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

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

Re: **BadgerCare Plus Handbook Release 23-04**

Release Date: 12/18/2023

Effective Date: 12/18/2023

EFFECTIVE DATE		The following policy additions or changes are **effective 12/18/2023** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.2	**Continuous Coverage for Qualifying Children**	New Page. Effective 01/01/2024.
7.1	**Health Insurance Conditions of Eligibility**	Added information about continuous coverage for children. Effective 01/01/2024.
8.1	**Pregnant Members**	Clarified the description of the eligibility period. Effective 01/01/2024.
9.8	**General Rules**	Clarified the ways a person can submit verification.
9.11.4	**Negative Actions**	Added information about continuous coverage for children. Effective 01/01/2024.
11.1.2	**Foster Care Medicaid Disenrollment**	Added information about continuous coverage for children. Effective 01/01/2024.
18.1.1	**Extensions Introduction**	Added information about continuous coverage for children. Effective 01/01/2024.
18.1.3	**Children**	Added information about continuous coverage for children. Effective 01/01/2024.
18.2.1	**Earned Income Extensions**	Added information about continuous coverage for children. Effective 01/01/2024.
18.2.2	**Supplemental Security Income Exception**	Added information about continuous coverage for children. Effective 01/01/2024.
18.4	**Income Changes During the Extension**	Added references to relevant handbook sections.
19.2.1	**Premium Calculations**	Added information about continuous coverage for children. Effective 01/01/2024.
19.3	**Premium Limits**	Added information about continuous coverage for children. Effective 01/01/2024.
19.5	**Initial Payments**	Updated terms and grammar.

19.10.2	**Increased Premium Amount**	Added information about continuous coverage for children. Effective 01/01/2024.
25.5.1.1	**Signatures from Representatives**	Clarified the types of legal guardians and POA who can act on behalf of the applicant.
26.1.3.2	**Administrative Renewal Selection Criteria**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023.
26.1.3.2.1	**Exclusions During the Administrative Renewal Process**	Deleted Section. Effective 06/30/2023.
26.1.3.3.1	**Successful Administrative Renewals**	Added policy about administrative being conducted at an individual level instead of case level. Effective 06/30/2023.
26.1.3.3.2	**Unsuccessful Administrative Renewals**	Added policy about administrative being conducted at an individual level instead of case level. Effective 06/30/2023.
26.1.3.3.3	**Change Reporting After Administrative Renewal**	Added policy about administrative renewals being conducted at an individual level instead of case level. Removed obsolete information on overpayments. Effective 06/30/2023.
32.2.2	**Temporary Enrollment Within the Last 12 Months**	Clarified the start date of the 12 month period.
34.1	**Authorized Representatives**	Clarified the types of legal guardians who can act on behalf of the applicant or member.
34.2	**Legal Guardians and Conservators**	Clarified the types of legal guardians who can act on behalf of the applicant or member.
34.3	**Power of Attorney**	Clarified the types of POA who can act on behalf of the applicant or member.
39.2.1	**Determining Eligibility**	Added information about continuous coverage for children.
41.6	**Eligibility End Date**	Added information about continuous coverage for children.
43.1	**Nonfinancial Requirements**	Updated the form number for the Wisconsin Tuberculosis Record.
45.4	**Suspension End Date**	Clarified language that members can report an upcoming release date and don't have to wait until after they are released from jail or prison.
45.8.1.2	**Children Whose Parent/Caretaker is an Inmate**	Added information about continuous coverage for children.
48.1.1	**Premiums for Children**	Added information about continuous coverage for children.
49.1	**Health Care Choice**	Updated text to remove incorrect age limit on WWWMA.

Contents

1.2 Continuous Coverage for Qualifying Children

On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law. This legislation requires that children in certain Medicaid programs and the Children's Health Insurance Program (CHIP) are provided with 12 months of continuous health care coverage, with some limited exceptions, effective January 1, 2024. Continuous coverage means that the child will not lose coverage during that time period, even if the family's situation changes.

1.2.1 Continuous Coverage Period

Effective January 1, 2024, most children under age 19 enrolled in BadgerCare Plus and Medicaid programs will have 12 months of continuous coverage, starting with the month of their health care application, new certification period at renewal, or when the child otherwise becomes eligible under a qualifying group. This also applies when a new child under 19 is added to a case that already has a child with 12 months of continuous coverage.

Example 1	Jane applies for health care for her and her son Sam on January 17, 2024, with a three month backdate, and they are determined eligible for BadgerCare Plus as of October 1, 2023. Sam will have continuous coverage from January 1 through December 31, 2024. If the household has a change in circumstances during the certification period, Jane may lose coverage, but Sam will remain eligible through December 31, 2024.

Note	Backdated months do not count toward the 12-month continuous coverage period. To qualify for a 12-month continuous coverage period, a child must be eligible for the application month and/or a following month. If a child is only eligible in a backdated month, they do not qualify for a 12-month continuous coverage period

Children who are already members of an applicable health care program on January 1, 2024, will have a continuous coverage period that extends to their next renewal date.

Example 2	Juan, age 17, was enrolled in BadgerCare Plus in May 2023. He is still enrolled as of January 1, 2024, so he will have continuous coverage from January 1, 2024, to his renewal date of April 30, 2024. Even if the household reports a change and the household's income goes above the program income limit, he will remain eligible through April 30, 2024.

At renewal, a child must meet the program's eligibility requirements in order to get a new 12-month period of continuous coverage.

Example 3	Gino is 16 and has been enrolled in Medicaid since May 2020. Gino's renewal is due in March 2024. Because Gino is enrolled as of January 1, 2024, he also has continuous coverage until his renewal in March 2024. At renewal, Gino's household income is over 306% of the federal poverty level. He no longer meets program rules, so his health care benefits end March 31, 2024. He does not qualify for a new 12-month continuous coverage period.

1.2.2 Populations

Children under age 19 in the following programs are eligible for 12 months of continuous coverage:

- BadgerCare Plus
- Supplemental Security Income (SSI) Medicaid
- SSI-Related Medicaid
- Special Status Medicaid
- Institutional Medicaid
- Home and Community Based Waiver (HCBW) Medicaid
- Family Planning Only Services (FPOS)
- Medicaid Purchase Plan (MAPP)
- Foster Care Medicaid
- Wisconsin Well Woman Medicaid
- Emergency Services Medicaid
- Tuberculosis-Related Medicaid
- Katie Beckett Medicaid
- Medicare Savings Programs

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility.
- Required to meet a deductible in order to enroll in BadgerCare Plus or Medicaid.

1.2.3 Termination of Coverage

Qualifying children under 19 will only lose health care coverage during their 12-month period for the following reasons:

- The child turns 19.
- The child is no longer a resident of Wisconsin.
- The child passes away.
- The child's citizenship or immigration status is not verified within the reasonable opportunity period.
- The child was eligible as a pregnant minor, turns 19, and their postpartum period ends.
- There is a voluntary request for disenrollment from BadgerCare Plus or Medicaid.

