WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
Madison WI 53703

To: Medicaid Eligibility Users

From: Rebecca McAtee, Bureau Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 20-03**

Release Date: 08/03/2020

Effective Date: 08/03/2020

EFFECTIVE DATE		The following policy additions or changes are **effective 08/03/2020** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.1.3.3	**Disabled Minors**	Updated policy reference
2.1	**Application Introduction**	Updated hyperlinks for Good Cause form
2.5.3	**Spousal Impoverishment Medicaid Signatures**	Removed requirement for witnessing community spouse's signature
2.9.2	**Denial**	Reorganized page for clarity
4.1	**Who is Nonfinancially Eligible for Medicaid?**	Updated links to other policy sections
5.3.6	**Routine SSI Medicaid Extension**	Moved note from 5.3.6.1
5.3.6.1	**Case Processing**	Moved section to Process Help 26.2
5.7.1	**Redetermination Introduction**	Clarified policy for DDB Redetermination Workgroup
8.3.2	**Notice**	Updated hyperlink for Good Cause form
8.3.3	**Good Cause Claim**	Updated hyperlink for Good Cause form
15.1.1	**Elderly, Blind, or Disabled Test Fiscal Group**	Updated references to CLTS
15.1.2	**Special Financial Test for Disabled Minors**	Updated references to CLTS
15.1.3	**Income**	Updated links to other policy sections
15.1.4	**Supplemental Security Income-**	Removed components for categorically needy income limit

	Related Test	
15.3.22	**Special Programs**	Removed Census 2010 information
15.6.5.1	**IRS Tax Forms and Worksheets**	Removed CWW system information
15.7.3	**Medical/Remedial Expenses**	Added MAPP expenses information
16.6.4.2	**Trust Established With Resources of the Individual or Spouse**	Updated example 4
16.7.9	**Vehicles (Automobiles)**	Updated use of "automobiles" to "vehicles" for clarity
16.7.32	**Independence Accounts**	*New section*
17.12.2	**Promissory Notes on or after January 1, 2009**	Added note about voluntary prepayments
18.1	**Spousal Impoverishment Assets Introduction**	Updated list of assets to not count
18.4.6.1.1	**Leaves Institution or Becomes Ineligible During the 12-Month Transfer Period**	Added examples
18.6.2	**Community Spouse Income Allocation**	Updated dollar amounts
18.6.3	**Family Member Income Allowance**	Updated dollar amounts
20.3.9	**Proof of Temporary Hardship**	*New section*
21.5	**Copayment**	Section rewritten
21.11	**Five Percent Cost Share Limit**	*New section*
22.2.8.1	**Premiums**	Moved Premium Refund Instructions to Process Help 25.1.7.3
22.4.5	**Required Documentation**	Removed link to DWSP-2303 form
24.1	**SSI Related Medicaid Introduction**	Removed information about categories of countable income
24.3	**Deductible Period**	Updated information about when an applicant can choose to begin the deductible period
24.6	**Changes During the Deductible Period**	Updated deductibles policy
24.7.1.1	**Countable Expenses**	Clarified that Medicare premiums paid by member are included
24.9	**Notice to Fiscal Agent**	Updated deductible policy for when more than one bill was incurred
24.12.2	**Income Changes**	Clarified when to determine eligibility
24.12.3	**Asset Changes**	Added example
24.12.4	**Non-Financial Changes**	Clarified when to reopen Medicaid
24.13.1	**Death During a**	Updated deductible policy when a spouse passes away

	Deductible Period Introduction	
26.3.5	**Health and Employment Counseling Program**	Updated policy for HEC programs with MAPP
26.4	**MAPP Financial Requirements**	Updated MAPP policy throughout page
26.4.2.1	**Deduction for Medicaid and Remedial Expenses over $500**	*New section*
26.5	**MAPP Premiums**	Updated MAPP policy throughout page
26.6	**MAPP Restrictive Re-Enrollment Period (RRP)**	Updated MAPP policy throughout page
26.7	**MAPP Changes**	Updated MAPP policy throughout page
27.7.1	**Introduction (Cost of Care Calculation)**	Added note for differences between eligibility determinations and Patient Liability Calculations
27.7.3.1	**Death**	Moved processing information to Process Help 11.2.2.3
28.6.4	**Cost Share Amount**	Clarified the differences between eligibility determinations and Patient Liability Calculations
32.2.1	**Introduction**	Updated policy to be eligible for QMB
39.4.1	**Elderly, Blind, or Disabled Assets and Income Table**	Updated dollar amounts
39.4.2	**Elderly, Blind, or Disabled Deductions and Allowances**	Updated dollar amounts
39.5	**MAPP Purchase Plan Premiums**	Updated FPL table
39.6	**Cost-of-Living Adjustment**	Updated COLA table
39.10	**Medicaid Purchase Plan Premiums**	Renamed section to “Medicaid Purchase Plan Premiums before August 1, 2020 only”
39.11.1	**SeniorCare Income Limits Introduction**	Removed repeated sentence
39.11.5.2	**Level 3: Fiscal Test Group of Two**	Updated example 3
39.12	**Five Percent Copay Limit Tiers**	*New section*
40.1	**Worksheets Table of Contents**	Added pre-August 2020 MAPP worksheet

1.1 INTRODUCTION TO MEDICAID

1.1.3.3 Disabled Minors

A blind or disabled minor (or ~~dependent~~*Dependent 18-year-old*) ~~can~~must have his or her Medicaid eligibility determined according to special procedures ~~when the disabled minor fails the BadgerCare Plus eligibility test or when the parent chooses to decline BadgerCare Plus for his or her child and have his or her child receive EBD Medicaid,~~ if eligible (see Section 15.1.2 Special Financial Tests for Disabled Minors).

Note: EBD Medicaid testing procedures are different from those used for HCBW Medicaid for the Children's Long-Term Support Waiver Program. ~~(See Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support~~(See Section 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program.)

2.5 VALID SIGNATURE

2.5.3 Spousal Impoverishment Medicaid Signatures

All *spousal impoverishment* Medicaid applications and ~~reviews~~renewals require the signatures of both the institutionalized person and the *community spouse* or of a person authorized to sign for them.

If the institutionalized person's signature is missing, deny the application.

Beginning with applications and renewals dated November 11, 2013, if the community spouse refuses to sign the application or renewal, disclose the value of assets, or provide required information on income or resources, deny the application or renewal unless the agency determines that denial or termination of eligibility would result in undue hardship for the person (see Section 22.4 Undue Hardship).

If the community spouse refuses to sign the application or renewal or provide required information, enter an "N–No" in the Health Care Signature field on the General Case Information page.

~~When policy requires a witness to the institutionalized person's signature, the community spouse's signature must also be witnessed.~~

2.9 DENIALS AND TERMINATIONS

2.9.2 Denial

If less than 30 days has passed since the applicant's eligibility was denied, allow the applicant or his or her representative to If the applicant re-sign and date the original application, sign page 16 of the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet, sign the signature page of the application summary, or call the agency to submit a telephonic signature to set a new filing date.

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

If the person is open for any other program of assistance, do not require him or her to re-sign his or her application or sign a new application if he or she provides the necessary information.

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

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

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

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

4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?

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

- Be *elderly*, blind, or disabled (Section 5.2 Determination of Disability, or Section ~~28.14 Home and Community-based Waivers~~37.1.2 Children's Long-~~Term Care Children's Long-Term~~term Support (CLTS) Waiver Program Introduction)
- Be a resident of the state of Wisconsin (see Section 6.1 Residency Eligibility)
- Be a U.S. citizen or Qualifying Immigrant (see Section 7.1 US Citizens and Nationals)
- Cooperate with medical support liability (see Section 8.1 Medical Support)
- Cooperate with *TPL* (see Section 9.1 Third Party Liability)
- Provide *SSN* or apply (see Section 10.1 SSN Requirements)
- Pay a premium if required (see Section 11.1 Premium or Cost Share)
- Pay a community waiver/FamilyCare cost share if required (see Section 11.1 Premium or Cost Share)

5.3 DISABILITY APPLICATION PROCESS

5.3.6 Routine SSI Medicaid Extension

An SSI Medicaid member is eligible for a redetermination of Medicaid eligibility when SSI is terminated. The person is allowed an extra month of SSI Medicaid eligibility to allow the IM agency to redetermine eligibility. The IM agency must fill the gap by ensuring continued Medicaid eligibility between the last date of SSI Medicaid and the date an eligibility determination for continuing Medicaid on another basis is completed. (see Process Help 26.2). Determining Medicaid eligibility should usually occur within the month after the person loses SSI.

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

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

- Death
- Leaving Wisconsin
- Incarceration

- Fleeing drug felon

~~**5.3.6.1 Case Processing**~~

~~The processes differ based on if the member is already open for another program in CARES or if they are not open in CARES.~~

~~Active CARES cases- An active case in CARES is one in which the person is part of a case where at least one person is currently open, or closed less than 30 days for at least one program of assistance. If the member has an active case in CARES, the fiscal agent sends a list to the agency's CARES coordinator of those losing SSI and sends those members a letter saying the IM worker will contact them if there is not enough information to determine eligibility.~~

~~As soon as the IM worker receives the list of those in active CARES cases, he or she:~~

~~1. Opens the member for Medicaid in CARES. This may seem unusual since he or she will show eligibility on MMIS for a grace month. The reason you open all of them in CARES is to provide a tracking mechanism to show you "filled the gap" and that the member receives the correct notice, if he or she fails eligibility later. CARES instructions are:~~

~~a. Case Information> ***Request Medicaid*** page- Request Medicaid~~

~~b. Benefits and School> ***Benefits Received*** page- Change the Y in the SSI field to N or on the ***Benefits Received*** page - change the Y in the 1619(b) field to N.~~

c. Don't change any financial information (unless you need to in order to make the person eligible). Complete any other required demographic information.
d. Verifications aren't required at this point.
e. Run eligibility and confirm.

2. The day after you open the case, request verification of any items you need to determine continued Medicaid eligibility. At this point, treat the case as a regular case, and all verification rules, etc. apply. The member has 10 days to provide verifications.

Non CARES - If the member does not have an active case on CARES, the fiscal agent sends a letter along with an application telling him or her that he or she must apply. The member sends the application to the fiscal agent and the fiscal agent forwards it to the CARES coordinator, who assigns it to a worker. The worker enters the case and determines eligibility. MMIS will close those cases that do not send an application within 30 days of their request.

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

a. Does not return the application (the fiscal agent takes care of this~~,~~), or
b. Fails to respond to an information request, or
c. No longer meets eligibility requirements (~~only forward from~~as of when the review or application is done).

5.7 REDETERMINATION

5.7.1 Redetermination Introduction

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

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

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

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

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

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

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

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

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

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid

benefits will continue until a hearing is held and a decision is made. DDB will retain the SSA-832 in these cases.

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

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

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

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

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

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

15.1 INCOME INTRODUCTION

15.1.1 Elderly, Blind, or Disabled ~~Test~~ Fiscal Test Group

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

There are some exceptions to this Policy:

- Blind or disabled minors (or dependent 18-year-olds): A blind or disabled *minor* (or *dependent 18-year-old*) living with his or her parents would be a one-person FTG. Special instructions for deeming parental income to the disabled minor are described in Section ~~28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support.~~ 15.1.2 Special Financial Tests for Disabled Minors
- Children and young adults who are applying for HCBW Medicaid for enrollment into the CLTS waiver program are a one-person FTG and have eligibility determined under the policy in Section 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program.

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

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

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

15.1.2 Special Financial Tests for Disabled Minors

A blind or disabled minor (or dependent 18-year-old) ~~would~~must have his or her Medicaid eligibility determined according to the following special procedures ~~when the disabled minor fails BadgerCare Plus financial tests.~~. This process ~~essentially~~ deems parental income to the disabled minor. The deemed parental income is added to the

disabled minor's income when determining the disabled minor's financial eligibility for EBD Medicaid.

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household member and therefore not included in any of the following procedures. The following procedures are also different from those used to test for HCBW Medicaid eligibility for the Children's Long-Term Support Waiver Program (see Section ~~28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support).~~37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program).

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

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

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

1. For each ineligible child in the household:

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

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

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

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

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

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

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

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

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

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

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

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

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

Parental living allowance -$1,157

Income deemed to eligible child = $107.50

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

Unearned income = $402.00

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

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

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

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

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

Income deemed to eligible child $20.50

15.1.3 Income

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

See BadgerCare Plus Eligibility Handbook Section ~~39.4~~43.2 ~~Elderly, Blind, or Disabled Deductions and Allowances~~Financial Test for *TB*-Related income limits.

15.1.4 Supplemental Security Income-Related Test

~~The SSI-related categorically needy income limit consists of two components: an income amount plus a shelter or utility amount. The SSI-related fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. The actual shelter or utility costs or the shelter or utility maximum, whichever is less, is added to the categorically needy income amount (Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables), and this total becomes the SSI-related categorically needy income limit.~~ A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test (see ~~Section 24.1 SSI-Related Medicaid Introduction~~Section 24.1 SSI-Related Medicaid Introduction for more information).

