–June 30.

While an agency is waiting to verify if a person has surpassed the annual income limit for a potential overpayment, that person could experience changes in circumstances, including but not limited to, changes in income or assistance group size. If more current information is available at the time of determining an overpayment, these changes must be taken into consideration in the determination.

Example 4: Effective February 1, Delia was eligible for BadgerCare Plus as a childless adult with an assistance group size of one. In August, she reports that her 8-year-old daughter, Zoe, has moved into the household, and she plans to claim Zoe as a tax dependent. Beginning in September, Delia is determined eligible as a parent or caretaker adult with an assistance group size of two.

In February of the next year, a worker is reviewing a **SWICA** discrepancy showing that Delia began a job in March of last year, which she did not report. The worker verifies that Delia's income is over the monthly income limit for April–November and sees that she had an annual income total of \$14,700 for last year. For part of that period, Delia was in a group size of one and surpassed the annual income limit for a group size of one. However, starting in September of last year, Delia's group size increased when Zoe was added to the case. Taking into consideration the change in group size during the overpayment period and Delia's annual income (\$14,700) compared to the annual FPL for a group size of two, there is no overpayment since Delia will be ending the tax filing year with a group size of two and will be below the annual income limit for a group size of two.

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28.4 Overpayment Calculation

28.4.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial BadgerCare Plus *application* or renewal, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (see Section 28.4.2 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 which 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.

28.4.2 Overpayment Amount

Use the actual income that was reported or required to be reported in determining if an overpayment has occurred. The amount of recovery may not exceed the amount of the BadgerCare Plus benefits incorrectly provided.

If the case was ineligible for BadgerCare Plus, recover the amount of fee-for-service claims paid by the state and any HMO capitation payments the state paid. Use ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). Deduct any amount paid in premiums for each month in which an overpayment occurred from the overpayment amount.

If the case is still eligible for BadgerCare Plus for the time frame in question but there was an increase in the premium, recover whichever is less of the following:

- The difference between the premiums paid and the premium amount owed

- The amount of claims and any HMO capitation payments the state paid for each month in question

When calculating the overpayment amount for premiums, the overpayment amount is the difference between the premium paid and premium owed, even if the premium that was paid was \$0. Premium adjustments are only made on months where there is an overpayment. If there is a month in which there is no overpayment, then the premium calculation for that month should not be adjusted.

Example 1: Tom and his daughter Candice are on a case. Candice is enrolled in BadgerCare Plus with no premium. Tom is not enrolled in BadgerCare Plus. A renewal for Candice's BadgerCare Plus eligibility is due in June. At the renewal, Tom failed to disclose income from a new second job, which would have resulted in a \$55 monthly premium for Candice. This new information was discovered in July.

Overpayment calculation:

\$55 premium owed for June
+ \$55 premium owed for July
<u>\$110 total premium owed</u>
- \$ 0 premium paid
\$110 overpayment

The state paid the HMO \$475 in capitation payments and \$50 in claims each month for Tom's family. Because the difference in premium amounts is less than the claims and HMO capitation payments, the overpayment is the \$110 difference in premiums.

If a member error increases a deductible amount before the deductible is met, there is no overpayment. Recalculate eligibility and notify the member of the new deductible amount.

If the member met the incorrect deductible and BadgerCare Plus paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount or the amount of claims and any HMO capitation payments the state paid over the six-month period (whichever is less).

If the member was ineligible for the deductible, determine the overpayment amount. If the member prepaid his or her deductible, deduct any amount he or she paid toward the deductible from the overpayment amount.

Example 2: Victoria had a deductible of \$2,000 for a six-month period. She met the deductible by paying \$1,000 and sending in verification of \$1,000 in outstanding medical bills. An IM worker discovers that Victoria moved out of state but did not report the move. After determining her overpayment amount, the worker must decrease the amount overpaid by the \$1,000 that Victoria prepaid toward her deductible. The worker would not decrease the overpayment amount by any of the medical bills that helped Victoria meet her 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 the state paid for any benefits on behalf of the member, and, if so, establish a claim for benefit recovery.

28.4.3 Liability

Except for minors, collect overpayments from the BadgerCare Plus member, even if the member has authorized a representative to complete the application or renewal for him or her. Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments.

Other household members who were not enrolled in BadgerCare Plus on the same case during the time the overpayment occurred are not jointly liable for overpayments.

Example 3: Josie is Danielle's authorized representative, and Josie applied on behalf of Danielle for BadgerCare Plus in December. It was later found that Josie did not report some of Danielle's income when she applied, which would have resulted in Danielle being ineligible for BadgerCare Plus. Danielle's BadgerCare Plus case closed March 31. Danielle was determined to be ineligible for BadgerCare Plus from December–March. Recover from Danielle any benefits that were provided to her from December–March. Even though Josie failed to report the information as the authorized representative, Josie is not liable.

Example 4: Alice and Jonas are married, filing taxes separately, and eligible for BadgerCare Plus as childless adults. An IM worker discovers that Alice did not report a new job that would have made her ineligible for BadgerCare Plus. Both Alice and Jonas are jointly liable for Alice's overpayment because they were married and living in the household during the time benefits were overpaid for Alice.

Example 5: Kevin and Linda are married, filing taxes jointly, and claiming their two children, ages 20 and 22, who live with them, Grace and Paul, as tax dependents. Kevin and Linda are enrolled in BadgerCare Plus as childless adults. Grace is enrolled in BadgerCare Plus as a childless adult on her own case. Paul is not enrolled in BadgerCare Plus. An IM worker discovers that Kevin and Linda earned more income than reported and it would have made them ineligible for BadgerCare Plus. Kevin and Linda are liable for the overpayment. Grace and Paul are not liable for the overpayment for Kevin and Linda's BadgerCare Plus enrollment.

If a minor received BadgerCare Plus 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.

Example 6: Susan applied for BadgerCare Plus for herself and her minor son, Billy, in January. Susan lives with Billy. Susan did not report some of her income when she applied, which would have resulted in her and Billy being ineligible for BadgerCare Plus. When the IM agency finds out about the income, Susan and Billy's BadgerCare Plus case closes April 30. They were determined to be ineligible for BadgerCare Plus from January-April. Recover from Susan any benefits that were provided to her and Billy from January-April. Susan is liable for Billy's overpayment because she is his parent and was living with him at the time of the overpayment.

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28.5 Member Notice

Notify the member or the member's representative of the period of ineligibility, the reason for his or her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

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28.6 Refer to District Attorney

See IMM Chapter 11 Program Fraud Overview for referral criteria when fraud is suspected. The agency may refer the case to the Department of Health Services (DHS) Office of the Inspector General (OIG) where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney, corporation counsel for investigation, or OIG. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

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28.7 Fair Hearing

The IM agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

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28.8 Agency Retention

The *IM* agency can retain 15 percent of the payments recovered (see Income Maintenance Manual Section 13.8 Local Agency Retention Portion of Claims).

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28.9 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his or her BadgerCare Plus 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 with a premium obligation, allow the member to pick which months he or she would like to receive benefits. Collect all premiums owed for those prior months before certifying the member for the months he or she chose.

If a member already paid for a BadgerCare Plus covered service, inform the member that he or she will need to contact his or her provider to bill BadgerCare Plus for services provided during that time. A BadgerCare Plus provider must refund the amount that BadgerCare Plus will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

28.9.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BadgerCare Plus and would result in a refund for the member, determine the correct premium amount for each month in which it was incorrect and report the error to the fiscal agent's BadgerCare Plus Unit. The *fiscal agent* will refund the amount of the premium the member overpaid. The report can be made either by:

1. Telephone: 1 (888) 907-4455 or
2. Fax: (608) 251-1513

When submitting a fax, write "Attn: BadgerCare Plus Premium Refunds".

When reporting the refund to the BadgerCare Plus Unit, include the:

1. The member's Social Security Number.
2. Months for which a refund needs to be issued.
3. New premium amount.
4. Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

Occasionally, a BadgerCare Plus member is certified for retroactive Katie Beckett or SSI eligibility for a period of time in which they were also certified for BadgerCare Plus. If the BadgerCare Plus member paid a premium during this time frame, they are entitled to a refund of any BadgerCare Plus premiums that they paid during the retroactive Katie Beckett or SSI *certification period*.

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29 Notices and Fair Hearings

29.1 Notices

A notice must be either mailed or sent electronically at least 10 days prior to a negative action, such as a termination of benefits or an increase in premium.

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29.2 Fair Hearings

Members have the right to a fair hearing, timely case decisions, and accurate notices of decision. See Chapter 3 of the IMM for specifics.

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30 Affirmative Action

30.1 Affirmative Action and Civil Rights

The Rehabilitation Act of 1973, requires a person with impaired sensory, manual or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Assistance must be provided to all BadgerCare Plus members to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the Wisconsin BadgerCare Plus Enrollment and Benefits brochure (P-00079).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

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31 Interagency Transfer

31.1 Interagency Transfer

A case transfer occurs when the primary person receiving benefits from a county or tribal Income Maintenance agency for a particular month, applies for aid from another Income Maintenance agency for the same or next month. The primary person must be a member of a currently open BadgerCare Plus, Child Care, EBD Medicaid, Food Share, or W2 Assistance Group or one that has been closed for less than a calendar month.

The agency to which the member reports the move must collect information about the changes, for example, the new address. If the agency does not have sufficient information about the changed circumstances, it must request information from the member, according to the BadgerCare Plus verification policy (Chapter 9).

The renewal date will remain the same after case transfer.

Do not require a renewal or new *application* for case transfers, except in the following programs:

- Community Waivers (EBD-MEH Chapter 28.1)
- Family Care (EBD-MEH Chapter 29.1)
- Deductible Met (EBD-MEH Chapter 24.2)

See Process Help, Section 6.1 Interagency Case/RFA Transfer Process, for information on how to process case transfers.

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32 Presumptive Eligibility

32.1 Introduction

Presumptive eligibility is a streamlined eligibility determination for temporary enrollment in BadgerCare Plus or Family Planning Only Services. It is based on preliminary household and financial information provided by the applicant. It allows eligible applicants immediate health care coverage for a short period until an application for ongoing coverage is completed and processed.

Note: See the Medicaid Eligibility Handbook Section 36.2.2.1 Temporary Enrollment/Presumptive Eligibility Available Only To Women Enrolling Through WWWP for information on temporary enrollment under the Wisconsin Well Women Medicaid program for women under age 65 with breast or cervical cancer.

32.1.1 Definitions

- **Express Enrollment:** The process of making a presumptive eligibility determination to temporarily enroll an individual in BadgerCare Plus or Family Planning Only Services. Qualified entities (see Section 32.1.2 Qualified Entities) make these determinations using ACCESS for Partners and Providers (see ACCESS Handbook Chapter 12 ACCESS for Partners and Providers).
- **Presumptive eligibility:** The determination of whether or not an applicant is eligible to temporarily enroll in BadgerCare Plus or Family Planning Only Services.
- **Temporary enrollment:** Short-term eligibility for BadgerCare Plus or Family Planning Only Services.

32.1.2 Qualified Entities

Qualified entities that can make presumptive eligibility determinations include hospitals, providers, and partners that are approved by ForwardHealth and have received Express Enrollment training. The table below explains which qualified entities can make presumptive eligibility determinations for a population and program:

	Can make presumptive eligibility determinations for:			
	Children	Pregnant Women	Family Planning Only Services	Adults, Parents, and Caretakers
Qualified Entities:				

Qualified Hospitals	X	X	X	X
Providers	X	X	X	
Partners	X			

Examples of qualified partners include:

- Head Start programs.
- Authorized child care providers.
- Women Infant and Children (WIC) agencies.
- Faith-based organizations such as the YMCA.
- Certain community-based organizations, such as the Boys and Girls Club.
- Authorized agencies offering emergency food and shelter.
- Elementary and secondary schools.
- Any other entity the state so deems as approved by the Secretary.

32.1.2.1 Process for a Qualified Entity to Temporary Enroll a Person

A qualified entity follows the process below for a person to get temporary enrollment in BadgerCare Plus or Family Planning Only Services:

1. Complete a presumptive eligibility application through one of the following methods:
 - a. Online using ACCESS for Partners and Providers. This is also known as an Express Enrollment application.
 - b. Fill out and submit a paper application.
 - i. BadgerCare Plus Express Enrollment for Pregnant Women application (F-10081).
 - ii. Temporary Enrollment for Family Planning Only Services application (F-10119).
2. If the applicant is found eligible:
 - . Provide a temporary ForwardHealth ID card.
 - a. Advise the applicant that a permanent ForwardHealth ID card will be mailed within 3-5 business days, if the member has not already been issued a ForwardHealth card. If the member has been issued a ForwardHealth card in the past, a new one will not be mailed. The member can use his or her previously issued ForwardHealth card or contact Member Services at 1-800-362-3002 to request a new one.
3. Provide a denial notice if the applicant is found not eligible.
4. Stress the importance of applying through the local agency for ongoing health care coverage. The qualified entity is encouraged to assist the applicant with

applying. Advise that the application can be submitted online, by telephone, by mail, or in person.

32.1.3 Coverage Period

32.1.3.1 Begin Date

Temporary enrollment in BadgerCare Plus or Family Planning Only Services begins on the date a person is found presumptively eligible by a qualified entity.

32.1.3.2 End Date

Temporary enrollment in BadgerCare Plus or Family Planning Only Services ends the month following the month in which the person was determined presumptively eligible or the date ongoing health care or Family Planning Only Services eligibility is determined (see Section 32.1.3.3 Early Termination and Section 32.1.3.4 Automatic Extension).

32.1.3.3 Early Termination

If a person applies for ongoing health care or Family Planning Only Services coverage and the *IM* agency makes an eligibility determination prior to the end date of the temporary enrollment period, the temporary enrollment period must end on the date the agency completes processing the application for ongoing coverage, regardless of the result of the eligibility determination. The early termination of temporary enrollment will be applied systematically. Tables 1 and 2 further explain when eligibility for ongoing health care or Family Planning Only Services coverage will end temporary enrollment.

Table 1: Systematic Early Termination of Temporary Enrollment—Applicant Applied for One Program		
Applicant is confirmed in <i>CARES</i> as:	Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:	Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:
Eligible for BadgerCare Plus or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment
Eligible for Family Planning Only Services	No change to temporary enrollment	End temporary enrollment
Not eligible for BadgerCare Plus or	End temporary enrollment	No change to temporary enrollment

other ongoing Medicaid coverage		
Not eligible for Family Planning Only Services	No change to temporary enrollment	End temporary enrollment

Table 2: Systematic Early Termination of Temporary Enrollment—Applicant Applied for Multiple Programs

Applicant is confirmed in CARES as:	Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:	Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:
Eligible for BadgerCare Plus or other ongoing Medicaid coverage but not for Family Planning Only Services	End temporary enrollment	End temporary enrollment
Eligible for Family Planning Only Services but not for BadgerCare Plus or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment
Not eligible for Family Planning Only Services, BadgerCare Plus, or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment

Example 1: Joe Green applied for presumptive eligibility for BadgerCare Plus for his son Jim on February 4 at the Center Street Boys Club. Jim was found presumptively eligible for BadgerCare Plus from February 4 through March 31. Joe submits a BadgerCare Plus ACCESS application to the local IM agency on February 10. The agency determines Jim's eligibility for ongoing BadgerCare Plus coverage on March 1. Jim is found ineligible for BadgerCare Plus for February and March and the application is denied. A notice is sent to Joe informing him Jim is not eligible for BadgerCare Plus and his BadgerCare Plus temporary enrollment is terminated effective March 1.