Example 4	Allison is 17 and enrolls in BadgerCare Plus February 1, 2024. On May 12, her household reports moving to Florida. Allison's BadgerCare Plus ends May 31, 2024.

Example 5	Margaret applies for BadgerCare Plus for her son Ricardo. Ricardo is eligible, but verification of his citizenship is still needed. Ricardo is enrolled in BadgerCare Plus as of February 1, 2024, and is given a reasonable opportunity period to verify his citizenship. Ricardo's citizenship is not verified by the due date of May 10, 2024, so his BadgerCare Plus ends May 31, 2024.

1.2.4 Incarceration

If a child becomes incarcerated and their eligibility is suspended, their continuous coverage will run in the background. If they are released from incarceration within the 12-month period, they will qualify for continuous coverage for the rest of the 12-month period.

If a child's only parent or caretaker becomes incarcerated, the child will keep their health care for the rest of the 12-month period. If the child becomes eligible on another case or if they are enrolled in Foster Care Medicaid, they will get a new 12-month period of continuous coverage. SEE SECTION 1.2.8 FOSTER CARE MEDICAID.

1.2.5 Emergency Services

An immigrant child enrolled in Emergency Services qualifies for a 12-month period of continuous coverage. Their enrollment is not limited to the period their provider indicates they require treatment of an emergency medical condition.

1.2.6 Premiums

A child can have a new premium obligation at application or renewal but cannot have a new premium once their 12-month continuous coverage period starts. Existing premiums for an individual child cannot increase during their 12-month continuous coverage period, but they may be reduced if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

Example 6	Kiley and Korbin are enrolled in BadgerCare Plus as of July 1, 2024. They each owe a $20 premium, for a total household premium of $40. Their individual premiums of $20 cannot increase during their 12-month period. The household has a reduction in income in December 2024, and their premiums lower to $10 each. Their premiums now cannot go above $10 for the rest of the 12-month period. If the household has an increase in income at any point in their remaining certification period, their premiums will not increase.

Example 7	Ryan is enrolled in BadgerCare Plus with no premium. Ryan's continuous coverage period ends on October 31, 2024. In July, his family reports an increase in income that would result in a $20 premium for Ryan. This premium will only take place in the new certification period, starting on November 1, 2024.

Note	While an individual child's premium cannot increase during their 12-month continuous coverage period, there may be instances where the household's total premium amount does increase, like when another child is added to the household and that new child owes a premium.

Example 8	Emily is enrolled in BadgerCare Plus as of June 1, 2024 with a premium of $20 for a total household premium of $20. The household reports another child, Kwan, has joined the household and he is added to the case. Kwan has a premium of $20, which would bring the new household premium to $40

1.2.7 Extensions

If a child's household has an increase in income that qualifies the parents for an earned income or spousal support extension, the child will stay in their current BadgerCare Plus assistance group while their parent(s) go into the extension.

1.2.8 Foster Care Medicaid

If a child under age 19 getting Foster Care Medicaid leaves their out-of-home placement, or their Subsidized Guardianship, or Adoption Assistance agreement ends, they will keep their Foster Care Medicaid for the rest of the 12-month period, or three months after their placement or agreement ends, whichever is later.

Example 9	Trey enrolled in Foster Care Medicaid on February 1, 2024. His placement ends July 28, 2024. Trey will keep his Foster Care Medicaid until January 31, 2025, which is the remainder of the 12-month period.

Example 10	Sally enrolled in Foster Care Medicaid on January 1, 2024. Her placement ends November 13, 2024. Sally will keep her Foster Care Medicaid until February 28, 2025 so she has three months to apply for other health care coverage.

1.2.9 Transitions Between CHIP and Medicaid

During the 12-month continuous coverage period, a child may not move from a Medicaid-funded category of health care to a CHIP-funded category of BadgerCare Plus

(see section 51.1 BadgerCare Plus Categories). However, a child may move from a CHIP-funded category of BadgerCare Plus to a full-benefit Medicaid program. One exception to this is that a child may not move from a CHIP-funded category of BadgerCare Plus into an earned income or spousal support extension.

7.1 Health Insurance Conditions of Eligibility

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

~~Are children~~The following groups are subject to the policies related to employer-sponsored health insurance access and coverage:

- Children ages one~~-~~ through five~~-~~ with household incomes over 191% of the FPL ~~and children~~
- Children ages six~~-~~ through 18 with household incomes over 156% of the FPL~~,~~

~~Are pregnant~~

Note: If a child qualifies for continuous coverage, their benefits cannot be terminated during the 12-month continuous coverage period because of health insurance coverage. Their benefits can only be denied or terminated during application or renewal.

- Pregnant persons~~-~~ eligible under the BadgerCare Plus Prenatal Program at any income level~~,~~

- ~~Are not~~However, persons in ~~an exempt category (see list below) and, Do not~~these groups who have access to health insurance coverage may still be eligible if they have a good cause reason for failure to enroll in an employer-sponsored health insurance plan (see section 7.2.2 Good Cause for the Past Access Test and Section 7.3.2 Good Cause for the Current Access Test).

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

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

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

Health insurance conditions that impact eligibility include:

- Past access (see Section 7.2 Past Access to Health Insurance)
- Current access (see Section 7.3 Current Access to Health Insurance)
- Coverage (see Section 7.4 Current Health Insurance Coverage)

IM workers are not responsible for determining current or past access to health insurance. The process ~~will be~~is done through the Employer Verification of Health Insurance database (see Section 9.9.7.1 Employer Verification of Health Insurance [EVHI] Database).

Childless adults are not eligible for BadgerCare Plus if they are enrolled in any part of Medicare except Medicare Part B Immunosuppressive Drug Benefit (Part B-ID).

8.1 Pregnant Members

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

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

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

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

A pregnant member with income over 306% of the ~~FPL~~Federal Poverty Level (FPL) at the time of application when eligibility is first determined can become eligible for BadgerCare Plus by meeting a deductible (see Section 17.2 Pregnant Members).

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

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

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

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 Verifying U.S. Citizenship).
2. If information has already been verified, the applicant or member does not need to verify it again except in the following situations:
    a. There is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made (see Section 9.10 Questionable Items).
    b. The member reported a change to information that is subject to mandatory verification rules or is questionable.
    c. At renewal, information is subject to mandatory verification rules or is questionable.
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 in person, by mail, fax, e-mail, or electronically through ~~another electronic device~~ACCESS or ~~through an authorized representative~~the MyACCESS mobile app. Verification is not required to be presented in person.
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~~can't be required for information that is not used to determine eligibility ~~can't be required~~.
8. During verification, 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 Eligibility for Parent or Caretaker Relative of Child Removed from Home), 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 based on the new information. The agency must explain this to the applicant or member when requesting verification.

