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To: BadgerCare Plus Handbook Users

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

Re: **BadgerCare Plus Handbook 22-02**

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Effective Date: 08/01/2022

EFFECTIVE DATE		The following policy additions or changes are **effective 08/01/2022** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY Updates		
2.8	**Modified Adjusted Gross Income Counting Rules**	Updated Expected to File threshold amounts and grammar.
4.3.3	**Immigrants Eligible for BadgerCare Plus**	Added information on immigration statuses for some immigrants from Iraq and Afghanistan.
4.3.8	**Immigration Status Chart**	Added new Registration Status Code.
4.3.9	**Refugee Assistance Programs**	Updated Refugee Assistance Programs information.
4.3.9.2	**Refugee Medical Assistance**	Updated the time period for Refugee Medical Assistance Benefits.
7.2.2	**Good Cause for the Past Access Test**	Updated reference to DHS CARES Call Center to DHS CARES Problem Resolution Team.
7.7.1	**Introduction**	Added list of BadgerCare Plus populations eligible for HIPP.
8.2	**Continuously Eligible Newborns**	Clarified current continuously eligible newborn policy.
9.8	**General Rules**	Updated grammar.
9.9	**Mandatory Verification Items**	Added clarification about Huber participation.
9.9.13	**Huber Law Exemption**	New Section
9.12	**Reasonable Compatibility for Health Care**	Updated the reasonable compatibility policy to include 20% threshold.
16.2	**Income Types Not Counted**	Clarified ABLE Accounts policy and added payment types related to COVID-19 Pandemic.
16.3.3	**Tax Deductions**	Updated teachers' tax-deductible expense amount and added information on write-in expenses.
16.5	**Other Income**	Added new income types.
19.4	**Premium Payment Methods**	Added online payment methods.
25.1	**Application**	Removed processing information.
25.5.1	**Valid Signature Introduction**	Updated to align text with Medicaid Eligibility Handbook.
25.5.1.1	**Signatures from Representatives**	Clarified representative signatures policy and aligned with text in Medicaid Eligibility Handbook.
28.2	**Recoverable Overpayments**	Clarified overpayment policies.
28.3.2	**Overpayment Claims Minimum Threshold**	Clarified overpayment policies.

28.3.5	**Eligibility and Premium Determinations Based on Reasonable Compatibility**	New section.
29.1	**Notices**	Updated section numbering.
29.2.1	**Fair Hearing Request**	Updated grammar.
31.1	**Interagency Transfer**	Removed obsolete information.
35.1	**Restoration of Benefits**	Added clarification on retroactive Katie Beckett or SSI certification period.
38.4	**HMO Enrollment**	Section rewritten.
39.5	**Non-Qualifying Immigrants No Longer Eligible for the BadgerCare Plus Prenatal Program**	Updated the section name, corrected the example, and clarified BadgerCare Plus Prenatal program policies.
41.1	**BadgerCare Plus Prenatal Program**	Added clarification on eligibility for BadgerCare Plus Prenatal Program.
45.8.4	**Huber Law**	Added examples of Huber Law policy.
45.8.5	**Out-of-State Inmates**	Updated example numbers.
45.9	**State Correctional Institutions**	Updated county locations for several facilities.

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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~~the child's or ~~her~~ tax dependent's income is only counted if ~~he or she is~~they are "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~~they are not required to, ~~his or her~~their income will not be counted. Tax ~~dependents'~~ dependent's 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~~they would not have a parent or tax filer eligible or counted in that group. As a result, ~~his~~the child's or ~~her~~tax dependent's income will always be counted, regardless of whether or not ~~she or he is~~ they are expected to be required to file taxes. Children in the care of a Non-legally Responsible Relative (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~~their income is not included in the eligibility determination for the assistance group.

The following amounts are effective January 1, ~~2021~~2022:

- $1,~~100~~ 150 per year in taxable unearned income*
- $12,~~550~~950 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~~100 per month; with an annual income of $~~12,600~~13,200. 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 files taxes. Janet works part-time at Copp's and makes $1,200 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.

4.3 Immigrants

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.

4.3.3.3 Iraqis and Afghans with Special Immigrant Status

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 SI6	Code 04
SI8	Children of an SI6	Code 04

In addition, immigrant Afghan spouses and children of former Special Immigrants who have become United States citizens are also to be treated like they are refugees when determining their eligibility for BadgerCare Plus. This treatment is to continue for as long as they have a status of Special Immigrant Conditional Permanent Resident (SI CPR). The Class of Admission codes for SI CPRs are CQ1, CQ2 and CQ3.

4.3.3.4 Afghan Parolees

Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States between July 31, 2021, and September 30,

2022, are to be treated like they are refugees when determining their eligibility for BadgerCare Plus.

In addition, Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States after September 30, 2022, are to be treated like they are refugees when determining their eligibility for BadgerCare Plus if they are one of the following:

- The spouse or child of an individual paroled between July 31, 2021, and September 30, 2022
- The parent or legal guardian of an individual paroled between July 31, 2021, and September 30, 2022, who is determined to be an unaccompanied child

All of the above individuals are to continue to be treated like they are refugees until either March 31, 2023, or the date their parole status expires, whichever is later.

The table below shows the Class of Admission Codes that are used for these groups:

Class of Admission Code	Description	CARES Alien Registration Status Code
SQ4, SQ5	Special Immigrant Parolee (SI Parolee)	Code 04
DT, OAR, OAW, PAR	Humanitarian Parolee	Code 04

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 Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible

09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian 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
22	Citizen of Compacts of Free Assoc (COFA)	Eligible	Eligible	Eligible	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~~Refugee Assistance Programs

The federal Office of Refugee Resettlement (ORR) provides resources for refugees, asylum seekers, and ~~Afghans With Special Immigrant Status~~other new arrivals to the U.S. to assist with their integration into their new community. Several benefit programs overseen by the ORR and operated by the Bureau of Refugee Programs in the Department of Children and Families are discussed here.

~~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~~

4.3.9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for BadgerCare Plus, ~~he or she~~they may apply for Refugee Medical Assistance, which is not funded by BadgerCare Plus or Medicaid. 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~~12 months after a special immigrant's date of entry. If it is not applied for in that ~~eight~~12-month period, it cannot be applied for later.

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 or Medicaid 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~~ Registration Status Code 04 remains the same.

7.2 Past Access to Health Insurance

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;
    c. And no one in the Test Group at that time was eligible for:
        i. BadgerCare Plus with an assistance group income above 156 percent of the FPL,
        ii. BadgerCare Plus extension, or
        iii. 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~~Problem Resolution Team for approval before granting good cause for any reason not stated above.

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 the following BadgerCare Plus members when it is cost effective to do so~~.~~:

- Children
- Pregnant Women
- Parents and Caretakers

HIPP is not available for childless adults.