If an SSI-related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in Section 39.4

Elderly, Blind, or Disabled Assets and Income Tables. If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid deductible. Refer to Section 24.2 Medicaid Deductible Introduction for more information about Medicaid deductibles and to Section 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid deductible.
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15.3 EXEMPT/DISREGARDED INCOME

15.3.22 Special Programs

Disregard income from all of the following:

- Active Corps of Executives

- ~~All wages paid by the Census Bureau for temporary employment related to Census 2010~~

- Emergency Fuel Assistance
- Foster Grandparents Program
- Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing *HUD* housing rent
- *Homestead* Tax Credit
- Low Income Energy Assistance Program
- Programs funded under Title V of the Older Americans Act of 1965 (see Section 15.5.13 Title V—Older Americans Act of 1965), except wages or salaries, which are counted as earned income.
- Retired Senior Volunteer Program
- Service Corps of Retired Executives
- University Year for Action Program
- Volunteers in Service to America
- Wisconsin's Family Support Program (Wis. Stat. § 46.985). This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.
- Senior Companion Program
- AmeriCorps State and National and AmeriCorps NCCC

15.6 SELF-EMPLOYMENT INCOME

15.6.5.1 IRS Tax Forms and Worksheets

IM workers should not complete any IRS tax forms on an applicant's or member's behalf. It is the responsibility of the applicant or member to complete IRS tax forms.

Workers should only consult IRS tax forms only if **all** of the following conditions are met:

- The business was in operation at least one full month during the previous tax year.
- The business has been in operation six or more months at the time of the application.
- The person does not claim a significant change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see Section 15.6.5.3 Anticipated Earnings).

If you decide to use IRS tax forms, use them together with the charts in Process Help, Section 16.2 Self-Employment Income, or the self-employment income worksheets, which identify which income and expenses need to be entered onto the Self-Employment page by line on the IRS tax forms.

For each operation, select the worksheet you need (if applicable) and, using the provided tax forms and/or schedule, complete the worksheet (if applicable) and enter the income and expenses onto the Self-Employment page.

1. *Sole Proprietor* - Farm and Other Business
   There is no worksheet for Sole Proprietor. See Process Help, 16.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines need to be entered in CWW for each of the following IRS tax forms:

   - IRS Form 4797 - Capital & Ordinary Gains
   - IRS Schedule C or C-EZ (Form 1040) - Profit or Loss From Business
   - IRS Schedule E (Form 1040) - Rental and Royalty Income
   - IRS Schedule F (Form 1040) - Farm Income

2. Partnership (F-16036)

   - IRS Form 1065 - Partnership Income
   - IRS Schedule K-1 (Form 1065) - Partner's Share of Income

3. Subchapter S Corporation (F-16035)

    - IRS Form - 1120S - Small Business Corporation Income
    - IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

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

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Do not apply a loss from unearned income to a gain in earned income. Losses from self-employment cannot be used to offset other earned or unearned income.

15.7 INCOME DEDUCTIONS–

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- *HCBW* programs
- Patient liability calculations for residents of a medical institution
- Cost share and *MAPP* premium calculations
- MAPP eligibility calculation if expenses are over $500 monthly (see Section 26.4.2.1 Deduction for Medical and Remedial Expenses over $500 for more information on this MAPP specific deduction)

Medical expenses are anticipated, incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

- Deductibles and copayments for Medicaid, Medicare, and private health insurances
- Health insurance premiums.
- Bills for medical services that are not covered by Wisconsin Medicaid
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

Medicaid overpayments are not medical expenses and cannot be used as an income deduction to lower a patient liability, cost share, or to meet a deductible.

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

- Case management
- Day care
- Housing modifications for accessibility
- Respite care

- Supportive home care
- Transportation
- Services recognized under Wis. Stat. § 46.27
- Community Options Program expenses that are included in the person's service plan

Remedial expenses do not include housing or room and board services.

16.6 NON-BURIAL TRUSTS

16.6.4.2 Trust Established With Resources of the Individual or Spouse

If the resources of the individual or the individual's spouse were used to form all or part of the principal of the trust, some or all of the trust principal and income may be considered a non-exempt asset, available to the individual. If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual at any time no matter how distant, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered non-exempt assets, available to the individual.

This treatment applies regardless of:

- the purpose for which a trust is established;
- whether the trustees have or exercise any discretion under the trust;
- any restrictions on when or whether distributions may be made from the trust; **or**,
- any restrictions on the use of distributions from the trust.

Example 1: Doug is a 65 year old Medicaid applicant. Several years ago, Doug transferred his life savings of $60,000 to an irrevocable trust, naming himself as the beneficiary. Doug's brother, Jim was appointed as the trustee. Under the terms of the trust, Jim could disburse up to $10,000 annually, from either trust principal or trust income, either directly to Doug or indirectly to provide some benefit for Doug. The trustee had sole discretion as to when and how these trust disbursements would be made, but under no circumstance could they exceed $10,000 in a 12 month period. Because the entire *corpus* (principal of the fund) could eventually be distributed, $60,000 would be considered an available non-exempt asset for Doug's Medicaid eligibility determination, even if the trustee decides not to make any actual disbursements.

Example 2: Al is a 65 year old Medicaid applicant. Six years ago, Al sold his farm for $300,000 and put the entire proceeds from the sale into an irrevocable trust, naming himself as the beneficiary. Al's friend, Scott was appointed as the trustee. Under the terms of the trust, Scott could disburse any amount of trust principal or trust income, at any time, either directly to Al or indirectly to provide some benefit for Al. The trustee had sole discretion as to when and how disbursements would be made as well as the amount that could be disbursed. Therefore $300,000 would be considered an available non-exempt asset for Al's Medicaid eligibility determination, even if the trustee never makes an actual disbursement.

Example 3: Dave is a 65 year old Medicaid applicant who won a $250,000 lottery several years ago and put the entire amount into an irrevocable trust, naming himself as the beneficiary. Dave appointed his brother Don as the trustee. Under the terms

of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed.

The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4: In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution.

The half of the generated income that is paid to ~~Don~~Dave would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note: If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (see Section 17.13 Trusts and Section 17.13.4 Exceptions).

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts described in Section 16.6.5 Special Needs Trust and Section 16.6.6 Pooled Trusts. The policies described above also do not apply to irrevocable trusts created by a will, unless the terms of the trust permit the individual/beneficiary to require that the trustee distribute principal or income to him or her.

16.7 LIQUID ASSETS

16.7.9 Vehicles (Automobiles)

Vehicle ~~or automobile means~~refers to any registered or unregistered vehicle used for transportation. Vehicles used for transportation include, but are not limited to, cars, trucks, motorcycles, boats, and snowmobiles.

16.7.9.1 Determining Equity Value

Equity value is:

- The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book) or the value as estimated by a sales representative at a local dealership.
- Minus any encumbrances (loans or mortgages) that are recorded on the vehicle's title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the *FTG* while others may not. To find what the FTG's equity value in the vehicle is, do the following:

1. Find the vehicle's wholesale value.
2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle's title. The result is the equity value.
3. Divide the equity value by the total number of owners.
4. Add the prorated equity values of the owners who are in the FTG. The result is the FTG's equity value in the vehicle.

16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

- One ~~automobile~~vehicle per ~~household~~eligible individual or couple is excluded regardless of the value if it is used for transportation of the eligible individual or couple or a member of the eligible individual's or couple's household. Assume the ~~automobile~~vehicle is used for transportation, absent evidence to the contrary.
- When an individual owns more than one ~~automobile~~vehicle apply the exclusion as follows:
    - Apply the exclusion in the manner most advantageous to the individual.
    - Apply the total exclusion to the ~~automobile~~vehicle with the greatest equity value if the eligible individual or couple own more than one

~~automobile~~vehicle used for transportation of the eligible individual or couple or a member of the individual's or couple's household.

- The equity value of any ~~automobile~~vehicle, other than the one wholly excluded, is a resource when it:
  - Is owned by an eligible individual or couple **and**
  - Cannot be excluded under another provision (e.g., property essential to self-support, plan to achieve self-support.)

Do not apply the vehicle exclusion to the following vehicles:

- A vehicle that has been junked
- A vehicle that is used only for recreational purposes

- When an individual owns two or more ~~automobiles~~vehicles, apply the following rules:
  - If only one ~~automobile~~vehicle is used for transportation, totally exclude the value of that ~~automobile~~vehicle.
  - If more than one ~~automobile~~vehicle is used for transportation, totally exclude the ~~automobile~~vehicle with the greatest equity value.

Example: George is applying for Medicaid. He has three vehicles: a car (equity value $2500), a truck (equity value $7500), and a snowmobile (equity value $750). He states that the snowmobile is used only for recreation in the winter. He uses the car and the truck interchangeably for transportation. The truck is excluded in the asset determination as it is used for transportation and has the highest equity value. While the car is also used for transportation, only one vehicle can be excluded. The equity value of the car counts in the asset determination. The equity value of the snowmobile also counts in the asset determination. Even if this was George's only vehicle, because he states that it is used for recreational purposes only, it would still be a counted asset.

For any ~~automobile~~vehicle that cannot be excluded for transportation reasons, consider excluding it under the provisions for property essential to self-support, plan to achieve self-support. If the ~~automobile~~vehicle does not qualify for the exclusion, count the equity value of the ~~automobile~~vehicle as a resource.

- If an individual owns ~~an automobile~~a vehicle that is temporarily inoperable (e.g., needs repairs) and states that the ~~automobile~~vehicle will be repaired and used for transportation within the next 12 calendar months, exclude the total value of the ~~automobile~~vehicle until the repairs are completed. At that point, apply the rules for determining if the ~~automobile~~vehicle should be excluded.

If an individual states that the vehicle will not be repaired and used for transportation in the next 12 calendar months, count the equity value of the ~~automobile~~vehicle as a resource.

16.7.32 Independence Accounts

Independence account balances will be exempt assets for all Medicaid programs. Any "pre-Independence account balance" will be a counted asset. Only funds deposited in a registered Independence Account while the member is eligible for MAPP may be exempted from the asset limit. Any deposits made prior to MAPP enrollment or during periods of MAPP ineligibility are not exempt assets. Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited. See Section 26.4.1.1 Independence Accounts for more information on these accounts.

17.12 PROMISSORY NOTES

17.12.2 Promissory Notes on or after January 1, 2009

The purchase of a promissory note, loan, land contract, or mortgage, on or after January 1, 2009, is a divestment unless such note, loan, land contract, or mortgage meets all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the person's life expectancy). The standards that must be used to decide whether or not a promissory note, loan, land contract, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the *SSA*. The standards are found in the Period Life Table, which is available on the ~~SSA website.~~ SSA website. Use this table to calculate the person's life expectancy as of the date the promissory note, loan, and contract, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that he or she would receive payment in full during his or her lifetime.
- Provides for payments to be made in equal amounts during the term of the loan with no deferral or *balloon payments* made. (Note: Voluntary prepayments that exceed the required regular monthly payment amount are not considered balloon payments.)
- Does not allow cancellation of the promissory note, loan, land contract, or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically canceled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a promissory note, loan, land contract, or mortgage contains language to cancel the balance upon the death of the lender, the promissory note, loan, land contract, or mortgage can be amended to remove this language and avoid a divestment penalty.

If all of the criteria above are not met, the purchase of the promissory note, land contract, loan, or mortgage is a divestment. The *divested amount* is the value of the outstanding balance due on the promissory note, loan, land contract, or mortgage as of the date of application for Medicaid *LTC* services.

If all of the criteria above are met, the purchase of the promissory note, land contract, loan, or mortgage is not a divestment. This applies even if the promissory note, land contract, loan, or mortgage cannot be sold because it is not negotiable, assignable, enforceable, or otherwise marketable.

Example 1: On February 1, 2009, Mary gave her adult daughter $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of $100 per month for the first 47 months and a $45,300 payment in the 48th month. Twelve months later, on February

1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid LTC services (February 1, 2010), Mary's daughter has repaid her mother only $1,200, and the outstanding balance on the note is $48,800. Mary's divested amount is $48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 2: John purchased a $60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid LTC services is $40,000. The divested amount that will be used in calculating John's divestment penalty period is $40,000.

Example 3: Jean gave her adult son $50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy with regular monthly payments. Later that year, Jean entered a nursing home and applied for Medicaid. Since the terms of the promissory note were actuarially sound (meeting all the conditions in Section 17.12.2 Promissory Notes on or After January 1, 2009), the transfer was not considered a divestment. As of the date of Jean's application for Medicaid LTC services, her son had repaid her only $1,200, and the outstanding balance on the note was $48,800. The promissory note would be considered an available asset for Jean with an assumed value of $48,800.

18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular Medicaid financial limits. Spousal impoverishment policy applies to institutionalized persons. For purposes of spousal impoverishment, an institutionalized person means someone who:

1. Participates in Group B or B Plus Home and Community-Based Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution, or
4. Is residing in an *IMD*. There is no 30 day requirement for this population.

The policy's purpose is to prevent impoverishment of the *community spouse*. A community spouse is:

1. Married to an institutionalized person and
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community spouse is not an institutionalized person residing in an institution, his or her living arrangement can have no effect on his or her asset share (see Section 18.2.2 Community Spouse Asset Share) or income allocation (see Section 18.6 Spousal Impoverishment Income Allocation).

Example 1: Joe is an institutionalized person living in a nursing home. His wife, Carla, is receiving HCBW services in a *CBRF*. Because Carla is not residing in a medical institution, Joe's eligibility is determined using Spousal Impoverishment rules.

Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, he or she is allowed to retain additional assets and income without liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See Section 2.5.3 Spousal Impoverishment Medicaid Signatures for application and review signature requirements.

18.4 SPOUSAL IMPOVERISHMENT ASSETS

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his or her *community spouse*. (**Note**: *Disregard* prenuptial agreements. They have no effect on *spousal impoverishment* determinations.) Add together all countable, available assets (see Section 16.1 Assets Introduction) the couple owns.

Do not count the following assets:

- *Homestead* property. If the institutionalized person and the community spouse each own home property and meet the criteria in Section 16.8.1.3 Exempt Home Property, exempt the institutionalized person's home but not the community spouse's home.