Example 2: Sandra was determined presumptively eligible for BadgerCare Plus for pregnant women on January 10. Her temporary enrollment period lasts from January

10 through February 28. She applied for ongoing BadgerCare Plus through her local income maintenance agency on January 15 and was found eligible on January 28 with an effective date of January 1. Her temporary enrollment will end on January 28.

32.1.3.4 Automatic Extension

If the income maintenance agency is unable to finish processing the application for ongoing coverage by the end of the temporary enrollment period, the system will automatically extend the temporary enrollment period for two additional calendar months. Tables 3 and 4 further explain when temporary enrollment will be extended.

Table 3: Systematic Extension of Temporary Enrollment—Applicant Applied for One Program

Applicant has applied for one program and eligibility has not been confirmed:	Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:	Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:
BadgerCare Plus or other ongoing Medicaid coverage	Extend temporary enrollment for BadgerCare Plus	Do not extend temporary enrollment for Family Planning Only Services
Family Planning Only Services	Do not extend temporary enrollment for BadgerCare Plus	Extend temporary enrollment for Family Planning Only Services

Table 4: Systematic Extension of Temporary Enrollment—Applicant Applied for Multiple Programs

Applicant has applied for multiple programs but eligibility has not been confirmed for all programs:	Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:	Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:
Eligibility has been confirmed for BadgerCare Plus or other ongoing full-benefit Medicaid coverage	Do not extend temporary enrollment for BadgerCare Plus	<ul style="list-style-type: none"> Do not extend temporary enrollment for Family Planning Only Services if the applicant is eligible for BadgerCare Plus or

but not for Family Planning Only Services		other ongoing full-benefit Medicaid coverage <ul style="list-style-type: none"> Extend temporary enrollment for Family Planning Only Services if the applicant is not eligible for BadgerCare Plus or other ongoing full-benefit Medicaid coverage
Eligibility has been confirmed for Family Planning Only Services but not for BadgerCare Plus or other ongoing full-benefit Medicaid coverage	Extend temporary enrollment for BadgerCare Plus	Do not extend temporary enrollment for Family Planning Only Services

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32.2 Eligibility

32.2.1 Current Enrollment in Ongoing Health Care Benefits

An applicant is not eligible for temporary enrollment if he or she is already receiving ongoing health care benefits. Table 1 describes the situations where this applies.

Table 1: Current Enrollment in Ongoing Health Care or Family Planning Only Services Coverage		
Applicant is currently enrolled in:	Applicant is applying for temporary enrollment in BadgerCare Plus:	Applicant is applying for temporary enrollment in Family Planning Only Services:
BadgerCare Plus or other ongoing Medicaid coverage	Deny temporary enrollment	Deny temporary enrollment
Family Planning Only Services	Allow temporary enrollment*	Deny temporary enrollment

*If all other temporary enrollment criteria are met

32.2.2 Temporary Enrollment Within the Last 12 Months

An applicant may only be temporarily enrolled once in a rolling 12-month period, or once per pregnancy. Table 2 describes the situations where this applies.

Table 2: Temporary Enrollment Within the Last 12 Months

Applicant was temporarily enrolled in:	Applicant is applying for temporary enrollment in BadgerCare Plus (non-pregnant woman):	Applicant is applying for temporary enrollment in BadgerCare Plus (pregnant woman):	Applicant is applying for temporary enrollment in Family Planning Only Services:
BadgerCare Plus (non-pregnant woman)	Deny temporary enrollment	Allow temporary enrollment*	Allow temporary enrollment*
BadgerCare Plus (pregnant woman)	Deny temporary enrollment	Allow temporary enrollment* as long as the previous temporary enrollment was not for the same pregnancy	Allow temporary enrollment*
Family Planning Only Services	Allow temporary enrollment*	Allow temporary enrollment*	Deny temporary enrollment
No programs	Allow temporary enrollment*	Allow temporary enrollment*	Allow temporary enrollment*

*If all other temporary enrollment criteria are met

32.2.3 Temporary Enrollment in BadgerCare Plus

32.2.3.1 Children

A child may get temporary enrollment for BadgerCare Plus if he or she meets all of the following financial and non-financial criteria:

- Be age 18 or younger. Children younger than age 18 must apply with a parent or guardian unless the child is living independently.
- Be a U.S. citizen or lawfully present in the U.S. (there is no requirement for the amount of time the person is lawfully present in the US).
- Has household income that is at or below the **FPL** for the child's age:
 - Younger than age 1: 306 percent of the FPL.
 - Age 1 through 5: 191 percent of the FPL.
 - Age 6 through 18: 156 percent of the FPL.

Note: See Section 16.1.2 Income Under Modified Adjusted Gross Income Rules for additional information on MAGI income disregards.

32.2.3.2 Pregnant Women

A pregnant woman may get temporary enrollment for BadgerCare Plus if she meets all of the following financial and nonfinancial criteria:

- Be pregnant. (Verification of pregnancy is not required.)
- Be a U.S. citizen or lawfully present in the U.S. (There is no requirement for the amount of time the person is lawfully present in the U.S.).
- Has household income that is at or below 306 percent of the FPL.
- Has not been temporarily enrolled for BadgerCare Plus for Pregnant Women at any time during her current pregnancy.

Note: Temporary enrollment in BadgerCare Plus for pregnant women only covers ambulatory pregnancy-related care. An application for ongoing health care benefits is required for inpatient services, including the delivery.

32.2.3.3 Adults

An adult (parent, caretaker, and childless adult) may get temporary enrollment for BadgerCare Plus if he or she meets the following financial and non-financial criteria:

- Has assistance group income at or below 100 percent of the FPL.
- Is not currently receiving Medicare Part A or B (applies to childless adults only).
- Meets one of the following:
 - Is a U.S. citizen

- Has been lawfully residing in the U.S. for at least five years
- Is lawfully residing in the U.S. and is a refugee or is seeking asylum
- Is from Cuba or Haiti and is lawfully residing in the U.S.
- Is lawfully residing in the U.S. under one of the eligible immigration statuses listed in Section 4.3.8 Immigration Status Chart.

32.2.3.4 Former Foster Care Youth

A Former Foster Care Youth may get temporary enrollment for BadgerCare Plus if he or she meets all of the following nonfinancial criteria:

- Be age 18 through 25.
- Had been receiving Foster Care, subsidized guardianship, or court-ordered Kinship Care on the date that he or she turned 18.
- Meet citizenship or immigration criteria for the population above that applies to them.

There is no income limit for Former Foster Care Youth.

32.2.3.5 Inmates

Qualified hospitals can make presumptive eligibility determinations for patients who are inmates of public correctional institutions (for example, county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The presumptive eligibility determination process for these patients is the same as for the populations listed above. Inmates of a state correctional facility are not eligible for temporary enrollment in BadgerCare Plus or Family Planning Only Services.

32.2.4 Temporary Enrollment in Family Planning Only Services

Refer to Section 40.2 Presumptive Eligibility for information.

32.2.5 Household Size

For presumptive eligibility for BadgerCare Plus, the household size must include all members of the household, even if they are not requesting presumptive eligibility and are not listed on the application. Household members include:

- Children under age 19. If the child is married, his or her spouse should also be included.
- The natural, adoptive or step parents living with the children under age 19.

- Spouses.
- Caretaker relatives.
- For pregnant woman, the number of babies she is expecting.

For presumptive eligibility for Family Planning Only Services, the household size can only be “1” regardless of whether the individual is under age 18, married and/or has children, so this field will be automatically filled with “1.”

32.2.6 Income

32.2.6.1 Monthly Earned Income

For presumptive eligibility for BadgerCare Plus, earned income from all household members listed in ACCESS Handbook Section 12.4.5.1 Household Size should be reported even if they are not requesting presumptive eligibility and are not listed on the application.

For presumptive eligibility for Family Planning Only Services, only the earned income of the individual on the application should be reported.

Earned income is income resulting from performing a job or providing a service. Earned income includes commissions, tips, salaries, wages and self-employment. To calculate the amount of the monthly earned income, the user must first determine how the employee is paid:

- **Paid Hourly:** If the employee is paid hourly, the user must multiply the number of hours worked per week by the amount of pay per hour and then multiply that amount by 4 to get the monthly income. The user should count monthly income before taxes are taken out but after any pre-tax deductions are taken out of the paycheck. Any overtime or weekend pay should also be counted.
- **Paid a Salary:** If the employee is paid a salary, the user must enter the monthly amount of the salary. If the salary is based on a yearly amount, the user should divide the yearly amount by 12 to determine the monthly amount. The user should count monthly income before taxes are taken out but after any pre-tax deductions are taken out of the paycheck.
- **Tips and Commission:** If the employee is paid in tips or commission, the user should count the average amount of tips or commission received monthly.

Note: Former Foster Care Youth are not subject to the income eligibility criteria. If an individual is a Former Foster Care Youth and is the only person in the household, the

user should enter income amounts of \$0. If an individual is a Former Foster Care Youth and is on the same presumptive eligibility for BadgerCare Plus application as other household members, the user must include the Former Foster Care Youth's income since it must be considered when determining the eligibility of the other household members. The Former Foster Care Youth's income will not be considered when determining the Former Foster Care Youth's eligibility.

Self-employment income: Self-employment income (income earned directly from one's own business, rather than earned as an employee with a specified salary or wages from an employer) should be counted as monthly earned income. However, self-employment expenses (the monthly average of expenses) should be deducted from self-employment income to determine the net self-employment amount.

Student income: Income earned from work-study jobs should be counted as monthly earned income.

The following should **not** be counted as monthly earned income:

- Tax refunds, including Earned Income Tax Credits payments.
- Allowances.

32.2.6.2 Other Monthly Income

For presumptive eligibility for BadgerCare Plus, other monthly income from all household members listed in ACCESS Handbook, Section 12.4.5.1 Household Size, should be reported even if they are not requesting presumptive eligibility and are not listed on the application.

For presumptive eligibility for Family Planning Only Services, only the other monthly income of the individual on the application should be reported.

Other monthly income includes taxable income from a source other than a job or self-employment. For example:

- Social Security (gross amounts should be used).
- Unemployment.
- Pensions (only the taxable amount should be counted).
- Annuity payments (only the taxable amount should be counted).
- Insurance benefits.
- Payments received for the rental of rooms, apartments, dwelling units, buildings or land (if not reported as self-employment income). Taxes and the expense of property maintenance may be deducted.

- Income from Tribal Per Capita payments from gaming revenue.

The following should **not** be counted as other monthly income:

- Supplemental Security Income (SSI).
- Student loans.
- Student financial aid including grants, scholarships and fellowships.
- Child support income.
- Workers' compensation.
- Veteran's benefits.
- Reimbursement for expenses that the applicant has incurred or paid, except for reimbursement for normal household living expenses such as rent, clothing or food eaten at home.
- Foster care or subsidized adoption payments.
- Life insurance policy dividends.
- Payments made by a third party directly to landlords or other vendors.
- Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the applicant for housing or utility costs (e.g., U.S. Department of Housing and Urban Development (HUD) utility allowances).
- Nutrition-related benefits, such as FoodShare Wisconsin.

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32.3 Qualified Hospitals

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

Qualified hospitals are certified by ForwardHealth to make presumptive eligibility determinations. Qualified hospitals can make presumptive eligibility determinations for the following populations:

- Children
- Pregnant women
- People applying for Family Planning Only Services (see Section 40.2 Presumptive Eligibility)
- Parents and caretakers
- Childless adults
- Women under age 65 with breast or cervical cancer (see the Medicaid Eligibility Handbook Section 36.2.2.1 Temporary Enrollment/Presumptive Eligibility Available Only To Women Enrolling Through WWWP)
- Inmates of public correctional institutions (see Section 32.2.3.5 Inmates)

Hospitals are required to notify ForwardHealth of their interest in becoming a qualified hospital for presumptive eligibility via the ForwardHealth Portal.

Only qualified hospital staff can make presumptive eligibility determinations at qualified hospital locations. Third-party contractors are **not** allowed to make presumptive eligibility determinations for a qualified hospital, though they can assist an applicant with completing the application for ongoing coverage.

Qualified hospitals are subject to standards on assisting the patient with also submitting an application for ongoing health care coverage. For patients eligible for temporary enrollment in BadgerCare Plus or Family Planning Only Services, qualified hospitals are subject to standards on assisting the patient with submitting an application for ongoing BadgerCare Plus or Family Planning Only Services coverage.

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32.4 Express Enrollment Process in ACCESS

Refer to ACCESS Handbook Chapter 12 ACCESS for Partners and Providers for information on making presumptive eligibility determinations for BadgerCare Plus or Family Planning Only Services using the Express Enrollment process in ACCESS.

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32.5 Reserved

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32.6 Reserved

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33 Estate Recovery

33.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and long-term care benefits received by BadgerCare Plus members through all the following:

- Liens against property after the death of a member
- Claims against estates
- Affidavits

A lien is never filed against the home of a BadgerCare Plus member during his or her lifetime, even if the member is living in a nursing home or institutionalized in an inpatient hospital.

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33.2 Recoverable Services

Not all services provided by BadgerCare Plus are recoverable. Recoverability depends on what was provided and the member's age when he or she received the benefit.

The following are services for which ERP may seek recovery:

1. All BadgerCare Plus services received on or after age 55 while living in a nursing home
2. All BadgerCare Plus services received on or after age 55 while institutionalized in an inpatient hospital.
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 55 or older on or after April 1, 2000.
4. All home and community-based waiver services Community Options Program (COP) Waiver, 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 and:
 - a. Prescription/legend drugs received by waiver participants.
 - b. 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 non-covered hospital services.

5. Family Care services received by members age 55 or older between February 1, 2000 and July 31, 2014 and:
 - a. Prescription/legend drugs received by waiver participants.
 - b. 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 services received by members age 55 and older while residing in a nursing home or while institutionalized in an inpatient hospital on or after March 1, 2009. All Family Care Partnership home and community-based waiver 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 Include, Respect, I, Self-Direct (IRIS) services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before July 31, 2014.
8. All BadgerCare Plus services received by members age 55 or older participating in a long-term care program on or after August 1, 2014. Long-term care programs include all home and community-based waiver 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 the Program of All-Inclusive Care for the Elderly (PACE)]. The capitation payment made to the Managed Care Organization on or after August 1, 2014 will be recovered for members receiving long-term care program services through managed care.

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33.3 Estate Claims

DHS recovers BadgerCare Plus 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% 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 BadgerCare Plus 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 BadgerCare Plus benefits, for those 55 years of age or older.**

Refer any questions about specific estate claims to the ERP staff.

33.3.1 Waiver of Estate Claim

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 §45.40(1m) Wis. Stats.

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.

33.3.2 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.

33.3.3 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 Division of Hearings and Appeals (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.

33.3.4 Personal Representative's Notice

The personal representative of the estate of a BadgerCare Plus member or the estate of a member's surviving spouse must notify DHS that the estate is being probated [§859.07(2), Wis. Stats.]. The notification must be by certified mail and include the date by which claims against the estate must be filed.