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~~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.

8.2 ~~Continously~~Continuously Eligible Newborns

Newborn children are automatically eligible for BadgerCare Plus as Continuously Eligible Newborns (CEN) from the date of birth through the end of the month in which they turn ~~1~~ one year old if both the following are true:

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

There is no income or resource test for these children while they are eligible under ~~this~~ CEN 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 eligible for the BadgerCare Plus Prenatal Program (and not eligible for any other type of BadgerCare Plus or Medicaid) on the date of the child's birth will not be eligible as CENs.

A child qualifies as a CEN if they are born to a mother whose ~~natural mother's~~ eligibility for one of the programs listed above was determined either prior to 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~~ one year old.

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

A newborn is not required to reside with ~~his or her~~the mother who gave birth 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~~the mother who gave birth but still resides in Wisconsin should remain eligible as a CEN through the end of the month in which ~~he or she turns 1~~ they turn one 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.

9.8 General Rules

1. Over-verification, including requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility, 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. If information has already been verified, the applicant or member does not need to verify it again except in the following situations:
    1. 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).
    1. The member reported a change to information that is subject to mandatory verification rules or is questionable.
    1. At renewal, information is subject to mandatory verification rules or is questionable.
3. One particular type of verification can't be exclusively required 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. Special groups or persons can't be targeted based on race, color, national origin, age, disability, sex, religion, or migrant status for special verification requirements.
6. 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.
7. Verification of information that is not used to determine eligibility can't be required.
8. During verification, ~~he~~the 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 9.9.7 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).

IM agencies must assist the applicant or member in obtaining verification if they request help or have difficulty in obtaining it.

The best information available should be used to process the application or change within the time limit when both of the following two conditions exist:

1. The applicant or member does not have the power to produce verification.
2. Information is not obtainable timely even with the IM worker's assistance.

Applicants meeting the health care program eligibility criteria based on this 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 their attempts to obtain verification. When the verification is received, benefits may need to be adjusted or recovered based on the new information. The agency must explain this to the applicant or member when requesting verification.

9.9 Mandatory Verification Items

1. 9.9.1 Social Security Number
    a. 9.9.1.1 Fraudulent Use of SSN
    b. 9.9.1.2 Newborns
    c. 9.9.1.3 BadgerCare Plus Emergency Services
    d. 9.9.1.4 BadgerCare Plus Prenatal Program
2. 9.9.2 Immigrant Status
3. 9.9.3 Pregnancy
4. 9.9.4 Medical Expenses
5. 9.9.5 Power of Attorney and Guardianship
6. 9.9.6 Income
    1. 9.9.6.1 Prison or Jail Job
7. 9.9.7 Access to Employer-Sponsored Health Insurance
    1. 9.9.7.1 Employer Verification of Health Insurance Database
    2. 9.9.7.2 Other Forms of Health Insurance Access Verification
8. 9.9.8 Tribal Membership, Descent, or Eligible to Receive Indian Health Services
9. 9.9.9 Pretax Deductions
10. 9.9.10 MAGI Tax Deductions
11. 9.9.11 Former Foster Care Youth
12. 9.9.12 Gross vs Taxable Portion of Pension
13. 9.9.13 Huber Law Exemption

The following items must be verified for BadgerCare Plus:

- SSN
- Citizenship and identity (see Section 4.2 Citizenship Verification)
- 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~~their 18th birthday
- Tribal membership or Native American descent
- Pre-tax deductions
- MAGI tax deductions

- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see SECTION 45.8.4 HUBER LAW)

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

9.9.13 Huber Law Exemption

Applicants and members who are incarcerated but allowed to leave jail under the Huber Law can become or remain eligible for full-benefit BadgerCare Plus if the reason for the release is to return home to care for their minor children (see SECTION 45.8.4 HUBER LAW for the Huber Law exemption criteria).

To qualify for the Huber Law exemption, verification that the applicant or member is returning home to care for minor children is required.

Acceptable verification sources include:

- Agency Form
- Court Order
- City or County Records, such as from the correctional facility
- Lawyer Statement or Record
- Other Acceptable Written or Verbal Statement, such as from the court or correctional facility staff

If the verification shows that the person is only allowed to leave jail under the Huber Law for a reason other than caring for a minor child, they are not eligible for the Huber Law exemption.

9.12 ~~Resonable~~Reasonable Compatibility for Health Care

1. 9.12.1 Programs for Which Reasonable Compatibility Will Apply
2. 9.12.2 Reasonable Compatibility Thresholds
3. 9.12.3 Reasonable Compatibility Test
4. 9.12.4 Determining a Data Exchange-Based Income Amount for the Reasonable Compatibility Test
5. 9.12.5 Use of Equifax Data for Verification of Income

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see SECTION 9.9.6.1 PRISON OR JAIL JOB), or information from the data source is not "reasonably compatible" with what the applicant has reported. Information from ~~the~~a data source ~~is "reasonably compatible" if it results in the same~~that supports an eligibility ~~outcome as member-reported~~determination based on the attested information~~:~~ provided by an applicant or member is considered "reasonably compatible."

The following list describes the potential scenarios and whether the scenario results in a determination of reasonable compatibility:

- 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, an additional test that uses a 20% threshold occurs.
    - If the individual's total countable income using information from the electronic data source is less than or equal to 120% of the individual's total countable income using the member-reported information, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
    - If the individual's total countable income using information from the electronic data source is more than 120% of the individual's total countable income using the member-reported information, 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~~is 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~~ is 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~~SECTION 16.5 OTHER INCOME) is verified as outlined in this chapter and in Process Help Chapter 44 Data Exchange. ~~-~~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~~are verified as outlined in ~~Process Help 16.4.4 and~~Process Help 16.2 Self-Employment Income, ~~SECTION 16.2.~~Process Help 16.6 In-Kind and Volunteer Hours, and Section 16.4.3 Self-Employment Income.

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~~ as the first step in determining whether reported information is reasonably compatible. In some cases, the threshold will be ~~a~~ an 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

If both the total countable income using information reported by the applicant or member and the total countable income using information from the electronic data source are equal to or less than the threshold, the reasonable compatibility standard is met, and no further verification is required.

If the total countable income using information reported by the applicant or member is equal to or less than the threshold and the total countable income using information from the electronic data source is greater than the threshold, a second step occurs.

In this second step, the total countable income using information from the electronic data source is compared to a threshold that is equal to 120% of the total countable income using information reported by the applicant or member. If the total countable income using information from the electronic data source is equal to or less than 120% of the total countable income using information reported by the applicant or member, the reasonable compatibility standard is met, and no further verification is required.