Example 1: One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home but exempt the spouse's home. Both homes cannot be exempt simultaneously.

- One vehicle, regardless of value or purpose. If the *AG* has more than one vehicle, completely disregard the vehicle with the highest equity value, regardless of purpose. Then, for the remaining vehicles, follow the *EBD* rules for vehicles (see Section 16.7.9 Vehicles [Automobiles]). Note: Do not allow additional vehicles to be exempted under Section 16.7.9, unless they meet the definition to exempt under the provisions for property essential to self-support, plan to achieve self-support or temporarily inoperable as outlined in the section.

  Example: Howard is applying for benefits. Howard is in an institution and Marianne is his community spouse. They own a boat with an equity value of $10,000 and an automobile with an equity value of $7,000. Because the boat has a higher equity value, it is disregarded. The automobile does not meet the criteria for exemption and so is a counted asset; count $7,000 in the asset assessment and the asset determination.

- All assets designated for burial purposes. Any unreasonable amount should be supported by documentation of the burial-related costs or contract.

Do not allow applicants and members to simply state that they are setting aside an unreasonable amount of cash (e.g., $1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

For example, ask the *member* to document that he or she has arranged to purchase a $100,000 casket or that a funeral home will provide them with a $75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (see Section 16.5 Burial Assets).

- Household goods and personal items, regardless of their value.
- All assets not counted in determining EBD Medicaid eligibility.
- *IRA* and work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs of an ineligible community spouse (see Section 16.7.20 Retirement Benefits).

18.4.6.1 Asset Transfer Period

The institutionalized spouse must transfer the assets to the community spouse by the next regularly scheduled review (12 months). If his or her assets are above $2,000 on the date of the next scheduled review, he or she will be determined ineligible. He or she will remain ineligible until his or her assets no longer exceed the $2,000 Medicaid asset limit.

Example 2: Robert was first institutionalized September 2013. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2013. The couple's total combined assets were $42,000, $32,000 of which were owned solely by Robert. Robert had until the next scheduled review (August 2014) to get his total assets under the $2,000 Medicaid asset limit.

CARES does not generate sufficient notice regarding the transfer of assets by the next scheduled renewal. See Section 18.8 Spousal Impoverishment Notices for information on manual notices that must be sent to the couple.

By August 2014, Robert had only transferred $23,000 to Lucinda. Robert still had $9,000 in assets. Robert became ineligible September 2014 and will remain ineligible as long as his assets are over $2,000.

18.4.6.1.1 Leaves Institution or Becomes Ineligible During the 12-Month Transfer Period

If the institutionalized spouse **during** the 12-month transfer period:

1. Leaves the institution for 30 days or more **and** becomes institutionalized again, **or**
2. Becomes ineligible for Medicaid **and** then becomes eligible for Medicaid once again.

The time allowed to transfer assets does not start over again.

Example 3: Daniel is in a nursing home, while Susan, his wife is in the community. Daniel is found eligible for Medicaid beginning March 28, 2020 (the date of institutionalization), starting the 12-month asset transfer period. In May 2020, Daniel is discharged from the nursing home and his Medicaid eligibility ends. In July 2020, Daniel returns to the nursing home. Because Daniel became institutionalized again within the 12-month transfer period, the transfer period does not start over.

Example 4: Betsy was admitted to the nursing home on April 14, 2018 and applied for Medicaid on June 6, requesting a two-month backdate. Nicholas, her husband, remains in the community. Betsy was discharged from the nursing home on May 7, 2019, the 12th month of her asset transfer period. Betsy returns to the nursing home on March 6, 2020 and reapplies for Medicaid on March 13. Because Betsy returned to the nursing home after her 12-month transfer period, she is allowed a new asset transfer period.

18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION

18.6.2 Community Spouse Income Allocation

To determine how much of the institutionalized spouse's income to allocate:

1. The community spouse maximum income allocation is one of the following:
   a. $2,~~818~~873.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,216.00.

"Excess shelter allowance" means shelter expenses above $~~845.50~~862.00. Subtract $~~845.50~~862.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,~~818~~873.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

Community spouse shelter costs include the community spouse's expenses for:

- Rent
- Mortgage principal and interest
- Taxes and insurance for principal place of residence. This includes renters insurance.
- Any required maintenance fee if the community spouse lives in a condominium or cooperative.
- The standard utility allowance established under FoodShare:

If the community spouse pays:	**Add:**
Heat and utilities	Heating Standard Utility Allowance*
Utilities only	Limited Utility Allowance*
Telephone only	Phone Utility Allowance*
If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee. * See the FoodShare Wisconsin Handbook Section 8.1.3 Deductions for the current standard utility allowance amounts.	

For *HCBW* cases, follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:

- If the waiver person's community spouse lives with him or her, do not add the excess shelter cost to the income allocation.
- If the waiver person's community spouse does not live with him or her, add the excess shelter cost to the income allocation.

b. A larger amount ordered by a fair hearing decision or a court order. A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his or her necessary and basic maintenance needs with the amount allocated.

2. The maximum allocated amount is the difference between the allowable community spouse income allocation and the community spouse's monthly gross income. Use the *EBD* income rules, but do not give earned income, unearned income, and work-related deductions.

The institutionalized spouse may choose to allocate less than the maximum amount.

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $~~704.58~~718.34 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $~~704.58~~718.34 and the actual monthly income of the dependent family member.

20.3 MANDATORY VERIFICATION ITEMS

20.3.9 Proof of Temporary Hardship for MAPP members

Verify a temporary hardship for MAPP applicants and members who apply for a temporary MAPP premium waiver due to hardship, Section 26.5.8.

21.5 COPAYMENT

21.5.1 Introduction

An EBD Medicaid *member* may be required to pay a part of the cost of a service. This payment is called a "copayment" or "copay."

~~The~~ 21.5.2 Copay Exempt Populations

Providers are prohibited from collecting copays from the following members ~~do not have to pay a copayment~~:

- ~~Children eligible for BadgerCare Plus who are:~~
  - ~~Under age 1 with income at or below 150 percent of the *FPL*~~
  - ~~Age 1 through 5 with income at or below 191 percent of the FPL~~
  - ~~Age 6 through 18 with income at or below 133 percent of the FPL~~

- Children under age ~~18 who are eligible for *SSI*~~19 regardless of income or benefit program.
- Children in foster care, regardless of age. or
- Children ~~eligible for~~ in adoption assistance, regardless of age..~~Katie Beckett~~

- ~~American Indians or Alaskan Native Tribal members, the son or daughter of a tribal member, the grandson or granddaughter of a tribal member, or anyone otherwise~~~~Pregnant women~~
- ~~People who are~~ eligible to receive ~~services from~~ Indian Health Services ~~or~~ , regardless of age or income level, when they receive items and services either directly from an ~~Urban~~ Indian ~~Health Center, members of a federally recognized tribe, or the child or grandchild of a tribal member~~
- ~~Nursing home residents~~

- ~~The following are medical~~health care provider or through referral under contract health services ~~that are exempt from copayments:~~.
- ~~Emergency hospital and ambulance~~Former Foster Care Youth
- Anyone receiving services through Express Enrollment
- Pregnant women

21.5.3 Copay Exempt Programs

Copays will not be charged for members enrolled in the following subprograms:

- Family Planning Only Services

- Institutional Medicaid (**not including** childless adults (CLAs) enrolled in BadgerCare Plus and residing in an institution)
- Katie Beckett~~and emergency~~
- Wisconsin Well Woman Medicaid

21.5.4 Copay Exempt Services

The following services ~~related to the relief of dental pain.~~do **not** require copayment:

- ~~Services related to pregnancy.~~
- ~~Family planning services and supplies.~~
- ~~Home health services~~
- ~~Personal care services.~~

- Case management services.

- ~~Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.~~
- ~~Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy (whichever occurs first, during one calendar year).~~

- Crisis intervention services.
- Community support program services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck.
- HealthCheck "Other Services."
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- Pregnancy related services.
- Preventive services with an A or B rating from the U.S. Preventive Services Task Force.
- School-based services.
- Substance abuse ~~(alcohol and other drug abuse)~~ day treatment services.

- ~~Respiratory care for ventilator-assisted members.~~
- ~~*CSP* services.~~

- Surgical assistance.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

21.11 FIVE PERCENT COST SHARE LIMIT

Members may not pay more than five percent of their household income for monthly premiums and copays for BadgerCare Plus or Medicaid card services. This limit does not apply to deductibles, patient liability for Institutional Medicaid, or cost sharing for Home and Community-Based Waiver services.

The five percent cost share limit applies to members eligible for BadgerCare Plus, SSI Medicaid, and most EBD Medicaid programs. Members enrolled in MAPP and SeniorCare do not have a cost-sharing limit.

For members subject to the cost-sharing limit, a copay limit will be set on a monthly basis. The copay limit is based on the assistance group's income used to determine eligibility. Copays are tracked based on copays the individual has incurred, not the amount of copays actually paid.

21.11.1 Copay Limits for Members and Programs exempt from copays

Members who are in a copay exempt category (21.5.2 Copay Exempt Populations) will not have a copay limit while they are copay exempt since they have no copays.

Members who are enrolled in any copay exempt subprograms (21.5.3 Copay Exempt Programs) will have a copay limit of $0 as there are no copays for members enrolled in these programs.

21.11.2 Programs Excluded from the Five Percent Cost Share Limit

Members enrolled in the following subprograms will continue to be charged premiums and copays with no five percent cost share limit set based on their income:

- Medicaid Purchase Plan (MAPP)
- SeniorCare

Note: Members who are enrolled only in Medicare Savings Programs (except for Qualified Medicare Beneficiaries (QMB)) do not receive Medicaid card services and thus do not have copays.

21.11.3 Determining the Copay Limit

For members enrolled in BadgerCare Plus or EBD Medicaid subprograms that have a copay limit, copay limits will be based on the assistance group's income used to

determine eligibility. Per-member copay limits will be set based on the income tiers (39.12 Five Percent Copay Limit Tiers).

If the member is married and both spouses are enrolled in a health care program that has a copay limit (and neither spouse is exempt from copays), the copay limit will be prorated between them. If one spouse is exempt from copays (for example, due to pregnancy), the other spouse will have the full individual copay limit for their income tier.

Example 1: Jane and Benji are married and enrolled in medically needy SSI-related Medicaid. The assistance group has counted income which puts their household income in the 50-100% of FPL income tier for an assistance group size of 2.

Since both Jane and Benji are eligible and have to pay copays, the $26 copay limit for the household will be prorated between Jane and Benji. They will each have a monthly copay limit of $13.

Note: If needed, use the following formula to determine the assistance group income FPL percentage and the appropriate tier:

Assistance Group Income / (100% FPL for the group size) = Assistance Group Size % FPL.

If spouses are enrolled in two different health care programs (and both programs have a copay limit), the copay limit for the household will be calculated based on the assistance group with **lower** income and prorated between spouses. This will prevent the spouse with lower income from paying cost sharing expenses in excess of the five percent limit.

Example 2: Dave, his wife Debbie, and their son Derek receive health care benefits. Dave is enrolled in SSI-Related Medicaid and Debbie and Derek are enrolled in BadgerCare Plus. Due to the different income budgeting rules for SSI-Related Medicaid and BadgerCare Plus:

- The countable income for SSI-Related Medicaid is 69% of the FPL for a group size of two. That puts the SSI-Related Medicaid assistance group income in the >50-100% of FPL income tier.
- The countable income for BadgerCare Plus is 48% of the FPL for a group size of three. That puts the BadgerCare Plus assistance group income in the 0-50% of FPL income tier.

To determine the copay limit for the household, the lower BadgerCare Plus assistance group income tier of 0-50% of FPL will be used. Debbie, Dave, and Derek each have a $0 copay limit, meaning they will not be charged any copays.

If

-a member who is enrolled in a health care program that has a copay limit is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the member will have the full individual copay limit for his or her income tier.

Example 3: Sean and Sandra are a married couple. Sean is enrolled in SeniorCare and Sandra is enrolled in medically needy SSI-related MA. The countable income for Sandra's SSI-Related Medicaid assistance group is 72% of the FPL, which puts this assistance group in the >50-100% of FPL income tier. Because Sean is enrolled in a program that has no copay limit, Sandra will pay the full individual copay limit of the income tier.

For members who are eligible for both QMB and a full benefit health care program that has a copay limit, the income used to determine eligibility for the full benefit program will be used to calculate the member's copay limit.

Example 4: Dwayne is eligible for both SSI-Related Medicaid and Medicare. He also qualifies for QMB. Under SSI-Related Medicaid, Dwayne's income is in the >50-100% of FPL tier. His copay limit is $26 per month based on his SSI-Related Medicaid eligibility. Since QMB is a limited benefit program, no copay limit will be set for QMB.

If Dwayne were only eligible for QMB, his copay limit would be set based on the income used to determine his eligibility for QMB.

For CLA members who pay a monthly premium, the premium amount will be subtracted automatically when the member's copay limit is calculated in CARES. For married couples with at least one spouse subject to CLA policy, the total household premium amount will be prorated evenly between the married couple's copay limits even if the spouses are on different benefit programs.

Example 5: Destiny and Marcus are married. Destiny is eligible for BadgerCare Plus as a childless adult with an $8 household premium. Marcus is eligible for SSI-Related Medicaid. The income used falls within the >50-100% FPL tier. However, since Destiny has a household premium, the premium is split and deducted evenly from both copay limits (subtract $4 from each copay limit). After the premium is counted, they each have a copay limit of $9 ($13-$4=$9).