9.11 Processing Timeframe

9.11.4 Negative Actions

Deny or reduce benefits when all of the following are true:

- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- ~~You need the~~The requested verification is required to determine current eligibility. ~~Do not deny current~~Current eligibility ~~because an applicant or member does not verify some~~cannot be denied for lack of verification of a past circumstance that does not ~~affecting~~affect current eligibility.
- The member is not a child in a continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

Note	Do not deny or terminate eligibility for failure to verify information that the member is not responsible to obtain, such as employer-sponsored health insurance (see Section 9.9.7 Access to Employer-Sponsored Health Insurance), Child Welfare parent cooperation (see Section 10.1 Eligibility for Parent or Caretaker Relative of Child Removed from Home), and former Foster Care status (see Section 11.2 Former Foster Care Youth). Do not deny or terminate eligibility for failure to verify medical expenses (see Section 9.9.4 Medical Expenses) and deductions (see Section 9.9.9 Pretax Deductions and Section 9.9.10 MAGI Tax Deductions). The disallowance of unverified expenses and deductions is the only penalty to be imposed. Do not deny or terminate eligibility for failure to verify tribal member status (see Section 9.9.8 Tribal Membership, Descent, or Eligible to Receive Indian Health Services).

11.1 Out-of-Home Care (Foster Care)

11.1.2 Foster Care Medicaid Disenrollment

~~When a child or youth is discharged from out-of-home care~~When a child getting Foster Care Medicaid leaves their out-of-home placement, or their Subsidized Guardianship or Adoption Assistance agreement ends, they will remain eligible under Foster Care Medicaid for the rest of their 12-month period, or three months after their placement or agreement ends, whichever is later.

If a youth ages out, is discharged, or their agreement ends, and the youth already is or will turn 19 during the 12-month continuous coverage period, their Foster Care Medicaid will end at the end of the month they turn 19 or three months after they age out, are discharged, or their agreement ended, whichever is later.

After a child leaves their out-of-home placement or their Subsidized Guardianship, or their Adoption Assistance agreement ends, Foster Care Medicaid eligibility must be maintained until one of the following occurs:

- The child or youth is determined eligible for another category of Medicaid or BadgerCare Plus.
- The child or youth is determined ineligible for all categories of Medicaid and BadgerCare Plus.
- The child, youth, or family failed to provide the required information to complete an eligibility determination or chooses not to pursue other Medicaid benefits.
- The child or youth dies or leaves Wisconsin.

When the child or youth is discharged from out-of-home care, ~~the child welfare agency will extend~~ or their Subsidized Guardianship or Adoption Assistance agreement ends the IM agency~~Foster Care Medicaid eligibility under the Foster Care medical status code for an additional three months. During this time, IM agencies~~ must redetermine the child or youth's health care eligibility with assistance from the child welfare agencies, when needed. The IM agency should set up a formal communication process with the child welfare agency to ensure IM agencies are made aware of all children leaving the Foster Care system, and provided with information necessary to redetermine eligibility. To prevent children from losing eligibility entirely, the Department of Health Services and Department of Children and Families have set up a process to send communication to families or share information with the IM agency. See Process Help, Section 9.6 Youths Discharged from Out-of-home Care and Updated All FFYC Processes for more information.

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

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

If the child or youth has not obtained other full benefits health care coverage, the state will send notice of Foster Care Medicaid ending approximately three months in advance, but at least 10 days before the Foster Care Medicaid end date.

18.1 Extensions

18.1.1 Introduction

A BadgerCare Plus extension is a period of eligibility given to a person when the assistance group's (AGs) monthly income increases above 100% FPL either due to an increase in earned income, spousal support, or both, and otherwise meets the BadgerCare Plus eligibility criteria for people with monthly incomes below 100% FPL.

A parent/caretaker relative or pregnant person can enter an extension due to a monthly income increase above 100% FPL in the AG's earned income, spousal support, or both. The children, stepchildren, and non-legally responsible relative (NLRR) children of the parent/caretaker ~~will~~may also enter the extension at this time, provided they are under age 19, living with the parent/caretakers, and meet the income requirements (see SECTION 18.1.3 CHILDREN). If the child is in their 12-month continuous coverage period, the child will stay in their current BadgerCare Plus assistance group while their parent(s) enter the extension. The child's BadgerCare Plus and the parent's extension renewal dates will align.

BadgerCare Plus members eligible as childless adults are not eligible for an extension. BadgerCare Plus members eligible based on annual income, known as gap filling, are not eligible for an extension.

If a family is moving out of the State of Wisconsin at the time of the income increase, they would not be eligible for the extension.

In late renewal situations, the renewal must have been submitted in the month the renewal is due in order for the family to be eligible for the extension.

If all members of the household are eligible for an extension, verification of income is not required. If a member of the household is eligible for BadgerCare Plus but not in an extension, the household may be required to provide verification of income for determining that person's BadgerCare Plus eligibility. If verification is not provided timely, it will not impact the other members' eligibility in a BadgerCare Plus extension.

Example 1	The Brown family's health care renewal is due July 31. The renewal is submitted to the agency on July 31. The agency processes the renewal on August 7. The agency determines that the Brown family's monthly income is now over 100% of the FPL and no financial verification is required since all members of the family meet the criteria to be eligible under a BadgerCare Plus extension. The Brown family enters into an extension starting August 1.
Example 2	The Williams family's health care renewal is due July 31. The renewal is submitted on August 9. They are not eligible for an extension.
Example 3	Janine and her son, Zachary, are open for BadgerCare Plus under an extension, and her daughter, Amy, is open for regular BadgerCare Plus (not an extension). Janine reports an increase in income. She will be required to verify her new

	income since her income is counted when determining Amy's BadgerCare Plus eligibility.

While on the extension, children are not subject to the health insurance access and coverage requirements. See SECTION 7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY for the full list of people exempt from the policies related to health insurance access and coverage requirements.

~~Example 4~~	~~Kevin and his children, 8-year-old Bianca and 12-year-old Tori, are open for regular BadgerCare Plus with monthly income at 80% of the FPL. Kevin reports an increase in income due to moving to a full-time job position. He also reports that he and his children are now enrolled in an employer-sponsored health insurance plan through his job. This earned income increases the household's monthly income to 175% of the FPL, and Kevin and his children enter into an extension. Since children in an extension are not subject to the health insurance access and coverage requirements, Bianca and Tori can enter into the extension, even though children ages 6 through 18 with household income over 156% of the FPL are generally subject to these requirements.~~

18.1.3 Children

If the child is in their 12-month continuous coverage period, the child will stay in their current BadgerCare Plus assistance group while their parent(s) enter the extension. The child's BadgerCare Plus and the parent's extension renewal dates will align.

Under most circumstances, the end of an extension will apply to all of the members of the BadgerCare Plus Test group. However, when the household income decreases to 100 percent FPL or less, the extension will end for the parent(s), but any children would remain in the extension. All dependent children, stepchildren, and NLRR children whose parent or caretaker ~~becomes~~ may become eligible for an extension will be eligible for the same extension provided that they are eligible for BadgerCare Plus in the month prior to the start of the extension and:

- Have AG income under 306% FPL and are under age one
- Have AG income under 191% FPL and are age one through age five
- Have AG income under 156% FPL and are age six through age 18

Conditions:

1. Children do not have to be eligible for BadgerCare Plus for three of the past six months.
2. The child's AG income does not have to be below 100% FPL at the time the extension starts.
3. CENs are not eligible for extensions.
4. A child who is currently in an extension is not eligible for a new extension.
5. If a parent's income decreases below 100% FPL, the child's extension continues.