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

~~Example 1~~Note: ~~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 per month. Equifax data is not available. SWICA reports that Marty has earnings of $4,600 per month. For a group size of four, 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 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 for Warren to become eligible.~~

~~If the family provides paystubs that show actual monthly income of more than 201% FPL, both children would be subject to a premium based on the income verified by paystubs.~~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.

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 per month. Equifax data is not available. SWICA reports that Marty has earnings of $4,600 per month. For a group size of four, 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, the reasonable compatibility threshold is 201% FPL. The household's income based on both the reported income and SWICA is below this threshold, so the reasonable compatibility standard is met, and no further verification is required for Alex. For Warren, 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. Therefore, the 20% threshold test is applied. The 20% threshold is $5,244 (the reported income of $4,370 multiplied by 120%, or 1.2). The income based on SWICA data ($4,600) is less than the 20% threshold ($5,244), so the reasonable compatibility standard is met, and no further verification is required for Warren.

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~~must be used to determine eligibility and premium amounts for health care.

~~In this situation,~~See SECTION 28.3.5 ELIGIBILITY AND PREMIUM DETERMINATIONS BASED ON REASONABLE COMPATIBILITY for information about when members ~~are not liable for overpayments because the initial determination was~~ with eligibility or premium determinations 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~~overpayments.

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 $1,132.50 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 $1,132.50 for BadgerCare Plus. He reports that his earnings are $900 per month. Equifax reports that he is paid twice a month at $600 per paycheck, for a monthly amount of $1,200. ~~Because there is a difference in the eligibility outcome when applying the Equifax reported income~~Lon's reported income is below the income threshold and the Equifax reported income is above the income threshold, so the 20% threshold test is applied. The income reported by Equifax ($1,200) is greater than the 20% threshold amount (120% of $900, or $1,080). Therefore, 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 $1,132.50 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 $1,132.50 for BadgerCare Plus. She applies for 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 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.

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 andas a verification code of "DE – Data Exchange." Because the wage has already been verified, the income amount which is not subject to a reasonable compatibility test will not be triggered for this employment.

If the worker is completing intakeprocessing an application 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 and pend the case for 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). SECTION 9.8 GENERAL RULES). 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/ per hour at 30 hours/ per 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 last four weekly paycheck amounts were for an hourly rate of $9.55~~/~~ per hour but for 33 hours~~/~~ per week, for a weekly paycheck of $315.15. The worker then confirms with Ryan that this amount is correct~~,~~ and enters this amount on the employment page ~~and uses DE as the verification code~~as verified. 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 income is not subject to reasonable compatibility ~~test is not invoked~~.

Example 8	Mindy applies online for herself and her ~~2~~two-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.~~pends the case fore employment verification. 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~~/~~ per month, or ~~90~~83% FPL, while the household income based on FDSH data is $1,960~~/~~ per month, or ~~110~~102% 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. Therefore, the 20% threshold test is applied. The income reported by Equifax ($1,960) is greater than the 20% threshold amount (120% of $1,600, or $1,920). 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.~~ and consider the income verified. 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~~pend the ~~Q? as the verification code~~case for the employment information 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.

16.2 Income Types Not Counted

48. 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 from someone other than the member, any interest or dividends earned, or other appreciation in value as income.

  Note: Someone using their earned or unearned income to contribute to an ABLE account does not make the income exempt for purposes of Medicaid eligibility. Income received by the designated beneficiary and deposited into their ABLE account is still income to the designated beneficiary. For example, an applicant can have contributions automatically deducted from their paycheck and deposited into an ABLE account. In this case, the income used to make the ABLE account contribution is included in the Medicaid eligibility determination as income, even though the ABLE account is an exempt asset.

- Exempt all distributions from these accounts to the beneficiary as long as they are for qualified disability expenses. and are not more than the beneficiary's 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.

50. Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as income for BadgerCare Plus and some payment types are not counted as income for BadgerCare Plus. The criteria used to evaluate whether a payment type is counted as income include:

- The text of the federal law that authorized the payment type~~;~~
- Guidance received from federal agencies~~;~~
- Whether the payment is taxable~~; and~~
- Whether the payment can be considered "disaster assistance~~."~~"

~~-~~The payment types that do not count as income for BadgerCare Plus include but are not limited to:

- Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency~~.~~
- Federal Pandemic Unemployment Compensation (FPUC) payments (these are payments in addition to regular unemployment benefits~~).~~)
- Lost Wages Assistance (LWA) payments (these payments are from a Federal Emergency Management Agency (FEMA) program that provides an additional $300 per week to eligible individuals who are unemployed or partially unemployed due to disruptions caused by COVID-19~~).~~)
- Wisconsin Emergency Rental Assistance (WERA) payments~~.~~
- Higher Education Emergency Relief Fund (HEERF) payments
- Economic relief payments paid directly from a tribal government to a tribal member using local government relief funds provided through the CARES Act
- A Paycheck Protection Program (PPP) loan. The loan itself is not counted as income. However, if the loan is being used to pay employee wages, the wages are counted as income for the employee who receives them.

See SECTION 16.5 OTHER INCOME #23 for countable types of pandemic-related unemployment compensation benefits

16.3 Income Deductions

16.3.3 Tax Deductions

5. Teachers' tax-deductible expenses

Applies to K-12 teachers who have up to $~~250~~300 in out-of-pocket work expenses (expenses not paid for by the employer). This is capped at a monthly amount of $~~21~~25.

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 and court costs paid to recover a judgment or settlement for a claim of unlawful discrimination, a claim against the U.S. Government, or a claim under section 1862(b)(3)(A) of the Social Security Act
- 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~~.~~

16.5 Other Income

4. Social Security Benefits

~~Although~~Although a portion of Social Security benefits are usually not taxable, they all 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).

11. Sick ~~Benefits~~Pay

~~Count~~Sick pay refers to any amounts paid to an employee for any period during which the employee is temporarily absent from work because of injury, sickness, or disability. Sick pay does not include disability retirement payments or payments for medical and hospitalization expenses.

The pay a person receives from an employer while the person is sick or injured is counted as income.

If a person receives sick pay benefits ~~received~~ from an insurance policy ~~if~~and the person paid the premiums on the insurance policy, the benefits the individual receives are not counted as income.

If a person receives sick pay benefits from an insurance policy and both the person and the employer paid the premiums on the insurance policy, only the benefits the person receives that are due to the employer's payments are counted as income.

If a person receives sick pay benefits through a cafeteria plan and the amount of the premiums was not included in the person's ~~employer contributed or paid for the benefit.~~ income, the benefits the person receives are counted as income. If a person receives sick pay benefits through a cafeteria plan and the amount of the premiums was included in the person's income, the benefits the person receives are not counted as income.

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

15. Capital and Ordinary Gains and Losses

Capital gains are profits from the sale of assets, such as stocks and bonds, real estate, collectibles, or personal items. If personal capital gains are regular and predictable, count as unearned income. Do not count personal capital gains as unearned income if they are not regular or predictable. 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.