Example 6: Alice and Barry are married and both eligible for BadgerCare Plus as childless adults with income at 85% of the FPL. They have a household premium of $6 because Alice completed a health survey and reported healthy habits while Barry did not. Their copay limit would be prorated at the >50-100% FPL tier and the $6 premium would be split evenly and deducted from their prorated copay limit (subtract $3 from both). Alice and Barry would each have a $10 copay limit.

Alice suffers injuries from a car accident. She is verified as disabled and becomes eligible for SSI-Related Medicaid. Because Alice is no longer a childless adult, her

health survey response does not result in a premium reduction for the household. Barry's household premium will increase to $8. The $8 premium would be split evenly and deducted from both Alice and Barry's copay limits (if they continue to have income greater than 50% of the FPL).

21.11.3.1 Determining Copay Limits for Community Waivers Group B and B Plus

For Group B and B Plus Home and Community Based Waiver members, the copay limit will be based on the member's cost share amount for Waiver services rather than the income used to determine the member's eligibility.

- If the Waiver services cost share amount is less than $27 (the full individual copay limit for the >50-100% of FPL income tier plus one dollar), the Group B or B Plus Waiver member will have the copay limit for the 0-50% of FPL income tier ($0).
- If the Waiver services cost share amount is $27 or greater, the Group B or B Plus Waiver member will have the copay limit for the >50-100% of FPL income tier ($26).

Example 6: Marge is a Group B waiver member. Her Waiver cost share amount is $15. Because this amount is less than $27, Marge's copay limit is $0, which means that she will not be charged any copays.

Example 7: George is a Group B waiver member. His Waiver cost share amount is $120. George's copay limit is $26 because his cost share amount is greater than $27.

If a Group B or B Plus Waiver member is married to someone who is also a Group B or B Plus Waiver member or is enrolled in another Medicaid subprogram that has a copay limit (and who is not exempt from copays), the copay limit calculated for the spouse in the lower copay limit tier will be prorated between the two spouses.

Example 8: If Marge and George in examples 6 and 7 above were a married couple, the copay limit for the household would be based on the spouse in the lower copay limit tier (in this case, Marge). Marge and George would therefore each have a copay limit of $0.

Example 9: Trevor and Kate are married and enrolled in different health care benefits. Trevor is eligible for SSI-Related Medicaid and his income falls in the >0-50% FPL tier. Kate is eligible for Community Waivers Group B. Her Waiver cost share amount is $65. Since Trevor's income would be in a lower FPL tier than Kate's Waiver cost share amount, Trevor and Kate would each have a copay limit of $0.

If a Group B or B Plus Waiver member is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the Waiver member will have the full individual copay limit for his or her copay limit tier.

Example 10: Steve and Angela are a married couple. Steve is a Group B Plus Waiver member and Angela is enrolled in MAPP. Steve's Waiver cost share amount is $30, so his copay limit is based on the >50-100% of FPL income tier. Angela has no copay limit.

21.11.3.2 Determining Copay Limits for Members in SSI Medicaid

- For SSI Medicaid members, whose Medicaid eligibility is determined by the Social Security Administration (SSA) rather than income maintenance agencies, per-member copay limits will be based on the >50-100% of FPL income tier (see Appendix 39.12 Five Percent Copay Limit Tiers).

If an SSI Medicaid member is married to someone who is enrolled in BadgerCare Plus or an EBD Medicaid subprogram that has a copay limit, each spouse's copay limit will be calculated individually and the copay limit will not be prorated between spouses.

Example 11: Chantal and Peter are married and both are receiving health care benefits. Chantal is eligible for SSI Medicaid and Peter is eligible for SSI-Related Medicaid with income at 84% of the FPL. Chantal and Peter will each have individual copay limits as listed in Appendix 39.12 Five Percent Copay Limit Tiers.

21.11.4 Changes to the Copay Limit

Once determined, the copay limit will remain the same from month to month unless changes are reported that affect the copay limit, such as a change in income or household composition. Members have the right to appeal their monthly copay limit.

Increases in copay limits may not be made without providing timely notice to the member. If a change results in an increase in the member's copay limit and eligibility is confirmed prior to adverse action for the month, the copay limit increase will be effective the following month. If eligibility is confirmed after adverse action, the copay limit increase will be effective two months after the month in which the change occurred.

If a change results in a decrease in the monthly copay limit, the decrease should be effective during the month in which the change occurred or, if the change was reported untimely (more than ten days after the change occurred), the month in which the change was reported, whichever is later.

21.11.5 Meeting the Copay Limit

Members are notified once they have incurred enough copays before the end of the month to meet their monthly copay limit. This notification is informational only and members may not appeal the date the copay limit was determined to have been met. Once the copay is met for a given month, it can never become "unmet" in the same month and the member will not be charged any more copays in that month.

Example 12: Tamika is enrolled in HCBW and has a copay limit of $26 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of $26. CARES issues Tamika an automated notice stating that her $26 copay limit has been met for the month of August and that she will have no copays for the remainder of the month. On August 21, Tamika has a doctor's appointment. She will have no copay for the doctor's appointment since her copay limit has already been met for the month of August. On September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

22.2 CORRECTIVE ACTION

22.2.8.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BadgerCare ~~or MAPP (MAPP offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through Wisconsin Medicaid.) and would result in a refund for the member, determine the correct premium amount for each month in which it was incorrect~~Plus or MAPP the member should receive a refund. See PH 25.1.7.3 for how to calculate and process a refund.

~~When reporting the refund to the BadgerCare or MAPP Unit, include:~~

- ~~The member's *SSN*.~~
- ~~Months for which a refund needs to be issued.~~
- ~~New premium amount.~~
- ~~Old premium amount.~~

~~Indicate if there is a hardship situation that requires the refund to be processed more quickly.~~

~~*22.2.8.1.1 BadgerCare*~~

~~If the premium was recalculated and reduced for prior month(s), report the premium refund to the BadgerCare Unit by:~~

- ~~Telephone: 1-888-907-4455.~~
- ~~Fax: 608-251-1513. When submitting a fax, write "Attn: BC Premium Refunds."~~

~~*22.2.8.1.2 Medicaid Purchase Plan*~~

~~If the premium was recalculated and reduced for prior month(s), report the premium refund to the MAPP Unit by:~~

- ~~Telephone: 1-888-907-4455.~~
- ~~Fax: 608-251-8185. When submitting a fax, write "Attn: MAPP Premium Refund.~~

22.4 UNDUE HARDSHIP–

22.4.5 Required Documentation

An applicant or member (or his or her authorized representative, power of attorney, or legal guardian) must submit both of the following verifications of undue hardship (unless otherwise noted):

- A statement signed by the applicant or member (or his or her authorized representative) which describes the following:
    - In cases where a community spouse refuses to cooperate with the application process, documentation of all attempts to get cooperation from the community spouse,
    - In cases of divestment, whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets,
    - In cases when an individual is denied due to having more than $750,000 in home equity, an explanation of why the home equity cannot be accessed
    - In cases where an individual in a spousal impoverishment case is denied due to excess assets, an explanation of why the excess assets cannot be accessed.
- Proof that an undue hardship would exist if eligibility is terminated or denied or the divestment penalty period is applied (required for all four situations to which Undue Hardship policy may apply) as follows:
    - **If the applicant or member is currently institutionalized**, he or she must submit a copy of the notification from the long term care facility which states both of the following:
        - The date of involuntary discharge
        - An alternative placement location

      Or other proof that if the undue hardship waiver is not approved, the applicant or member will:

        - Not receive medical care resulting in his or hers health or life to be endangered
        - He or she will not have food, clothing, shelter, or other necessities of life.
    - **If the applicant or member is applying for HCBW**, including FamilyCare, FamilyCare Partnership, PACE, or IRIS he or she must submit an estimate of the cost of the long term care services needed to meet his or her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing, and other necessities of life.

These two estimates must be compared to the applicant, member, or couple's income and assets. If the IM agency determines that the applicant or member does not have enough income and/or assets to pay for his or her long term care and other needs (i.e., food, shelter, etc.), consider the applicant or member's health to be endangered.

If the required documentation is **not** submitted with the request for an undue hardship waiver, send a written request for verification ~~by completing a manual Request for Verification (DWSP-2303) and mailing it~~ to the applicant or member, giving a verification due date of 10 calendar days from the date the request is mailed. If the applicant or member fails to submit the required verification within 10 calendar days after the request is mailed, deny the undue hardship waiver request and notify the applicant or member by sending a Notice of Denial of Benefits/Negative Change in Benefits ~~(F-16001).~~(F-16001). The deadline to submit the required documentation may be extended for up to ten calendar days if the individual communicates to the agency a need for additional time or assistance to obtain verification.

24.1 SSI RELATED MEDICAID INTRODUCTION

SSI-related Medicaid is the original, basic Medicaid program for individuals who are *elderly*, blind, or disabled. SSI related individuals must meet all appropriate Medicaid nonfinancial eligibility requirements. SSI related Medicaid has the lowest income and asset limits of all EBD Medicaid programs/categories. It has two income limits which are referred to as the categorically needy limit and the medically needy limit.

Allow the following income disregards to the fiscal group's income in the order below to determine the countable net income.

- The 65 & ½ earned income *disregard*
- Special exempt income (15.7.2 Special Exempt Income)
- $20.00 SSI general income disregard.

~~The SSI-related categorically needy income limit consists of two components; an income amount plus a shelter/utility amount. The SSI-related fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables), and this total becomes the SSI-related categorically needy income limit.~~ A fiscal group with countable net income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test.

If ~~an SSI-related~~a fiscal group's countable net income exceeds the categorically needy income limit, their income is then compared to a medically needy limit of 100% FPL, which is found in Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables. If the fiscal group's countable net income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

If ~~an SSI-related~~a fiscal group fails the medically needy income test because their countable net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter 24.2 Medicaid Deductible Introduction for more information about Medicaid Deductibles and to chapter 24.5 Calculating the Deductible for instructions on how to calculate a Medicaid Deductible.

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for more information.

24.3 DEDUCTIBLE PERIOD

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. It begins in the month which the *applicant* chooses, and it ends six months later. See 5.9.5 Eligibility for an exception to the 6 month deductible period for backdate periods after a formal *disability* determination has been made for a *member* certified under a PD.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month after the month of application.

> **Example 1:** John applies for Medicaid in July. He can choose to begin his six month Medicaid deductible period in April, May, June, ~~or~~ July, or August.

~~The applicant cannot choose a Medicaid deductible period which includes a month in which, if he or she had applied, he or she would have been ineligible due to excess assets.~~

The applicant may choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month after the month of application. However, the first month of a deductible period may not be a month in which the person is ineligible for excess assets or is non-financially ineligible. The applicant may choose a 6-month Medicaid deductible period which includes a month or more (except for the first month) in which he or she is ineligible for excess assets or for a non-financial reason. Excess income is still calculated and included in the deductible amount for any months that the applicant may be ineligible due to assets or a non-financial reason. If the applicant meets the deductible, the individual may only be certified for Medicaid during the dates when he or she was non-financially and asset eligible.

> **Example 2:** Doyle applies for Medicaid in July. He has excess income in July. He wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the $5,000 on May 31, so he can begin his Medicaid deductible period in May.

> **Example 3:** Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.
>
> In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31~~. Therefore, she cannot include May or any months prior to May in her Medicaid deductible~~

~~period. She~~, but no longer had the $5,000 on June 30~~, so she can begin her Medicaid~~. Her deductible period will run from April through September. However, if she meets the deductible ~~period~~in April, she would only be eligible through the end of April and from June 1 to September 30. If she meets the deductible in ~~June~~May, she would only be eligible from June 1 to September 30. Due to excess assets in May, she may not be eligible for any day in that month.

~~The applicant can choose a Medicaid deductible period which includes a month in which, if he or she had applied, he or she would have been ineligible for a non-financial reason. Although excess income is still calculated over a six month period, the individual can only be certified for Medicaid during the dates when he or she was non-financially eligible.~~

Example 4: Marion applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.

Marion was incarcerated from April 30th through May 18th. She meets the deductible with a countable expense from April 10th, so she should be certified from April 10th through April 29th, and May 19th through September 30th.

Example 5: Janet applies for Medicaid in July and requests a Medicaid deductible period from April through September. She gave birth on June 30th. Janet paid the full deductible amount, so is certified from April 1st through June 30th.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his or her eligibility in the backdate month is determined by whether or not he or she had excess assets on the last day of the month.

Example 6: Jack applies for Medicaid in July. He wants a Medicaid deductible period that goes back two months to include May and June. In May, he ~~would have been eligible except for excess income. In June he had~~ received a $10,000 gift. On ~~June~~May 29 he ~~went to the track and lost~~spent the $10,000~~. Had he applied~~ on ~~June 30 he would have been eligible. Jack can include~~a new roof. His assets were below the asset limit by the last day of the month, and he is otherwise eligible except for excess income for both ~~May and June in~~ backdated months, so his ~~Medicaid~~ deductible period can begin in May.

~~**Example 7:** Mansour applies for Medicaid in July. He is found to be eligible. He had medical bills in April and May. He also had excess income in April and May. He wants a Medicaid deductible period that includes April and May. Unfortunately, he was the recipient of a $5,000 cash gift on June 29. It was several days before he was able to spend it on groceries and other legitimate~~

~~purchases. Mansour will not be able to include April or May in the deductible period because on June 30, had he applied, he would have been determined ineligible.~~

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period.

Example ~~8~~7: Jeff applies for Medicaid on 1/1/14 and his monthly excess income is $100.00. His Medicaid deductible is $600.00 and his deductible period is January 01, 2004 through June 30, 2014. In April 2014, Jeff's monthly excess income decreases to $10.00 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have his worker recalculate the original $600.00 deductible which would then become a $330.00 deductible (three months of $100.00 excess income and three months of $10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2014 through September 30, 2014 with a $60.00 deductible obligation ($10.00 x 6 = $60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (See 24.6.1 Changes During the Deductible Period> Income Changes.)

