WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
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To: BadgerCare Plus Handbook Users

From: Jori Mundy, Bureau Director
Bureau of Eligibility and Enrollment Policy

Re: **BadgerCare Plus Release 22-01**

Release Date: 04/04/2022

Effective Date: 04/04/2022

EFFECTIVE DATE		The following policy additions or changes are **effective 04/04/2022** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
5.3.2	**Notice**	Updated to remove process
9.6	**Collateral Contacts**	Updated to remove process
9.6.1	**Third-Party Cooperation**	Added new section
9.8	**General Rules**	Added information from Income Maintenance Manual
9.10.1	**Front End Verification**	Added information from Income Maintenance Manual
9.12.2	**Reasonable Compatibility Thresholds**	Updated FPL values
9.12.3	**Reasonable Compatibility Test**	Updated FPL values
16.9.1 .1	**People Found Eligible Under Gap Filling Rules**	Added copay limit
16.9.2	**Determining Annual Income for Gap Filing Referrals and Requests**	Updated FPL values
19.3	**Premium Limits**	Updated FPL values
25.5.1	**Valid Application**	Updated phrasing
25.7.2	**Changes**	Removed link to Income Maintenance Manual
28.1	**Overpayments Introduction**	Page rewritten
28.2	**Recoverable**	Page rewritten

	Overpayments	
28.3	**Unrecoverable Overpayments**	Updated to remove process
28.3.1	**Date of Discovery and Lookback Period**	New section
28.3.2	**Overpayment Claims Minimum Threshold**	New section
28.3.3	**Non-member Errors**	New section
28.3.4	**Gap Filling Eligibility Considerations**	Renumbered section 28.3.1 to 28.3.4 and section rewritten
28.4.1	**Overpayment Period**	Added links
28.4.2	**Overpayment Amount**	Updated phrasing, removed process, and added example
28.4.3	**Liability**	Updated phrasing and removed process
28.5	**Member Notice**	Updated phrasing
28.6	**Refer to District Attorney**	Removed reference to Income Maintenance Manual and updated phrasing
28.7	**Fair Hearing**	Added link to Fair Hearing section
28.8	**Agency Retention**	Deleted
28.9	**Restoration of Benefits**	Moved to section 35.1
29.1	**Notices**	New section
35.1	**Restoration of Benefits**	Page rewritten and moved from section 28.9 to 35.1
43.2	**Financial Tests**	Updated with new COLA values
48.1.3	**Five Percent Premium Caps for Children**	Updated FPL values
50.1	**Federal Poverty Level Table**	Updated FPL values
53.1	**Five Percent Copy Limit Tiers**	Updated chart title, but values remain unchanged

Contents

5.3 Claiming Good Cause

5.3.2 Notice

~~The IM agency~~An applicant or member must ~~provide~~receive 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~~.~~ from the absent parent.

Applicants and members are not required to sign the Good Cause Notice in order to be eligible for BadgerCare Plus.

~~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 CSA refers anyone who wants to claim good cause back to the IM agency for a determination of whether or not good cause exists.~~

9.6 Collateral Contacts

Collateral contacts ~~consists~~consist of oral confirmations of circumstances by persons other than ~~food unit (FS) or group (BadgerCare Plus)~~ members~~.~~ of the health care assistance group. 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~~Third-Party Cooperation

Wisconsin Stats. 49.78(11) allows DHS, consortia, county, and tribal IM agencies to request third-party cooperation from any person in Wisconsin in the verification of data. Third parties are obligated in the law to provide information within seven days of the request. No compensation to the third party is required, and the lack of compensation is not a valid reason for the third party to refuse to cooperate. The law also provides protections to third parties for providing any information requested by IM agencies otherwise allowed by law.

Note: Failure of a third party to provide may not result in any loss or denial of eligibility for a member or applicant.

~~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.~~

9.8 General Rules

1. ~~Avoid over~~Over-verification ~~(~~, including 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~~, is prohibited. Once the accuracy of a written or verbal statement has been established~~.~~, additional verification can't be required. For example, once U.S. citizenship is verified, a member or applicant never has to verify it again (see Section 4.2 Citizenship Verification).
2. ~~Do not verify~~ If information has already been verified ~~unless there~~, the applicant or member does not need to verify it again except in the following situations:

    a. There is reason to believe the information is fraudulent or differs from more recent information. ~~-~~If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made (see Section 9.10.1 Questionable Items).

    b. ~~Do not exclusively require one~~The member reported a change to information that is subject to mandatory verification rules or is questionable.

    c. At renewal, information is subject to mandatory verification rules or is questionable.

~~2.~~3. One particular type of verification can't be exclusively required when various types are adequate and available.

~~3.~~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.

~~4.~~5. ~~Do not target special~~Special groups or persons can't be targeted based on ~~the basis of~~ race, ~~religion~~color, national origin~~-~~, age, disability, sex, religion, or migrant status for special verification requirements.