Note:	If a person is in the business of buying and reselling items, it should be reported as self-employment.

Example 3	Danielle is moving to a different city in Wisconsin. She sold her house and made a profit. This house was her primary residence, and she did not sell it as part of a real estate business. The profit she made from the sale is taxed as capital gains. Since the sale of her house was a one-time event, and the capital gains from the sale are not regular and predictable, these capital gains are not counted as unearned 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~~4	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 months = $62.50/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.

23. Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as income for BadgerCare Plus and some

payment types are not counted as income for BadgerCare Plus. The criteria used to evaluate whether a payment type is counted as income include:

- The text of the federal law that authorized the payment type~~;~~
- Guidance received from federal agencies~~;~~
- Whether the payment is taxable~~; and~~
- Whether the payment can be considered "disaster assistance~~".~~"

The payment types that count as income for BadgerCare Plus include but are not limited to:

- Retroactive Pandemic Unemployment Assistance (PUA), Pandemic Emergency Unemployment Compensation (PEUC),~~ and~~ Mixed Earner Unemployment Compensation (MEUC) payments~~. These~~, and Extended Benefits (EB) unemployment compensation (these payments are counted as income in the month they are received~~.~~)
- Workforce Retention and Recognition Stipend Program payments~~. These~~ (these payments are awarded to child care professionals~~.~~)
- We're All In Small Business Grants~~.~~
- Child Care Counts ~~supplementary payments. These~~Supplementary Payments (these payments are awarded to child care providers~~.~~)
- Child Care Counts Stabilization Payments (these payments are awarded to child care providers)
- USDA Coronavirus Food Assistance Program – Direct Payments to Farmers and Ranchers~~.~~

See SECTION 16.2 INCOME TYPES NOT COUNTED #50 for non-countable types of pandemic-related unemployment compensation benefits.

24. Virtual Currency

Virtual currency is counted as income when it is received in the following situations:

- Received as payment for goods or services
- Received by an independent contractor for performing services
- Received from an employer as remuneration for services (i.e., wages)

If virtual currency is sold, income received from the sale is counted as income for BadgerCare Plus only if the income is regular and predictable or if the sale occurs as part of a trade or business.

25. Railroad Retirement Benefits

Although a portion of Railroad Retirement benefits are usually not taxable, they all must be counted as unearned income. Count all Railroad Retirement benefits as unearned income in the month received.

26. Prizes and Awards

Count cash prizes and awards. If the prize of award is in the form of a good or service, count the fair market value of the prize of award.

19.4 Premium Payment Methods

~~Upon request from~~ Initial premium payments must be paid by check or money order and are collected by the ~~member, the fiscal agent (1-888-907-4455)~~IM agency.

For ongoing premium payments, premium statements will be sent monthly. The statement will provide ~~members with instructions for choosing~~the amount due and how to pay the premium.

Members have several options to pay their ~~preferred payment method from the list below.~~ongoing monthly premiums, including:

~~Approved payment methods include:~~

- ~~Direct payment by check or money~~Check
- Money order~~.~~
- Electronic Funds Transfer (EFT~~).~~)
- Wage withholding ~~from each~~
- Credit or debit card

Members can make one-time payments using a credit or debit card, or EFT from a checking or savings account, through the ACCESS website.

For recurring EFT payments, members must submit a complete BadgerCare Plus Premium Member/Employer Electronic Funds Transfer form (F-13026). To have premiums taken out of a paycheck ~~received~~, the BadgerCare Plus Premium Employer Wage Withholding form (F-13025) must be submitted by an employer. Members must submit payments through one of the other methods until they get confirmation that their recurring EFT or wage withholding request has been processed.

~~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.~~

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~~their behalf unless ~~he or she is~~ they are 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~~ they choose in completing an application.

~~Encourage anyone~~Anyone who expresses interest in applying should be encouraged to file an application as soon as possible~~. When an application is requested:~~ (see Section 25.2 Application Methods).

~~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~~The agency must provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (~~DWSP-2477) and Good Cause Claim form (DWSP-2019~~DWSP-2477) and Good Cause Notice (DWSP-2018) 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/~~

People open for non-health care program(s) who want to enroll in a health care program must sign an application or program request for health care. If the person or someone else in the household is already open for a health care program, they can request another health care program without a new application or new signature.

Example 1:	Tim and Carrie are married. When Tim applies for health care, he indicates that he is requesting health care for himself but Carrie is not requesting health care. Tim is determined eligible for BadgerCare Plus. Four months later, Carrie decides that she would also like to enroll in BadgerCare Plus. Carrie does not need to submit a new application or new signature. She can contact the IM agency to request BadgerCare Plus.

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 4four months after the date of death, ~~he or she is~~they are not eligible.

25.5 Valid Signature

25.5.1 Valid ~~Application~~Signature Introduction

The applicant~~-~~, their representative (see below), or the applicant's caretaker relative must sign one of the following (using their own signature):

1. The paper application form
2. The signature page of the Application Summary, either over the phone, electronically, or ~~providing~~with a handwritten signature
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:~~the applicant's behalf.

~~1. Guardian of the estate; or~~
~~2. Guardian of the person and the estate; or~~
~~3. 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~~one of the following, only the guardian, not the applicant, may sign the application or appoint ~~another~~an authorized representative~~.~~:

1. Guardian of the estate
2. Guardian of the person and the estate
3. Guardian in general

If the applicant only has a legal **guardian of the person**, the ~~applicant must~~ guardian may sign the application ~~unless the~~since they are acting responsibly for an incompetent or incapacitated person. however, a legal guardian of the person can't appoint an authorized representative. The applicant must be the one to appoint an authorized representative if they choose to have one.

The applicant ~~has appointed his or her~~may appoint their guardian of the person to be the authorized representative. If the guardian of the person has been appointed the

authorized representative by the applicant, the guardian may sign the application as the authorized representative.

2. Conservator (Wis. Stat. 54.76(2))

A conservator is a person who is appointed by a court at an individual's request under Wis. Stat. 54.76(2) to manage the estate of the individual. When an application is submitted with a signature of someone claiming to be the applicant's conservator, a copy of the document that designates the signer of the application as the conservator is required.

3. Authorized Representative

The applicant may authorize someone to represent ~~him or her.~~ them. An authorized representative can be an individual or an organization~~. See~~ (see Section 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).

4. 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:

1. Obtain a copy of the document the applicant used to designate the signer of the application as the durable power of attorney.
2. 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~~ the above conditions are met. An individual's Durable Power of Attorney may appoint an authorized representative for purposes of making a ~~BadgerCare Plus~~health care 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.