6. Once a child is in an extension, the child does not lose the extension for any reason except for death, moving out of Wisconsin, or turning 19 while in an earned income extension.

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

18.2 Increase in Earnings Extensions

18.2.1 Earned Income Extensions

To receive a 12-month BadgerCare Plus extension due to an increase in earnings, a parent, caretaker, or pregnant person must meet all of the following requirements:

1. The monthly income increase which caused the countable income for their BadgerCare Plus assistance group (AG) to exceed 100% FPL must be due solely to one of the following:
    a. Increased earnings (of anyone in the same AG).
    b. Increased earnings along with other income (changed or unchanged).
2. They must be a BadgerCare Plus member with monthly income at or below 100% FPL at the time the income increased to over 100% FPL.
3. They must have been enrolled in BadgerCare Plus with monthly income that was at or below 100% FPL for at least three of the six months immediately preceding the month in which the income went above 100% FPL.
4. They must otherwise meet the BadgerCare Plus eligibility criteria for persons with monthly income below 100% FPL.
5. They must not be eligible as a Former Foster Care Youth.

Note	These requirements do not apply to children (see SECTION 18.1.3 CHILDREN).

Example 1	Jane lives with her two teenage children and Dave, the non-marital co-parent of the two children. Jane is claiming both children on her taxes and her monthly income for her MAGA AG of three is 90% FPL. Dave's MAGA AG consists only of himself, and he is eligible for BadgerCare Plus with monthly income of 95% FPL. The children-in-common are eligible in a MAGC AG group of four, with both parents as counted adults in their AG and their group's monthly income is 121% FPL. Jane was enrolled in BadgerCare Plus with income below 100% FPL for three of the prior six months. In June, her earned monthly income increased to 120% FPL. She is eligible for a 12-month BadgerCare Plus extension. Dave is not included in the extension because he was not a counted member of Jane's AG. The children are eligible for a 12-month extension because they were eligible in June when Jane's monthly income rose above 100% and their own AG's monthly income was below 156% FPL at the time. The children will remain in their current BadgerCare Plus AG under continuous coverage for children, but their renewal date will align with Jane's extension renewal date.

18.2.2 Supplemental Security Income Exception

A person who was eligible for SSI benefits may be eligible for a 12-month BadgerCare Plus extension if they lose SSI and would have been eligible for BadgerCare Plus with countable monthly income at or below 100% if they had not been an SSI recipient.

Example ~~1~~2	Mary is receiving SSI. Her two children are enrolled in BadgerCare Plus with countable monthly income at or below 100% FPL. Mary started a job and her earnings put her above the SSI income limit. Her earned income also caused the BadgerCare Plus countable monthly income to exceed 100% FPL. Both Mary and her two children are eligible for a 12-month BadgerCare Plus extension. The children will remain in their current BadgerCare Plus AG under continuous coverage for children, but their renewal date will be extended to the end of the extension period.

18.4 Income Changes During the Extension

During an extension, a group or person's monthly income may decrease to an amount at or below 100% ~~FPL~~Federal Poverty Level (FPL) for the group size and then increase again to exceed the 100% FPL. When the monthly income decreases, the person will be removed from the extension and placed in regular BadgerCare Plus. The remaining months of the extension will continue to run in the background. Verification of the monthly income decrease to at or below 100% FPL is required in order to make the person eligible in regular BadgerCare Plus. If income verification is not provided, the person will remain in the extension for the remaining months.

If the person's countable monthly income again increases above the 100% FPL, they would be eligible under the previous extension for any remaining months. If the person is eligible for a new extension when the monthly income again increases, because they meet ~~all of the criteria above,~~ all of the criteria (see SECTION 18.2 INCREASE IN EARNINGS EXTENSIONS and section 18.3 Increase in Spousal Support or Family Support Income Extensions), the person will enter into the new extension.

Example 1	A BadgerCare Plus group with a 12-month extension from January through December has a monthly decrease in income in February that puts them back below 100% FPL. The group provides pay stubs to verify the decrease in income. The extension continues to run while the group is on regular BadgerCare Plus. In October the group's countable monthly income again increases to above 100% FPL, this time due to an increase in spousal support income. They are now eligible for a four-month spousal support extension, which would run from November through February. Since the four-month extension would be longer than the current extension, the new four-month extension applies.

19.2 Premium Calculations

19.2.1 Premium Calculations

Premiums are initially calculated on an individual basis and then a total for the case is determined. The general rules for calculating the premium amounts are explained below.

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

Effective January 1, 2024, a child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

19.3 Premium Limits

Children in an assistance group with income above 201% of the Federal Poverty Level (FPL) are required to pay premiums. The total premium for the household is the total of the individual premiums for all children in the household, not to exceed a 5% cap. The cap is 5% of the income of the assistance group (AG) with the highest income (in terms of dollar amount) in the case.

Example 1

Susan and Alan are non-marital co-parents caring for four children: Susan's son, Aaron (15); Alan's daughters Rachel (12) and Hannah (11); and Susan and Alan's son Jacob (9). Alan claims Rachel and Hannah as his two tax dependents, while Susan claims Aaron and Jacob. Susan earns $2,500 per month as a waitress, and Alan earns $4,500 per month as a computer analyst. None of the children have income. All four children are eligible for BadgerCare Plus.

Child	MAGI Group Formation	Assistance Group Income Amount	FPL	Premium Amount
Aaron	Susan, Aaron, and Jacob	$2,500	121%	$0
Rachel	Alan, Rachel, and Hannah	$4,500	217%	$10
Hannah	Alan, Rachel, and Hannah	$4,500	217%	$10
Jacob	Susan, Alan, Aaron, Rachel, Hannah, and Jacob	$7,000	209%	$10

Aaron does not have a premium. Rachel, Hannah, and Jacob each have a $10 premium. Jacob's MAGI group has the greatest income, so this group determines the 5% cap. The maximum premium for this group is 5% of $7,000 per month, or $350 per month. Altogether, the household's monthly premiums are $30. The household will pay $30 in premiums for their children's coverage.

Effective January 1, 2024, a child cannot be charged a new or increased premium during their 12-month continuous coverage period, so if an AG's income increases from at or below 201% to above 201% FPL during their 12-month continuous coverage period, they will not be required to pay a premium.

19.5 Initial Payments

Payment of the BadgerCare Plus premium is a non-financial condition of eligibility. Initial premium payments must be made before eligibility is confirmed and the members are enrolled. The first month is free if no one in the BadgerCare Plus group was eligible for BadgerCare Plus or Medicaid in the previous month, and the BadgerCare Plus assistance group (AG) has not received a free month in the previous 12 months. Consider someone with an unmet deductible as not being eligible for BadgerCare Plus. Free months occur at application and when members reopen after serving ~~an RRP~~a Restrictive Re-enrollment Period (RRP) (and not reinstating during the RRP) and no one was on BadgerCare Plus in the previous month or received a free month in the last 12 months.