~~5.~~6. ~~Do not require the~~ The applicant or member can't be required to sign a release form (either blanket or specialized) when the applicant or member provides required verification.

~~6.~~7. ~~Do not require verification~~Verification of information that is not used to determine eligibility can't be required.

8. During verification, he applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.

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 applicant or 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~~IM agencies must assist the applicant or member in obtaining verification if he or she ~~requests~~they request help or ~~has~~have difficulty in obtaining it.

~~Use the~~The best information available should be used to process the *application* or change within the time limit ~~and issue benefits~~ when both of 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~~the IM worker's assistance.

~~Do not deny~~Applicants meeting the health care program eligibility ~~in~~ criteria based on this ~~situation, but~~ best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in ~~your~~their attempts to obtain verification. When ~~you have received~~ the verification~~, you~~ is received, benefits may need to ~~adjust~~be adjusted or ~~recover benefits~~recovered based on the new information. ~~Explain~~The agency must explain this to the applicant or member when requesting verification.

9.10 Questionable Items

9.10.1 Front End Verification

Front End Verification (FEV) is intensive verification of a case by a special unit or worker. A group should be referred for FEV only when its characteristics meet a designated profile (see Process Help Section 31.3.5.1 FEV/Fraud Referral vs. Claim Referral).

9.12 Reasonable Compatibility for Health Care

9.12.2 Reasonable Compatibility Thresholds

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 $4,370~~055/~~ per month. Equifax data is not available. SWICA reports that Marty has earnings of $4,600~~270/~~ per month. For a group size of four~~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~~is 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 201~~0~~% FPL, both children would be subject to a premium based on the income verified by paystubs.

9.12.3 Reasonable Compatibility Test

Example 2	Joe is a single childless adult with an income limit of $1,~~040.83~~ 132.50 for BadgerCare Plus. He reports that his earnings are $500~~/~~ per 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~~132.50 for BadgerCare Plus. He reports that his earnings are $900~~/~~ per month. Equifax reports that he is paid twice a month at $~~550.50~~600 per ~~month~~paycheck, for a monthly amount of $1,~~101.00~~200. 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~~132.50 for BadgerCare Plus. She reports that her earnings are $1,200~~/~~ per 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~~/~~ per 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~~132.50 for BadgerCare Plus. She applies for ~~FS~~FoodShare and BadgerCare Plus. She reports that her earnings are $800~~/~~ per 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~~/~~ per month, this information ~~would~~will 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.

16.9 Gap Filling

16.9.1 Processing Gap Fililng Referrals and Requests

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,~~ unless the member is eligible for gap filling for ~~only~~ certain months due to having other eligibility through the remainder of the calendar year.)
- ~~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.)~~
- Copay limit ~~amount (This is based on yearly~~
    - If the annual AG income is less than or equal to 50% of FPL, the member's copay limit is $0
    - If the annual AG income is greater than 50% of FPL, the member is in the >50-100% of FPL copay limit tier
    - If the member is married and the spouse is also in a health care program with a copay limit and the spouse is not exempt from copays, use the prorated amount. If the member and spouse are in different health care AGs and neither spouse is exempt from copays, the AG with lower income should be used to determine the copay limit tier for both spouses.

Example 1	Deb applies for BadgerCare Plus on April 14 with no backdate request. Deb provides her paystubs to the IM agency. Deb is found eligible for BadgerCare Plus under gap filling filing rules from April 1 through December 31.

Example 2	Katy applies for BadgerCare Plus on August 25 with a three month backdate request. She was employed but her job ended in August. She provides paystubs for May, June, July, and August. Her income is over the BadgerCare Plus monthly income limit for May, June, and July, but she is below the BadgerCare Plus annual income limit. Her income is below the BC+ monthly income for August and ongoing months. She is eligible for BC+ under gap filling for May,

Note: Because their eligibility is manually certified, childless adults who are determined eligible under gap filling rules cannot be subject to the premium or treatment needs question requirements ~~described in~~ (see Section~~s~~ 44.2 Premiums for Childless Adults and Section 44.3 Treatment Needs Question for Childless Adults).

	June, and July. She is eligible under regular BadgerCare Plus rules for August and ongoing months.

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
- Copay limit ~~amount~~

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.

16.9.2 Determining Annual Income for Gap Filling Referrals and Requests

Example 3	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 $~~5,800~~6,400, and the unemployment query shows that she was fired in February and that she started receiving unemployment compensation on March 1. Based on income she has already received this year ($~~5,800~~6,400 in wages plus $7,260 in unemployment from March to July), she has already received $13,~~060~~660 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).