33.3.5 Real Property as Part of the Estate

When real property is part of the estate, ERP may file a lien equal to the BadgerCare Plus 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 1: Mr. A dies. A claim on his estate is filed and the estate includes 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 home and community-based waiver services, **and**
 - c. That child provided care that delayed the member's move to the nursing home, hospital, or his or her receipt of home and community-based waiver 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 caretaker 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 caretaker 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.

33.3.6 Affidavits in Small Sum Estates and Non-Probate Property

Heirs, guardians and trustees of revocable trusts created by a deceased BadgerCare Plus member must notify ERP before transferring any of the deceased's property through a Transfer by Affidavit (\$50,000 and under) (§867.03, Wis. Stats.). 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/recipient 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 BadgerCare Plus member, whether non-probate or transferred by affidavit, is subject to a lien if the state's claim cannot be satisfied through other assets.

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.

33.3.7 Patient Fund Account

Nursing homes are required to notify ERP when a BadgerCare Plus 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 BadgerCare Plus.

33.3.8 Native Americans

Native Americans: Income, Resources and Property Exempt from BadgerCare Plus Estate Recovery

The following income, resources, and property are exempt from BadgerCare Plus 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 BadgerCare Plus 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 BadgerCare Plus 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.

33.3.9 *Reparation Payments to Individuals*

Government reparation payments to special populations are exempt from BadgerCare Plus estate recovery.

33.3.10 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, BVC I 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.

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 5% 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.

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33.4 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form is on the database.

The database is compared to the death record files of the Division of Medicaid Services, Vital Records and State Registrar Section.

When a match shows a BadgerCare Plus 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.

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33.5 Notify Members

A copy of the Wisconsin Estate Recovery Program Handbook (P-13032) must be provided to every BadgerCare Plus member 54 1/2 years old or older at application and review. CARES is programmed to send this automatically.

Have each member or his or her representative read the notice of liability on the application form ("Recovery of BadgerCare Plus"). He or she acknowledges understanding of this notice when signing the application.

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33.6 Disclosure Form

The Estate Recovery Program (ERP) must be provided with asset information whenever a BadgerCare Plus 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 is programmed to send this information to ERP automatically.

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33.7 Estate Recovery Program (ERP)

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.

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33.8 Incentive Payments

DHS will return to local agencies 5% 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 BadgerCare Plus.

The payments are discretionary. DHS will make them based on compliance with program requirements.

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33.9 Other Programs

ERP also recovers for Medicaid, the Community Options Program (COP), Wisconsin Chronic Disease Program (WCDP), Medicaid and non-Medicaid Family Care.

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34 Representatives

34.1 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:

- ACCESS, when applying
- 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.)
- 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 two witness signatures. If any of the required signatures are missing, the following three conditions apply:

- The authorized representative appointment is not valid.
- This authorized representative cannot take action on behalf of the applicant or member.
- The agency cannot disclose information about the case to the invalid authorized representative.

There can only be 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:

- Apply for or renew benefits
- Report changes in the applicant or member's circumstances or demographic information
- Receive copies of the applicant or member's notices and other communications from the agency
- Work with the IM agency on any benefit related matters
- 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 to their IM agency. To remove an authorized representative, the member needs to let the agency know of the removal in writing, for example 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.

34.1.1 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 allowed to do the following tasks:

- Enroll the applicant or member in an HMO
- 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 on Section 1 Part C of the Appoint, Change or Remove Authorized Representative: Person form (F-10126). 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.

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35-37 Reserved

Reserved

PROGRAM COVERAGE (CHAPTERS 38-47)

38 Covered Services

38.1 Covered Services

A covered service is any health care service that BadgerCare Plus will pay for an eligible member, if billed. The Division of Medicaid Services enrolls qualified health care providers and reimburses them for providing BadgerCare Plus covered services to eligible BadgerCare Plus members. Members may receive BadgerCare Plus services only from enrolled providers, except in medical emergencies. BadgerCare Plus reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-enrolled provider.

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38.2 List of Covered Services and Copayments

38.2.1 Introduction

A BadgerCare Plus member may be required to pay a part of the cost of a service. This payment is called a "copayment" or "copay." The following table shows some of the covered services and copayments under BadgerCare Plus.

Services	Description
Chiropractic Services	Full coverage. Copayment \$.50 to \$3 per service (varies by service provided).
Dental	Full coverage of preventive, restorative and palliative services. Copayment \$.50 to \$3 per service (varies by service provided).
Disposable Medical Supplies (DMS)	Full coverage. Copayment \$0.50 to \$3.00 per service.
Drugs (See also 38.7 Impact on Dual Eligible Individuals)	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to 5 prescriptions per month for opioid drugs. Copayments: \$.50 for OTC Drugs \$1.00 for Generic Drugs \$3.00 for Brand Name Drugs Copayments are limited to \$12.00 per member, per provider, per month. OTCs are excluded from this \$12.00 maximum.
Durable Medical Equipment (DME)	Full coverage. C-payment \$0.50 to \$3.00 per item (varies by item provided).

	Rental items are not subject to a co-payment.
Health Screenings for Children	Full coverage of Health Check screenings and other services for individuals under age 21 years. Copayment \$1 per screening for those 18, 19 and 20 years of age.
Hearing Services	Full coverage. Copayment \$.50 to \$3 per procedure. No copayments for hearing aid batteries.
Home Care Services (home health, private duty nursing and personal care)	Full coverage. No copayment.
Hospice	Full coverage. No copayment.
Hospital - Inpatient	Full coverage. Copayment \$3 per day with a \$75 cap per stay.
Hospital - Outpatient	Full coverage. Copayment \$3 per visit.
Hospital - Outpatient Emergency Room	Full coverage. No copayment.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). Copayment \$.50 to \$3 per visit (limited to the first 15 hours or \$500 of services, whichever comes first, provided per calendar year). Copayment not required when services are provided in a hospital setting.
Nursing Home	Full coverage. No copayment.

Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	<p>Full coverage.</p> <p>C-payment \$.50 to \$3 per provider, per date of service.</p> <p>Copayment obligation is limited to the first 30 hours or \$1,500 whichever occurs first, during one calendar year (copayment limits are calculated separately for each discipline.)</p>
Physician Visits	<p>Full coverage, including laboratory and radiology.</p> <p>Copayment \$.50 to \$3 copayment per service (varies by service provided).</p> <p>Limited to \$30 per provider per calendar year.</p> <p>No copayment for emergency services, anesthesia or clozapine management.</p>
Podiatric Services	<p>Full coverage.</p> <p>Copayment \$.50 to \$3 per service.</p>
Prenatal/Maternity Care	<p>Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems.</p> <p>No copayment.</p>
Reproductive Health Services	<p>Full coverage, excluding infertility treatments, surrogate parenting and related services, including but not limited to artificial insemination, and subsequent obstetrical care as a non covered service, and the reversal of voluntary sterilization.</p> <p>No copayment for family planning services.</p>
Routine Vision	<p>Full coverage including coverage of eye glasses.</p> <p>Copayment \$.50 to \$3 per service (varies by service provided).</p>
Smoking Cessation Services	<p>Coverage includes prescription and over-the-counter tobacco cessation products.</p>

	Copayment (see drugs)
Transportation	<p>Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.</p> <p>Copayments are:</p> <ul style="list-style-type: none"> • \$2 for non-emergency ambulance trips. • \$1 per trip for transportation by an SMV. <p>No copayment for transportation by common carrier or emergency ambulance.</p>

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

38.2.2 Copay Exempt Populations

Providers are **prohibited** from collecting copayment from the following members:

- Children under age 19, regardless of income or benefit program.
 - Children in foster care, regardless of age.
 - 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

38.2.3 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

38.2.4 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.
- PDN and PDN services for ventilator-dependent members.
- Pregnancy related services.
- Preventive services with an A or B rating from the U.S. Preventive Services Task Force.
- School-based services.
- Substance abuse day treatment services.
- Surgical assistance.

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38.3 Transportation

Federal regulations require the Medicaid program provide transportation for members who have no other way to receive a ride to their Medicaid health care appointments. Transportation can be by ambulance, specialized medical vehicle (SMV) or common carrier.

38.3.1 Ambulance

Ambulance transportation is a covered service, if it is provided by a 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.

38.3.2 Specialized Medical Vehicle (SMV)

An SMV is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of an SMV must meet driver requirements in accordance with DHS 105.39 Wis. Admin Code.

SMV transportation is a covered service if provided by a 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

38.3.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

38.3.4 Transportation Coordination

Non-emergency Medical Transportation (NEMT) is coordinated by Department of Health Services' NEMT manager, Medical Transportation Management, Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for

members who have no other way to receive a ride. Rides can include ambulance, SMV or common carrier transportation depending on a member's medical and transportation needs.

The NEMT manager does not coordinate transportation for the following members:

- Members who are residing in a nursing home.
 - Members residing in a nursing home have their NEMT services coordinated by the nursing home.

- Members who are enrolled in Family Care.
 - Members enrolled in Family Care receive NEMT services from the Family Care Managed Care Organization (MCO).

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38.4 HMO Enrollment

Most BadgerCare Plus members who are eligible for BadgerCare Plus and reside in a BadgerCare Plus HMO service area must enroll in an HMO.

Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the member's family must choose the same HMO. However, individuals within a family may be eligible for an exemption from enrollment.

This is the enrollment process:

1. Members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.
2. If the member lives in an area covered by two or more HMOs, enrollment is mandatory. In areas with only one available HMO, enrollment is voluntary and the process stops here.
3. If the member lives in a mandatory area and does not choose an HMO, 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.

Exemptions: A member may qualify for an exemption from HMO enrollment if he or she meets certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.

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 he or she receives.

38.4.1 Change of Circumstances

Members who lose BadgerCare Plus 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, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, he or she will receive an enrollment packet, and the enrollment process will start over.

38.4.2 Disenrollment

Members are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a BadgerCare Plus subprogram that does not require enrollment in an HMO.
2. They become eligible for Medicare.
3. They lose eligibility.
4. They move out of the HMO's service area.

Members can be disenrolled by the HMO's request in the following situations:

1. They become inmates of a public institution.
2. They need an experimental transplant.

Note: HMO disenrollment is not automatic in these situations.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member's new area, he or she remains fee-for-service.

38.4.3 Fiscal Agent Ombuds

Members with questions about their rights as HMO members may call 1-800-760-0001 or write:

HMO Ombudsman
P.O. Box 6470
Madison, WI 53791-9823

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38.5 BadgerCare Plus Cards

38.5.1 BadgerCare Plus Cards Introduction

All BadgerCare Plus members are issued ForwardHealth cards. These cards are plastic and display the words "ForwardHealth."

Members use the same ForwardHealth card each month to receive services on a fee for service basis and/or through a managed care organization, if enrolled. Monthly cards are not issued.

Each person in the family who is eligible receives his or her own card for the benefit plan for which they are eligible. Members may have multiple ID cards if they have been in one or more of the plans listed above.

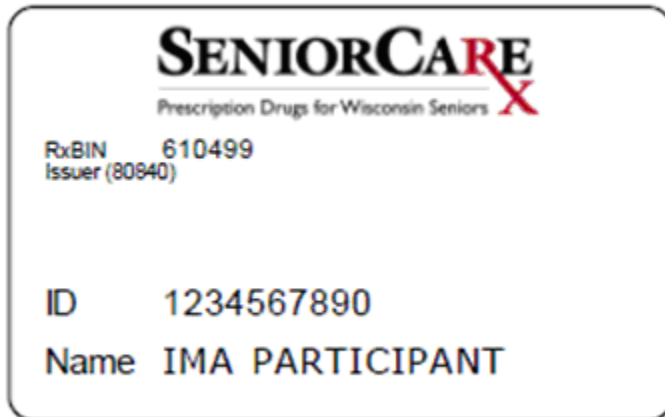
The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Members will know if they are eligible, and for which benefit plan, based on positive and negative notices sent from the IM agency. They will also receive separate notices if enrolled in a Managed Care Organization. Members who receive a notice that they are no longer eligible for BadgerCare Plus 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 log into ACCESS> Change My Benefits or call Member Services at 1-800-362-3002.

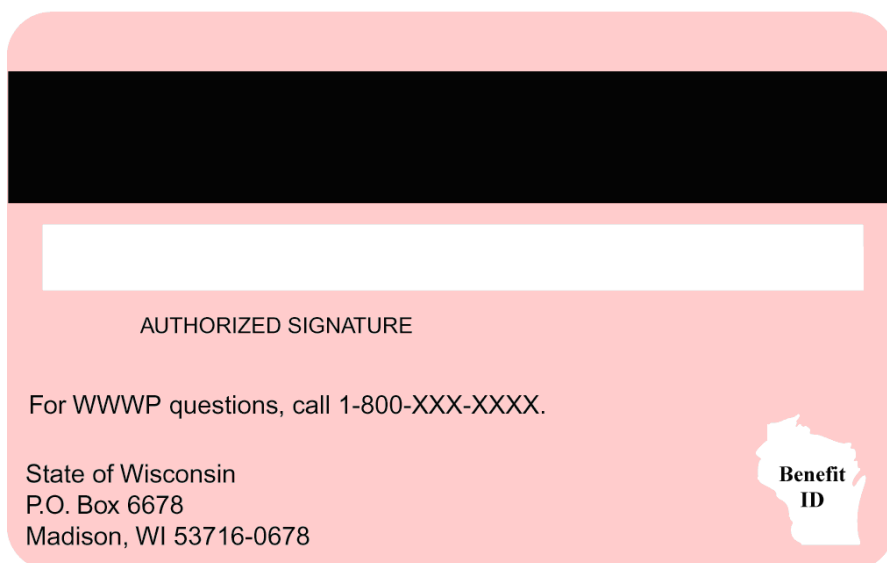
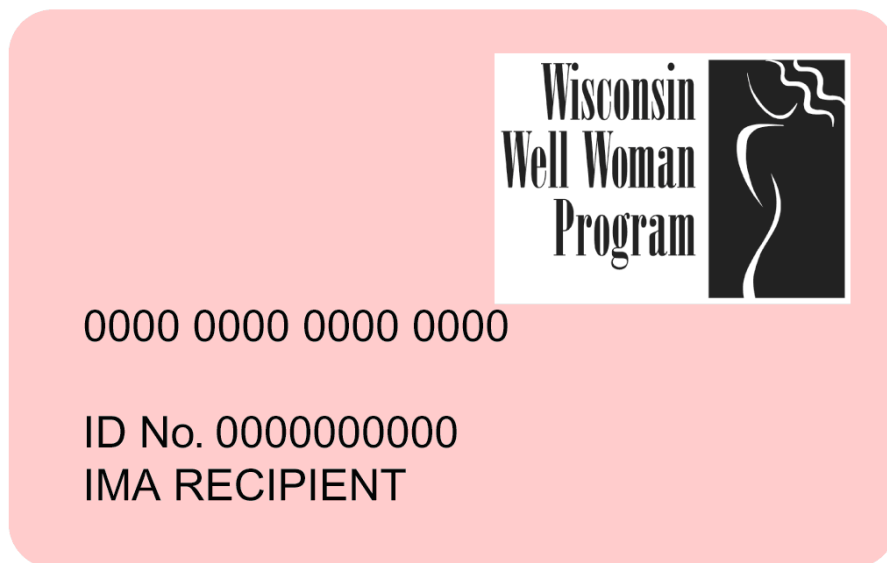
38.5.1.1 ForwardHealth Card Image



38.5.1.2 SeniorCare Card Image



38.5.1.3 Wisconsin Well Woman Program Card Image



38.5.2 Appeals

Keep a BadgerCare Plus case in appeal status open if the member makes a request prior to the closure date. The member can continue to use his or her ForwardHealth card until a decision is made regarding his or her eligibility.