5. Someone acting responsibly for an incompetent or incapacitated person

Example 1	Carl is in a coma in the hospital. ~~Sherry~~Marco, a nurse who works at the hospital, can apply for ~~BadgerCare Plus~~ health

	care on Carl's behalf.

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

7. A ~~Warden~~warden or ~~Warden's Designee~~warden's designee

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

8. The ~~Director~~superintendent of a ~~County Social or Human Services Department~~county psychiatric institution

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~~a county psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director has delegated to them (in writing) the authority to sign and witness ~~an application~~applications for residents of the institution. Retain a copy of this written authorization. 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.

28.2 Recoverable Overpayments

28.2.1 Date of Discovery and Look Back 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~~look back 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~~then BadgerCare Plus or ~~Wisconsin~~WIsconsin Medicaid paid HMO capitation fees or fee for service claims were incurred more than two months after the ~~move occurred~~member moved out of state.

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~~then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee for service

claims were incurred more than two months after the ~~move occurred~~member moved out of state.

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:

- **Applicant or member error**

  Applicant or member error occurs when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates or omits facts at application or renewal, and this results in the member receiving a benefit that they are not entitled to or more benefits than they are entitled to. This can include having lower premiums or other cost share amounts than the member should have had.

  Applicant or member error also occurs when the member, or any person responsible for giving information on the member's behalf, fails to report required changes in financial (income, expenses, etc.) (see SECTION 27.3 INCOME CHANGE REPORTING REQUIREMENTS) or nonfinancial (see SECTION 27.2 NONFINANCIAL CHANGE REPORTING) information that would have adversely affected eligibility, the benefit plan, or the premium amount.

  See SECTION 28.3.5 ELIGIBILITY AND PREMIUM DETERMINATIONS BASED ON REASONABLE COMPATIBILITY for information about when members with eligibility or premium determinations based on income that was reasonably compatible can

be subject to overpayments after failing to report required changes in financial information.

Example 3	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 January 1 that Joe was required to report by February 10. Because of the new family income, Olivia's monthly premium increased to $82. The worker entered the new income in CARES and confirmed the increase in the premium amount for December. 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~~ 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.
Example 4	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. 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:

- 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~~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~~look back 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.

28.3 Unrecoverable Overpayments

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~~then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee for service claims were incurred more than two months after the ~~move occurred~~member moved out of state.

28.3.5 Eligibility and Premium Determinations Based on Reasonable Compatibility

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and then verifies their earned income at a later date (for example, because verification is required for another program), the verified earnings must be used to determine eligibility and premium amounts. The member cannot be subject to an overpayment because the initial determination was based on income that was reasonably compatible with a data exchange.

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and subsequently fails to report a required income change, the member can only be subject to an overpayment if their new income amount is more than 20% greater than the total income amount that was used to make the eligibility or premium determination.

Example 5	Cameron is a single childless adult with an income limit of $1,132.50 for BadgerCare Plus. He applies for BadgerCare Plus in January and reports that his earnings are $1,100 per month. The monthly earned income amount reported by Equifax is $1,200 per month. Because Cameron's reported income is below the income threshold and the Equifax-reported income is above the income threshold, the 20% threshold test is applied. The income reported by Equifax ($1,200) is less than the 20% threshold amount (120% of $1,100, or $1,320), so his reported information is reasonably compatible, and he does not need to verify his earned income. In April Cameron applies for FoodShare. Cameron must provide verification of his earned income when applying for FoodShare. His

	verified earned income is $1,300, and it is discovered that he failed to report in February that his income increased to $1,300. This amount is over the BadgerCare Plus income limit of $1,132.50, so Cameron is no longer eligible for BadgerCare Plus. However, this amount is not more than 20% greater than the income amount of $1,100 that was used to determine that he was eligible for BadgerCare Plus in January. Therefore, he cannot be subject to an overpayment. The amount that is 20% greater than $1,100 is $1,320. If Cameron's income had increased to an amount greater than $1,320 and he failed to report the increase, he could have been subject to an overpayment.

29.1 Notices

A notice must be either mailed or sent electronically at least 10 days prior to 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~~ 3 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~~ 4 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.

29.1.34.1 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

29.1.4.2 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

29.2 Fair Hearings

29.2.1 Fair Hearing Request

For BadgerCare Plus and FPOS, the applicant, member, or representative may request a fair hearing in writing by filling out the Request for Fair Hearing form or writing a letter with the request and sending it to the Division of Hearings and Appeals (DHA).

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Fax (608) 264-9885

Email: DHAMail@wisconsin.gov

DHA will schedule a hearing upon receipt of the hearing request. DHA has jurisdiction to conduct hearings for BadgerCare Plus and FPOS if the request is received by DHA within 45 days of the action effective date. DHA may dismiss a request if the action being appealed is a result of a change in federal or state law or policy affecting a significant number of members, unless the member questions its application specific to their case. When a hearing request is dismissed, DHA will notify the applicant or member.

A hearing request from an applicant or member who plans to move from Wisconsin before a decision would normally be issued, such as a migrant worker, will be expedited so the applicant or member can receive a decision and any restored benefits before they leave the state.

A group of individuals may request a group hearing if individual issues of fact are not disputed and the sole issue being appealed is a ~~state,~~ federal or state law~~,~~ or policy. DHA may also consolidate several hearings on the same topic into one~~,~~ but only on questions of policy. Procedures for group hearings are the same as in individual hearings. Each applicant or member must be notified of the right to withdraw from a group hearing and pursue an individual hearing.

31.1 Interagency Transfer

A case transfer occurs when the primary person who is currently 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~~(or whose benefits have been closed for less than ~~a~~one calendar month~~.~~) reports that they have moved to a different county or tribal area. The only exception to this is protective placements (see Section 25.3.2 Intercounty Placements).

A case transfer does not impact the certification period(s) of the case members. A new application or renewal is not required when a case is transferred.

The agency to which the member reports the move must collect information about the changes, ~~for example,~~including the new residential 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 (see Chapter 9 Verification).

~~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.~~

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.

Occasionally, a BadgerCare Plus member is certified for retroactive Katie Beckett Medicaid or SSI Medicaid 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 Medicaid or SSI Medicaid certification period.

38.4 HMO Enrollment

In Wisconsin, health maintenance organization (HMO) refers to managed care organizations that contract with health care providers and facilities to provide services for BadgerCare Plus and the Medicaid for Elderly, Blind or Disabled programs.

The HMO Enrollment Specialist ~~to choose the best one for their needs. They may choose at any time during the~~is an organization under contract with DHS to provide unbiased HMO enrollment ~~process. All eligible~~counseling to BadgerCare Plus and SSI Medicaid members and outreach about enrollment choice options. The HMO Enrollment Specialist also assists members ~~of the member's family must choose the same HMO. However, individuals within a family may be eligible for~~in making an ~~exemption from enrollment.~~

~~This is the enrollment process:~~

1. ~~Members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.~~
2. ~~If the member lives in an area covered by two or more HMOs, enrollment is mandatory. In areas with only one available HMO, enrollment is voluntary and the process stops here.~~
3. ~~If the member lives in a mandatory area and does not choose and HMO, 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~~HMO selection and responds 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~~enrollment.