19.3 Premium Limits

Children ~~with~~in an assistance group with income above 201% of the FPL ~~will be~~are required to pay premiums. The total premium ~~amount~~ for the household is the total of the ~~individually calculated~~individual premiums for all children in the household, not to exceed a 5% cap. The cap ~~will be~~is 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 $2,500per~~/~~month as a waitress, and Alan earns $~~4500~~4,500 per~~/~~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~~130%	$0
Rachel	Alan, Rachel, and Hannah	$4,500	~~249~~234%	$~~23~~15
Hannah	Alan, Rachel, and Hannah	$4,500	~~249~~234%	$~~23~~15
Jacob	Susan, Alan, Aaron, Rachel, Hannah, and Jacob	$7,000	~~239~~226%	$~~15~~10

Aaron does not have a premium, Rachel and Hannah have $~~23~~15 premiums, and Jacob has a $10 premium ~~of $15. In this example, 5% of~~. Jacob's MAGI group has the greatest income ~~of~~, so this group determines the ~~assistance~~5% cap. The maximum premium for this group ~~with the highest income~~ is 5% of ~~Jacob's MAGI group, or 5% of $7000/~~$7,000 per month, or $350 per month. Altogether, the household's monthly premiums are $~~61~~40. The household will pay $~~61~~40 in premiums for their children's coverage.

25.5 Valid Signature

25.5.1 Valid ~~Signature Introduction~~Application

The applicant or the applicant's caretaker relative must sign (using ~~his or her~~their own signature):

- The paper application form~~,~~
- The signature page of the ~~application (telephone~~Application Summary, either over the phone, electronically~~, or face to face) or~~ or providing a handwritten signature
- The ACCESS application form with an electronic signature~~.~~
- The online or paper Application for Health Coverage & Help Paying Costs from the Federally~~-facilitated~~ Facilitated Marketplace~~.~~

25.7 Timeframes

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.~~

28.1 ~~OverPayments~~Overpayments Introduction

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~~ a member should have paid a higher amount of ~~recovery may not exceed~~premiums. The dollar amount of an overpayment is the amount of the BadgerCare Plus benefits incorrectly provided~~. Some examples of how overpayments occur are:~~ or the amount of underpaid premiums, whichever is less.

- ~~Concealing or not reporting income.~~

~~Failure~~

Overpayments can only be recovered if the member received a benefit they weren't entitled to receive, more benefits than they were entitled to receive, or a lower premium than they should have been charged because the member did one or more of the following:

- Provided incorrect or incomplete information at application
- Provided incorrect or incomplete information at renewal
- ~~Concealing or not reporting income.~~
- Failed to report a change they were required to report
- ~~Providing misinformation at the time of application or renewal regarding any information that would affect eligibility.~~

Overpayments not caused by the member, including overpayments caused by the agency, system issues, or timely notice requirements, can't be recovered.

If a member fails to correctly report income or a change in income~~.~~ which results in monthly income that makes the member ineligible, an overpayment doesn't exist if the member could have been eligible under gap filling rules (see Section 28.3.4 Gap Filling Eligibility Considerations).

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

Use the best available information to determine whether an overpayment exists in situations where verification has been requested but has not been provided (see Section 9.8 General Rules for more information on best available information).

28.2 Recoverable Overpayments

~~Initiate recovery for a BadgerCare Plus overpayment, if the incorrect payment resulted from one of the following:~~

28.2.1 Date of Discovery and Lookback Period

The date of discovery of the overpayment is the date the worker creates the overpayment claim in the system and an overpayment notice is triggered to be sent to the member.

Most recoverable health care overpayments will have a look back period of 12 months prior to the date of discovery. The lookback period for health care overpayments based on fraud convictions, a signed Intentional Health Care Program Violation Acknowledgement form, or a member receiving duplicate benefits is limited to six years prior to the date of discovery.

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and received services under BadgerCare Plus or Wisconsin Medicaid more than two months after the move occurred.

Example 1: Max applied for BadgerCare Plus and was determined eligible starting April 1, 2022. In October 2022, Max started a new job but did not report this to his IM agency. Max didn't complete his renewal, so his BadgerCare Plus ended on March 31, 2023. In August 2024, the IM agency discovered his job that was not reported and that his income was over the income limit for BadgerCare Plus. However, the IM agency found that Max misunderstood the change reporting requirements and there was no intention to commit fraud. There is no fraud conviction, and Max didn't sign the Intentional Health Care Program Violation Acknowledgement form. The 12-month lookback period applies in this situation. Since the overpayment period is more than 12 months prior to the date of discovery, the overpayment is not recoverable.

28.2.2 Overpayment Claims Minimum Threshold

The minimum threshold for each claim is $500 for recoverable health care overpayments. If the overpaid amount is less than $500, no claim will be established unless it meets one of these criteria:

- Health care overpayments based on fraud convictions or a signed Intentional Health Care Program Violation Acknowledgement form
- Overpayments related to a member receiving duplicate benefits

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and received services under BadgerCare Plus or Wisconsin Medicaid more than two months after the move occurred.

Example 2: John and his family were determined eligible for BadgerCare Plus starting January 1. John accepted a new job in South Carolina, and he and his family moved there on July 20. John and his family enrolled in Medicaid in South Carolina starting August 1.

John did not report their change in state residency to his IM agency in Wisconsin, so capitation payments continued to be made for John and his family. John didn't complete a BadgerCare Plus renewal, so BadgerCare Plus closed December 31. Giving 10 days to report and following adverse action logic, the case would have closed August 31 had John reported the change timely to his IM agency.