Individuals who have been certified for Medicaid after meeting a deductible, will have to complete a review to establish a new deductible period. CARES does not send a review notice to the member regarding the new deductible period if he or she did not meet the deductible for the current period.

24.6 CHANGES DURING THE DEDUCTIBLE PERIOD

24.6.1 Income or Deduction Changes

If there are income or deduction changes during the Medicaid deductible period, that result in a decrease in the deductible amount, recalculate the Medicaid deductible amount. Beginning July 1, 2020, the deductible amount will no longer be increased when an unmet deductible assistance group has an increase in income or a decrease in deductions. Once a deductible period and deductible amount are determined and the member has been notified of his or her deductible amount, the deductible amount will never increase during the same deductible period.

~~24.6.1 Income Changes~~

At the time of initially determining a deductible period, the amount of the deductible must be determined by taking into account all changes in income, deductions and household composition known at the time the deductible is created.

To determine the amount of a decreased deductible:

1. Add together the monthly excess income of the months of the Medicaid deductible period that have already gone by.
2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.
3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.
4. Add the results of #1, #2, and #3.

Example 1: Cicely applied for Medicaid in July. She had excess income of $20 a month. Her Medicaid deductible was $120. In November she reports a pay ~~increase~~decrease of $10 a month. Now you must recalculate her Medicaid deductible.

1. Add together the excess income of months July through October. The result is $80.
2. Calculate her November excess income. The result is excess income of $~~30~~10.
3. Prospective income for December is $~~30~~10.
4. Cicely's new Medicaid deductible: $80 + $~~30 + $30 = $140~~10 + $10 = $100.

If the income change results in **lower excess income** in the month of change, the *applicant* can choose to:

1. Recalculate the Medicaid deductible, **or**

2. Create a new deductible period.

Example 2: Winston goes from full time to part time employment in the fourth month of his Medicaid deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his Medicaid deductible or to have a new deductible period.

If he recalculates, the resulting deductible will be lower than the previous one.

His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he had met the previous deductible.

If the income change results in **no excess income** the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. **Begin eligibility immediately.**

Example 3: If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

24.6.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, you must recalculate the deductible~~.~~ if the result is a decrease in the deductible amount. Beginning July 1, 2020, the deductible amount may no longer be increased when an unmet deductible assistance group has a change in group size. Once a deductible period and deductible amount are established, the deductible amount will never increase during the same deductible period. Deductible amounts may be decreased due to changes in group size. Compare the new group's income with the new group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes ~~(24.6.1 Income Changes).~~(24.6.1 Income or Deduction Changes).

Example 4: John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group.~~–~~ On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be

recalculated using the smaller group size (one person fiscal test group) as of March 1.

If after subtracting John's income the amount of excess income above the new income limit for the group of one is lower than it was for the group of 2, use the lower income and deductible amount to recalculate Sally's deductible. However, if the amount of excess income above the income limit for a group of one is higher than what it was for the group size 2, and using that amount would increase the amount of the deductible, leave the deductible amount unchanged.

24.6.3 Asset Changes

If the fiscal test group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible~~. End~~ for that month. Excess income may still be calculated during the ~~deductible period~~dates the individual is ineligible due to assets, however the individual can only be certified for Medicaid during the dates he or she has assets below the asset limit.

24.7 MEETING THE DEDUCTIBLE

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 24.7.1 Countable Costs:

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

   Note: ForwardHealth interChange (iC) data may be used to calculate Medicaid co-payments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses are:
   a. Case management
   b. Day care.
   c. Housing modifications for accessibility.
   d. Respite care.
   e. Supportive home care.

      Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

      - Assistance with activities of daily living
      - Attendant care
      - Supervision
      - Reporting changes in the participant's condition,
      - Assistance with medication and medical procedures which are normally self-administered, or
      - The extension of therapy services, ambulation and exercise.
      - Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well being and care at home.

f. Transportation.

g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (*AFH*), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

Remedial expenses do not include housing or room and board expenses.

CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation (21.4.2 Transportation).

4. Medical insurance premiums paid by a member of the fiscal test group or FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. This includes all Medicare premiums paid by the member. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period. This includes all Medicare premiums owed by the member during the deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible.

Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).

6. Medical services received at a Hill-Burton facility. -The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities.– Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.

7. In-kind payments.– These are services or goods supplied to the provider in lieu of cash. -Self declaration of the bill being satisfied is adequate verification.

8. Medical or remedial expenses that are paid or will be paid– by a state, county, city or township administered program that meets the conditions detailed in 24.7.1. # 3.

Examples include:

a. General Assistance
b. Community Options Program
c. AIDS Drug Assistance Program (ADAP)

Example 10: Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 11: Sally received a medical service in January which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in 24.7.1 # 3

Example 12: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 13: Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

24.9 NOTICE TO FISCAL AGENT CONCERNING ANY REMAINING DEDUCTIBLE

When the *member* receives a medical bill that is equal to or greater than the amount he or she still owes on the deductible, he or she can be certified for Medicaid. He or she must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update (F-10109) to the fiscal agent indicating the amount of the bill that the member owes. The fiscal agent subtracts this amount from the bill and Medicaid pays the rest.

Fill out the Medicaid Remaining Deductible Update (F-10109) only if:

A Medicaid certified provider has provided the billed services.

The person, having met the deductible, is being certified. If he or she is not being certified, Medicaid will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the member is not eligible until he or she has met the deductible, he or she still owes for all bills prior to that date.

~~Do not send~~If more than one bill~~. In~~ was incurred on the ~~series of bills which the member may submit to you, there will be only one bill which is larger than the amount needed to meet~~date the deductible~~.~~ was met, send additional Medicaid ~~will consider the remainder of the bill~~Remaining Deductible Update (F-10109) forms for ~~payment.~~ any other bills for which the member would be responsible.

24.12 CHANGES AFTER MEETING A DEDUCTIBLE

24.12.2 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period once the deductible has been met. However, workers must determine if eligibility for the deductible should have begun on an earlier date due to a reduced deductible amount and manually certify eligibility for the appropriate dates. A met deductible period may not be shortened due to any changes which would have increased the amount of the deductible.

24.12.3 Asset Changes

If the Medicaid group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue Medicaid eligibility.

If the group's assets fall below the limit before the end of the met deductible period, reopen the deductible for the remainder of the original deductible period.

Example 1: Jim has a deductible period from July through December. He meets his deductible on July 18. In August, Jim reports that he inherited $5,000 and he still has it as of August 31. His case closes for October for excess assets. On November 5, Jim reports that he spent the money and his assets are now below $2,000. Since he is still in his deductible period and no longer ineligible because of his assets, his deductible should be reopened for November 1 through December 31.

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

The deductible period (24.3 Deductible Period) for which excess income is calculated may include a month(s) in which, if a *member* had applied, he or she would have been ineligible for a non-financial reason.

If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.

If an *adult* caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his or her name will appear on the Medicaid card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, ~~the member may choose:~~reopen Medicaid for the dates when he or she was non-financially eligible.

~~1. to continue with the current deductible period, **or**~~

~~2. to reapply and establish a new deductible period if his or her income still exceeds the appropriate Medicaid income limit.~~

24.13 DEATH DURING A DEDUCTIBLE PERIOD

24.13.1 Death During a Deductible Period Introduction

If the *member* dies during the deductible period, and is not already certified, look at all countable costs (see Section 24.7.1 Countable Costs) prior to death. If those countable costs meet the deductible, certify the deceased person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income~~.~~ ~~The~~ for a group size of 1. For a group size of 2, if the spouse passes away, the deductible amount should be recalculated~~.~~ for all months after the date of death with a group size of 1 and only with the surviving spouse's income. In both cases, the deductible amount must be recalculated.

If the deductible was met, ~~eligibility~~met on a date after the first day of the deductible period and before the member dies, recalculate the amount of the deductible. If the new deductible amount will ~~be~~ cause the member to meet the deductible on an earlier date, recertify the deductible using that earlier date. Eligibility will be granted from the point from which ~~eligibility~~the deductible was determined to have been met through the date of death.

26.3 NONFINANCIAL REQUIREMENTS

26.3.5 Health and Employment Counseling Program

The HEC Program is a program certified by the *DHS* to arrange services that help ~~a~~an applicant or member reach his or her employment goals. HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months, members can re-enroll in HEC to meet the eligibility criteria for MAPP as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

~~Members who are not working can meet the MAPP work requirement if participating in an HEC program. If an *applicant* is not currently working and wants to meet with an HEC screener, pend the case for up to 30 days beyond the application processing period. For an ongoing case, pend the case for up to 30 days after the change is reported or eligibility review is completed. This allows time for the screener to determine if the person qualifies for HEC.~~

~~If a determination has not been provided by the HEC screener within the 30 days, deny the case. The member is responsible for reporting HEC participation to the IM agency. The IM agency is not responsible for tracking HEC participation.~~

26.3.5.1 Health and Employment Counseling Processing

~~As of January 1, 2012, there are not HEC specialists around the state.~~ ~~People~~Applicants or members wishing to enroll in HEC are required to complete the Health and Employment Counseling (HEC) Application (F-00004) and send it to the ~~DHS MAPP Unit~~HEC Coordinator at the following address:

Employment Initiatives Section
HEC ~~Manager~~Coordinator
Room 527
1 W. Wilson St.
Madison, WI 53708

Fax: 608-223-7755
Phone: 866-278-6440

The ~~DHS MAPP Unit~~HEC Coordinator will make a final approval or disapproval decision within 10 working days.

If the application is not approved, the member will be informed that he or she has not been approved and that he or she has the right to file a fair hearing.

If the application is approved, the ~~DHS MAPP Unit~~HEC Coordinator will send the

member an approval letter~~. In order to receive MAPP, the member is responsible for providing the IM worker with~~ and send a copy ~~of~~to the ~~approval letter~~CDPU/MDPU.

IM workers should give the Health and Employment Counseling (HEC) Application along with the Medicaid Purchase Plan Fact Sheet (P-10071) to any MAPP applicant who ~~is not yet employed.~~requests HEC. The applicant can complete the application on his or her own or with the assistance of the HEC ~~Manager.~~Coordinator or an advocate. IM workers are not expected to assist with filling out or submitting the form to the HEC ~~Manager~~Coordinator.

26.3.5.2 Health and Employment Counseling Extension

A participant can apply to extend an HEC period by contacting HEC to request an extension.

If the HEC period is ending prior to the member meeting his or her employment plan goals, but the goals can be met within the three months after the regular HEC period will end, the ~~DHS MAPP Unit~~HEC Coordinator can extend the HEC participation for three months.

26.3.5.3 Health and Employment Counseling Participation Changes

~~The HEC counselor/screener monitors the participation of the member as he or she pursues the goals described in his or her Health and Employment Counseling (HEC) Application.~~ Whenever a member notifies the IM agency that he or she has stopped participating in the HEC program~~, the~~ and is not meeting the work requirement in another way, MAPP eligibility will be terminated with an adverse action notice.

~~Whenever an~~When a HEC participant notifies the IM agency that he or she is now employed, information about the employment will be needed and eligibility will need to be redetermined.

26.4 MAPP FINANCIAL REQUIREMENTS

26.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account~~.~~ — after MAPP eligibility has been confirmed. These accounts are an exempt asset. ~~-~~There is no limit to the number of accounts, and no restriction on what the money can be used for. The accounts are for the member to deposit earned and unearned income into. They cannot be used for the member to deposit other assets, such as an inheritance.

Only ~~assets~~funds deposited in a registered Independence Account while ~~MAPP~~ the member is eligible for MAPP may be exempted~~. Deposits~~ from the asset limit. Any deposits made ~~between~~prior to MAPP enrollment or during periods of MAPP ~~eligibility~~ ineligibility are not exempt~~.~~ assets.

Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited:

- **Existing retirement/pension accounts** may be registered as Independence Accounts after the applicant has been approved for MAPP. The amount that was already accumulated in the retirement/pension account before it was designated as an Independence Account is called the "Pre-Independence Account Balance." The Pre-Independence Account Balance is considered a countable asset when MAPP eligibility is determined. Funds may be deposited in a retirement/pension account designated as an Independence Account during periods of MAPP ineligibility. However, any funds deposited during a period of MAPP ineligibility must be added to the account's Pre-Independence Account Balance and considered a countable asset.
- **Non-retirement/pension accounts** may only be opened and registered as Independence Accounts after the applicant has been approved for MAPP. Non-retirement/pension accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP. **If any funds are deposited in a non-retirement/pension account during a period of MAPP ineligibility, the Independence Account's entire balance will be considered a countable asset.**
    - For non-retirement/pension accounts registered as Independence Accounts **on or after August 1, 2020,** there should be no Pre-Independence Account Balance at any time because the only deposits that are allowed into these accounts are those made while the account owner is a MAPP member.
    - For non-retirement/pension accounts that were registered as Independence Accounts **prior to August 1, 2020,** any existing amount entered in the Pre-Independence Account Balance field will continue to count for all Medicaid programs, and the Independence Account Balance

will be exempt for all Medicaid programs that have an asset test. However, no new funds may be deposited in non-retirement/pension accounts during months when the member is ineligible for MAPP. If new funds are deposited during months when the member is ineligible, the entire asset will be counted.