Note: ~~The~~This section only addresses policies ~~in this section also apply~~related to ~~members whose~~enrollment in a BadgerCare Plus ~~is suspended due to incarceration but they regain full BadgerCare Plus eligibility once they are released from jail~~HMO and does not cover enrollment in an SSI HMO or ~~prison.~~Long-Term Care Managed Care Organization (LTC MCO).

38.4.1 BadgerCare Plus HMO Enrollment

~~2 Disenrollment~~

~~Members are automatically disenrolled from the HMO program if:~~

~~Their medical status code changes to a subprogram that does not require enrollment in an HMO.~~

1. ~~They become eligible for Medicare.~~
2. ~~They lose eligibility.~~
3. ~~They move out of the HMO's service area.~~
4. ~~Their BadgerCare Plus is suspended due to incarceration in jail or prison.~~

~~Members can be disenrolled by the HMO's request if they need an experimental transplant. HMO disenrollment is not automatic in this situation.~~

~~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~~

BadgerCare Plus is a mandatory HMO enrollment program, meaning most BadgerCare Plus members are required to enroll in an HMO. All eligible BadgerCare Plus members in the same household must enroll in the same HMO. Members who are eligible for suspended BadgerCare Plus or enrolled in a long-term care managed care organization (MCO) cannot enroll in a BadgerCare Plus HMO. Certain members within a household may enroll in an HMO on a voluntary basis (see Section 38.4.1.1 Voluntary HMO Enrollment) or qualify for an exemption from HMO enrollment (SEE SECTION 38.4.5 ENROLLMENT EXEMPTIONS).

HMO enrollment always begins ~~again. If no HMO covers~~the 1st of a month. The month in which enrollment begins h depends on the time of the month when eligibility was

established or when the member's ~~new area, he or she remains~~enrollment status changed:

- If eligibility was established prior to the 10th of the month, HMO enrollment will begin the 1st of the following month.
- If eligibility was established on the 10th of the month or later, HMO enrollment will begin the 1st of the month following the next month.

Until a member's HMO enrollment has started, the member will receive their services on a fee-for-service basis, which means they can receive covered services from any BadgerCare Plus-certified provider.

If the member's enrollment status changes during the month (for example, going from being exempt from HMO enrollment to no longer being exempt), the member will be enrolled in an HMO effective the 1st of the following month.

Retroactive enrollment (backdating HMO enrollment) may be allowed in some circumstances but may also require approval from the HMO. Members who would like to request backdated enrollment should contact the HMO Enrollment Specialist. The HMO Enrollment Specialist will review retroactive enrollment backdating requests and coordinate with the HMO if necessary.

The list of Medical Status Codes under which a member is eligible for BadgerCare Plus HMO enrollment can be found on the ForwardHealth Enrollment Information page. This list does not differentiate between voluntary or mandatory HMO enrollment and is only a compilation of all Medical Status codes under which a member could be enrolled in an HMO.

38.4.~~3 Fiscal Agent Ombuds~~1.1 Voluntary HMO Enrollment

Voluntary HMO enrollment means a member is not required to enroll in an HMO but can choose to enroll in an HMO if they want to. Someone is considered voluntary for BadgerCare Plus HMO enrollment if they meet any of the following:

- The member is residing in a service area where there is only one HMO available.
- The member reports they are Native American, American Indian, an Alaskan Native, or a member of a federally recognized tribe, or has verified their tribal member status for eligibility purposes.
- The member is eligible for both BadgerCare Plus and Medicare, often referred to as a dual eligible (see Section 38.7 Impact on Dual Eligible Individuals).

If anyone within the household meets the voluntary enrollment criteria listed above, everyone in the household who is enrolled in BadgerCare Plus is considered voluntary.

38.4.2 HMO Selection and Assignment

Members can choose an HMO after they are found eligible for BadgerCare Plus. Applicants who are applying for benefits online through ACCESS can indicate an HMO preference when they submit their application. Indicating a preference does not guarantee they will be enrolled in the HMO they selected when they submitted the application, but the preference will be taken into account when assigning the member to an HMO after they become eligible for benefits. If the member did not indicate a preference when they submitted their application, an HMO will be assigned for the BadgerCare Plus household based on the primary applicant's previous enrollment in a BadgerCare Plus, if applicable, or based on a round-robin HMO assignment.

If the member was previously enrolled in a BadgerCare Plus HMO in the last 12 months, they will be assigned to the previous HMO unless they are joining a household that is already enrolled in a BadgerCare Plus HMO. If the member is joining a household that is already enrolled in a BadgerCare Plus HMO, the member will be enrolled in the same HMO as the other members of the household effective the 1st of the next month.

For members who are required to enroll in an HMO, if the member never indicated a preference to begin with, they will be assigned to an HMO and will receive an HMO enrollment packet in the mail. The enrollment packet includes a cover letter with information on their assigned HMO and start date, a BadgerCare Plus HMO Program Guide (P-12020) with a list of available HMOs and their service areas, an enrollment form, and instructions on how to choose or change an HMO.

Voluntary members will also receive an HMO enrollment packet but will not be assigned to an HMO. They will receive a cover letter explaining they are not required to enroll in an HMO but can choose one if they want to.

To select an HMO, check their current enrollment status, or make a change to their current enrollment, members can:

- Login to their ACCESS account and navigate to the "Manage My HMO" tab
- Complete and return the HMO Enrollment Choice form by mail
- Call the HMO Enrollment Specialist by phone at 1-800-291-2002

Members with questions about their rights as HMO members ~~may call 1-800-760-0001 or write:~~or concerns about the care they receive from the HMO may contact the HMO Ombuds. The HMO Ombuds can assist members in researching and resolving grievances or conflicts about their care.

HMO ~~Ombudsman~~Ombuds

P.O. Box 6470

Madison, WI ~~-~~53791-9823

Phone: 1-800-760-0001 (Monday through Friday from 8 a.m. to 4:30 p.m.)

38.4.3 Open Enrollment and Lock-in Periods

Once a member has been assigned to an HMO, they will have a three-month open enrollment period beginning from their initial HMO enrollment date in which they can change HMOs freely. After the three-month open enrollment period, the member enters a lock-in period for nine months. During the lock-in period, they cannot change HMOs or disenroll from the HMO without a qualifying reason such as an exemption or a change to an enrollment status that does not require HMO enrollment.