Two years later, the IM agency discovered that John and his family had duplicate benefits in Wisconsin and South Carolina for more than two months after the move. Since this is a duplicate benefits situation, the lookback period is six years, and the minimum threshold doesn't apply, fee-for-service claims and any HMO capitation payments for September, October, November, and December are recoverable.

See Section 28.4 Overpayment Calculation for information on determining the overpayment amount.

28.2.3 Recoverable Overpayment Types

BadgerCare Plus overpayments resulting from any of these reasons are subject to recovery:

1. Applicant or member error

Applicant or member error ~~exists~~occurs 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)~~or omits facts~~, which~~ at application or renewal, and this results in the member receiving a benefit that ~~he or she is~~they are not entitled to or more benefits than ~~he or she is~~they are entitled to. ~~Failure to report nonfinancial facts that impact eligibility or~~ This can include having lower premiums or other cost share amounts ~~is a recoverable overpayment.~~

~~-~~than the member should have had.

Applicant or member error also occurs when ~~there is one of the following:~~

a. ~~Misstatement or omission of facts by an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf at a BadgerCare Plus application or renewal.~~
b. ~~Failure on the part of~~ the member, or any person responsible for giving information on the member's behalf, fails 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)~~(see SECTION 27.3 INCOME CHANGE REPORTING REQUIREMENTS) 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 3~~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~~January 1 that Joe was required to report by ~~October~~February 10. Because of the new family income, Olivia's monthly premium increased to $82~~55~~. 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 March through November is incorrect. Following the overpayment calculation policies in section 28.4 Overpayment Calculation, the worker determined that the overpayment amount is $648, which is the difference between the correct premium for March through November (total of $738) and the premium amount that was paid (total of $90). This is a recoverable overpayment because it is within the 12-month lookback period and is for an amount that is at least $500.

~~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. 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 4~~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. This amount is $750. This is a recoverable overpayment because it is within the 12-month lookback period and is for an amount that is at least $500.

- 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:
  a. Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment~~.~~
  b. Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments~~.~~
  c. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event~~.~~
  d. 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).

  Overpayments based on fraud convictions or a signed Intentional Health Care Program Violation Acknowledgement (F-02913) have a lookback period of six years preceding the date of discovery. The minimum threshold does not apply for these overpayments.

- 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.~~

28.3 Unrecoverable Overpayments

28.3.1 Date of Discovery and Lookback Period

Overpayments for periods prior to the lookback period are not recoverable.

28.3.2 Overpayment Claims Minimum Threshold

Claims under $500 can only be recovered if the claim meets one of the following criteria:

- Health care overpayments based on fraud convictions or a signed Intentional Health Care Program Violation Acknowledgement form
- Overpayments related to a member receiving duplicate benefits

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and received services under BadgerCare Plus or Wisconsin Medicaid more than two months after the move occurred.

28.3.3 Non-member Errors

Overpayments resulting from non-member errors are not recoverable, including these situations:
~~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.

~~Do not initiate recovery for a BadgerCare Plus overpayment~~ Overpayments for any months when rules preventing health care terminations during the COVID-19 public health emergency were in effect are not recoverable. This means benefits issued March 2020 and any months after March 2020 for which~~the policy~~ continuous coverage due to the COVID-19 public health emergency is in effect for that member. This includes individuals whose health care was granted, extended, or both due to agency or state error.

In addition, some BadgerCare Plus childless adults were granted health care eligibility effective February 1, 2020 in error. For these individuals, do not initiate recovery for a Medicaid overpayment starting February 2020 and any months after February 2020 when the prevention of terminations policy is in effect.

~~The only exception to recovering overpayments during this time period is when there is a fraud conviction.~~

28.3.~~1~~4 Gap Filling Eligibility Considerations

~~For any potential overpayments for BadgerCare Plus on or after February 1, 2014,~~If a member ~~should not be subject~~fails to correctly report income or a change in income which results in monthly income making the member ineligible, an overpayment doesn't exist if ~~he or she~~the member 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~~.

For this reason, when researching a potential overpayment due to excess monthly income for a given calendar year, an IM agency must determine that the person surpassed 100% of the FPL based on his or her annual income before an overpayment can be established. 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~~doesn't have any information to indicate that Richard's job will not continue for the rest of the year, he ~~would not~~wouldn't be found eligible under gap filling rules. However, for benefit recovery purposes, he ~~has not~~hasn't yet exceeded the 100% ~~percent~~of the FPL annual income limit, so the IM agency cannot say definitively that he ~~would not~~wouldn't have been eligible under gap filling rules. The worker ~~may not~~can't 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~~haven't 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.

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.~~) within the applicable lookback period (see Section 28.2.1 Date of Discovery and Lookback Period).

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.~~ within the applicable lookback period (see Section 28.2.1 Date of Discovery and Lookback Period).