38.5.3 Homeless

Make ID cards available to homeless BadgerCare Plus members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

38.5.4 Pharmacy Services Lock-in Program

Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce unnecessary physician and pharmacy utilization and to discourage the nonmedical 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 they should continue enrollment in the Pharmacy Services Lock-In Program.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth identification card or excessive use of emergency room services.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services at 800-947-9627 or by writing to the following:

Division of Medicaid Services
Bureau of Benefits Management
P.O. Box 309
Madison, WI 53701-0309

38.5.5 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering.

38.5.6. Lost-Stolen Cards

If a member needs a replacement card, he or she or an *authorized representative*, can request a replacement card by:

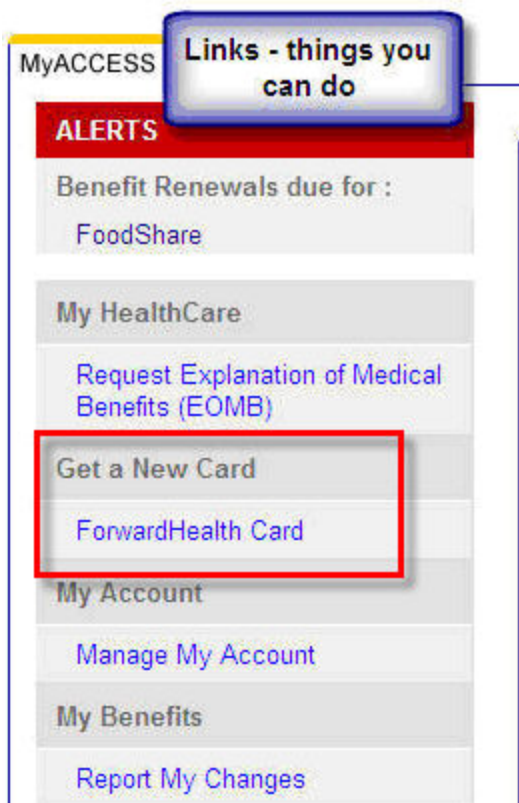
1. Going to ACCESS
 - Create a MyACCESS Account, then
 - Go to your MyACCESS Page and select a new ForwardHealth card, or
2. Contacting Member Services at 1-800-362-3002.

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 a Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 (formerly DES 3070) or *CARES*.



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38.6 Good Faith Claims

38.6.1 Definition of Good Faith Claims

A good faith claim is a claim that has been denied by BadgerCare Plus with an eligibility-related Explanation of Benefits (EOB) code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to ForwardHealth 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, ForwardHealth will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact the IM agency to verify eligibility. The Good Faith Medicaid/BadgerCare Plus Certification form, F-10111 is used for this purpose. A good faith claim cannot be reimbursed until the member file has been updated.

38.6.2 Denials

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a Good Faith claim

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.
614	Medicaid number doesn't match recipient's first name.

38.6.3 Causes and Resolutions

Causes and a good faith claim can occur when:

1. A member presents an ID card that is invalid because:
 - a. You issued a temporary ID card for a prior period or manually determined case and did not update CARES or send ForwardHealth a Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 (formerly DES 3070) to update the member's eligibility file. ForwardHealth will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the member is eligible for the dates on the card. The letter will include instructions on how to complete an Good Faith

Medicaid/BadgerCare Plus Certification form, F-10111 and the information that is needed.

b. The provider suspects the member of misusing or abusing a ForwardHealth card (i.e. using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and ForwardHealth can tell that it was altered, ForwardHealth will contact you to verify that the member was eligible or forward it to the Division of Medicaid Services for review.

2. The member's name has changed since the card was issued. ForwardHealth can usually resolve claims that are denied with code "029" and "614". If necessary, ForwardHealth will contact you to confirm the information.

With the implementation of the ForwardHealth cards, providers are less likely to receive one of the eligibility-related denials used for Good Faith claims submission. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When the provider verifies the member's eligibility, they are getting the most current information available on the ForwardHealth interChange. Therefore, it is unlikely that they will be told the member is eligible when 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 BadgerCare Plus before the eligibility is updated on ForwardHealth interChange, or perhaps the eligibility was never sent to ForwardHealth interChange. In either case, if the member presents a valid temporary BadgerCare Plus ID card for the dates of service, and the provider sends a copy of the card with the Good Faith claim, ForwardHealth will update the member's eligibility file with a good faith segment and pay the claim immediately.

ForwardHealth 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, ForwardHealth 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.

38.6.4 Process

ForwardHealth initiates claim processing by sending workers a partially completed Good Faith Medicaid/BadgerCare Plus Certification form, F-10111, and one or two letters, depending on the eligibility documentation the provider included with the claim. Workers should finish completing the Good Faith Medicaid/BadgerCare Plus Certification form if this is a new member (cert. 1) or complete the Medicaid/BadgerCare Plus Eligibility Certification form, F-10110, (formerly DES 3070) for amended certifications (cert. 3). Send completed forms by fax to 608-221-8815 or by mail to:

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

38.6.5 Instructions

Agency Denial

If the member identified on the Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Recipient Did Not Have ID Card After Date of Service

Place an "X" in this box if you are certain that the member did not possess a valid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible

Place an "X" in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found

Place an "X" in this box if the member has never been eligible for BadgerCare Plus in your agency.

Dates of Services

ForwardHealth 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

ForwardHealth will check one of these boxes:

1. Initial Certification

ForwardHealth will place an "X" in this box when the member and BadgerCare Plus ID number submitted on the claim cannot be found on the eligibility master file.

2. Amended Certification

ForwardHealth will place an "X" in this box when the member is on interChange, but no eligibility exists for the claimed dates of service.

Agency Number

ForwardHealth will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number

ForwardHealth will enter the known or suspected interChange case number (primary person's **SSN** + tie-breaker) of the member listed on the provider's claim.

Action Date

ForwardHealth enters the date they completed the Good Faith form.

Medical Status Code

When ForwardHealth 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). ForwardHealth 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, ForwardHealth enters a "71" medical status code and pays the claim immediately. ForwardHealth 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 Medicaid/BadgerCare Plus Certification form, F-10111, remove the "71" medical status code and write in the correct code. Attach a Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 (formerly DES 3070) to add the **certification period** and appropriate medical status code for the time when the member was eligible for BadgerCare Plus.

Period of Certification

If ForwardHealth has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete an F-10110 (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for

the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth

ForwardHealth 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 file.

Current ID Number

ForwardHealth will enter the member's current ID number.

Date of Birth

ForwardHealth completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birth date as MM/DD/CCYY.

Signature of Agency Director

Good Faith forms must have an authorized signature for initial certifications.

Worker ID

On initial certifications, enter the six-digit worker code of the certifying IM worker.

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38.7 Impact on Dual Eligible Individuals

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for BadgerCare Plus under a Title 19 (Medicaid) funded Med Stat Code are referred to as Dual Eligible individuals. Since January 1, 2006, Medicaid does not provide prescription drug coverage for these individuals. Instead these individuals receive prescription drug coverage through Medicare Part D.

These Dual Eligible individuals are deemed eligible for "Extra Help" from CMS to help pay for their Medicare Part D drug costs.

A Medicare Part D Preferred Drug Plan (PDP) card will be issued to them and it must be used for prescription drugs instead of their Forward Card.

For more information on Medicare Part D, see:

<http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx>

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38.8 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.

38.8.1 Copay Limits for Members and Programs exempt from copays

Members who are in a copay exempt category (38.2.2 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 (38.2.3 Copay Exempt Programs) will have a copay limit of \$0 as there are no copays for members enrolled in these programs.

38.8.2 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.

38.8.3 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 (Chapter 53 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 with two children. The entire family is enrolled in BadgerCare Plus. 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 four.

Since both parents 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.

Example 2: Marianne, who is pregnant, and Joe are a married couple enrolled in BadgerCare Plus with income that falls in the >50-100% of FPL income tier for a group size of three. Marianne has a pregnancy due date of March 10. Marianne is exempt from copays beginning with the first month she is certified as a pregnant woman until May 31 (the end of the month in which her 60-day postpartum period ends). While Marianne is certified as a pregnant woman and exempt from copays, Joe's monthly copay limit is \$26. After the end of the postpartum period, eligibility and copay limits will be redetermined. Beginning June 1, the household's copay limit will be split between Marianne and Joe and they will each have a \$13 copay limit.

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 3: 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.

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.

38.8.3.1 Premiums

For 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 split evenly between the married couple even if the spouses are on different benefit programs.

Example 4: Mark is a CLA with income that falls in the >50-100% of FPL income tier. He is enrolled in BadgerCare Plus and pays an \$8 monthly premium. His copay limit is calculated as \$26 minus the \$8 premium. Mark's monthly copay limit, after his premium has been deducted, is \$18.

Example 5: 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).

38.8.4 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 (after the 10th of the month in which the change was supposed to be reported), the month in which the change was reported, whichever is later.

38.8.5 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 6: Tamika is enrolled in BadgerCare Plus and has a copay limit of \$13 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of \$13. CARES issues Tamika an automated notice stating that her \$13 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. Starting on September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

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39 Emergency Services

39.1 Emergency Services Income Limits

BadgerCare Plus Emergency Services is a limited BadgerCare Plus benefit for documented immigrants who have not been in the U.S. for 5 years or more and for undocumented immigrants.

A citizen is not eligible for BadgerCare Plus Emergency Services even when he or she cannot produce citizenship and/or identity verification.

Example 1: Jill applies for BadgerCare Plus, declares U.S. citizenship and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services BadgerCare Plus does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However, the IM worker cannot process BadgerCare Plus Emergency Services eligibility for persons declaring to be U.S. citizens. BadgerCare Plus Emergency Services is reserved for non-qualifying non-citizens.

Because Emergency Services is funded through Title XIX only those who would receive their BadgerCare Plus benefits under Title XIX are eligible for BadgerCare Plus Emergency Services. Therefore, not everyone who meets the income limits for BadgerCare Plus qualifies for BadgerCare Plus Emergency Services.

Immigrants who only meet the criteria for BadgerCare Plus under the childless adults' coverage group are ineligible for Emergency Services.

An immigrant who is ineligible for BadgerCare Plus because of his or her *immigration status* is eligible for BadgerCare Plus Emergency Services coverage if:

1. He or she meets the income limits listed in the chart below and
2. Meets all other eligibility requirements, except having or applying for an *SSN*.

BadgerCare Plus Emergency Services Income Limit

Group	Income
Pregnant Women	Up to 306% FPL
Newborns to age 1	Up to 306% FPL

Children ages 1 - 5	Up to 191% FPL
Children ages 6 - 18	Up to 156% FPL
Former Foster Care Youth	Any FPL Level
Parents and Caretakers	Up to 100% FPL

Note: Pregnant *non-qualifying immigrants* may be eligible under the BadgerCare Plus Prenatal Program.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical treatment could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

BadgerCare Plus Emergency Services covers :

- Only those medical services needed for the treatment of an emergency medical condition.
- All labor and delivery services for eligible non-qualifying immigrants.

See Process Help, Section 11.1 BC+ Emergency Services Manual Application Processing, for BadgerCare Plus Emergency Services manual *application* processing.

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Effective Date: 04/11/2017*

39.2 Determining if an emergency exists

It is not the responsibility of the IM agency to determine if the applicant's condition is or was an emergency condition and reimbursable under BadgerCare Plus Emergency Services. The medical provider submits claims for emergency medical services to the *fiscal agent*. The fiscal agent then determines if a condition is an emergency medical condition covered by BadgerCare Plus Emergency Services.

39.2.1 Determining Eligibility

It is the IM agency's responsibility to manually determine if the non-qualifying immigrant meets all eligibility requirements during the dates of service and to certify if he or she is eligible for Emergency Services.

Medicaid providers who have treated non-US citizens for emergency services can provide them the Certification of Emergency for Non-U.S. Citizens form, F-01162, to verify that the services provided were to treat an emergency medical condition. Providers are instructed to have the patient present this to the local IM agency when applying for assistance.

Note: The Certification of Emergency for Non-U.S. Citizens form is not required to certify Emergency Services eligibility.

If a non-qualifying immigrant provides a "Certification of Emergency for Non-U.S. Citizens" at the time of *application*, his or her eligibility for BadgerCare Plus Emergency Services is determined for the dates of the emergency indicated on the form.

If a non-qualifying immigrant does not have the form at the time of application, ask him or her for the dates that he or she received emergency services.

Emergency Services coverage begins at the time of the first treatment for the emergency and ends when the condition is no longer an emergency.

Determine eligibility of a pregnant immigrant on the date emergency services were provided. The pregnancy due date is required to determine eligibility for pregnant immigrants. (See 39.3 for Emergency Services certification dates for pregnant women.)

*If a non-qualifying immigrant would only qualify for BadgerCare Plus if he or she was disabled, follow disability determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

Certification of Emergency Services is not done through **CARES** and must be done manually. However, all applications should be processed through CARES to determine BadgerCare Plus eligibility. If the immigrant does not have an **SSN**, CARES will assign a pseudo SSN. That pseudo SSN should be used when submitting the manual certification. When an immigrant is determined eligible for Emergency Services, complete and submit a Medicaid/BadgerCare Plus Eligibility Certification form, F-10110 (formerly DES 3070) (see Process Help, Section 81.3 F10110 Manual Form). The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

Note: The Federally Facilitated Marketplace will send accounts to state consortia and tribal agencies for individuals who have been assessed as potentially eligible for BadgerCare Plus Emergency Services.

Submit completed Medicaid/BadgerCare Plus Eligibility Certification forms by fax to 608-221-8815 or by mail to:

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

An individual eligible for BadgerCare Plus Emergency Services will not receive a ForwardHealth card because BadgerCare Plus Emergency Services eligibility ends when the emergency ends.

However, women determined eligible for the BadgerCare Plus Prenatal Program will be issued a ForwardHealth Card, which can also be used to access emergency services under the Emergency Services coverage group after the BadgerCare Plus Prenatal Program coverage ends.

39.2.2 Providing Manual Positive or Negative Notice

The IM agency must provide a manual positive or negative notice regarding the applicant's eligibility. Positive notices must provide the dates of eligibility for BadgerCare Plus Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

Effective Date: 12/13/2017

39.3 Emergency Services For Pregnant Women

A pregnant non-qualifying immigrant may apply for emergency services up to one calendar month before her due date. Certify an eligible pregnant non-qualifying immigrant from the date of *application*, if she applies no more than one calendar month prior to her due date, through the end of the month in which the 60th day occurs following her due date. Adjust the *certification period* based on the actual pregnancy end date, once it is known.