~~**Example 1:** Freda creates an Independence Account out of an existing pension account in January with a pre-existing $5,000 when she becomes MAPP eligible. In March, while MAPP eligible Freda deposits another $2,000 in her Independence Account. Freda became MAPP ineligible in April and deposited another $1,200 in her Independence Account. Freda became MAPP eligible again in July. In the second period of MAPP eligibility the Independence Account pre-amount would change from $5,000 to $6,200. The only assets that can be exempted are the deposits made while MAPP eligible. In this case $2,000 would be exempt and $6,200 would be counted as an asset.~~ **Example 1:** Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was considered a countable asset during her eligibility determination. Sheila registers the retirement account as an Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance will continue to be a countable asset.

Example 2: Mac is approved for MAPP in October. He fills out the Independence Account form to register his already established savings account as an Independence account. The IM worker will be unable to approve this account as an Independence Account because it was opened and established with funds deposited prior to Mac's MAPP eligibility.

Example 3: Tom is approved for MAPP. After he receives his Notice of Decision, he opens a savings account and registers it as an Independence Account. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November to December, and eligible for MAPP again in January. Although his Independence Account will be considered exempt when his eligibility for both MAPP and Medically Needy SSI-related Medicaid is determined, he may not deposit any money into the account during November and December because he is not eligible for MAPP during that time. If he does deposit money during those months, the Independence Account's entire balance will be considered a non-exempt asset.

Example 4: Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP

again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

To qualify as an Independence Account, ~~it~~an account must be:

1. Registered with the *IM* Agency.~~–~~ Completing the F-10121 Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency. ~~Place the completed F-10121 in the member case file~~Scan the completed F-10121 to ECF and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the ~~exception of pension and retirement accounts (See 26.4.1.3 Pension or Retirement Accounts)~~following exceptions
    - Pension and retirement accounts (See 26.4.1.3 Pension or Retirement Accounts)
    - Non-retirement accounts that were registered as Independence Accounts before August 1, 2020 during a member's previous period of MAPP eligibility

(Note that cash, escrow accounts for a home sale, money owed, prepaid debit cards, and tax refunds may not be designated as Independence Accounts.)

A member's deposits (earned or unearned income) in an independence account may total up to 50% of gross ~~earning~~earnings over a 12-month period, without penalty.~~–~~ If the member's deposits, from actual (earned or unearned income), exceed 50% of his or her actual gross earnings over the same twelve-month period, a penalty is assessed (See 26.5.1.1 Penalty). Amounts withdrawn from a MAPP Independence Account during a twelve month period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example ~~2:~~ 5: Fred earns $5000 gross from January - December. Total deposits into the independence account were $3000 for the same period. ~~A~~Although a $500 withdrawal was made in December of that same year to pay for car repairs. ~~The~~ $500 withdrawal is ~~ignored~~irrelevant when determining the penalty.

The penalty is based solely on total deposits which exceeded 50% of gross earnings over a twelve month period. The result in this example would be a $500 penalty~~. (See 26.4.1.3 Pension or Retirement Accounts)~~ (50% of $5000 = $2500. The $3000 in deposits - $2500 = $500 penalty). (See 26.4.1.3 Pension or Retirement Accounts)

26.4.1.2 Independence Account Exemption Status

If a member with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) ~~is~~will remain exempt for all future ~~MAPP~~ application(s~~). The entire balance is a countable asset~~) for all ~~other~~EBD Medicaid ~~subprograms~~programs.

26.4.1.3 Pension or Retirement Accounts

A member who has a pension or retirement account can designate that account as an Independence Account. ~~-~~The initial balance is a countable asset (16.7.21 Retirement Benefits). Any dividends, interest, and deposits to the account while they are MAPP eligible are exempt from the date the Independence Account is approved.~~–~~ Continue to count the initial balance and any dividends, interest, and deposits to the account during periods of MAPP ineligibility as ~~an~~a countable asset.

26.4.2 Income

The *spouse* and applicant or member's net income must not exceed 250% of the *FPL* (See 39.5 FPL) for appropriate fiscal test group size. ~~-~~To determine this, do the following:

1. ~~1.~~ Determine ~~family~~ earned income.~~-~~ Count the member and his or her spouse's income if residing together.

2. ~~2.~~ Deduct the $65 and ½ of the earned income *disregard* from the spouse and member's earnings (15.7.5 $65 and ½ Earned Income Deduction).

3. ~~3.~~ Deduct the member's and spouse's IRWEs (15.7.4 Impairment Related Work Expenses (IRWE)). The result is the adjusted earned income.

4. ~~4.~~ Determine unearned income.~~-~~ Count the ~~member~~ applicant or member's unearned income and his or her spouse's unearned income if residing together.

5. ~~5.~~ Add the adjusted earned and unearned income together.

6. ~~6.~~ Deduct $20 from the combined income.

7. ~~7.~~ Deduct special exempt income (15.7.2 Special Exempt Income).

8. ~~8.~~ Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (or his or her spouse, if living together), if the monthly total of those expenses is above $500.

~~8.~~9. If a MAPP member receives Social Security payments, subtract the current *COLA* disregard between January 1st and the date the FPL is effective in CARES for that year.

> **Example ~~3:~~ 6:** Ed's Social Security payment amounts were $875 a month for the previous year and $900 for the current year. Calculate the current COLA disregard by subtracting ~~the~~ Ed's previous Social Security payment amounts from the current payments. Allow $25 as the current COLA disregard.

10. ~~9.~~ Subtract the historical COLA *Disregard* Amount (39.6 COLA) for MAPP members who are also determined to be a 503 (25.1 503 Eligibility) or Disabled Adult Child (DAC) (25.2 DAC).

11. ~~10.~~ Compare the result to 250% of the FPL (39.5 FPL Table). Include the member's minor dependent children (natural or adoptive) when determining fiscal test group size. Include the member's *dependent 18-year-old* child(ren) in the FTG. Do not include the member's stepchildren in the fiscal test group size.

26.4.2.1 Deduction for Medical and Remedial Expenses over $500

For MAPP only, if an applicant or member (or his or her spouse, if living together) has verified monthly out-of-pocket medical and remedial expenses that total over $500, the total amount of these expenses will be deducted from the applicant or member's and his or her spouse's income when determining whether that income is above 250% FPL in the calculation shown in 26.4.2 Income.

> **Example 7:** Shelly applies for MAPP. She verifies $350 in out-of-pocket remedial expenses for herself and $200 in out-of-pocket medical expenses for her spouse that cannot be covered by MAPP or any other third party. $550 will be deducted from income as a part of Shelly's eligibility determination.

> **Example 8:** Mary applies for MAPP. She verifies $600 in monthly out-of-pocket medical and remedial expenses, which brings her under the 250 percent of FPL

income limit for MAPP. It is possible that these expenses might be covered by MAPP once Mary is eligible, but the IM worker correctly processes the application using these verified out-of-pocket expenses. One month later, Mary realizes that MAPP is now paying for $500 of these medical and remedial expenses. Mary is required to report this change in expense within 10 days. She reports that her medical expenses have dropped to $100. The IM worker enters this change, and Mary is no longer financially eligible for MAPP because the decrease in her out-of-pocket medical and remedial expenses increases her countable income. If Mary applied again using the same expenses, the IM agency would not allow the expenses because they are now known to be covered by Medicaid.

Example 9: Jim applies for MAPP. He verifies $500 in out-of-pocket medical expenses. Because the expenses are not above $500, these expenses cannot be allowed as an income deduction for the MAPP eligibility determination.

26.5 MAPP PREMIUMS

26.5.1 Calculation

Calculate premiums using only the *member*'s income. Calculate a premium if the member's ~~gross~~ monthly ~~amount equals or~~Premium Gross Income exceeds ~~150~~100 percent of the *FPL* (see Section 39.5 Federal Poverty Level Table) for the appropriate *FTG* size.

To calculate monthly premium amount:
~~From~~

1. Determine the ~~gross~~ member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income~~, subtract~~.
~~1.~~2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:

~~a. Special exempt income (see Section 15.7.2 Special Exempt Income).~~
~~b. Standard Living Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).~~
~~c. *IRWE*. For *MAPP*, use only anticipated incurred expenses. Past medical expenses are not allowed (see Section 15.7.4 Impairment-Related Work Expenses).~~
~~d. Medical or remedial expenses. For MAPP, use only anticipated incurred expenses. Past medical expenses are not allowed (see Section 15.7.3 Medical/Remedial Expenses).~~

- ~~Current~~The member's own verified monthly impairment-related work expenses (any amount)
- The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
- The current COLA disregard from January 1 through the date the FPL is effective in CARES for that year~~.~~, if applicable

~~2.~~3. ~~The balance is the Adjusted Countable Unearned~~Determine Premium Net Income~~. This number may be~~ by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number~~.~~, change it to zero.
4. Multiply the premium net income by three percent (0.03).
5. Add the $25 Base Premium Amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount (see the Medicaid Eligibility Handbook, Section 26.5.1.1 Independence Account Penalty).

The result is the member's monthly premium amount.

Note: 503, DAC, widow or widower disregards allowed in eligibility determinations cannot be allowed in premium calculations.

~~2. From gross monthly earned income, subtract any remaining deductions from #1. If the result from #1 is a negative amount, change it to a positive number. The balance is the Adjusted Earned Income.~~
~~3. Multiply the adjusted earned income by three percent (.03).~~
~~4. Add the results of #3 and #1 together.~~
~~5. Compare the result from #4 to the premium schedule (see Section 39.10 Medicaid Purchase Plan Premiums) to determine the monthly premium amount.~~

Example 1: Shannon applies for MAPP. Her Premium Gross income is under 100 percent of the FPL. She has no premium.

Example 2: Michael applies for MAPP. His Premium Gross income is 105 percent of the FPL. Even though his impairment-related work expenses and medical/remedial expenses decrease his Premium Net Income to $0, Michael will still have a $25 monthly MAPP premium.

Example 3: Susan is a MAPP member whose Premium Gross income is 206 percent of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below:
$2,200 Premium Gross Income
− $300 monthly IRWE deduction
− $150 monthly medical/remedial deduction

$1,750 Countable Net Income
− $1,063.33 (100% of the FPL)

$686.67 Premium Net Income
$686.67 Premium Net Income
X 0.03 (3%)

$20.60
+$25 Base Premium Amount

$45.60 (round down to nearest whole dollar)
Susan's monthly MAPP premium is $45.

26.5.1.1 Independence Account Penalty

If the member ~~puts~~deposits income (earned or unearned) in an amount that exceeds 50 percent of the ~~actual~~ member's gross earnings into an Independence Account, the

member ~~would~~will be penalized using the following formula. ~~At review~~At renewal or re-application for MAPP, look back 12 months and:

1. Take the total verified Annual Deposits minus 50 percent of verified annual gross earned income divided by 12 to get the monthly assessment.
2. Add this monthly assessment to the premium for the next 12 months of eligibility. ~~Only~~CWW will only impose Independence Account penalties if the member is otherwise required to pay a premium.

Example ~~1~~4: Brenda deposited $1,200 more than 50 percent of her actual annual gross earned income in her Independence Account. If Brenda's income ~~equals or~~ exceeds ~~150~~100 percent of the FPL (see Section 39.5 Federal Poverty Level Table) and she is responsible for a monthly premium, add the monthly assessment of $100 to her monthly premium for the next 12 months. If Brenda's income is less than ~~150~~or equal to 100 percent of the FPL, do not impose a penalty.

26.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the member must pay applicable premiums for the initial benefit month and for any ~~backdate~~backdated months for which the member ~~elects~~is eligible and requests coverage. If determining eligibility in the month after application, the premium for the second month also must be paid before confirming eligibility.

Example ~~2~~5: Eric applies for MAPP on January 29, but his application is not processed until February 11. The *IM* agency determines that he owes a $50 premium per month. Before eligibility is approved (confirmed), Eric must pay a $50 premium for January and a $50 premium for February.

Example ~~3~~6: Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

CARES will send premium information to MMIS~~, but the~~ and the Medicaid Purchase Plan Premium Information/Payment (F-00332) is sent to the member with the verification checklist (VCL). The IM worker continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the member ~~elects~~is eligible for and requests coverage~~. Complete the premium Medicaid Purchase Plan Premium Information/Payment (F-00332) and record~~ and recording receipt of the premium payment in CARES. Refer to ~~Process Help 25.1.6 Processing a MAPP Application Requiring a Premium.~~ Process Help 25.1.6 Processing a MAPP Application Requiring a Premium.

26.5.8 Temporary MAPP Premium Waivers due to Hardship

MAPP applicants and members who experience a temporary hardship that makes them unable to pay their premium can apply for a temporary premium waiver. There is no limit to how many temporary premium waivers may be requested, but the temporary premium waiver cannot exceed 12 months in duration **for the same hardship reason**. Applicants and members may request the premium waiver for a backdated period of up to three months, but the premium waiver cannot exceed 12 months. If a temporary premium waiver is approved for months where a premium has already been paid, those premiums must be refunded.

To request a temporary premium waiver, MAPP applicants and members will use the Request for a Temporary Waiver of Your Medicaid Purchase Plan Premium Because of a Difficult Situation (F-02603) form. The applicant or member must describe the short-term hardship and state when it began (up to three months in the past) and its expected duration.

Note that temporary premium waiver periods can begin no earlier than August 1, 2020.