28.4.2 Overpayment Amount

~~Use the~~The actual income that was reported or required to be reported is used in determining if an overpayment has occurred. If the information needed to determine if an overpayment exists is incomplete, the best available information is used to determine the overpayment. The amount of recovery may not exceed the amount of the BadgerCare Plus benefits incorrectly provided.

Example 1: Camila is enrolled in Badger Care Plus. On October 1, an IM worker discovers an unreported job for Camila through a SWICA wage match and requests verification of historical wages. The verification due date is October 30. Camila does not provide verification to IM by the due date of October 30. The worker must use the best available information to calculate the overpayment, which is the information from SWICA.

If the case was ineligible for BadgerCare Plus, ~~recover~~the overpayment amount is 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.~~, minus any premiums paid during the overpayment period.

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~~the overpayment amount is ~~less~~the lesser 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~~2: 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~~the following March.

Overpayment calculation:

10 months
x $55 premium owed for each month (June – March) =
~~$55 premium owed for July~~$550~~110~~ total premium owed
- $ 0 premium paid
$550~~110~~ overpayment

The state paid the HMO $475 in capitation payments and $~~150~~50 in claims each month during that 10-month period for Tom's family for a total of $5,250. Because the difference in premium amounts is less than the claims and HMO capitation payments, the overpayment is the $550~~110~~ difference in premiums.

28.4.2.1 Deductible-Related Overpayments

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 overpayment amount is 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 prepaid the deductible but was actually ineligible for the deductible, ~~determine~~ the ~~overpayment~~ amount~~. If the member prepaid his or her deductible, deduct any amount he or she paid~~ prepaid toward the deductible is deducted from the overpayment amount.

Example ~~2~~3: 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 wouldn~~not~~'t 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~~ for the ~~member's eligibility, determine whether the state~~benefits that BadgerCare Plus already 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~~Overpayments are collected from the BadgerCare Plus member, even if the member has authorized a representative to complete the application or renewal for ~~him or~~

herthem. Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments. Members under age 18 are not liable for overpayments. Dependent 18-year-olds are not liable for overpayments in cases where their parent or other caretaker relative is the primary person for the case.

If a member age 18 or younger received BadgerCare Plus in error, the member's parent(s) or non-legally responsible relative is liable for the overpayment if the parent or non-legally responsible relative was living with the member at the time of the overpayment.

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 43: 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. Danielle is liable for the overpayment. 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 54: 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 65: Kevin and Linda are married, filing taxes jointly, and claiming their two children, Grace (ages 20) and Paul (age 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 76: 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. Susan is liable for the overpayment for both her and Billy 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.

28.5 Member Notice

~~Notify the~~The member or the member's representative must receive a notice of the overpayment that includes the period of ineligibility, the reason for ~~his or her~~their ineligibility, the amounts incorrectly paid, and ~~request arrangement of~~information on arranging for repayment within a specified period of time.

28.6 Refer to District Attorney

~~See IMM Chapter 11 Program Fraud Overview for referral criteria when fraud is~~ Overpayments involving suspected~~. The agency~~ fraudulent activity by the member may ~~refer the case~~ be referred 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 may be referred 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.

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. See section 29.2 Fair Hearings for more information on the fair hearings process.

28.8 ~~Agency Retention~~Reserved

~~The IM agency can retain 15 percent of the payments recovered (see Income Maintenance Manual Section 13.8 Local Agency Retention Portion of Claims).~~

28.9 ~~Restoration of Benefits~~Reserved

~~If it is determined that a member's benefits have been incorrectly denied or terminated, restore his or her BadgerCare Plus should be restored 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 should be allowed to pick choosewhich months he or she would like to receive benefits. Collect Aall premiums owed for those prior monthsfor which the member would like to receive benefits must be paid before the member is enrolled for those months before certifying the member for the months he or she chose should be paid.~~

~~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.~~

~~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 needs to be determined and reported 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:~~
~~Telephone: 1 (888) 907-4455 or~~
~~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:~~

- ~~The member's Social Security Number.~~
- ~~Months for which a refund needs to be issued.~~
- ~~New premium amount.~~
- ~~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.~~

29.1 ~~Notice and Fair Hearings~~Notices

A notice must be either mailed or sent electronically at least 10 days prior to ~~a negative~~the effective date of an adverse action, such as a termination of benefits or an increase in premium.

29.1.1 Notice Requirements

Applicants and members must receive written notice of:

- The decision on an application or renewal
- Any action to discontinue or suspend a member's benefits
- Any action that changes the form or amount of benefits

29.1.2 Notice of Approval

Any notice of approval of eligibility must include:

- The basis and effective date of eligibility and which individuals are eligible
- The circumstances under which the individual must report and procedures for reporting any changes that may affect the individual's eligibility
- If applicable, the amount of medical expenses that must be incurred to meet a deductible
- If applicable, basic information on the level of benefits and services available based on the individual's eligibility, including:
    - A description of any premiums and cost sharing required
    - An explanation of how to receive additional detailed information on benefits and financial responsibilities
    - An explanation of any right to appeal the eligibility status or level of benefits and services approved

29.1.2.1 Notice of Denial

Any notice of denial of BC+ eligibility for an individual or the household must include:

- The month(s) that were denied and which individuals were determined ineligible
- The reason(s) for the denial, including citations to the law or policy that supports the action
- An explanation of the right to a fair hearing and how to request one

29.1.3 Notice of Adverse Action

An adverse action is a change made by an IM agency that will stop or reduce benefits or increase cost sharing. Members have the right to adequate and timely notice of an adverse action.