Note: Pregnancy does not need to be verified (see Section 9.9.3 Pregnancy).

Example 1: Sara is a pregnant non-qualifying immigrant applying for BadgerCare Plus Emergency Services. Sara has two weeks until her due date, which is March 3. Certify Sara for BadgerCare Plus Emergency Services from the date of application through the end of May.

Example 2: Erica applied for BadgerCare Plus Emergency Services because she was a pregnant non-qualifying immigrant on March 13. Her expected due date is April 5. Erica is certified for BadgerCare Plus Emergency Services from March 13 through the end of June. Erica delivers her son on March 15. Her certification period should be adjusted from March 13 through the end of May.

If a pregnant non-qualifying immigrant applies prior to the calendar month, before her due date, and she has not received a service, deny her BadgerCare Plus Emergency Services eligibility because she has not received a service.

If a woman applies for BadgerCare Plus Emergency Services, within three months after her pregnancy has ended, certify her from the pregnancy end date through the end of the month in which the 60th day occurs.

Example 3: Vienne miscarries on April 5, which is more than one month from her due date of July 15. Vienne applies on April 6 for BadgerCare Plus Emergency Services. Certify Vienne for BadgerCare Plus Emergency Services from April 5 through the end of June.

Example 4: Guadeloupe was in a car accident and admitted to a Fort Atkinson Hospital on February 18. On March 15, Guadeloupe applied for BadgerCare Plus Emergency Services for both the February hospital stay and her pregnancy, with a due date of April 15. Certify Guadelupe for BadgerCare Plus Emergency Services from February 18 through the end of June.

An immigrant who gives birth while enrolled in BadgerCare Plus Emergency Services remains eligible for emergency services for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. The emergency does not have to be related to the pregnancy.

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39.4 Newborns

Babies born to mothers covered under BadgerCare Plus Emergency Services are BadgerCare Plus eligible as continuously eligible newborns, if all other eligibility conditions are met. (Chapter 8.2)

*This page last updated in Release Number: 07-01
Release Date: 10/29/07
Effective Date: 02/01/08*

39.5 Eligibility Begin Date for non-qualifying immigrants who lose eligibility for the BadgerCare Plus Prenatal Program

A non-qualifying immigrant, who loses eligibility for the BadgerCare Plus Prenatal Program (Chapter 41) when her pregnancy ends, or for any reason other than moving out of state, is eligible for BadgerCare Plus Emergency Services from the date she lost BadgerCare Plus Prenatal Program eligibility. Like other pregnant immigrants, these women should have BC + Emergency Services coverage through the end of the month in which the 60th day occurs, following her due date or the pregnancy end date, if that is known.

Example 1: A pregnant non-qualifying immigrant is found eligible for the BadgerCare Plus Prenatal Program. Her expected due date is July 10th. She is terminated effective April 30th from the BadgerCare Plus Prenatal Program due to non-payment of the BC premium. CARES will send the fiscal agent a record terminating her BadgerCare Plus on April 30th, and send a record to certify her as eligible for BadgerCare Plus Emergency Services from May 1st through September 30th.

Pregnant *non-qualifying immigrants* who are not found eligible for the BC Prenatal Program should have BadgerCare Plus Emergency Services eligibility determined according to the instructions in 39.3.

Example 2: A pregnant non-qualifying immigrant applies on January 15th. Her expected due date is May 10th. She is denied BadgerCare Plus Prenatal Program eligibility due to access to health insurance through her employer. To receive Emergency Services, she must re-apply no earlier than April 10th. BadgerCare Plus Emergency Services eligibility continues through the end of the month following the 60th day after the pregnancy ends.

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39.6 BadgerCare Plus Deductible

Immigrants who apply for Emergency Services and who are under 19 years of age and ineligible due to access to health insurance or who are pregnant and have countable household income over 306 percent of the FPL, may become eligible for BadgerCare Plus Emergency Services through a BadgerCare Plus *deductible*. If, on the date he or she applies and he or she meets all other eligibility criteria, apply the same deductible policies to him or her as any other *applicant* (see Chapter 17 Deductibles).

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40 Family Planning Only Services (FPOS)

40.1 Family Planning Only Services Program

The Family Planning Only Services Program provides limited benefits for family planning services for women and men with income at or below 306 percent of the *FPL* and who are:

1. Of child bearing or reproductive age, and
2. Not enrolled in BadgerCare Plus or receiving other full-benefit Medicaid.

For more information about income disregards under MAGI rules, see Section 16.1.2 Income Under Modified Adjusted Gross Income Rules.

Individuals who are eligible for the Family Planning Only Services Program may be eligible to receive more than one limited benefit program. These include:

- Tuberculosis-related (Chapter 43 Tuberculosis-Related Medicaid)
- Qualified Medicare Beneficiary (Medicaid Eligibility Handbook, Section 32.2)
- Specified Low-Income Medicare Beneficiary (Medicaid Eligibility Handbook, Section 32.3).

In certain circumstances, women enrolled in the Family Planning Only Services Program may be eligible for the Wisconsin Well Woman Medicaid plan (see Medicaid Eligibility Handbook chapter 36).

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40.2 Presumptive Eligibility

40.2.1 Introduction

Presumptive eligibility for Family Planning Only Services provides family planning and family planning-related services only. For more information about presumptive eligibility, see Section 32.1 Introduction.

40.2.1.1 Qualified Entities

Qualified entities that can be certified by ForwardHealth to make presumptive eligibility determinations for Family Planning Only Services include:

- Medicaid providers
- Qualified hospitals

For more information about qualified entities, see Section 32.1.2 Qualified Entities.

40.2.1.2 Coverage Period

For information about when coverage begins and ends, early terminations, and automatic extensions, see Section 32.1.3 Coverage Period.

40.2.2 Eligibility

A person can get temporary enrollment for Family Planning Only Services if he or she meets all of the following financial and nonfinancial criteria:

- Be of child bearing or reproductive age.
- Be a Wisconsin resident.
- Have income at or below 306 percent of the *FPL*.

Note: For information about income disregards under *MAGI* rules, see Section 16.1.2 Income Under Modified Adjusted Gross Income Rules.

- Meet one of the following:
 - For people age 18 and younger:
 - Be a U.S. citizen

- Be lawfully present in the U.S. (no requirement for the amount of time the person is lawfully present in the U.S.)
- For people age 19 and older:
 - Be a U.S. citizen
 - Be lawfully residing in the U.S. under one of the eligible immigration statuses or situations listed in Section 4.3.8 Immigration Status Chart
- Is not currently receiving Family Planning Only Services, BadgerCare Plus, or other full benefit Medicaid.

40.2.3 Express Enrollment in ACCESS

Refer to ACCESS Handbook Chapter 12 ACCESS for Partners and Providers for information on making presumptive eligibility determinations for Family Planning Only Services using the Express Enrollment process in ACCESS.

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40.3 Application

Eligibility for **FPOS** begins on the first of the month of *application* , if all non-financial (40.4) and financial (40.5) eligibility requirements are met. FPOS may be backdated up to three months from the month of application

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40.4 Nonfinancial Requirements

The following are **FPOS** specific nonfinancial requirements:

- The person must be of child bearing or reproductive age
- The person must be a Wisconsin resident
- The person must not be enrolled in BadgerCare Plus or receiving other full benefit Medicaid
- The person must be one of the following:
 - **If under age 19:** Lawfully residing in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).
 - **If age 19 and older:** Either a U.S. citizen or Lawfully residing in the United States under one of the eligible immigration statuses/situations listed in Section 4.3.8 Immigration Status Chart.
- The person must meet all BadgerCare Plus non-financial criteria (see Section 2.1 Nonfinancial Program Requirements) with the exceptions listed below:
 - An individual applying for or receiving BadgerCare Plus FPOS is not subject to the health insurance access or coverage policies.
 - An individual applying for or receiving BadgerCare Plus FPOS is not required to cooperate with Medical Support, unless he or she is also applying for or receiving BadgerCare Plus for any child for whom he or she is the caretaker relative .
 - An individual applying for or receiving BadgerCare Plus FPOS is not required to cooperate with Third Party Liability (**TPL**), unless he or she is also applying for or receiving BadgerCare Plus for any child for whom he or she is the caretaker relative.
 - Any individual applying for or receiving FPOS who refuses to cooperate with MSL or TPL requirements when he or she has a child in the home who is receiving BadgerCare Plus or Medicaid, is ineligible for FPOS unless he or she is under 19 or has **good cause**.

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40.5 Financial Requirements

40.5.1 Financial Eligibility Requirements Specific to FPOS

The following specific financial eligibility requirements apply to **FPOS** members, regardless of the methodology used to determine his or her **FPOS** income:

1. Countable income calculated in the **application** month is used to determine the member's financial eligibility for the entire 12-month eligibility period. Income changes do not need to be reported until the next review. This policy does not apply to backdated months. Backdated months are determined in addition to the 12-month certification period and are not used as the basis for whether someone's eligibility will be maintained after an increase in income. As with other health care requests, the 12-month certification period will be set based on the filing month, not the first month of backdated eligibility.
2. Any change in income or household size reported after confirmation for **FPOS** during the 12-month eligibility period is only applied if it results in enrollment in BadgerCare Plus with no premium or eligibility for other full benefit Medicaid.
3. All changes in income or household composition that result in enrollment in BadgerCare Plus with no premium or eligibility for other full benefit Medicaid will result in **FPOS** closure prior to the 12th month.
4. All changes in income will be applied at the 12-month **FPOS** eligibility renewal.

40.5.2 Income

Because FPOS eligibility is determined based on a group size of one, the applicant's taxable earned and unearned income is the only income that should be used when calculating their income for purposes of FPOS eligibility (see Chapter 16 Income for information on taxable income). When a child under 19 is applying, their parents' income is not included in his or her eligibility determination. If a married individual is applying for FPOS coverage, do not include the income of the spouse, even if he or she is living with his or her spouse.

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40.6 FPOS Group

For all individuals, including children under 19, the group size of the applicant will always be one, regardless of his or her marital status and whether or not he or she has children or tax dependents.

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40.7 Program Choice

An individual applying for both BadgerCare Plus and **FPOS** may request at any time to discontinue enrollment in BadgerCare Plus in order to receive only FPOS. Change the health care request on the program request page to "No" in order to receive the FPOS.

An individual applying for both BadgerCare Plus and FPOS is not given a choice at the time of confirmation if he or she meets the eligibility for both benefits. He or she will be enrolled in BadgerCare Plus.

An individual found to be eligible for a **deductible** may also be eligible for FPOS benefits during a deductible period. The member may receive FPOS benefits until he or she has met a deductible. The member can report any out-of-pocket medical bills incurred while he or she is receiving services through FPOS, in order to meet a deductible. Once a deductible has been met, he or she is receiving full-benefit BadgerCare Plus/ Medicaid, and is no longer eligible for FPOS. However, he or she will continue to receive the same family planning services through BadgerCare Plus/Medicaid.

Example: Theresa is an 18-year-old woman applying for Medicaid, BadgerCare Plus and FPOS for herself and for BadgerCare Plus for her daughter Sara (age three). She is found to be eligible for BadgerCare Plus with a premium or a deductible. If Theresa chooses BadgerCare Plus, she is required to pay a premium but would be able to receive family planning services through BadgerCare Plus as well as having coverage for her whole family. If she chooses the deductible, she can receive family planning-related services through FPOS until her deductible has been met.

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40.8 Reporting Changes

Members receiving **FPOS** only are not required to report changes in income or household composition during the 12-month **certification period**. However, FPOS members are still required to report all other changes that would result in ineligibility such as moving out of state, incarceration, etc. within 10 days of the change.

Changes in income do not affect FPOS eligibility during the 12-month certification period even if the income exceeds the FPOS income limit. Once eligibility has been established, the increase in income will not be considered until the next annual renewal that was originally set for the FPOS eligibility.

Note: Household composition changes will not affect eligibility as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

Changes reported in income or household composition resulting in eligibility for BadgerCare Plus should be applied. If there is a request for BadgerCare Plus on file, he or she will be found eligible for BadgerCare Plus. At that time, FPOS will end.

FPOS eligibility terminates when a member loses non-financial eligibility. Terminate eligibility, using **adverse action** logic, when she:

1. Moves out of state.
2. Is 19 years or over and is no longer cooperating with TPL, Medical Support, or **SSN** requirements.
3. Enrolls in BadgerCare Plus or becomes eligible for other full benefit Medicaid.
4. Becomes an inmate of a public institution.

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40.9 Ongoing Eligibility

Changes in income do not affect *FPOS* eligibility during the 12-month *certification period*, even if the income exceeds the FPOS income limit. Once eligibility has been established, the increase in income will not be considered until the next annual renewal that was originally set for the FPOS eligibility.

This policy does not apply to backdated months. Backdated months are determined in addition to the 12-month certification period, and are not used as the basis for whether someone's eligibility will be maintained after an increase in income.

Note: Household composition changes will not affect eligibility as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

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40.10 Reviews and Recertifications

A renewal/recertification (see Chapter 26 Renewal) is required every 12 months, after an initial eligibility determination. At the time of the *FPOS* renewal, income and household composition are again tested against the FPOS eligibility criteria.

If a member completes a renewal for another program of assistance at any time during the 12 month FPOS *certification period* and the information collected from that renewal indicates that she still meets FPOS eligibility requirements, the FPOS renewal date will be set 12 months from that renewal date.

If a member completes a renewal for another program of assistance at any time before the 12th month of FPOS eligibility ends, and reports income that is over the income limit for FPOS, this increase in income will not affect FPOS eligibility. It will not be considered until the next annual renewal that was originally set for the FPOS eligibility. He or she will be required to complete a renewal at the end of the original 12-month certification period. If at this renewal, he or she is found to still have income in excess of the FPOS limit, eligibility for FPOS ends.

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40.11 Confidentiality

Members applying for or receiving **FPOS** benefits will have all of the confidentiality protections as other BadgerCare Plus applicants, as well as the following additional confidentiality protections:

1. If requested, member can have written communication sent to an alternate address instead of the home address.
2. Minors are not referred to child support.
3. Eligibility information regarding minors who apply independently for FPOS is kept confidential from parents or guardians, unless the member gives clear consent for release of the information.

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41 BadgerCare Plus Prenatal Program

41.1 BadgerCare Plus Prenatal Program

The BadgerCare Plus Prenatal Program provides coverage for women who:

- Meet the nonfinancial and financial eligibility requirements for BadgerCare Plus outside of incarceration or immigration status
- Are not eligible for BadgerCare Plus because they are either inmates of a public institution or *non-qualifying immigrants*

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41.2 Eligibility Requirements

Pregnant women (or when applicable, their assistance group), must meet the following BadgerCare Plus eligibility requirements to qualify for the BadgerCare Plus Prenatal Program:

1. The applicant's net countable income must not exceed 306% of the FPL.
2. The applicant must not have current or past access to an employer's health insurance benefit where the employer pays 80% or more of the premium cost or to any State of Wisconsin health insurance plan.
3. The applicant must provide any required verifications.

Note: Pregnancy will only be verified if the worker has information that contradicts the applicant's self-declared information (see Section 9.9.3 Pregnancy).

4. The applicant must not have health insurance coverage (Chapter 7) through any HIPAA standard plan now or in the three calendar months prior to the BadgerCare Plus Prenatal request.