A temporary hardship may include, but is not limited to, the following:

- The applicant or member has an unusual expense related to his or her health or ability to work. An unusual expense is an expense that is necessary for the ability of the individual to work or take care of his or her health that is not a regular, recurring, or planned expense. The expense cannot be anything that was used to establish eligibility or the premium amount for the individual, as these should be regular and recurring.
- The applicant or member has experienced a decrease in work hours.
- The applicant or member has lost a job but remains non-financially eligible due to a medical exemption or participation in a HEC plan.
- The applicant or member is the survivor of a crime, such as someone who has experience domestic violence or sexual assault, battery, theft, and other crimes. As a result, the member has incurred extra expenses or is unable to access his or her funds due to the crime.
- The applicant or member is experiencing temporary transportation issues, causing a decrease in the hours he or she can work.
- The applicant or member is experiencing temporary child care issues, causing a decrease in the number of hours he or she can work.
- The applicant or member has experienced a sudden increase in household expenses such as rent, vehicle insurance, utilities, gas, etc.

IM workers will be required to review temporary premium waiver requests and approve or deny them within 30 calendar days after receipt of the request.

In determining whether there is hardship, the IM worker may only consider circumstances that are documented. Hardship must be verified (see Section 20.1 Verification). Proof includes, but is not limited to, the following:

- Agency form
- Employer statement/paystub/taxes/Employer Verification of Earnings form (EVF-E)
- Collateral contact
- A statement from a health care or mental health provider, such as a medical doctor, psychiatrist, social worker, AODA professional, or psychologist, that identifies there is an issue and time period in which the individual cannot work.
- A receipt for the unusual health or work related expense.

Verification must be received by the due date (or the extended due date if additional time is requested) in order to process an application for a temporary waiver of premium. If verification is not received by the due date or extended due date, the request must be denied. This denial does not prevent the applicant or member from submitting another request for the same time period and being approved once verification has been received, as long as the request does not include a backdate of longer than three months prior to the month the request is received.

Example 7: On November 1, John requested a temporary waiver of premium starting August 1, but he did not provide the requested verification, so the request was denied. On December 1, John submits a new request for a temporary waiver of premium with the appropriate verification. The earliest that the waiver could be approved is September 1.

If the request for temporary waiver of premium is denied, the waiver applicant will be notified. The waiver applicant has the right to appeal the decision through a written request to the Division of Appeals (DHA). The waiver applicant has 45 calendar days from the date of the notice issuance to file the appeal.

If the request is approved, the premium waiver period will begin on one of the following:

- The first day of the month in which the temporary premium waiver request was received.
- The first day of the month after the month in which the temporary premium waiver request was received.
- The first day of the month one, two, or three months prior to the month in which the temporary premium waiver request was received, if the applicant or member stated on the request form that the temporary hardship began in the past.

Note: When processing temporary premium waiver requests received before October 2020, IM workers should remember that the premium waiver period can begin no earlier than August 1, 2020, even if the hardship began before August 1.

Example 8: Susie requests a temporary waiver of premium on March 31. If approved, the premium waiver period could start as early as December 1 and as late as April 1, depending on the request and the verification.

The member's premium will be waived for the duration approved by the agency (up to 12 months). Temporary premium waivers that have been granted for a shorter duration than 12 months can be extended at the member's request for up to the full 12-month limit for a given hardship reason.

Example 9: Mae is a MAPP member who uses a car to get to work. Her vehicle requires an expensive fix by a mechanic. She requests a three month temporary premium waiver to help her redirect the funds toward the repairs on the car. The request is approved. When the repairs are completed, they were twice what she was quoted. She requests a three month extension of her temporary premium waiver in order to redirect those funds to the remaining repair bill. That request is approved.

Example 10: Stan is a MAPP member. He is experiencing health concerns that impact his ability to work the number of hours he typically works. While the IM worker has adjusted his premium due to the decrease in income, his doctor tells him it could be nine months before he will be back to normal work hours. He requests a temporary premium waiver and is approved. At month eight of his premium waiver, Stan's doctors inform him that they cannot approve an increase in his hours for another six months. Stan requests an extension to his temporary premium waiver. Because he has an approved nine month waiver and the maximum time a waiver can be granted for the same hardship reason is 12 months, the IM worker can only approve an additional three months to extend the waiver.

26.6 MAPP RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

26.6.1 MAPP Restrictive Re-enrollment Period Introduction

~~When a~~A MAPP member ~~is placed in a restrictive re-enrollment period (RRP), he~~who fails to pay the premium on time will lose his or ~~she is ineligible for the next six consecutive~~her MAPP benefits and will be subject to an RRP of three months ~~following~~, beginning with the ~~closure of *MAPP*, unless there is good cause (26.6.2 Good Cause). After~~month after the ~~six consecutive months,~~ missing payment month. (For example, if the member ~~may~~does not pay the December premium by the due date (December 10), an RRP will be imposed at December adverse action from January to March). A MAPP member will be able to regain eligibility ~~if he or she~~during the RRP if any of the following conditions are met:

- The member pays all ~~arrears and current~~past-due premiums~~. After 12 calendar months, he or she may regain eligibility~~ by the last day of the RRP. Members must pay the overdue premium(s) that resulted in case closure, but do not have to pay the premium owed for the following month, unless the late payment is made after the benefit month.
- The member becomes eligible for MAPP without ~~paying the past due premiums~~a premium (that is, the member's gross monthly income is reduced to at or below 100 percent of the FPL). Note: The RRP will still run in the background and will be reinstated if the member's income increases above 100 percent of the FPL during the RRP.
- The member is granted a temporary premium waiver for the duration of the RRP or makes the past due payments for any RRP months not covered by the temporary premium waiver.

Example 1: Amy is eligible for MAPP with a premium. She misses her April MAPP premium payment and an RRP is imposed for May, June, and July. In May, she applies for and is granted a temporary MAPP premium waiver for April 1 through August 31. The RRP is lifted and Amy is eligible for MAPP with no premium effective April 1. She will be required to pay premiums again starting in September.

Example 2: Lynn is eligible for MAPP with a premium. She misses her June premium payment and is placed in an RRP on July 1. Lynn pays for June and July's premiums on July 30 to end her RRP and become eligible for MAPP. Her August premium is not due until August 10, so she is not required to pay that amount in order to end the RRP.

Example 3: John is eligible for MAPP with a premium. He misses his January MAPP premium payment and an RRP is imposed for February, March, and April. In March, his employer decreases his work hours and John's gross income is now under 100 percent of the FPL, making him eligible without a premium starting March 1. He pays

the January and February premium arrears and regains MAPP eligibility effective January 1. If John did not pay the January and February premiums, he would open as of March 1.

RRPs are tied to non-payment of premiums only. RRPs do not apply to recipients who have not met HEC requirements.

26.7 MAPP CHANGES

26.7.1 MAPP Changes Introduction

The *member* must report within ten days all changes to income, household composition, allowable deductions, including medical and remedial expenses that were once out of pocket but are covered once the applicant is a MAPP member, and other non-financial changes, including loss of employment, which affect eligibility. The *IM* worker should re-determine eligibility as a result of the changes. If it is determined that he or she remains eligible for *MAPP* and owes a premium, recalculate the premium amount.

Example 1: Nancy does not have health insurance and currently pays $550 a month for a variety of medical/remedial expenses. She applies for MAPP and is found eligible as of December 1. Once she is eligible, MAPP will cover some of her medical/remedial expenses and reduce her out of pocket medical/remedial expenses down to $50 a month in December. Because Nancy must wait until the end of December to determine the final decrease in her monthly out of pocket expenses, she must report this decrease no later than January 10th.

27.7 COST OF CARE CALCULATION

27.7.1 Introduction

After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount the person will pay each month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution, including those enrolled in Family Care, Family Care Partnership, or PACE who are in or likely to be in a medical institution for 30 or more days. Institutionalized people are expected to pay their patient liability to the institution they are residing in, or to their MCO if they are enrolled in Family Care, Family Care Partnership, or PACE, as of the first day of the month.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a *community spouse*, subtract the following from the person's monthly income:
    a. $65 and ½ earned income *disregard* (see Section 15.7.5 $65 and ½ Earned Income Deduction).
    b. Monthly cost for health insurance (see Section 27.6.4 Health Insurance).
    c. Support payments (see Section 15.7.2.1 Support Payments).
    d. Personal needs allowance (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).
    e. Home maintenance costs, if applicable (see Section 15.7.1 Maintaining Home or Apartment).
    f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (see Section 27.6.6 Fees to Guardians or Attorneys).
    g. Medical or remedial expenses (see Section 27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services).

2. For a Medicaid member in a medical institution who has a community spouse, follow the directions in Section 18.6 Spousal Impoverishment Income Allocation.
3. For a community waivers member with or without a community spouse, follow the directions in Section 28.5 Home and Community-Based Waivers Long-Term Care Cost Sharing.
4. There is no cost of care for *SSI* recipients.
5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

Note: 503, DAC, Widow or Widower, and COLA disregards that are used in eligibility determinations for Special Status Medicaid are not used in Patient Liability Calculations.

If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

27.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month~~, send a completed Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) by fax to 608-221-8815 or by mail to:~~ and the nursing home requests it, the patient liability can be adjusted to be equal to the nursing home charges for that month. See PH 11.2.2.3.

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

~~Indicate the patient liability amount as equal to the nursing home charges for the month. This is done for potential retroactive nursing home rate adjustments. The nursing home will notify the Estate Recovery Program of who received the excess income. The Estate Recovery Program will attempt recovery even if the money goes to the heir directly. The Estate Recovery Program uses the same process to recover this excess income as it does for recovering patient fund accounts (see Section 22.1.5.7 Patient Fund Account).~~

28.6 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE ELIGIBILITY GROUPS AND COST SHARING

28.6.4 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (Section 25.0 Special Status Medicaid Introduction) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, he or she does not owe a cost share to the new MCO that month.

IRIS, Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.

Cost Share or Patient Liability Effective Dates
Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- Before adverse action: Effective the first of the following month.
- After adverse action: Effective the first of the month after the following month.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later.

32.2 QUALIFIED MEDICARE BENEFICIARY

32.2.1 Introduction

To be eligible for QMB the person must:

1. Meet non-financial Medicaid requirements
2. Be receiving Medicare Part A

The following Medicaid members are categorically eligible for *QMB* benefits:

- People who are receiving or are eligible to receive *SSI*.
- People who are eligible for categorically or medically needy SSI-related Medicaid as a:
  - 503 assistance group (as defined in Section 25.1 503 Eligibility).
  - *DAC* (as defined in Section 25.2 Disabled Adult Child).
  - Widow or widower (as defined in Section 25.3 Widows and Widowers).

Note: If a member is not eligible for categorically or medically needy SSI-related Medicaid through any of these four groups, he or she is not automatically eligible for QMB benefits.

Example 1: Kate receives an SSDC payment from Social Security. Due to other unearned income, however, Kate is not eligible for categorically or medically needy SSI-related Medicaid as a DAC. Even though she receives a "DAC" payment, she is not automatically eligible for QMB because she is not eligible for Medicaid through the receipt of SSI or through Special Status Medicaid.

A 503 assistance group, DAC, and widow or widower, as defined above, have the option of not taking the QMB benefit.

39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

The values in the following table were effective January 1, 2020.

Group Size				
Category		**1**		**2**
SSI-Related Categorically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$~~605~~866.78 ~~(+ actual shelter up to $261.00~~(effective 8/1/2020)	Income	~~$915.38 (+ actual shelter up to $391.67)~~$1,307.05 (effective 8/1/2020)
SSI-Related Medically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$1063.33 (effective 2/1/2020)	Income	$1,436.67 (effective 2/1/2020)
***SSI* Payment Level**				
Federal SSI Payment Level	Income	$783.00	Income	$1,175.00
SSP	Income	$83.78	Income	$132.05
Total	Income	$866.78	Income	$1,307.05
SSI Payment Level + E Supplement	Income	$962.77 (Home Maintenance Maximum Allowance)		$1,652.41
SSI E Supplement	Income	$95.99		$345.36

Community Waivers Special Income Limit	Income	$2,349.00		
Institutions Categorically Needy Income Limit	Income	$2,349.00		
Substantial Gainful Activity Limit (non-blind individuals)	Income	$1,260.00		
Substantial Gainful Activity Limit (blind individuals)	Income	$2,110.00		

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2019.

Description		**Amount**
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,349.00
EBD Deeming Amount to an Ineligible ~~*Minor*~~Minor		$392.00
Community Waivers Basic Needs Allowance		$963.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$783.00 $1,175.00

MAPP Standard Living Allowance Standard Living Allowance = SSI + State Supplement + $20 **Note:** This amount is only used in MAPP premium calculations made prior to August 1, 2020.	$886.00

The spousal impoverishment values in the following table were effective July 1, ~~2019~~2020.