29.1.3.1 Adequate Notice of Adverse Action

To be "adequate", a notice of an adverse action must include the following:

- A statement describing the intended action
- The reason(s) for the intended action, including a citation to the law, regulation, rule, or policy that supports or requires the action
- An explanation of the right to a fair hearing and how to request one
- A statement on the availability of free representation
- A statement that if a hearing is requested before the action's effective date, benefits will continue until the hearing decision is made

- A statement that the member may have to repay any benefits continued during the appeal if the hearing decision isn't in their favor or they abandon or withdraw the hearing request
- The telephone number and the name of the agency to contact for more information

29.1.4 Timely Notice of Adverse Action

Timely notice must be provided at least **10 days** before the effective date of any intended adverse action **unless** one or more of the following circumstances apply:

- Factual information confirms a recipient or payee's death and there is no relative to take their place as primary person
- A clear, written statement initiated and signed by the member is submitted stating they no longer wish to receive benefits
- The member has applied for and is receiving benefits from another state

35.1 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, their BadgerCare Plus should be restored from the date of the incorrect denial or termination through the time period that they would have remained eligible.

If the member was incorrectly denied or terminated for BadgerCare Plus with a premium obligation, the member should be allowed to choose which months they would like to receive benefits. All premiums owed for the months for which the member would like to receive benefits must be paid before the member is enrolled for those months.

If a member already paid for a BadgerCare Plus covered service, the member will need to contact their 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.

If it is determined that a premium amount was incorrectly calculated for BadgerCare Plus and would result in a refund for the member, the correct premium amount for each month in which it was incorrect needs to be determined and reported to the fiscal agent's BadgerCare Plus Unit. The fiscal agent will refund the amount of the premium the member overpaid.

43.2 Financial Tests

There is no asset test for Tuberculosis (TB)-Related Medicaid.

The income limit for one adult is $1,~~673~~767. For a married couple, the limit is $2,~~467~~607. 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).~~ SECTION 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~~a child is determined ineligible for BadgerCare Plus, the countable MAGI income for the child ~~will be applied~~is tested against the TB-related Medicaid individual monthly income limit of $1,~~673~~767. If the countable monthly MAGI income for the child is at or less than $1,767 and the child meets all other TB-related Medicaid eligibility criteria, the child is eligible for TB-Related Medicaid. 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~~600, which is ~~103~~105% of the FPL for a group of ~~2~~two. This makes Greg ineligible for ~~BC+~~BadgerCare Plus as a childless adult. However, that same MAGI income amount is less than the $1,~~673~~767 TB income limit for an unmarried individual, which makes Greg eligible for TB-Related Medicaid.

48.1 BadgerCare Plus Children's Premium Tables

48.1.3 Five Percent Premium Caps for Children

The table below displays the ~~five percent~~5% caps of BadgerCare Plus premiums for children in certain households with incomes above 201 ~~percent~~% and at or below 306 ~~percent~~% of the FPL. Families ~~will~~ pay the combined premiums for the children ~~or an amount equal to five percent~~, but no more than 5% 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 $486. 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	101.00	106.00	111.00	116.00	121.00	126.00	132.00	137.00	142.00	147.00	152.00
2	137.00	144.00	151.00	158.00	165.00	172.00	179.00	185.00	192.00	199.00	206.00
3	174.00	182.00	191.00	200.00	208.00	217.00	225.00	234.00	243.00	251.00	260.00
4	210.00	220.00	231.00	241.00	252.00	262.00	272.00	283.00	293.00	304.00	314.00
5	246.00	258.00	270.00	283.00	295.00	307.00	319.00	332.00	344.00	356.00	368.00
6	282.00	296.00	310.00	324.00	338.00	352.00	366.00	380.00	395.00	409.00	423.00
7	318.00	334.00	350.00	366.00	382.00	398.00	413.00	429.00	445.00	461.00	477.00
8	354.00	372.00	390.00	407.00	425.00	443.00	460.00	478.00	496.00	513.00	531.00
9	391.00	410.00	430.00	449.00	468.00	488.00	507.00	527.00	546.00	566.00	585.00
10	427.00	448.00	469.00	491.00	512.00	533.00	554.00	576.00	597.00	618.00	639.00
11	463.00	486.00	509.00	532.00	555.00	578.00	601.00	624.00	647.00	670.00	694.00
12	499.00	524.00	549.00	574.00	599.00	623.00	648.00	673.00	698.00	723.00	748.00
13	535.00	562.00	589.00	615.00	642.00	669.00	695.00	722.00	749.00	775.00	802.00
14	572.00	600.00	628.00	657.00	685.00	714.00	742.00	771.00	799.00	828.00	856.00