41.2.1 Unique Aspects of BadgerCare Plus Prenatal Program

1. Providing an **SSN** is not an eligibility requirement for either inmates or **non-qualifying immigrants** applying for the BadgerCare Plus Prenatal Program.
2. Cooperation with Child Support Enforcement is not an eligibility requirement for this program.
3. Unlike regular BadgerCare Plus which locks in eligibility throughout the pregnancy, BadgerCare Plus Prenatal Program eligibility may be terminated with timely notice for failure to meet any of the BadgerCare Plus eligibility requirements listed in 41.1.
4. There is no Presumptive Eligibility for the BadgerCare Plus Prenatal Program. Eligibility for the BadgerCare Plus Prenatal Program may only be determined by the IM agencies.
5. There is no 3-month backdating option available for Prenatal Program members.
6. Unlike BadgerCare Plus for Pregnant Women, Prenatal Program members are not eligible for the 60-day pregnancy extension, but are eligible for Emergency Services during that time.

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41.3 Policy for Non-qualifying Immigrants

1. For immigrants who are legally present in the United States, verify immigration status through normal SAVE procedures in order to determine eligibility for BadgerCare Plus. If SAVE verifies the pregnant woman is a non-qualifying immigrant, proceed with determining eligibility for the BadgerCare Plus Prenatal Program.
2. For immigrants who do not have legal immigration status, do not request SAVE verification and continue with the determination of eligibility for the BadgerCare Plus Prenatal Program.
3. A non-qualifying immigrant whose immigration status changes while she is pregnant and receiving BadgerCare Plus Prenatal benefits must have her eligibility re-determined using the new immigration status. If her new status makes her eligible for BadgerCare Plus for Pregnant Women, she is no longer eligible for the BadgerCare Plus Prenatal Program.

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41.4 Policy For Inmates

1. Inmates will always be considered to be residing in the county where the jail or prison facility is located.
2. An inmate who is released from jail or prison while receiving BadgerCare Plus Prenatal Program must have her eligibility re-determined based on her new circumstances. Once released from an institution, she is no longer eligible for the BadgerCare Plus Prenatal Program.

Note: When a BadgerCare Plus Prenatal Program member notifies the IM agency that she has become a citizen or qualifying immigrant, or is released from prison or jail, **CARES** will redetermine BadgerCare Plus eligibility based on the new information.

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41.5 Eligibility Begin Date

BadgerCare Plus Prenatal Program eligibility begins no sooner than the first of the month in which a valid *application* is received.

Pregnant *non-qualifying immigrants* who are not eligible for the BadgerCare Plus Prenatal Program should have Emergency Services eligibility determined according to policy in Chapter 39 Emergency Services.

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41.6 Eligibility End Date

BadgerCare Plus Prenatal Program eligibility ends when the pregnancy ends. Benefits will continue through the end of the month following timely notice requirements.

Non-qualifying immigrants who lose eligibility for the BadgerCare Plus Prenatal Program when their pregnancy ends, for any reason other than moving out of state, are eligible for Emergency Services (see Chapter 39 Emergency Services) from the time they lose BadgerCare Plus Prenatal Program eligibility.

Note: When the pregnancy ends, CARES will automatically send ForwardHealth an emergency services certification through the end of the month in which the 60th day occurs.

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41.7 Determining the BadgerCare Plus Prenatal Group

Follow the rules outlined in Chapter 2 BadgerCare Plus Group in order to form group size for the BadgerCare Plus Prenatal Program.

Pregnancy, the number of fetuses, and the due date are not required to be verified unless the worker has information that contradicts the applicant's self-declared information (see Section 9.9.3 Pregnancy). The effective begin date for the BadgerCare Plus Prenatal Program is the first of the month in which they apply and are otherwise eligible.

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41.8 Benefit Information

Women determined eligible for the BadgerCare Plus Prenatal Program receive a ForwardHealth card, which can also be used to access emergency services under BadgerCare Plus Emergency Services only after BadgerCare Plus ends.

BadgerCare Plus Prenatal Program and BadgerCare Plus Emergency Services members will not be enrolled in an HMO. Services will only be provided on a fee-for-service basis.

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42 Long-Term Care for Childless Adults

Institutionalized childless adults who do not meet the eligibility criteria for **EBD** Medicaid but are eligible for BadgerCare Plus are eligible to have their **LTC** services covered by BadgerCare Plus if they are functionally eligible. "Institutionalized" means the individual has resided in a medical institution for 30 or more consecutive days or is likely to reside in a medical institution for 30 or more consecutive days.

Note: Once institutionalized and considered out of the home, a parent would be considered a childless adult and may qualify for long-term care as a childless adult.

42.1 Long-Term Care Eligibility Requirements for Childless Adults Eligible for BadgerCare Plus

In order to be eligible to have their LTC services covered by BadgerCare Plus while they are institutionalized, childless adults need to meet the following requirements:

- They do not meet the eligibility criteria for EBD Medicaid. This includes any of the following:
 - They do not meet the asset test for EBD Medicaid.
 - They do not meet the income test for EBD Medicaid.
 - They fail to provide or verify asset information or any other information needed to determine EBD Medicaid eligibility.
 - They have not yet been determined disabled.
 - They have not yet been determined presumptively disabled.
- They are eligible for BadgerCare Plus as a childless adult.
- They have not divested in order to qualify for receipt of LTC services (see the Medicaid Eligibility Handbook Chapter 17 Divestment). Institutionalized childless adults who divest are not eligible for LTC services although they remain eligible for Medicaid services.
- They disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouse have an interest.
- They designate the state of Wisconsin as the remainder beneficiary of any annuities purchased or created on or after January 1, 2009.
- If they own their own home, the equity interest in the home must not exceed \$750,000 (see the Medicaid Eligibility Handbook Section 16.8.1.4 Home Equity over \$750,000.00) in order to receive LTC services.
- They assign to the state of Wisconsin their rights to payments from a nursing home, hospital, or LTC insurance policy and send any payments to the state of Wisconsin that they received from a nursing home, hospital, or LTC insurance carrier while receiving BadgerCare Plus.

Note: Institutionalized childless adults are not subject to the premium or treatment needs question requirements described in Sections 44.2 Premiums for Childless Adults and 44.3 Treatment Needs Question for Childless Adults.

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42.2 Patient Liability, Estate Recovery, and Other Policies for Childless Adults Eligible for BadgerCare Plus While in Long-term Care

The following conditions apply to any childless adult who is eligible for BadgerCare Plus while institutionalized:

- The person does not have any nursing home patient liability.
- The person is still subject to regular copayments for medical services unless his or her net countable income is equal to \$0.
- The person is exempt from HMO enrollment unless he or she is enrolled in a Family Care *MCO*, in which case, the person can continue to be enrolled in the Family Care MCO.
- The person is not subject to an asset limit but is subject to divestment rules (see Medicaid Eligibility Handbook Chapter 17 Divestment).
- The person is not subject to having a lien put on his or her home (see the Medicaid Eligibility Handbook Section 22.1.4 Liens).
- The LTC services the person receives are not subject to estate recovery (see the Medicaid Eligibility Handbook Section 22.1.2 Recoverable Services) unless the individual is 55 years old or older.

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42.3 Institutionalized Individuals Determined Eligible for Elderly, Blind, or Disabled Medicaid

The conditions outlined in Section 42.2 Patient Liability, Estate Recovery, and Other Policies for Childless Adults Eligible for BadgerCare Plus While in Long-Term Care only apply to institutionalized individuals while they remain eligible for BadgerCare Plus as a childless adult. When an institutionalized individual has been determined eligible for **EBD** Medicaid, he or she is not eligible for BadgerCare Plus as a childless adult. When an individual becomes eligible for **LTC** under EBD Medicaid rules, he or she is subject to regular estate recovery rules and will have to pay the monthly nursing home patient liability. If the individual later becomes ineligible for EBD Medicaid, he or she may again become eligible for BadgerCare Plus.

Example 1: Andrew is institutionalized and is eligible for BadgerCare Plus as a childless adult. BadgerCare Plus covers his LTC services. Andrew starts receiving Medicare on August 1, so he is no longer eligible for BadgerCare Plus as a childless adult as of August 1. To continue receiving coverage for LTC services, Andrew would have to meet all regular EBD Medicaid eligibility criteria. He would then be subject to regular estate recovery rules and patient liability.

Example 2: Jana is an institutionalized childless adult eligible for BadgerCare Plus and is waiting on a disability determination. She will receive coverage for LTC services under BadgerCare Plus until the agency receives and processes the disability determination. Once this happens, if she meets all other criteria for EBD Medicaid (including providing asset information and meeting the asset test), she will begin receiving coverage of LTC services under EBD Medicaid. However, if Jana still does not meet all of the eligibility criteria for EBD Medicaid (for example, because she fails to verify assets), she will continue to receive coverage for LTC services under BadgerCare Plus as long as she continues to meet all of the eligibility criteria for BadgerCare Plus.

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43 Tuberculosis-Related Medicaid

43.1 Nonfinancial Requirements

Adults who are infected with tuberculosis (TB) and who are not otherwise eligible for full benefit BadgerCare Plus or Medicaid may be eligible for Tuberculosis (TB)-related Medicaid, a special category of Medicaid.

"Infected with TB" means that a physician has examined them and found that one or more of the following diagnoses apply to them:

- They are infected with latent or active TB.
- They have a positive TB skin test.
- They have a negative TB skin test but a positive sputum culture for the TB organism.
- They have a negative test for TB, but a physician certifies that they require TB-related drug therapy, surgical therapy, or both.
- A physician certifies that they require testing to confirm the presence or absence of TB.

A member's statement that he or she has one or more of the above conditions should be accepted unless the information provided is questionable (see Section 9.10 Questionable Items). If questionable, accept any of the following as verification:

- A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.
- Wisconsin Tuberculosis Record (Form DPH 4756). This card identifies the person and the physician's diagnosis and has the name and telephone number of the treatment provider.

To be eligible for TB-Related Medicaid, a person must also meet the following criteria:

- Be a Wisconsin resident (see Chapter 3 Residence)
- Be a U.S. citizen or qualified immigrant (see Chapter 4 Citizenship and Immigration Status)
- Provide documentation of citizenship and identity or of immigration status (see Section 4.1 U.S. Citizens and Nationals)
- Cooperate with establishing medical support and TPL (see Chapter 5 Medical Support and Third Party Liability)

- Sign over to the state his or her rights to payments from a third party for medical expenses (see Section 5.2 Medical Support/Child Support Agency Cooperation)
- Meet BadgerCare Plus SSN requirements (see Chapter 6 Social Security Number Requirements)
- Cooperate with verification requests when information is mandatory or deemed questionable (see Chapter 9 Verification)

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43.2 Financial Tests

There is no asset test for Tuberculosis (TB)-Related Medicaid.

The income limit for one adult is \$1,651. For a married couple, the limit is \$2,435. A person's income is determined using MAGI budgeting rules (see Section 2.3 Modified Adjusted Gross Income Test Group, Section 2.8 Modified Adjusted Gross Income Counting Rules, and Chapter 16 Income).

For children infected with TB, income must be budgeted using MAGI rules, the same way it is for children applying for BadgerCare Plus (see Section 2.3 Modified Adjusted Gross Income Test Group). If the child is determined ineligible for BadgerCare Plus, the countable MAGI income for the child will be applied against the TB-related Medicaid individual monthly income limit of \$1,651. This income limit applies to each child no matter how many persons are in the assistance group.

Example 1: Mary and her spouse George are both applying for TB-related Medicaid. Test Mary and George as one MAGI Test Group. Test their MAGI income against the income limit for a married couple.

Example 2: Greg is a 20-year-old with TB and is applying for BadgerCare Plus. Greg lives with his dad, Barry, and is Barry's tax dependent. Under MAGI budgeting rules, Barry and Greg are one MAGI Test Group and we must count Barry's MAGI income (which includes Greg's income if he is required to file taxes). The monthly MAGI income for Barry and Greg is \$1,500, which is 106% of the FPL for a group of 2. This makes Greg ineligible for BC+ as a childless adult. However, that same MAGI income amount is less than the \$1,651 TB income limit for an unmarried individual, which makes Greg eligible for TB-Related Medicaid.

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43.3 Tuberculosis-Related Services

People who become eligible for Tuberculosis (TB)-related Medicaid are only eligible for the following Medicaid services:

- Prescribed drugs.
- Physicians' services.
- Laboratory and X-ray services, including services to diagnose and confirm the presence of infection.
- Clinic services and federally qualified health care (FQHC) services.
- Targeted case management services.
- Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients.
- Services that are necessary as a result of the side effects of prescribed drugs for TB treatment.

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43.4 Immigrants

Tuberculosis (TB)-related services may be covered for individuals who do not meet citizenship requirements under Emergency Services (see Section 4.3 Immigrants and Section 39.1 Emergency Services Income Limits).

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43.5 Processing

See Process Help Section 9.2 TBMA (Tuberculosis) Manual Application Processing.

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44 BadgerCare Plus Childless Adults

44.1 Introduction

A childless adult is a person 19 to 64 years old who is not receiving Medicare and who does not have any dependent children younger than 19 years old who reside with him or her at least 40 percent of the time. Marital status has no effect on a person being a childless adult.

Effective February 1, 2020, childless adults without an exemption must meet two new requirements to become or remain eligible for BadgerCare Plus:

- Pay monthly premiums
- Answer a treatment needs question at application and renewal

In addition, childless adults can take an optional BadgerCare Plus Health Survey to possibly reduce their household's monthly premium.

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44.2 Premiums for Childless Adults

Childless adults are subject to a household premium of \$8 a month unless they are exempt for any of the following reasons:

- Has a household income at or below 50% of the FPL
- Has verified status as a tribal member, child or grandchild of a tribal member, or individual who is eligible to get Indian Health Services
- Has a verified disability
 - A childless adult is considered to have a verified disability only if they have been determined by the Wisconsin Disability Determination Bureau (DDB) to be disabled, MAPP disabled, or by the DDB or the IM agency as presumptively disabled.
- Has resided in or is expected to be residing in an institution for at least 30 days
- Is homeless or has been homeless in the last twelve months
 - The definition of homeless is someone who lacks a fixed and regular nighttime residence or someone whose primary nighttime residence is one of the following:
 - A supervised shelter designed to provide temporary accommodations
 - A halfway house or similar institution that provides temporary residence for individuals intended to be institutionalized
 - A temporary accommodation for not more than 90 days in the residence of another individual
 - A place not designed for, or ordinarily used as a regular sleeping accommodation for human beings
- Is deceased

Members will not be subject to premiums for backdated months.

Childless adults may qualify for a premium-free month under both of the following conditions:

- No one in the BadgerCare Plus group was eligible for BadgerCare Plus or Medicaid in the previous month.
- No one in the group received a free month in the previous 12 months.

44.2.1 Premium Policy Effective Date

The premium requirement will apply for new applications with a filing date on or after February 1, 2020.

For renewals, when the premium requirement will apply depends on the status of the renewal:

- If it is a renewal either submitted early or late, the requirement applies as of February 1, 2020.
- If it is a timely renewal, the requirement applies to renewals due on or after March 31, 2020 (impacting benefits starting in the first month of the new certification period).