The eligibility policy and time frame procedures for premium payments are as follows:

1. Initial eligibility date and confirmation occur in the month of application.
   When an application is processed in the same month it was received, and a premium for the initial month of eligibility is not due because they are eligible for a free month, the premium for the second month of eligibility must be paid in advance before a family can be enrolled in BadgerCare Plus.

Example 1	Lisa and her family applied for BadgerCare Plus on January 25. On January 31, the worker determined that the family met eligibility requirements effective January 1. Since the family had not been previously eligible for BadgerCare Plus, a premium for January was not assessed since they were eligible for the free month. However, Lisa had to pay the February premium for her family before their eligibility could be confirmed.

2. Eligibility begins in the month of application~~ – confirmation~~. Confirmation occurs in a future month.
   When an application is not processed within the 30-day application processing period and the family is eligible for a free month, the family must pay both the second- and third-months' premium before enrollment. CARES requires that premiums for both the second and third months be paid before confirmation when eligibility is processed any time in the third month.

Example 2	Cheryl and her family applied for BadgerCare Plus on March 25. No one in her family was eligible for BadgerCare Plus in the previous month. At Cheryl's request, the IM worker extended the 30-day processing time period by ~~ten~~10 days for additional verification. The application for BadgerCare Plus was processed on May 2, but the family was determined eligible effective March 1. A premium is not due for March because it is a free month. However, Cheryl had to pay the premium amount for April and May before BadgerCare Plus eligibility could be confirmed.

3. Eligibility begins in a future month, but application is processed in the month of application.

   When an application is processed within 30 days but eligibility does not begin until a future month, the free month is the first future month of eligibility. The

family will receive an invoice for the premium amount through the mail. They must pay the premium due for the second month by the 10th of the benefit month to remain eligible for BadgerCare Plus.

Example 3	Arnie and his family applied for BadgerCare Plus on April 12. He and his family were determined to be eligible for BadgerCare Plus beginning May 1. A premium is not assessed for May. A coupon for Arnie's June premium was mailed on May 20 with payment due by June 10.

19.10 Premium Changes

19.10.2 Increased Premium Amount

~~A 10-day notice must be given to the member when the group is required to pay a premium for the first time or is required to pay a higher premium. The increase is effective the following month if BadgerCare Plus eligibility is confirmed before adverse action. If the change is confirmed after adverse action, the increase is not effective until the month after the following month.~~

~~Example 1~~	~~Jessica has BadgerCare Plus with a premium for her and her family. She reports a change in income to her worker on April 23 that results in a higher premium amount. Jessica's premium amount will increase effective June 1. She will receive the coupon for the new premium amount at the end of May.~~

Effective January 1, 2024, a child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

If a new child with a premium is added to a case, a household may have an increase in its total premium amount, but an individual child cannot have an increase in premium during the 12-month period.

25.5 Valid Signature

25.5.1 Valid Signature Introduction

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, the IM agency must 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 the applicant's behalf.

When someone has been designated as one of the following, only the guardian, not the applicant, may sign the application or appoint an authorized representative:

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

3. Guardian of the person and the court document appointing the legal guardian of the person specifically grants the guardian the authority to enroll their ward in BadgerCare Plus, Medicaid, or public assistance programs.

If the applicant only has a ~~legal **guardian of the person**~~**guardian of the person**, and the applicant's guardian does not have the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs, the guardian may sign the application since they are acting responsibly for an incompetent or incapacitated person. However, a ~~legal~~ guardian of the person ~~can't~~ who does not have the authority to enroll the person in Medicaid or public assistance programs cannot appoint an authorized representative. The applicant must be the one to appoint an authorized representative if they choose to have one.

The applicant 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.

The conservator is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has a conservator, the applicant can still sign the application on their own behalf.

3. Authorized Representative

The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see SECTION 34.1 AUTHORIZED REPRESENTATIVES). 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 (Person F-10126A or Organization F-10126B). When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

The authorized representative is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has an authorized representative, the applicant can still sign the application on their own behalf.

4. Durable Power of Attorney for Finances (Wis. Stat. ch. 244)

A durable power of attorney for finances 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. Only ~~a~~an activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for the purposes of providing a valid signature on the application.

When a submitted application is signed by someone claiming to be the applicant's activated durable power of attorney for finances, 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 for finances.
2. Review the document for a reference that indicates the power of attorney for finances authority continues notwithstanding any subsequent disability or incapacity of the applicant.

Do not consider the application properly signed unless both of the above conditions are met. An individual's activated durable power of attorney for finances may appoint an authorized representative for purposes of making a health care application if authorized on the Durable Power of Attorney for Finances form (F-00036).

The Durable Power of Attorney for Finances form will specify what authority is granted. The appointment of a durable power of attorney for finances does not prevent an applicant from filing their own application for BadgerCare Plus, nor does it prevent the

applicant from granting authority to someone else to apply for public assistance on their behalf.

5. Someone acting responsibly for an incompetent or incapacitated person

Example 1	Carl is in a coma in the hospital. Marco, a nurse who works at the hospital, can apply for health care on Carl’s behalf.

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

7. A warden or 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 superintendent of a county psychiatric institution

The superintendent of 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 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.

26.1 Renewals

26.1.3 Administrative Renewals

26.1.3.2 Administrative Renewal Selection Criteria ~~and Exclusions~~

To be considered for an administrative renewal, a ~~case~~member must be due for renewal in the following month and have eligibility in one or more qualifying BadgerCare Plus, Family Planning Only Services (FPOS~~,~~), or Elderly, Blind, or Disabled (EBD) Medicaid assistance groups (AGs) open, including ~~health care assistance groups~~ members open with a suspended status.

~~BadgerCare Plus and FPOS~~ A member's health care eligibility can be administratively renewed if all ~~members on~~of the ~~case have:~~

~~Only income that~~information necessary to determine the member's eligibility is on file and can be verified through a data exchange (for example, income with a SWICA match or Equifax match through ~~the~~ FDSH~~), or only~~, Social Security ~~or~~income, Unemployment income).

- ~~No tax deductions on file~~

~~BadgerCare Plus and FPOS cannot be~~Some members in a household may have their eligibility administratively renewed ~~if any~~while other members ~~on the case have or are:~~

- ~~Income or deductions that cannot be verified through a data exchange (for example, self-employment, in-kind income, or financial aid if ending~~ in the ~~current month or up to two months into the future)~~
- ~~Tax deductions on file~~
- ~~An unverified or missing SSN~~
- ~~An unresolved discrepancy~~
- ~~An expired immigration status~~

~~BadgerCare Plus Extension due for~~household must complete a regular renewal to continue their eligibility.