Example	A family with seven children and an income of 295% of the FPL would ordinarily owe premiums amounting to seven times $82, which equals $574. However, if the children's assistance group size, including the parent, is eight, the 5% cap found in the table below is $565. That is the maximum premium amount that the family should be charged for that month.

grou	201 -	211-	221-	231-	241-	251-	261-	271-	281-	291-	301-

p	211%	221%	231%	241%	251%	261%	271%	281%	291%	301%	306%
size	-	-	-	-	-	-	-	-	-	-	-
1	$113.00	$119.00	$125.00	$130.00	$136.00	$142.00	$147.00	$153.00	$159.00	$164.00	$170.00
2	$153.00	$160.00	$168.00	$176.00	$183.00	$191.00	$199.00	$206.00	$214.00	$222.00	$229.00
3	$192.00	$202.00	$212.00	$221.00	$231.00	$240.00	$250.00	$260.00	$269.00	$279.00	$288.00
4	$232.00	$243.00	$255.00	$267.00	$278.00	$290.00	$301.00	$313.00	$324.00	$336.00	$348.00
5	$271.00	$285.00	$298.00	$312.00	$326.00	$339.00	$353.00	$366.00	$380.00	$393.00	$407.00
6	$311.00	$326.00	$342.00	$357.00	$373.00	$388.00	$404.00	$419.00	$435.00	$450.00	$466.00
7	$350.00	$368.00	$385.00	$403.00	$420.00	$438.00	$455.00	$473.00	$490.00	$508.00	$525.00
8	$390.00	$409.00	$429.00	$448.00	$468.00	$487.00	$507.00	$526.00	$545.00	$565.00	$584.00
9	$430.00	$451.00	$472.00	$494.00	$515.00	$537.00	$558.00	$579.00	$601.00	$622.00	$644.00
10	$469.00	$492.00	$516.00	$539.00	$563.00	$586.00	$609.00	$633.00	$656.00	$679.00	$703.00
11	$509.00	$534.00	$559.00	$585.00	$610.00	$635.00	$661.00	$686.00	$711.00	$737.00	$762.00
12	$548.00	$575.00	$603.00	$630.00	$657.00	$685.00	$712.00	$739.00	$767.00	$794.00	$821.00
13	$588.00	$617.00	$646.00	$675.00	$705.00	$734.00	$763.00	$793.00	$822.00	$851.00	$880.00
14	$627.00	$658.00	$690.00	$721.00	$752.00	$783.00	$815.00	$846.00	$877.00	$908.00	$939.00

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	$1,2,880 13,590	$1,073.33 12.50	$1,427.53 506.23	$1,610.00 698.75	$1,674.39 766.70	$2,050.06 163.08	$2,157.39 276.33	$3,219.99 397.50	$3,284.39 465.45
2	$17,420 18,310	$1,451.67 525.83	$1,930.72 2,029.35	$2,177.51 288.75	$2,264.61 380.29	$2,772.69 914.34	$2,917.86 3,066.92	$4,355.01 577.49	$4,442.11 669.04
3	$21,960 23,030	$1,830.00 919.17	$2,433.90 552.50	$2,745.00 878.76	$2,854.80 993.91	$3,495.30 665.61	$3,678.30 857.53	$5,490.00 757.51	$5,599.80 872.66
4	$26,500 27,750	$2,208.33 312.50	$2,937.08 3,075.63	$3,312.50 468.75	$3,444.99 607.50	$4,217.91 416.88	$4,438.74 648.13	$6,624.99 937.50	$6,757.49 7,076.25
5	$31,040 32,470	$2,586.67 705.83	$3,440.27 598.75	$3,880.01 4,058.75	$4,035.21 221.09	$4,940.54 5,168.14	$5,199.21 438.72	$7,760.01 8,117.49	$7,915.21 8,279.84
6	$35,580 37,190	$2,965.00 3,099.17	$3,943.45 4,121.90	$4,447.50 648.76	$4,625.40 834.71	$5,663.15 919.41	$5,959.65 6,229.33	$8,895.00 9,297.51	$9,072.90 483.46
7	$40,120 41,910	$3,343.33 492.50	$4,446.63 645.03	$5,015.00 238.75	$5,215.59 448.30	$6,385.76 670.68	$6,720.09 7,019.93	$10,029.99 47 7.50	$10,230.59 68 7.05
8	$44,660 46,630	$3,721.67 885.83	$4,949.82 5,168.15	$5,582.51 828.75	$5,805.81 6,061.89	$7,108.39 421.94	$7,480.56 810.52	$11,165.01 65 7.49	$11,388.31 89 0.64
9	$49,200 51,350	$4,100.00 279.17	$5,453.00 691.30	$6,150.00 418.76	$6,396.00 675.51	$7,831.00 8,173.21	$8,241.00 601.13	$12,300.00 83 7.51	$12,546.00 13 ,094.26
10	$53,740 56,070	$4,478.33 672.50	$5,956.18 6,214.43	$6,717.50 7,008.75	$6,986.19 7,289.10	$8,553.61 924.48	$9,001.44 391.73	$13,434.99 14 ,017.50	$13,703.69 14 ,297.85
11	$58,280 60,790	$4,856.67 5,065.83	$6,459.37 737.55	$7,285.01 598.75	$7,576.41 902.69	$9,276.24 675.74	$9,761.91 10,182.32	$14,570.01 15 ,197.49	$14,861.41 15 ,501.44
12	$62,820 65,510	$5,235.00 459.17	$6,962.55 7,260.70	$7,852.50 8,188.76	$8,166.60 516.31	$9,998.85 10,427.01	$10,522.35 97 2.93	$15,705.00 16 ,377.51	$16,019.10 70 5.06
13	$67,360 70,230	$5,613.33 852.50	$7,465.73 783.83	$8,420.00 778.75	$8,756.79 9,129.90	$10,721.46 11 ,178.28	$11,282.79 76 3.53	$16,839.99 17 ,557.50	$17,176.79 90 8.65