Example 1: Jane was a childless adult enrolled in BadgerCare Plus with a renewal due December 31, 2019. Jane did not renew her benefits on time, so her BadgerCare Plus closed. On February 20, 2020, Jane submits a late health care renewal to regain eligibility as of January 1, 2020. Because Jane is submitting a late renewal after February 1, 2020, she will be subject to the new premium requirement. However, because the requirement did not go into effect until February 1, 2020, Jane will not owe a premium for the month of January. Jane will begin to owe monthly premiums as of February 2020, unless she qualifies for any exemption.

Example 2: Mary is a childless adult currently enrolled in BadgerCare Plus. Her certification period began in October 2019. Mary will not be subject to the new premium requirement until she renews her health care benefits in September 2020 and her new certification period starts, if she remains a childless adult and does not qualify for any exemption.

The premium requirement will apply if a health care member becomes a childless adult during a certification period that starts after the policy effective date. This includes the member joining an existing childless adult assistance group.

Example 3: James and Beth are currently enrolled in BadgerCare Plus as parents, along with their 18-year old daughter, Sara. Their certification period began in June 2019. They complete a renewal in May 2020. Because they are parents, the premium requirement does not apply to James and Beth at the time of renewal. Sara turned 19 in July 2020, so James and Beth become childless adults. Because their certification period began after February 1, 2020, James and Beth will begin to owe monthly premiums upon this change (unless they qualify for any exemption).

44.2.2 Increase or Decrease in Household Income During the Certification Period

If the household income rises above 50% of the FPL due to a change in income or household composition, the premium payment requirement will apply the following month (subject to timely notice requirements).

If the household income drops to 50% of the FPL or less, then the premium payment requirement will no longer apply as of the same month in which the change in income was reported.

44.2.3 Premium Payment Amount

The monthly premium is assessed at the household level, not the individual level. The monthly premium amount is \$8 regardless of household size. However, this amount can be lowered during the certification period based on healthy habits reported through response(s) to the health survey, or by the response(s) to the treatment needs question by childless adults in the household. The reductions for the monthly premium are as follows:

Premium Amount	Applicable Reductions
\$4	One-person household with that person receiving a reduction
	Two-person household with both people receiving a reduction
\$6	Two-person household with only one person receiving a reduction
\$8	One- or Two-person household with no reduction for the household

Example 4: There are two childless adults in the household: Alice and Barry. The household pays a \$6 monthly premium because Alice took the health survey and reported healthy habits, but Barry did not. Their certification period began April 1, 2020.

Alice suffers injuries in a car accident in June 2020. Subsequently, she is verified disabled effective July 2020 and becomes eligible for EBD 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 premiums will increase to \$8 but he could reduce that amount to \$4 if he completes the health survey and shows that he has healthy habits.

Reductions based on the health survey or treatment needs question apply as of the month the health survey or treatment needs question was received. However, if a health survey is submitted within the first two months of the certification period, any premium reductions will be retroactively applied back to the beginning of the certification period.

44.2.4 Premium Due Dates

Like other health care premiums, the premium that childless adults pay for BadgerCare Plus will be due on the 10th day of the benefit month. However, failure to pay the premium will not result in disenrollment until the end of the certification period. Premiums are tied to the certification period, not the calendar year. Any accrued premium amount the childless adult has not paid will result in disenrollment at the following times:

- Adverse Action of the 12th month of the certification period.
- Early renewals.
- BadgerCare Plus termination, either due to ineligibility or because they have de-requested health care.

Example 5: Aaron applies for BadgerCare Plus in March 2020. He is a childless adult with no applicable exemption and an income over 50% of the FPL. This is the first time he has applied for a health care benefit. He does not receive a reduction for the monthly premium amount.

The month of March 2020 is premium-free for Aaron. Over the next 10 months, he does not pay any premiums.

In January 2021, Aaron submits an early renewal for BadgerCare Plus. He will need to pay his entire \$80 arrears (\$8 monthly premium x 10 months (April 2020 – January 2021)) to remain eligible for BadgerCare Plus as of February 2021.

Members cannot pre-pay monthly premiums. They can pay each month, pay multiple owed months, or wait until the end of the certification period to pay. For example, if the certification period is February 2020 through January 2021, the member cannot pay in advance for future months on February 15, 2020. Instead, the member can:

- Pay for a premium each month it becomes due
- Pay for current and past months (in April, the member could pay February, March, and April premiums)
- Pay all owed premiums in January 2021

44.2.5 Premium Payment Methods

Premium statements will be sent to childless adults monthly. The statement will display the following information:

- Amount due for the current month
- Amounts due for past months (if applicable)
- Total amount due (arrears for the certification period)
- Statement informing the childless adult that the premiums for the entire certification period must be paid upon renewal
- How to pay their premiums

A mail-in section will be provided for members to include with their check or money order.

Childless adults will have several options to pay the monthly premiums:

- Check
- Money order
- Electronic Funds Transfer (EFT)
- Credit or debit card

Childless adults will be able to pay using a credit or debit card, or pay by EFT from a checking or savings account, through the ACCESS website or MyACCESS mobile app. Members may mail in a check or money order as payment, but only when the premium payment is a condition of eligibility (for example, at renewal) can the member submit a check or money order directly to the IM agency.

44.2.6 Restrictive Re-enrollment Period

The childless adult will enter a six-month RRP when there are unpaid premiums at the end of the certification period. During the RRP, the childless adult must pay the full amount of unpaid premiums to have benefits reinstated. The childless adult can also regain eligibility if they meet an exemption (for example, they become homeless), their income has dropped to 50% or less of the FPL, or they become eligible under a different category of Medicaid. If one of these three conditions applies, the RRP would run in the background in case their situation changes (for example, they later regain eligibility as a BadgerCare Plus childless adult, or their income increases to more than 50% of the FPL).

When the childless adult chooses not to pay the full amount during the RRP, he or she must wait until the RRP ends to re-request health care benefits. At the end of the six-month RRP, the arrears on the unpaid premiums are no longer required. At application, the member may ask for backdated eligibility (up to 3 months), even if those months

overlap with the completed RRP. In any case, the member is not subject to premiums for backdated months.

Example 6: Kim applies for BadgerCare Plus in January 2021 and has a monthly premium set at \$8. She is enrolled but does not pay the premiums for January, February, March, April, and May.

Kim reports that she has moved to Minnesota on May 9, 2021. Her benefits end May 31, 2021, and a six-month RRP is established for June through November 2021.

Kim moves back to Wisconsin in July 2021. She reapplies for BadgerCare Plus and the worker pends eligibility to obtain the outstanding premiums. If Kim chooses not to pay the premiums by the due date, her application will be denied due to the existing RRP. She decides to pay the arrears incurred in early 2021 and her application is approved. However, she could have chosen to forgo coverage until December 2021 when she could reapply and enroll in BadgerCare Plus without paying the arrears.

Example 7: Ben applies for BadgerCare Plus in January 2021 and has a monthly premium set at \$4. He is enrolled but does not pay the premiums for January, February, March, and April.

Ben enters a nursing home in May 2021. He stays more than 30 days and qualifies for Institutional Medicaid. His BadgerCare Plus certification period ends and his Institutional Medicaid certification begins on May 1, 2021. Because Ben's BadgerCare Plus certification ended, and he had unpaid premiums, a six-month (May 2021 to October 2021) RRP will be established and run in the background.

Ben reports that he returned home on July 8, 2021. The worker updates the case and BadgerCare Plus pends eligibility to obtain the outstanding premiums. If he pays the arrears, he would become eligible for a new certification period as a childless adult as of August 2021. However, if he chooses not to pay the arrears, he will fail due to an RRP until he pays his premiums from the previous BadgerCare Plus certification period (January-April 2021), or until the RRP expires.

Example 8: Aaron applies for BadgerCare Plus in March 2020 and has a monthly premium set at \$8.

The month of March 2020 is premium-free for Aaron. Over the next 10 months, he does not pay any premiums. On January 10, 2021, Aaron submits an early renewal for BadgerCare Plus, during which he reports his income is less than 50% of the FPL.

Aaron is not be required to pay monthly premiums for the certification period beginning February 2021, and he would remain enrolled in BadgerCare Plus. However, he would have an RRP in the background for payment on his \$80 arrears (\$8 monthly premium x 10 months). If his income increased to more than 50% of the FPL during the RRP, he would no longer be eligible for BadgerCare Plus until he pays all of his arrears, or until the RRP expired.

Note: Childless adults will not be notified or automatically re-enrolled in health care at the end of the RRP. Instead, the notice that informs the member that he or she has entered an RRP will state the length of the RRP.

44.2.7 Refunds

Refunds of childless adult premiums are based on the current policy regarding refunding BadgerCare Plus premiums:

- If a premium is paid for a month in which a childless adult household was ineligible for BadgerCare Plus, the premium will be refunded.
- If the premium is paid for a month in which the household's income decreased and they no longer owe a premium, the premium will be refunded.
- If the premium is paid for a month in which the household qualifies for a premium reduction, the excess premium paid will be refunded as of the month that the reduction applied (for example, if the member paid \$8 and later that month they qualified for a reduction to \$4 based on their health survey, the extra \$4 will be refunded).

The refund will always be paid to the member regardless of who paid the premium. Refunds will always be paid in the form of a check.

44.2.8 Premium Notification

Information on the required premium payments for childless adults will be included in the Notice of Decision. The Notice of Decision will also include information on an RRP if applicable.

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44.3 Treatment Needs Question for Childless Adults

The treatment needs question is a screening tool that helps determine whether or not an applicant or member has used drugs in ways that have caused problems for them or their family, and if they are open to getting help for drug use.

After implementation, childless adults will be required to answer the treatment needs question as a condition of eligibility. A treatment needs question must be answered:

- For new applications, the requirement will apply for applications with a filing date on or after February 1, 2020.
- For renewals, when the requirement applies depends on the status of the renewal:
 - If it is a renewal either submitted early or late, the requirement applies as of February 1, 2020.
 - If it is a timely renewal, the requirement applies to renewals due on or after March 31, 2020 (impacting benefits starting in the first month of the new certification period).
- If a health care member becomes a childless adult during a certification period that starts after the policy effective date. This includes the member joining an existing childless adult assistance group.

During annual renewals, childless adults must answer the treatment needs question.

Example 1: Anna is a childless adult currently enrolled in BadgerCare Plus. Her certification period began in August 2019. On February 18, 2020, Anna submits an early health care renewal. Because Anna is submitting an early renewal after February 1, 2020, she will be subject to the new policies and will need to answer the treatment needs question as part of her renewal for health care.

Example 2: Edith is a childless adult currently enrolled in BadgerCare Plus. Her certification period began in November 2019. Edith will need to answer the treatment needs question in October 2020 as part of her renewal for health care.

Example 3: Brad is currently enrolled in BadgerCare Plus as a parent, along with his son Oliver. His certification period began in May 2019. Brad completes a renewal for him and Oliver in April 2020. Because he is a parent, the childless adult policies do not apply. Brad reports that Oliver has left the household in July 2020, so Brad becomes a childless adult. Brad will need to answer the treatment needs question to remain eligible for BadgerCare Plus.

The childless adult will not need to answer a treatment needs question or affirm an existing response if they fall under any of the following:

- Has a verified status as a tribal member, child or grandchild of a tribal member, or individual who is eligible to get Indian Health Services
- Has a verified disability
 - A childless adult is considered to have a verified disability only if they have been determined by the Wisconsin Disability Determination Bureau (DDB) to be disabled, MAPP disabled, or by the DDB or the IM agency as presumptively disabled.
- Has resided in or is expected to be residing in an institution for at least 30 days
- Is deceased

Childless adults who are not required to answer the treatment needs question may voluntarily do so.

44.3.1 Answering the Treatment Needs Question

The treatment needs question will collect a self-attested answer to a question about substance abuse and desire for treatment.

If the treatment needs question is not answered (either answered Yes, or answered No) the response does not meet the requirement for BadgerCare Plus eligibility. Health care eligibility cannot be denied or terminated for failure to sign the treatment needs question.

Whether the person responds Yes or No to the treatment needs question does not affect their eligibility for health care. But the response will be used to determine whether a referral should be made to a provider for substance use disorder (SUD) treatment:

- If the answer is NO, the childless adult has met the treatment needs question requirement and no further action is taken.
- If the answer is YES, the childless adult has met the treatment needs question requirement.
 - If they are enrolled in a health maintenance organization (HMO) or managed care organization (MCO), the HMO or MCO will be notified of their response to help them get into treatment.
 - If they are exempt from HMO or MCO enrollment, they will be provided information about accessing treatment.

The treatment needs question response will also be used to determine whether the member qualifies for a reduction in the monthly premium. If the member answers “Yes” to the question, they will receive a premium reduction.

44.3.2 Who Can Answer the Treatment Needs Question

Each childless adult must answer a treatment needs question. In addition to the childless adult, any of the following may answer the treatment needs question on behalf of all childless adults in the household:

- Primary person
- Spouse
- Authorized representative
- Financial power of attorney
- Legal guardian over the estate
- Someone authorized by the individual

44.3.3 Submitting the Treatment Needs Question

Childless adults will have several different ways to submit a response to the treatment needs question:

- Online as part of ACCESS and MyACCESS
- Phone or in person through the IM worker
- The Treatment Needs Question paper form, F-02547 (available through the Department of Health Services’ Forms Library or attached to the Verification Checklist)

Childless adults will be able to answer a new treatment needs question at any time.

44.3.4 Real-Time Eligibility and Administrative Renewals

Childless adults who answer the treatment needs question as part of the ACCESS application can have their eligibility determined through Real-Time Eligibility (RTE).

For the first administrative renewal after implementation, childless adults may be administratively renewed, but will be asked to answer the treatment needs question separately in order to keep their eligibility. For subsequent administrative renewals, where a treatment needs question response is on file, the childless adult will be asked to report if their treatment needs question response has changed.

44.3.5 Treatment Needs Question Notification

The Case Summary will identify whether each childless adult has answered the required treatment needs question. However, each childless adult's response to the treatment needs question will not be printed on the Case Summary in order to protect this sensitive information. Instead, a PIN-based summary will be mailed to each childless adult with their own treatment needs question response. This summary will be sent any time a Case Summary (including an Administrative Renewal Case Summary) is generated.

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44.4 BadgerCare Plus Health Survey for Childless Adults

The BadgerCare Plus Health Survey (health survey) is available to all childless adults. It is optional. The survey will collect self-attested answers to questions about healthy habits and any health conditions that prevent healthy habits. Healthy habits include such things as wearing a seatbelt, exercising, or not smoking.

The response of the health survey will be used to determine premium reductions for childless adults. A premium reduction is granted when any one of the following is true:

- The childless adult reports at least one healthy habit.
- The childless adult reports having a health condition that prevents their ability to engage in a healthy habit.
- The childless adult reports managing their health risks.

The results of the health survey will be valid for the certification period. When completing a new application or renewal, childless adults can complete a new health survey to determine if they qualify for a premium reduction. Also, to account for renewal processing timeframes, a health survey completed in the previous 45 days will be valid at renewal.

The health survey is self-attested. The IM agency will not audit responses, nor will it pursue overpayments based on a reduction in the premium.