- ~~Deductibles~~
- ~~Pregnant women whose due date is in or before the renewal month~~
- ~~Former Foster Care Youth turning 26 years old~~
- ~~Continuously Eligible Newborns (CENs) turning 13 months old~~
- ~~Persons turning 19 or 65 years old~~

~~Additionally, BadgerCare Plus cannot be administratively renewed if any members on the case have or are calendar year tax dependent(s) for a past year.~~

~~BadgerCare Plus and FPOS also cannot be administratively renewed if anyone on the case is receiving EBD Medicaid, Medicaid Purchase Plan (MAPP), or Medicare Savings Program (MSP) benefits and has any of the exclusions for those programs, found in the~~

~~Medicaid Eligibility Handbook, Section 3.1.5.2 Administrative Renewal Selection Criteria and Exclusions.~~

~~26.1.3.2.1 Exclusions During the Administrative Renewal Process~~

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

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

26.1.3.3 Administrative Renewal Process

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

26.1.3.3.1 Successful Administrative Renewals

~~Cases that~~Members who have a successful administrative renewal will have health care or FPOS eligibility redetermined and will be recertified for a new 12-month certification period~~. The member~~ and will receive a notice of decision.

If all members in the household can be administratively renewed, they will be sent a letter notifying them that their eligibility has been renewed, along with a case summary. The member(s) must review the information on the case summary and report if any of the information is incorrect within 30 days of the mailing date. The member(s) can make the changes on the summary and mail or fax it to their agency, or they can report their changes through ACCESS or by phone. If all of the information on the case summary is correct, the member(s) will not need to take any other action~~. The member will be sent a Notice of Decision~~.

If any members of the household cannot be administratively renewed, the household will be sent a renewal letter and a pre-printed renewal form. If the household does not complete this renewal process, then only the members who were administratively renewed will continue to be eligible in the next 12-month certification period.

26.1.3.3.2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from

SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the ~~case~~member will be excluded from the administrative renewal process, and ~~the member~~they will be sent a 45-day renewal letter and a Pre-Printed Renewal Form (PPRF~~.~~). The member will have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS.

26.1.3.3.3 Change Reporting After Administrative Renewal

~~Cases that~~Members who have a successful administrative renewal remain subject to change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the information provided in the attached case summary~~ and informs them of the potential consequences for not reporting those changes. If a member does not correct information that is wrong and gets benefits that they should not get, the member is liable for any resulting overpayments.~~. In addition, ~~administrative renewal cases~~members who are administratively renewed will receive a Notice of Decision that identifies program-specific change reporting requirements~~, as well as the potential consequences for not reporting changes timely.~~. Changes reported for a ~~case that~~member who has undergone an administrative renewal should be processed under existing policy.

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

32.2 Eligibility

32.2.2 Temporary Enrollment Within the Last 12 Months

An applicant may only be temporarily enrolled once in a rolling 12-month period, or once per pregnancy.- The 12-month period starts the first day of the presumptive eligibility (PE) period.

Example 1	David is determined presumptively eligible for Family Planning Only Services (FPOS) on January 14. He cannot enroll again in presumptive eligibility for FPOS for 12 months after January 14.

Table 2 describes the situations where this applies.

Table 2: Temporary Enrollment Within the Last 12 Months

Applicant was temporarily enrolled in:	Applicant is applying for temporary enrollment in BadgerCare Plus (non-pregnant members):	Applicant is applying for temporary enrollment in BadgerCare Plus (pregnant members):	Applicant is applying for temporary enrollment in Family Planning Only Services:
BadgerCare Plus (non-pregnant members)	Deny temporary enrollment	Allow temporary enrollment*	Allow temporary enrollment*
BadgerCare Plus (pregnant members)	Deny temporary enrollment	Allow temporary enrollment* as long as the previous temporary enrollment was not for the same pregnancy	Allow temporary enrollment*
Family Planning Only Services	Allow temporary enrollment*	Allow temporary enrollment*	Deny temporary enrollment
No programs	Allow temporary enrollment*	Allow temporary enrollment*	Allow temporary enrollment*

*If all other temporary enrollment criteria are met

34.1 Authorized Representatives

Applicants or members can appoint either an individual or an organization as authorized representative. An authorized representative can be appointed through any of the following means:

- ACCESS, when applying
- Federally Facilitated Marketplace (Note: When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.)
- Paper form (signed in writing or electronically):
    - Appoint, Change, or Remove an Authorized Representative: Person (F-10126A)
    - Appoint, Change, or Remove an Authorized Representative: Organization (F-10126B)

If an applicant or member is represented by a ~~legal~~ guardian of the person and the estate, ~~legal~~ guardian of the estate, ~~legal guardian in general,~~ or conservator, the ~~legal~~ guardian or conservator must appoint the authorized representative. A guardian of the person can appoint the authorized representative only if the court document appointing the guardian of the person grants them the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs.

If the applicant or member only has a ~~legal guardian of the person~~**guardian of the person**, and the applicant's guardian does not have the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs, the applicant or member must appoint the ~~legal~~ guardian of the person as an authorized representative if the applicant or member would like the ~~legal~~ guardian of the person to act on their behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an "X," a valid appointment requires two witness signatures. If any of the required signatures are missing, the following three conditions apply:

- The authorized representative appointment is not valid.
- This authorized representative cannot take action on behalf of the applicant or member.
- The agency cannot disclose information about the case to the invalid authorized representative.

For other valid signature requirements, refer to SECTION 25.5 VALID SIGNATURE.

There can only be one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The

appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new Appoint, Change or Remove Authorized Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- Apply for or renew benefits
- Report changes in the applicant or member's circumstances or demographic information
- Receive copies of the applicant or member's notices and other communications from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant or member's eligibility

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form to their IM agency. To remove an authorized representative, the member needs to let the agency know of the removal in writing, for example completing Section 1 of the Appoint, Change, or Remove an Authorized Representative form or submitting a signed letter indicating the removal. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

Example 1	Penny is due for renewal of her BadgerCare Plus benefits on August 31. In July, she receives her case summary as part of the administrative renewal process. Penny's case summary lists her mom, Darlene, as her authorized representative. Penny no longer wants Darlene to be her authorized representative. Penny crosses out the authorized representative information on the case summary, signs it, and mails it to the IM agency. The IM agency receives the case summary on August 3. Based on Penny's handwritten update on the case summary, the IM agency removes Darlene as Penny's authorized representative effective on August 3.

34.2 Legal Guardians and Conservators

Persons or interested parties may petition a court to appoint a guardian or conservator. There are a variety of reasons that an appointment may be sought including but not limited to:

- Inability to manage finances
- Inability to manage personal health
- Inability to function safely without supervision
- Parent or guardian of minor is now deceased

Some of these appointments might be an emergency or temporary reason or for the purposes of succession after the death of the previous guardian or conservator.

A judge grants the guardian or conservator powers based on the circumstances of the person. A ~~legal~~ guardian of the person and the estate~~, legal~~ or a guardian of the estate~~, or legal guardian in general~~ is considered to be the applicant or member's ~~legal~~ guardian for BadgerCare Plus purposes. A guardian of the person is the applicant's or member's guardian for BadgerCare Plus purposes if the court document appointing the legal guardian of the person grants them the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs.

If a person or entity is one of these ~~legal~~ guardian types, or the conservator, the applicant or member does not need to separately appoint them as the authorized representative. The legal guardian or conservator appointment grants them the powers that an authorized representative would have on the BadgerCare Plus case.