	$71,90074,950	$5,991.676,245.83	$7,968.928,306.95	$8,987.519,368.75	$9,347.01743.49	$11,444.0992 9.54	$12,043.2655 4.12	$17,975.0118,737.49	$18,334.5119,112.24
15	$76,44079,670	$6,370.0063 9.17	$8,472830.10	$9,555.00958.76	$9,937.2010,357.11	$12,166.7068 0.81	$12,803.7013,344.73	$19,110.0091 7.51	$19,492.20,315.86
16	$80,98084,390	$6,748.337,032.50	$8,975.289,353.23	$10,122.5054 8.75	$10,527.3997 0.70	$12,889.3113,432.08	$13,564.14,135.33	$20,244.9921,097.50	$20,649.8921,519.45
17	$85,52089,110	$7,126.6742 5.83	$9,478.47876.35	$10,690.0111,138.75	$11,117.6158 4.29	$13,611.9414,183.34	$14,324.6192 5.92	$21,380.0122,277.49	$21,807.6122,723.04
18	$90,06093,830	$7,505.0081 9.17	$9,981.6510,399.50	$11,257.5072 8.76	$11,707.8012,197.91	$14,334.5593 4.61	$15,085.0571 6.53	$22,515.0023,457.51	$22,965.3023,926.66
19	$94,60098,550	$7,883.338,212.50	$10,484.8392 2.63	$11,825.0012,318.75	$12,297.9981 1.50	$15,057.1668 5.88	$15,845.4916,507.13	$23,649.9924,637.50	$24,122.9925,130.25
20	$99,140103,270	$8,261.6760 5.83	$10,988.0211,445.75	$12,392.5190 8.75	$12,888.2113,425.09	$15,779.7916,437.14	$16,605.9617,297.72	$24,785.0125,817.49	$25,280.7126,333.84
21	$103,680107,990	$8,640.0099 9.17	$11,491.2096 8.90	$12,960.0013,498.76	$13,478.4014,038.71	$16,502.4017,188.41	$17,366.4018,088.33	$25,920.0026,997.51	$26,438.4027,537.46
22	$108,220112,710	$9,018.3392.50	$11,994.3812,492.03	$13,527.5014,088.75	$14,068.5965 2.30	$17,225.0193 9.68	$18,126.8487 8.93	$27,054.9928,177.50	$27,596.0928,741.05
23	$112,760117,430	$9,396.6785.83	$12,497.5713,015.15	$14,095.0167 8.75	$14,658.8115,265.89	$17,947.6418,690.94	$18,887.3119,669.52	$28,190.0129,357.49	$28,753.8129,944.64
24	$117,300122,150	$9,775.0010,179.17	$13,000.7553 8.30	$14,662.5015,268.76	$15,249.0087 9.51	$18,670.2519,442.21	$19,647.7520,460.13	$29,325.0030,537.51	$29,911.5031,148.26
Each Additional Person	$4,540.007 20	$378393.33	$503.18523.13	$567.50590.00	$590.19613.59	$722.61751.26	$760.44790.59	$1,134179.99	$1,157.69203.59
-	-	BadgerCare Plus Extensions trigger limit, BadgerCare Plus adults	-	BadgerCare Plus child deductible limit	BadgerCare Plus limit for children 6-18 years old subject to access,	BadgerCare Plus limit for children 1-5 years old subject to access,	BadgerCare Plus children premium limit	BadgerCare Plus pregnant women deductible limit	BadgerCare Plus pregnant women, children, and Family Planning Only

		limit			backdating, and presumptive eligibility	backdating, and presumptive eligibility			Services limit

53.1 Five Percent Copay Limit Tiers

~~2020~~2022 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