The health survey responses will be shared with the childless adult's HMO or MCO.

44.4.1 Completing the Health Survey

Each childless adult can complete the health survey. However, one of the following may complete the health survey on behalf of a childless adult:

- Authorized representative
- Financial power of attorney
- Legal guardian over the estate
- Someone authorized by the individual

Childless adults will have several different ways to complete the health survey:

- Online as part of ACCESS and MyACCESS

- Phone or in person by speaking with the Enrollment Broker
- The BadgerCare Plus Health Survey paper form, F-02548 (available through the Department of Health Services' Forms Library) processed by the Enrollment Broker

The health survey is not a condition of eligibility and is not part of the application or renewal. It is offered to childless adults as an optional action only after they submit an application or renewal.

Childless adults may complete a health survey at any time and there is no restriction on how often they may do so. The ability to complete the survey at any time will permit childless adults to provide an update for any change to a health risk behavior or condition. Only the results of the most recent survey will provide the basis for calculating the premium and will be shared with the HMO or MCO.

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45 Reserved

45.1 Reserved

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46-47 Reserved

Reserved

TABLES (CHAPTERS 48-53)

48 Premiums for Children

48.1 BadgerCare Plus Children's Premium Tables

48.1.1 Premiums for Children

Non-exempt children with an assistance group income above 201 percent of the *FPL* will be required to pay premiums. Each child's premium will be based on his or her own assistance group's size and income. The five percent cap for the cost of total household premiums for children will continue to apply. The cap will be five percent of the income of the premium paying assistance group with the highest countable income amount. The total household's premiums will be determined based on the combined amount of all children's premiums or the five percent cap, whichever amount is less. See Section 19.2 Premium Calculations and Section 19.3 Premium Limits for more information on premium caps.

The below table outlines the premium amounts for children.

FPL Income Range	Above 201% to 210.99%	211% to 220.99%	221% to 230.99%	231% to 240.99%	241% to 250.99%	251% to 260.99%	261% to 270.99%	271% to 280.99%	281% to 290.99%	291% to 300.99%	301% to 306.00%
Premium Amounts	\$10	\$10	\$10	\$15	\$23	\$34	\$44	\$55	\$68	\$82	\$97.53

Note: Children in extensions are not required to pay premiums (see Section 19.1 BadgerCare Plus Premiums). If a parent in the household is in an extension, the children are exempt from paying premiums regardless of their income.

48.1.2 Reserved

48.1.3 Five Percent Premium Caps for Children

The table below displays the five percent caps of BadgerCare Plus premiums for children in certain households with incomes above 201 percent and below 306 percent of the FPL. Families will pay the combined premiums for the children or an amount equal to five percent of the family's countable income, whichever is less. For example, a family with six children and an income of 295 percent of the FPL would ordinarily owe premiums amounting to six times \$82, which equals \$492. However, if the children's AG size, including the parent, is seven, the five percent cap found in the table below is

\$472. That is the maximum premium amount that the family should be charged for that month.

Group Size	201– 211%	211– 221%	221– 231%	231– 241%	241– 251%	251– 261%	261– 271%	271– 281%	281– 291%	291– 301%	301%– 306%
1	104.00	109.00	115.00	120.00	125.00	130.00	135.00	141.00	146.00	151.00	156.00
2	141.00	148.00	155.00	162.00	169.00	176.00	183.00	190.00	197.00	205.00	212.00
3	178.00	187.00	196.00	205.00	214.00	223.00	231.00	240.00	249.00	258.00	267.00
4	215.00	226.00	237.00	247.00	258.00	269.00	280.00	290.00	301.00	312.00	322.00
5	252.00	265.00	277.00	290.00	302.00	315.00	328.00	340.00	353.00	365.00	378.00
6	289.00	304.00	318.00	332.00	347.00	361.00	376.00	390.00	404.00	419.00	433.00
7	326.00	342.00	359.00	375.00	391.00	407.00	424.00	440.00	456.00	472.00	489.00
8	363.00	381.00	399.00	418.00	436.00	454.00	472.00	490.00	508.00	526.00	544.00
9	400.00	420.00	440.00	460.00	480.00	500.00	520.00	540.00	560.00	580.00	600.00
10	437.00	459.00	481.00	503.00	524.00	546.00	568.00	590.00	611.00	633.00	655.00
11	474.00	498.00	522.00	545.00	569.00	592.00	616.00	640.00	663.00	687.00	710.00
12	511.00	537.00	562.00	588.00	613.00	639.00	664.00	690.00	715.00	740.00	766.00
13	548.00	576.00	603.00	630.00	658.00	685.00	712.00	739.00	767.00	794.00	821.00
14	585.00	614.00	644.00	673.00	702.00	731.00	760.00	789.00	818.00	848.00	877.00

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49 Health Care Choice

49.1 Health Care Choice

Federal law requires that once a person 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 a person is pending for EBD Medicaid or if a person has an unmet deductible for EBD Medicaid, he or she 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 eligible for Medicare. If a person 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.

In addition, women age 45-65 diagnosed with cervical or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Women who are eligible for both Wisconsin Well Woman Medicaid and BadgerCare Plus should be enrolled in Wisconsin Well Woman Medicaid.

See the Medicaid Eligibility Handbook for more information about the Medicaid subprograms.

EBD Eligibility	BadgerCare Plus Eligibility	System Choice
MS/NS/MAPP w/no premium	No premium	EBD
MS/NS/MAPP w/no premium	Premium	EBD
MS/NS/MAPP w/o premium	BadgerCare Plus Deductible	EBD
MAPP w/premium	No premium	BadgerCare Plus
NS Deductible	No premium	BadgerCare Plus
MAPP w/premium	Premium	The program with the lesser premium
NS Deductible	Premium	Member Choice
MAPP Premium	Deductible	Member Choice
NS Deductible	Deductible	Member Choice

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50 Federal Poverty Level Table

50.1 Federal Poverty Level Table

Group Size	Annual FPL	100% FPL	133% FPL	150% FPL	156% FPL	191% FPL	201% FPL	300% FPL	306% FPL
1	\$12,760	\$1,063.33	\$1,414.23	\$1,595.00	\$1,658.79	\$2,030.96	\$2,137.29	\$3,189.99	\$3,253.79
2	\$17,240	\$1,436.67	\$1,910.77	\$2,155.01	\$2,241.21	\$2,744.04	\$2,887.71	\$4,310.01	\$4,396.21
3	\$21,720	\$1,810.00	\$2,407.30	\$2,715.00	\$2,823.60	\$3,457.10	\$3,638.10	\$5,430.00	\$5,538.60
4	\$26,200	\$2,183.33	\$2,903.83	\$3,275.00	\$3,405.99	\$4,170.16	\$4,388.49	\$6,549.99	\$6,680.99
5	\$30,680	\$2,556.67	\$3,400.37	\$3,835.01	\$3,988.41	\$4,883.24	\$5,138.91	\$7,670.01	\$7,823.41
6	\$35,160	\$2,930.00	\$3,896.90	\$4,395.00	\$4,570.80	\$5,596.30	\$5,889.30	\$8,790.00	\$8,965.80
7	\$39,640	\$3,303.33	\$4,393.43	\$4,955.00	\$5,153.19	\$6,309.36	\$6,639.69	\$9,909.99	\$10,108.19
8	\$44,120	\$3,676.67	\$4,889.97	\$5,515.01	\$5,735.61	\$7,022.44	\$7,390.11	\$11,030.01	\$11,250.61
9	\$48,600	\$4,050.00	\$5,386.50	\$6,075.00	\$6,318.00	\$7,735.50	\$8,140.50	\$12,150.00	\$12,393.00
10	\$53,080	\$4,423.33	\$5,883.03	\$6,635.00	\$6,900.39	\$8,448.56	\$8,890.89	\$13,269.99	\$13,535.39
11	\$57,560	\$4,796.67	\$6,379.57	\$7,195.01	\$7,482.81	\$9,161.64	\$9,641.31	\$14,390.01	\$14,677.81
12	\$62,040	\$5,170.00	\$6,876.10	\$7,755.00	\$8,065.20	\$9,874.70	\$10,391.70	\$15,510.00	\$15,820.20
13	\$66,520	\$5,543.33	\$7,372.63	\$8,315.00	\$8,647.59	\$10,587.76	\$11,142.09	\$16,629.99	\$16,962.59
14	\$71,000	\$5,916.67	\$7,869.17	\$8,875.01	\$9,230.01	\$11,300.84	\$11,892.51	\$17,750.01	\$18,105.01
15	\$75,480	\$6,290.00	\$8,365.70	\$9,435.00	\$9,812.40	\$12,013.90	\$12,642.90	\$18,870.00	\$19,247.40
16	\$79,960	\$6,663.33	\$8,862.23	\$9,995.00	\$10,394.79	\$12,726.96	\$13,393.29	\$19,989.99	\$20,389.79
17	\$84,440	\$7,036.67	\$9,358.77	\$10,555.01	\$10,977.21	\$13,440.04	\$14,143.71	\$21,110.01	\$21,532.21
18	\$88,920	\$7,410.00	\$9,855.30	\$11,115.00	\$11,559.60	\$14,153.10	\$14,894.10	\$22,230.00	\$22,674.60
19	\$93,400	\$7,783.33	\$10,351.83	\$11,675.00	\$12,141.99	\$14,866.16	\$15,644.49	\$23,349.99	\$23,816.99
20	\$97,880	\$8,156.67	\$10,848.37	\$12,235.01	\$12,724.41	\$15,579.24	\$16,394.91	\$24,470.01	\$24,959.41

21	\$102,360	\$8,530.00	\$11,344.90	\$12,795.00	\$13,306.80	\$16,292.30	\$17,145.30	\$25,590.00	\$26,101.80
22	\$106,840	\$8,903.33	\$11,841.43	\$13,355.00	\$13,889.19	\$17,005.36	\$17,895.69	\$26,709.99	\$27,244.19
23	\$111,320	\$9,276.67	\$12,337.97	\$13,915.01	\$14,471.61	\$17,718.44	\$18,646.11	\$27,830.01	\$28,386.61
24	\$115,800	\$9,650.00	\$12,834.50	\$14,475.00	\$15,054.00	\$18,431.50	\$19,396.50	\$28,950.00	\$29,529.00
Each Additional Person	\$4,480.00	\$373.33	\$496.53	\$560.00	\$582.39	\$713.06	\$750.39	\$1,119.99	\$1,142.39
		Badger Care Plus Extensions trigger limit, Badger Care Plus adults limit		Badger Care Plus child deductible limit	Badger Care Plus limit for children 6-18 years old subject to access, backdating, and presumptive eligibility	Badger Care Plus limit for children 1-5 years old subject to access, backdating, and presumptive eligibility	Badger Care Plus children premium limit	Badger Care Plus pregnant women deductible limit	Badger Care Plus pregnant women, children, and Family Planning Only Services limit

For an online tool to calculate the FPL using household income in dollars, go to www.safetyweb.org/fpl.php.

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51 BadgerCare Plus Categories

51.1 BadgerCare Plus Categories

Note: For a list of medical status codes, see Process Help, Chapter 81 Forward Health iChange.

The following table identifies the copays or premiums for which BadgerCare Plus members may be responsible. The table also provides information on the federal program under which members are eligible, if applicable.

Description	Income (FPL)	Subject to Copays	Premium	Funding
Pregnant woman	>0 - 306%	No	No	T19
Pregnant woman deductible	>300%	No	No	T19
Pregnant minor under age 19	>0 - 306%	No	No	T19
Pregnant non-qualifying immigrant	>0 - 306%	No	No	T21 Separate CHIP
Pregnant inmate	0 - 306%	No	No	State- Funded
<i>CEN</i>	0 - 156%	No	No	T19
CEN—Mom on T19 on DOB	>156%	No	No	T19
Child under age 19	0 - 100%	No	No	T19
Child under age 6	>100 - 156%	No	No	T19
Child < age 1	>156 - 306%	No	No	T19
Child age 1 through 5	>156 - 191%	No	No	T19
Child age 1 through 5	>191 - 201%	No	No	T21 Separate CHIP
Child age 1 through 5 who is a tribal member	>191% - 201%	No	No	T21 Separate CHIP

Child age 6 through 18	>100 - 133%	No	No	T19
Child age 6 through 18	>133 - 156%	No	No	T19
Child age 6 through 18	>156 - 201%	No	No	T21 Separate CHIP
Child age 6 through 18 who is a tribal member	>156% - 201%	No	No	T21 Separate CHIP
Child age 1 through 18	>201 - 306%	No	Yes	T21 Separate CHIP
Child age 1 through 18 who is a tribal member	>201 - 306%	No	No	T21 Separate CHIP
Child, under age 19 deductible	>150%	No	No	T19
Adult Parent/Caretaker	0%	No	No	T19
Adult Parent/Caretaker	>0 - 100%	Yes	No	T19
Youth exiting out-of-home care up to age 21	N/A	No	No	T19
Former Foster Care Youth up to age 26	N/A	No	No	T19
Childless Adult	0%	No	No	T19
Childless Adult	>0 - 100%	Yes (if >50% FPL)	No	T19
Childless Adult	>0 - 50%	No	No	T19
Childless Adult	>50 - 100%	Yes	No	T19
Childless Adult	>50 - 100%	Yes	Yes	T19
Transitional Childless Adult	>0 - 50%	No	No	T19
Transitional Childless Adult	>50 - 100%	Yes	No	T19
Transitional Childless Adult	>50 - 100%	Yes	Yes	T19

Transitional Childless Adult	0%	No	No	T19
Transitional Childless Adult	>0 - 100%	Yes (if >50% FPL)	No	T19
12-Month BadgerCare Plus Extension Benefit Adult	>100 - 133%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit Adult	>133%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit Disabled Adult	>100%	Yes	No	T19
4-Month BadgerCare Plus Extension Benefit, Adult	>100 - 133%	Yes	No	T19
4-Month BadgerCare Plus Extension Benefit, Adult	>133%	Yes	No	T19
4-Month BadgerCare Plus Extension Benefit, Disabled Adult	>100%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit, Child Under 19	>100%	No	No	T19
4-Month BadgerCare Plus Extension Benefit, Child Under 19	>100%	No	No	T19
Presumptive eligibility for a child under 1	0 - 306%	No	No	T19
Presumptive eligibility for a child >1, <6	>0 - 191%	No	No	T19
Presumptive eligibility for a child >5, <19	0 - 156%	No	No	T19
Presumptive eligibility for a pregnant woman	0 - 306%	No	No	T19
Presumptive eligibility for parent/caretaker	0 - 100%	No	No	T19
Presumptive eligibility for childless adult	0 - 100%	No	No	T19
Emergency Services for Non-Qualifying Immigrants**	≤306%	N/A	No	T19
Family Planning Only Services	≤306%	N/A	No	T19

**See Section 39.1 Emergency Services Income Limits.

Note: All of the categories listed in the table have BadgerCare Plus Standard Plan coverage, except the following:

- People enrolled in Emergency Services for Non-Qualifying Immigrants only have emergency services coverage.
- People enrolled in Family Planning Only Services only have family planning services coverage.

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52 Reserved

52.1 Reserved

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53 Five Percent Copay Limit Tiers

53.1 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

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