~~A person or entity with~~If the court document appointing the guardian ~~type **legal guardian** ~~ of the person ~~is~~does not ~~considered~~grant the authority to ~~be~~enroll the applicant or ~~member's legal guardian for~~member in BadgerCare Plus~~ purposes. The~~, Medicaid, or public assistance programs, the applicant or member must appoint the ~~legal~~ guardian of the person as an authorized representative if the applicant or member would like the ~~legal~~ guardian of the person to act on their behalf.

Depending on their court-appointed powers, a guardian or conservator can apply for and act in the same capacity as an authorized representative for the household. It is possible the court-appointed powers will give the guardian or conservator sole authority to manage the person's eligibility.

The ~~legal~~ guardian or conservator should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The ~~legal~~ guardian or conservator can take any action on the application or case on behalf of the applicant or member~~,~~ unless the guardianship or conservatorship court order limits their powers.

Applicant and member notices and other communications from the agency will be sent to the ~~legal~~ guardian or conservator.

See Section 9.9.5 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See SECTION 25.5 VALID SIGNATURE for information on valid application signatures by ~~legal~~ guardians or conservators.

34.3 Power of Attorney

A person may appoint a power of attorney. A power of attorney may act within the scope of authority granted in the power of attorney appointment.

A durable power of attorney for finances 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. Only ~~a~~an activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for BadgerCare Plus purposes.

If a person has ~~a~~an activated durable power of attorney for finances, the applicant or member does not need to separately appoint them as an authorized representative. The durable power of attorney for finances appointment grants them the powers that an authorized representative would have on the BadgerCare Plus case.

The durable power of attorney for finances should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The durable power of attorney for finances can take any action on the application or case on behalf of the applicant or member unless the power of attorney appointment limits their powers.

See Section 9.9.5 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See SECTION 25.5 VALID SIGNATURE for information on valid application signatures by a power of attorney.

39.2 Determining if an Emergency Exists

39.2.1 Determining Eligibility

It is the IM agency's responsibility to manually determine if the non-qualifying immigrant meets all eligibility requirements during the dates of service and to certify if they are eligible for Emergency Services.

Medicaid providers who have treated non-US citizens for emergency services can provide them the Certification of Emergency for Non-U.S. Citizens form (F-01162) to verify that the services provided were to treat an emergency medical condition. Providers are instructed to have the patient present this to the local IM agency when applying for assistance.

Note	The Certification of Emergency for Non-U.S. Citizens form is not required to certify Emergency Services eligibility.

If a non-qualifying immigrant provides a "Certification of Emergency for Non-U.S. Citizens" at the time of application, their eligibility for BadgerCare Plus Emergency Services is determined for the dates of the emergency indicated on the form. A child under age 19 must remain eligible for 12 months.

If a non-qualifying immigrant does not have the form at the time of application, ask them for the dates that they received emergency services.

Emergency Services coverage begins at the time of the first treatment for the emergency and ends when the condition is no longer an emergency for adults or the end of a 12-month period for children under age 19.

Determine eligibility of a pregnant immigrant on the date emergency services were provided. The pregnancy due date is required to determine eligibility for pregnant immigrants (see Section 39.3 Emergency for Pregnant Members).

If a non-qualifying immigrant would only qualify for BadgerCare Plus if they were disabled, follow disability determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

Certification of Emergency Services is not done through CARES and must be done manually. However, all applications should be processed through CARES to determine BadgerCare Plus eligibility. If the immigrant does not have an SSN, CARES will assign a pseudo SSN. That pseudo SSN should be used when submitting the manual certification. When an immigrant is determined eligible for Emergency Services, complete and submit a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) (see Process Help, Section 81.1.3 F10110 Manual Form). The fiscal agent needs a beginning and end date to process eligibility. In setting the end date,

- For adults, use the last day of the emergency.
- For children under age 19, use the end of a 12-month period.

- For a child who is turning 19 in the next 12-month period, use the last day of the emergency or the last day of the month the child turns 19, whichever is later.

If ~~that~~ the last day of the emergency is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

Note	The Federally Facilitated Marketplace will send accounts to state consortia and tribal agencies for individuals who have been assessed as potentially eligible for BadgerCare Plus Emergency Services.

Submit completed Medicaid/BadgerCare Plus Eligibility Certification forms by fax to 608-221-8815 or by mail to:

ForwardHealth

Eligibility Unit

P.O. Box 7636

Madison, WI 53707-7636

An individual eligible for BadgerCare Plus Emergency Services will not receive a ForwardHealth card because BadgerCare Plus Emergency Services eligibility ends when the emergency ends.

However, women determined eligible for the BadgerCare Plus Prenatal Program will be issued a ForwardHealth Card, which can also be used to access emergency services under the Emergency Services coverage group after the BadgerCare Plus Prenatal Program coverage ends.

41.6 Eligibility End Date

BadgerCare Plus Prenatal Program eligibility ends when the pregnancy ends. Benefits will continue through the end of the month following timely notice requirements.

Non-qualifying immigrants who lose eligibility for the BadgerCare Plus Prenatal Program when their pregnancy ends, for any reason other than moving out of state, are eligible for Emergency Services ~~from the time~~after they lose BadgerCare Plus Prenatal Program eligibility (see Chapter 39.5 Non-Qualifying Immigrants No Longer Eligible for the BadgerCare Plus Prenatal Program).

When the pregnancy ends, CARES will automatically send ForwardHealth an emergency services certification through the end of the month in which the 60th day occurs for adults, or 12 months for children under age 19.

43.1 Nonfinancial Requirements

~~Adults~~Individuals who are infected with tuberculosis (TB) and who are not otherwise eligible for full benefit BadgerCare Plus or Medicaid may be eligible for Tuberculosis (TB)-related Medicaid, a special category of Medicaid.

"Infected with TB" means that a physician has examined them and found that one or more of the following diagnoses apply to them:

- They are infected with latent or active TB.
- They have a positive TB skin test.
- They have a negative TB skin test but a positive sputum culture for the TB organism.
- They have a negative test for TB, but a physician certifies that they require TB-related drug therapy, surgical therapy, or both.
- A physician certifies that they require testing to confirm the presence or absence of TB.

~~A member's~~An individual's statement that they have one or more of the above conditions should be accepted unless the information provided is questionable (see Section 9.10 Questionable Items). If questionable, accept any of the following as verification:

- A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.
- Wisconsin Tuberculosis Record (Form ~~DPH 4756~~P-03429). This card identifies the person and the physician's diagnosis and has the name and telephone number of the treatment provider.