~~39.5 Non-Qualifying Immigrant who lose eligibility for BadgerCare Plus Prenatal~~

~~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~~Note:	~~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.~~The open enrollment and lock-in periods do not align with the 12-month eligibility certification period for BadgerCare Plus.

~~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~~1	~~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.~~Lynn applies and is found eligible for BadgerCare Plus on September 15 with a BadgerCare Plus certification period of September 1 through August 31. She is assigned to HMO A with an enrollment start date of November 1. Her open enrollment period is from

	November 1 through January 31. Her lock-in period is from February 1 through November 30.

If a member is regaining HMO enrollment after more than two months not being enrolled, the member will be assigned to their previous HMO (if they were enrolled in this HMO in the last 12 months) but will get a new open enrollment and lock-in period.

After the lock-in period has ended, the member is able to change HMOs at any time and does not need a qualifying reason to change HMOs. However, when a new HMO is selected, it will restart the open enrollment and lock-in cycle again effective with the start date of enrollment in the new HMO. If the member does not change HMOs after the lock-in period has ended, they will be reminded once every year (if they continue to be eligible for BadgerCare Plus) that they can change HMOs.

38.4.4 HMO Disenrollment

Members may be disenrolled from the HMO for a variety of reasons. Some disenrollments are automatic, meaning the disenrollment occurs based on changes to the member's eligibility or enrollment status. There are also voluntary disenrollments, which can be requested by the member, the member's family, or a legal guardian, and involuntary disenrollments, which are requested by the HMO.

38.4.4.1 Automatic Disenrollment

Automatic disenrollment occurs when there are changes to the member's eligibility or enrollment status that affect their HMO enrollment and typically occurs automatically once eligibility has been updated. The table below includes a list of automatic disenrollments and the date on which the disenrollment is effective.

Reason for Disenrollment	Disenrollment Date
Loss of BadgerCare Plus eligibility	End of the month in which the loss/termination occurred, even if that is prior to when the loss of benefits is effective.
Date of Death Entered	Date of Death
Moving outside of the HMO's service area	End of the month in which move was reported
Incarceration or Institutionalization	End of the month in which the incarceration or institutionalization was reported
Enrollment in a Waiver program or Long-Term Care MCO	End of the month prior to the month when waiver program or LTC MCO enrollment occurs
Becoming eligible for Medicare	Depending on when notification of

	Medicare eligibility was received and the Medicare eligibility start date, if the notification is received: • Prior to the Medicare eligibility start date, the disenrollment date is the end of the month in which notification was received. • After the Medicare eligibility begin date, the disenrollment date is the end of the month prior to the month of notification.

38.4.4.2 Voluntary Disenrollment

The member may voluntarily disenroll from the HMO for any reason as long as they are no longer in their lock-in period.
If the member is still in the lock-in period, he member, the member's family, or the legal guardian must request a voluntary disenrollment based on a qualifying reasons.

Qualifying reasons for voluntary disenrollments may include but are not limited to:

- A temporary loss of eligibility caused the member to miss their open enrollment period.
- The HMO does not cover the service the member seeks, due to moral or religious objections.
- If the member needs related services (for example, a cesarean section and tubal ligation) to be performed at the same time and not all related services are within the provider network and the member's primary care provider, or another provider determines the risk of receiving services separately would subject the member to unnecessary risk.
- Other reasons, including poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the member's care needs

Voluntary disenrollments are effective no later than the first day of the month following the month in which the disenrollment was requested.

38.4.4.3 Involuntary Disenrollment

The Department of Health Services may approve involuntary disenrollments with an effective date of the following month, if approved with the exception of a just cause disenrollment, which may require additional review of the effective date of disenrollment based on the circumstances.

The HMO must submit a disenrollment request to the Department and include evidence attesting to the reason. The HMO must direct all members for whom an involuntary

disenrollment request has been made to the HMO Enrollment Specialist for assistance and/or for choice counseling.

Involuntary disenrollments may include but are not limited to:

- Just Cause – A situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with medically necessary services for reasons beyond the HMO's control. An HMO cannot request just cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished capacity or uncooperative disruptive behavior resulting from the member's special needs (except when their continued enrollment in the HMO seriously impairs the HMO's ability to furnish services to the member or other members).
- The member is residing in a nursing home for longer than 30 days – The member, the nursing home or the HMO may contact the HMO Enrollment Specialist to disenroll the member from the BadgerCare Plus HMO so that nursing home services can be billed fee-for-service. Once the member is no longer residing in the nursing home, the member may be eligible for HMO enrollment.

38.4.5 Enrollment Exemptions

Members with specific needs can disenroll or opt out of HMO enrollment and receive their health care under fee-for-service if they meet the rules for an enrollment exemption. Most exemption requests must come from the member, the member's family, or the member's legal guardian. They may need to be approved by either the HMO Enrollment Specialist, an HMO Ombuds, or state Nurse Consultant. Exemptions apply to individuals, not households.

Exemptions will generally be effective the first day of the next month after the month in which the exemption was requested, unless otherwise specified. Exemption requests will not be backdated unless an exception is granted by the Department. The duration of the exemption may vary depending on the type of exemption. Members should be directed to the HMO Enrollment Specialist for assistance in requesting an exemption and/or choice counseling.

Note: The state Nurse Consultant provides consultation and technical assistance on topics related to health needs and complex care. The Nurse Consultant may need to make decisions on enrollment exemptions related to complex health care needs.

Types of Enrollment Exemptions

Exemption	Description
Admission or Enrollment in the Birth to 3 Program (BadgerCare Plus only)	The head of the household or the county Birth to 3 Program may request an exemption on behalf of the child when the

	child is enrolled in the Birth to 3 Program. Birth to 3 Program providers are encouraged to work with the member's HMO before requesting the enrollment exemption. This exemption can be backdated up to two months from the month the request is received.
Commercial Insurance or Commercial HMO Enrollment	The member is enrolled in a commercial insurance plan or commercial HMO that limits them to a restricted private network and does not align with the BadgerCare Plus provider network.
Continuity of Care	A one- to two-month continuity of care exemption may be granted when a member is newly enrolled or about to be enrolled in an HMO and has an upcoming appointment (within the next two months) with a provider with whom they have a previously established-relationship and that provider is not part of the HMO's network. If the member has more complex medical needs and requires an exemption longer than two months, the HMO Enrollment Specialist will refer the member to the State Nurse Consultant. In addition, a longer continuity of care exemption can be granted for a pregnant member who wants to see a nurse midwife/practitioner of their choosing who is not part of aa BadgerCare Plus HMO's provider network. For a pregnant member, the exemption can be applied at any time starting from the month of request through two months after the estimated due date.
Distance	This exemption may be granted for a one-to-two-month period when a member has moved out of an HMO's service area while their eligibility has not yet been updated to reflect the change in address AND the member needs immediate care in the area that is not covered by their