Description	Amount
~~*Community Spouse*~~Community Spouse Lower Income Allocation Limit	$2,~~818~~873.34
Community Spouse Excess Shelter Cost Limit	$~~845.50~~862.00
Family Member Income Allowance	$~~704.58~~718.34

39.5 FEDERAL POVERTY LEVEL TABLE

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL	160% FPL	185% FPL	191% FPL	200% FPL	201% FPL	240% FPL	~~260~~ 250% FPL	300% FPL	306% FPL	300% of 200% FPL
1	$12,760	$1,063.33	$1,276.00	$1,414.23	$1,435.50	$1,595.00	$1,658.79	$1,701.33	$1,967.16	$2,030.96	$2,126.66	$2,137.29	$2,551.99	$2,658.33	$3,189.99	$3,253.79	
2	$17,240	$1,436.67	$1,724.00	$1,910.77	$1,939.50	$2,155.01	$2,241.21	$2,298.67	$2,657.84	$2,744.04	$2,873.34	$2,887.71	$3,448.01	$3,591.68	$4,310.01	$4,396.21	$862.00
3	$21,720	$1,810.00	$2,172.00	$2,407.30	$2,443.50	$2,715.00	$2,823.60	$2,896.00	$3,348.50	$3,457.10	$3,620.00	$3,638.10	$4,344.00	$4,525.00	$5,430.00	$5,538.60	
4	$26,200	$2,183.33	$2,620.00	$2,903.83	$2,947.50	$3,275.00	$3,405.99	$3,493.33	$4,039.16	$4,170.16	$4,366.66	$4,388.49	$5,239.99	$5,458.33	$6,549.99	$6,680.99	

5	$30,680	$2,556.67	$3,068.000	$3,400.37	$3,451.50	$3,835.01	$3,988.41	$4,090.67	$4,729.84	$4,883.24	$5,113.34	$5,138.91	$6,136.01	$6,391.68	$7,670.01	$7,823.41	
6	$35,160	$~~9~~2,930.000	$3,516.000	$3,896.90	$3,955.50	$4,395.000	$4,570.80	$4,688.000	$5,420.50	$5,596.30	$5,860.000	$5,889.30	$7,032.000	$7,325.000	$8,790.000	$8,965.80	
7	$39,640	$3,303.333	$3,964.000	$4,393.43	$4,459.50	$4,955.000	$5,153.19	$5,285.333	$6,111.116	$6,309.36	$6,606.666	$6,639.69	$7,927.999	$8,258.333	$9,909.999	$10,108.19	
8	$44,120	$3,676.667	$4,412.000	$4,889.97	$4,963.50	$5,515.001	$5,735.561	$5,882.667	$6,801.884	$7,022.44	$7,353.334	$7,390.11	$8,824.001	$9,191.668	$11,030.01	$11,250.61	
9	$48,600	$4,050.000	$4,860.000	$5,386.50	$5,467.50	$6,075.000	$6,318.000	$6,480.000	$7,492.50	$7,735.50	$8,100.000	$8,140.50	$9,720.000	$10,125.00	$12,150.00	$12,393.00	
10	$530	$4,442	$5,330	$5,888	$5,997	$6,663	$6,930	$7,007	$8,118	$8,444	$8,884	$8,889	$10,666	$11,110	$13,332	$13,535	

	80	3.333	8.000	3.003	1.150	5.000	0.339	7.333	3.166	8.556	6.666	0.889	15.999	58.333	69.999	35.339	
11	$57,560	$4,796.667	$5,756.000	$6,379.557	$6,475.550	$7,195.001	$7,482.881	$7,674.667	$8,873.884	$9,161.64	$9,593.334	$9,641.311	$11,512.001	$11,991.668	$14,390.001	$14,677.81	
12	$62,040	$5,170.000	$6,204.000	$6,876.100	$6,979.500	$7,755.000	$8,065.200	$8,272.000	$9,564.500	$9,874.700	$10,340.000	$10,391.700	$12,408.000	$12,925.000	$15,510.000	$15,820.20	
13	$66,520	$5,543.333	$6,652.000	$7,372.663	$7,483.550	$8,315.000	$8,647.559	$8,869.333	$10,255.166	$10,587.766	$11,086.666	$11,142.09	$13,303.999	$13,858.333	$16,629.999	$16,962.559	
14	$71,000	$5,916.667	$7,100.000	$7,869.117	$7,987.550	$8,875.001	$9,230.001	$9,466.667	$10,945.584	$11,300.084	$11,833.334	$11,892.51	$14,200.001	$14,791.668	$17,750.001	$18,105.001	
15	$75,480	$6,290.000	$7,548.000	$8,365.770	$8,491.550	$9,435.000	$9,812.400	$10,064.	$11,636.	$12,013.	$12,580.	$12,642.	$15,096.	$15,725.	$18,870.	$19,247.	

								00	50	90	00	90	00	00	00	40	
16	$79,960	$6,663.33	$7,996.00	$8,862.23	$8,995.50	$9,995.00	$10,394.79	$10,661.33	$12,327.16	$12,726.96	$13,326.66	$13,393.29	$15,991.99	$16,658.33	$19,989.99	$20,389.79	
17	$84,440	$7,036.67	$8,444.00	$9,358.77	$9,499.50	$10,555.01	$10,977.21	$11,258.67	$13,017.84	$13,440.04	$14,073.34	$14,143.71	$16,888.01	$17,591.68	$21,110.01	$21,532.21	
18	$88,920	$7,140.00	$8,892.00	$9,855.30	$10,003.50	$11,115.00	$11,559.60	$11,856.00	$13,708.50	$14,153.10	$14,820.00	$14,894.10	$17,784.00	$18,525.00	$22,230.00	$22,674.60	
19	$93,400	$7,783.33	$9,340.00	$10,351.83	$10,507.50	$11,675.00	$12,141.99	$12,453.33	$14,399.16	$14,866.16	$15,566.66	$15,644.49	$18,679.99	$19,458.33	$23,349.99	$23,816.99	
20	$97,880	$8,156.67	$9,788.00	$10,848.37	$11,011.50	$12,235.01	$12,724.41	$13,050.67	$15,089.84	$15,579.24	$16,313.34	$16,394.91	$19,576.01	$20,391.68	$24,470.01	$24,959.41	

21	$102,360	$8,530.000	$10,236.000	$11,344.900	$11,515.500	$12,795.000	$13,306.800	$13,648.000	$15,780.500	$16,292.300	$17,060.000	$17,145.300	$20,472.000	$21,325.000	$25,590.000	$26,101.800	
22	$106,840	$8,903.333	$10,684.000	$11,841.433	$12,019.500	$13,355.000	$13,889.199	$14,245.333	$16,471.166	$17,005.366	$17,806.666	$17,895.699	$21,367.999	$22,258.333	$26,709.999	$27,244.199	
23	$111,320	$9,276.667	$11,132.000	$12,337.977	$12,523.500	$13,915.001	$14,471.601	$14,842.667	$17,161.884	$17,718.444	$18,553.334	$18,646.611	$22,264.001	$23,191.668	$27,830.001	$28,386.601	
24	$115,800	$9,650.000	$11,580.000	$12,834.550	$13,207.500	$14,475.000	$15,054.000	$15,440.000	$17,852.550	$18,431.150	$19,300.000	$19,396.550	$23,160.000	$24,125.000	$28,950.000	$29,529.000	
eachadditionalpe	$4,480	$373.333	$448.000	$496.653	$504.000	$560.000	$582.399	$597.333	$690.666	$713.306	$746.666	$750.399	$895.999	$933.333	$1,119.999	$1,142.399	

rson																	
		QMB BC+ Extension s trigger limit BC+ Adults limit	SLMB	BC+ adult premium limit	QI-1 (slmb+)	MAP Premium limit	MAGI/ BC+ Limit for kids 6-18 s subject to access / backdate / EE	Senior Care tier one limit	BC+ EE for kids ages 1-5	MAGI/ BC+ limit for kids 1-5 subject to access / backdate / EE	QDWI & lower SIInc Alloc BC+ kids premiums BC+ adults limit	MAGI/ BC+ kids premiums	Senior Care tier three limit	MAPP	BC+ pregnant women kids limit	MAGI/ BC+ pregnant women kids limit	excess shelter allowance

		Annual figures for SeniorCare	

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39.6 COST-OF-LIVING ADJUSTMENT

To calculate the *COLA disregard* amount, do the following:

1. Find the *AG*'s current gross *OASDI* Benefits income. The gross OASDI income is the sum of the following:

    - OASDI check.
    - Any amount that has been withheld for a Medicare premium.
    - Any amount withheld to repay an earlier overpayment.

    Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.

2. On the COLA Disregard Amount Table below, find the last month in which the person was eligible for and received a check for both OASDI and *SSI*.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount	
January to December 2019	0.015748
January to December 2018	0.042556
January to December 2017	0.061330
January to December 2016	0.064137
January to December 2015	0.064137
January to December 2014	0.079781
January to December 2013	0.093380
January to December 2012	0.108535
January to December 2011	0.139513
January to December 2010	0.139513

January to December 2009	0.139513
January to December 2008	0.186685
January to December 2007	0.204971
January to December 2006	0.230369
January to December 2005	0.260681
January to December 2004	0.280118
January to December 2003	0.294924
January to December 2002	0.304659
January to December 2001	0.322280
January to December 2000	0.345198
January to December 1999	0.360545
January to December 1998	0.368751
January to December 1997	0.381734
January to December 1996	0.399159
January to December 1995	0.414385
January to December 1994	0.430335
January to December 1993	0.444771
January to December 1992	0.460493
January to December 1991	0.480177
January to December 1990	0.506809
January to December 1989	0.528948
January to December 1988	0.547066

January to December 1987	0.565322
January to December 1986	0.570900
January to December 1985	0.583803
January to December 1984	0.597877
July 1983 to December 1983	0.611475
July 1982 to June 1983	0.638245
July 1981 to June 1982	0.674681
July 1980 to June 1981	0.715381
July 1979 to June 1980	0.741020
July 1978 to June 1979	0.756827
July 1977 to June 1978	0.770375
July 1976 to June 1977	0.784187
July 1975 to June 1976	0.800173

39.10 MEDICAID PURCHASE PLAN PREMIUMS BEFORE AUGUST 1, 2020 ONLY

The following are *MAPP* premiums for months of eligibility **up to and including July 2020** for members whose gross monthly income equals or exceeds 150 percent of the *FPL* for the appropriate fiscal test group size.

For MAPP premiums for months of eligibility starting August 1, 2020 please reference Section 26.5 MAPP Premiums.

MAPP PREMIUM SCHEDULE prior to August 1, 2020					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
$0	$25.00	$0.00	500.01	525.00	500.00
25.01	50.00	25.00	525.01	550.00	525.00
50.01	75.00	50.00	550.01	575.00	550.00
75.01	100.00	75.00	575.01	600.00	575.00
100.01	125.00	100.00	600.01	625.00	600.00
125.01	150.00	125.00	625.01	650.00	625.00
150.01	175.00	150.00	650.01	675.00	650.00
175.01	200.00	175.00	675.01	700.00	675.00
200.01	225.00	200.00	700.01	725.00	700.00
225.01	250.00	225.00	725.01	750.00	725.00
250.01	275.00	250.00	750.01	775.00	750.00
275.01	300.00	275.00	775.01	800.00	775.00

300.01	325.00	300.00	800.01	825.00	800.00
325.01	350.00	325.00	825.01	850.00	825.00
350.01	375.00	350.00	850.01	875.00	850.00
375.01	400.00	375.00	875.01	900.00	875.00
400.01	425.00	400.00	900.01	925.00	900.00
425.01	450.00	425.00	925.01	950.00	925.00
450.01	475.00	450.00	950.01	975.00	950.00
475.01	500.00	475.00	975.01	1000.00	975.00
			1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than $1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs, depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his or her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1:** Co-Payment (Annual income is at or below 160% of the *FPL*.)
- **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b**: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL may be adjusted annually. See 39.5 Federal Poverty Level Table for current FPLs. ~~If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.~~

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $20,416 per individual or $27,584 per couple annually.*	▪ No deductible or spenddown. ▪ $5 co-pay for each covered generic prescription drug. ▪ $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL**	▪ $500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the $500 deductible is met. ▪ After $500 deductible is met, pay a $5 co-pay for each covered generic prescription

$20,417 to $25,520 per individual and $27,585 to $34,480 per couple annually.*	drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% and at or below 240% of FPL** $25,521 to $30,624 per individual and $34,481 to $41,376 per couple annually.	▪ $850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $30,625 or higher per individual and $41,377 or higher per couple annually.*	▪ Pay retail price for drugs equal to the difference between the member's and $30,625 per individual or $41,377 per couple. This is called "spenddown." ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an $850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2020 federal poverty guidelines, which typically increase by a small amount each year.

39.11.5.2 Level 3: Fiscal Test Group of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most

covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 2: Bob and Alice's annual income is $43,376, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his or her costs count toward the spenddown. He or she pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 3: Tracy and Dave's annual income is $43,376, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of ~~her~~his benefit period.

39.12 FIVE PERCENT COPAY LIMIT TIERS

2020 Per-Member Copay Limits											
Status	Assistance Group Income Tier as Percentage of the Federal Poverty Level										
	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	$0	$26	$53	$79	$106	$132	$159	$186	$212	$239	$265
Prorated (split between counted spouses)	$0	$13	$26.50	$39.50	$53	$66	$79.50	$93	$106	$119.50	$132.50

40.1 WORKSHEETS TABLE OF CONTENTS

The following is a list of Medicaid worksheets. ~~All~~Workers should come here each time a worksheet is needed to insure they are using the most up to date worksheets ~~should be copied for your use~~.

WORKSHEETS	
NUMBER	**NAME**
Wkst 01	Medicaid Non-Financial
Wkst 02	Dependent Care
Wkst 03	Medicaid Deductible
Wkst 04	Medicaid Institution Determination
Wkst 05	Medicaid Extensions (obsolete)
Wkst 06	Supplemental Security Income-Related Determination Worksheet
Wkst 07	Spousal Impoverishment Income Allocation
Wkst 08	Medicaid Purchase Plan (MAPP) Eligibility as of 8/1/2020 Medicaid Purchase Plan (MAPP) Eligibility prior to 8/1/2020
Wkst 09	Medicaid Purchase Plan (MAPP) Premium Calculation as of 8/1/2020 Medicaid Purchase Plan (MAPP) Premium Calculation prior to 8/1/2020
Wkst 10	Medicaid Purchase Plan (MAPP) Work Expenses
Wkst 11	Medicaid Purchase Plan (MAPP) Medicaid/Remedial Expenses
Wkst 12	Family Care Eligibility – Non-MA Financial Determination (obsolete)
Wkst 13	FFU Income (obsolete)
Wkst 14	AFDC-Related Determination Worksheet