To be eligible for TB-Related Medicaid, a person must also meet the following criteria:

1. Be a Wisconsin resident (see Chapter 3 Residence)
2. Be a U.S. citizen or qualified immigrant (see Chapter 4 Citizenship and Immigration Status)
3. Provide documentation of citizenship and identity or of immigration status~~-~~ (see Section 4.1 U.S. Citizens and Nationals)
4. Cooperate with establishing medical support and third-party liability (TPL) (see Chapter 5 Medical Support and Third Party Liability)
5. Sign over to the state their rights to payments from a third party for medical expenses (see Section 5.2 Medical Support/Child Support Agency Cooperation)
6. Meet BadgerCare Plus SSN requirements (see Chapter 6 Social Security Requirements)
7. Cooperate with verification requests when information is mandatory or deemed questionable (see Chapter 9 Verification)

45.4 Suspension End Date

~~When a member in a~~ A member's suspension is ~~released from prison or jail~~lifted and ~~this information becomes known to the income maintenance agency,~~ full-benefit BadgerCare Plus coverage will start on the first of the month in which the member is released if the member continues to meet the eligibility ~~can be reinstated without a~~criteria for BadgerCare Plus. A new application ~~for benefits. Upon~~is not needed to lift the suspension and start full-benefit BadgerCare Plus.

Members can report their expected release~~, the suspended member's~~ date to their IM agency prior to their release. If the expected release date is known, the IM agency will redetermine BadgerCare Plus eligibility ~~must be redetermined. If~~ prior to the release to lift the suspension and start full-benefit BadgerCare Plus, if eligible, ~~the member's BadgerCare Plus coverage will start~~on the first of the month in which the member is released. ~~The member's health care certification renewal date will not change.~~

Example 1	~~Cameron~~Dolores is incarcerated and enrolled in suspended BadgerCare Plus. ~~His renewal~~On August 25, she reports to her IM agency that her expected release date is ~~June 30, 2021. Cameron is released on December 15, 2020. Cameron opens for~~September 20. The IM agency redetermines her eligibility. Her suspension will be lifted and full-benefit BadgerCare Plus ~~starting December~~will be opened on September 1~~, 2020. His renewal date remains June 30, 2021~~.

The suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. However, this retroactive lifting may only go as far back as the beginning of the current certification period.

Example 2	Risha is incarcerated and enrolled in suspended BadgerCare Plus. Her current certification period started January 1. She was released on April 3, but she doesn't inform the IM agency that she has been released. She continues to be enrolled in suspended BadgerCare Plus. On July 5, she reports to the IM agency that she was released from jail on April 3. The IM agency lifts her suspension and reinstates full-benefit BadgerCare Plus starting April 1.

The member's health care certification renewal date will not change.

Example 3	Cameron is incarcerated and enrolled in suspended BadgerCare Plus. His renewal date is June 30, 2021. Cameron is released on December 15, 2020. Cameron opens for full-benefit BadgerCare Plus starting December 1, 2020. His renewal date remains June 30, 2021.

45.8 Special Policy Considerations

45.8.1 Children

45.8.1.2 Children Whose Parent/Caretaker is an Inmate

If the only parent(s~~)~~) or caretaker(s) in the household are incarcerated, any children on the case open for BadgerCare Plus will remain eligible for ~~a three~~the remainder of their 12-month ~~grace~~continuous coverage period ~~to allow for eligibility to be determined on another case prior to termination.~~. Eligibility for the children will end ~~after~~at the ~~three~~end of the 12-month ~~grace~~ period unless they open for health care on another case.

Example 1	Faye and her 10-year-old daughter, Chantelle, are both enrolled in BadgerCare Plus as a household of two~~.~~ as of January 1, 2024. On March 9, ~~2021~~2024, Faye is incarcerated. Faye's suspended BadgerCare Plus starts April 1, ~~2021~~2024. Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for ~~three months.~~the remainder of her 12-month continuous coverage period. Chantelle's BadgerCare Plus will end ~~June 30, 2021~~December 31, 2024. Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.

48.1 BadgerCare Plus Children's Premium Tables

48.1.1 Premiums for Children

Non-exempt children with an assistance group income above 201% of the Federal Poverty Level (FPL) will be required to pay premiums. Each child's premium will be based on their own assistance group's (AG) size and income. The 5% cap for the cost of total household premiums for children will continue to apply. The cap will be 5% of the income of the premium paying assistance group with the highest countable income amount. The total household's premiums will be determined based on the combined amount of all children's premiums or the 5% cap, whichever amount is less. See SECTION 19.2 PREMIUM CALCULATIONS and SECTION 19.3 PREMIUM LIMITS for more information on premium caps.

The below table outlines the premium amounts for children.

FPL Income Range	Above 201% to 210.99%	211% to 220.99%	221% to 230.99%	231% to 240.99%	241% to 250.99%	251% to 260.99%	261% to 270.99%	271% to 280.99%	281% to 290.99%	291% to 300.99%	301% to 306.00%
Premium Amounts	$10	$10	$10	$15	$23	$34	$44	$55	$68	$82	$97.53

Note	Children in extensions are not required to pay premiums (see SECTION 19.1 BADGERCARE PLUS PREMIUMS). If a parent in the household is in an extension, the children are exempt from paying premiums regardless of their income.

Effective January 1, 2024, a child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period. If the AG's size and income changes during the 12-month period, the child's premium amount may not align with the FPL percentage of the AG's income, as shown in the table above.

49.1 Health Care Choice

Federal law requires that once a person has been determined eligible for Elderly, Blind, or Disabled (EBD) Medicaid, they must be enrolled in EBD Medicaid, even if they are also eligible for BadgerCare Plus, unless they have a change in circumstances that results in ineligibility for EBD Medicaid. The only exception to this policy is pregnant ~~women~~people who are eligible for both EBD Medicaid and BadgerCare Plus. In these instances, the pregnant ~~woman~~person will be enrolled in BadgerCare Plus.

If a person is pending for EBD Medicaid or if a person has an unmet deductible for EBD Medicaid, they are not considered eligible for EBD Medicaid and can enroll in BadgerCare Plus. Pending for EBD Medicaid includes, but is not limited to, waiting for a disability determination from ~~DDB~~the Disability Determination Bureau (DDB) or not eligible for Medicare. If a person enrolled in EBD Medicaid becomes ineligible for EBD Medicaid for any reason, including going over the asset limit or failure to pay a Medicaid Purchase Plan (MAPP) premium, they can enroll in BadgerCare Plus if they are still eligible to do so.

~~In addition, women age 45 to 65 diagnosed with cervical or breast cancer may be eligible for~~ People~~Wisconsin Well Woman Medicaid. Women~~ who are eligible for both Wisconsin Well Woman Medicaid and BadgerCare Plus should be enrolled in Wisconsin Well Woman Medicaid.

See the Medicaid Eligibility Handbook, Chapters 24 - 38 for more information about the Medicaid subprograms.

EBD Eligibility	BadgerCare Plus Eligibility	System Choice
MS/NS/MAPP w/no premium	No premium	EBD
MS/NS/MAPP w/no premium	Premium	EBD
MS/NS/MAPP w/o premium	BadgerCare Plus Deductible	EBD
MAPP w/premium	No premium	BadgerCare Plus
NS Deductible	No premium	BadgerCare Plus
MAPP w/premium	Premium	The program with the lesser premium

NS Deductible	Premium	Member Choice
MAPP Premium	Deductible	Member Choice
NS Deductible	Deductible	Member Choice