	current HMO.
HIPP Determination in progress or enrollment in the HIPP program	This exemption may be granted if the member is pending an eligibility determination for the HIPP program or is enrolled in the HIPP program, and the employer-sponsored insurance plan limits the member to a restricted provider network that does not align with the BadgerCare Plus HMO's provider network.
Long Term Complex Care	The state Nursing Consultant may apply this exemption for up to 12 months for individuals who have complex needs and may need specialized care outside of a member's HMO network.
Low Birth Weight	The state Nurse Consultant may apply this exemption to newborns with a low birth weight (birth weight less than 2,500 grams or 5 lbs. 8 oz.).
Native American, American Indian, Alaskan Native or member of a federally recognized Tribe	If the member attests they are a Native American, American Indian, Alaskan Native, or a member of a federally recognized tribe, they are not required to enroll in an HMO. The member can choose to remove this exemption at any time to enroll into an HMO.
Care4Kids Extension	This exemption applies to children in BadgerCare Plus who are still receiving services under the Care4Kids 12-month extension after being discharged from out-of-home care. Care4Kids is a specialized managed care program for children in out-of-home care in Kenosha, Ozaukee, Milwaukee, Racine, Washington, and Waukesha counties.
Transplants	The member had a transplant that is considered experimental such as liver, heart, lung, heart-lung, pancreas, pancreas-kidney, stem cell or bone

	marrow transplant. The member will be permanently exempted from HMO enrollment effective the first of the month in which the surgery is performed. Transplant exemption requests may be made by the HMO and directed to the state Nurse Consultant.

39.5 Non-Qualifying Immigrants No Longer Eligible for the BadgerCare Plus Prenatal Program

A non-qualifying immigrant is eligible for BadgerCare Plus Emergency Services starting the date BadgerCare Plus Prenatal Program enrollment ends due to the end of the pregnancy or any other reason other than moving out of state. These members are eligible for BadgerCare Plus Emergency Services coverage through the end of the month in which the 60th day occurs, following the member's due date or the pregnancy end date, if that is known.

Example 1	Sofia is a pregnant non-qualifying immigrant who is enrolled in the BadgerCare Plus Prenatal Program. Her expected due date is July 10. On April 5, the agency finds out that she now has access to health insurance through her employer, and the employer will pay over 80% of the premium cost. Her BadgerCare Plus Prenatal Plan enrollment ends on April 30 due to this access to health insurance. Sofia is eligible for BadgerCare Plus Emergency Services starting May 1. She gives birth on July 8. The 60th day after her pregnancy ends falls in September, so her enrollment in BadgerCare Plus Emergency Services lasts through September 30.

See Section 39.3 Emergency for Pregnant Women for information on BadgerCare Plus Emergency Services eligibility for pregnant non-qualifying immigrants who are not eligible for the BadgerCare Plus Prenatal Program.

41.1 BadgerCare Plus Prenatal Program

The BadgerCare Plus Prenatal Program provides coverage for women who otherwise meet the nonfinancial and financial eligibility requirements for BadgerCare Plus and are at least one of the following:

- ~~Meet the nonfinancial and financial eligibility requirements for BadgerCare Plus outside of incarceration or immigration status~~
- ~~Are not~~Not eligible for BadgerCare Plus because they are non-qualifying immigrants
- ~~Are inmates~~Inmates of a public institution~~. See~~ (see Section 45.8.3 Pregnant Women~~.~~).

45.8 Special Policy Considerations

45.8.4 Huber Law

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

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

This is known as the Huber Law exemption.

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

Example 2	Shannon is incarcerated in jail. During her incarceration, her 8-year-old daughter, Jada, lives with Shannon's mother. Shannon is allowed to leave jail under the Huber Law for employment. Shannon leaves jail during the day to work and then returns to jail every night. She sends part of her paycheck to her mother to help with Jada's expenses. Even though Shannon provides financial support for Jada, she is not eligible for the Huber Law exemption because her court documents do not list attending to the needs of her family as a reason for her participation in the Huber Program.
Example 3	Dennis is incarcerated in jail. During his incarceration, his 3-year-old and 5-year-old children live with his wife, Brenda. Dennis is allowed to leave jail under the Huber Law to attend school and care for his children while Brenda is at work. Dennis leaves jail during the day to attend school and return to his family's home to care for the children. Dennis is eligible for the Huber Law exemption because his court documents list attending to the needs of his family as a reason for his participation in the Huber Program.

45.8.5 Out-of-State Inmates

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

Example ~~2~~4	Oscar resides in Wisconsin. He commits a crime in Wisconsin and is incarcerated in a Wisconsin Department of Corrections facility. Due to a shortage of space, Oscar is transferred to a prison in Minnesota. Oscar remains a

	Wisconsin resident and may be eligible for suspended BadgerCare Plus while he is residing in the prison in Minnesota.

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

Example ~~3~~5	Connor resides in Wisconsin. He commits a crime in Illinois and is incarcerated in an Illinois correctional facility. Connor is an Illinois resident while he is residing in the facility in Illinois. He is not eligible for BadgerCare Plus in Wisconsin since he is not a Wisconsin resident.

45.9 State Correctional Institutions

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

Brown
Green Bay Correctional Institution (GBCI)

~~Sanger Powers Correctional Institution (SPCI)~~

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

Columbia
Columbia Correctional Institution (CCI)

Crawford
Prairie du Chien Correctional Institution (PDCI)

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

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

Douglas
Gordon Correctional Center (GCC)

Fond du Lac
~~McNaughton Correctional Center (MCC)~~

Taycheedah Correctional Institution (TCI)

Grant
Wisconsin Secure Program Facility (WSPF)

Jackson

Black River Correctional Center (BRCC)
Jackson Correctional Institution (JCI)

Juneau
New Lisbon Correctional Institution (NLCI)

Kenosha
Kenosha Correctional Center (KCC)

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

Milwaukee
Marshall E. Sherrer Correctional Center (MSCC)
~~**Kenosha**~~

~~Kenosha Correctional Center (KCC)~~

~~**Lincoln**~~

~~Copper Lake School (CLS)~~

~~Lincoln Hills School (LHS)~~

~~**Milwaukee**~~

~~Marshall E. Sherrer Correctional Center (MSCC)~~

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

Oneida
McNaughton Correctional Center (MCC)

Outagamie
Sanger Powers Correctional Institution (SPCI)

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

Sturtevant Transitional Facility (STF)

St. Croix
St. Croix Correctional Center (SCCC)

~~**Sauk**~~

~~New Lisbon Correctional Institution (NLCI)~~

Sawyer
Flambeau Correctional Center (FCC)

Sheboygan
Kettle Moraine Correctional Institution (KMCI)

Waushara
Redgranite Correctional Institution (RCI)

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