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

To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 20-04**

Release Date: 11/23/2020

Effective Date: 11/23/2020

EFFECTIVE DATE		The following policy additions or changes are **effective 11/23/2020** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.9	**Denials and Terminations**	Updated policy for signatures on re-requests
6.9	**Inmates**	Moved policy to new chapter 13
9.6.2	**Policies Not to Report**	Updated step 2 of policy for premiums
13.1	**Introduction**	*New section*
13.2	**Covered Services**	*New section*
13.3	**Suspension Start Date**	*New section*
13.4	**Suspension End Date**	*New section*
13.5	**Renewals**	*New section*
13.6	**Change Reporting**	*New section*
13.7	**Household Composition**	*New section*
13.8	**Special Rules**	*New section*
13.9	**State Correctional Institutions**	*New section*
15.3.14	**Payments to Native Americans**	Added new payment type
15.3.30	**Federal Coronavirus Recovery Rebates (Stimulus Payments)**	*New section*
15.3.31	**Federal Pandemic Unemployment Compensation (FPUC)**	*New section*
15.3.32	**Retroactive Pandemic Unemployment Assistance (PUA)**	*New section*
15.3.33	**Retroactive Pandemic**	*New section*

	Emergency Unemployment Compensation (PUEC)	
15.3.5	**Disaster and Emergency Assistance**	Clarified emergency assistance payments that can be disregarded
15.4.23	**Rental Income**	*New section*
15.5.18	**Prison or Jail Job**	*New section*
15.5.3	**Rental Income**	Moved Rental Income policies to new section 15.4.32
15.6.4	**Self-Employed Income Sources**	Moved Rental Income policies to new section 15.4.32
16.2.2	**Real Property**	Updated policy for when property is available as an asset
16.5.4	**Spaces**	Updated language used in policy and added reference
16.7.11.3	**Reimbursement of Cost Share or Patient Liability Payments**	*New section*
16.7.33	**Federal Coronavirus Recovery Rebates (Stimulus Payments)**	*New section*
16.7.34	**Retroactive Federal Pandemic Unemployment Assistance (PUA)**	*New section*
16.7.35	**Retroactive Federal Pandemic Emergency Unemployment Compensation (PEUC) Payments**	*New section*
16.7.36	**Retroactive Federal Pandemic Unemployment Compensation (FPUC) Payments**	*New section*
16.8	**Exempt Home Property**	Added reference for home exemptions
17.4	**Exceptions**	Updated exceptions for COVID-19
18.4.1	**Spousal Impoverishments Assets**	Clarified policy
18.4.2	**Asset Assessment**	Removed clarification on when a person is determined functionally eligible for HCBW
18.8	**Spousal Impoverishment Notices**	Added note for Group A requirements
18.9	**Community Spouse's Medicaid Application**	Updated policy for counting assets
20.3.8	**Income**	Added note for Suspended members
20.3.8.1	**Reasonable Compatibility for Income for Health Care**	New Section
21.6.3	**Changes in Circumstances**	Added note for Suspended members
21.6.4	**Disenrollment**	Added instances members are disenrolled from HMO program
22.2.8.1	**Premiums**	Updated policy and added Process Help reference

22.5.3	**Community Spouse as Representitive**	*New Section*
24.7.1	**Countable Costs**	Added new examples
24.7.2	**Noncountable Costs**	Removed Plan B Premiums from not being counted for deductible
26.3.3.3	**Employment Ending**	Clarified policy and added example
26.3.8	**Institutionalization**	Updated text
26.3.9	**Community Waivers**	Updated text
27.7.1	**Introduction**	Updated text and hyperlinks
28.1.1	**Adult Home and Community Based Waivers Long-Term Care Disability Policy**	Updated policy for child disability determination
28.5.1	**Urgent Services**	Moved process to Process Help 11.3.4 and added reference
28.10	**Home and Community-Based Waivers Long-Term Care Notices**	Removed section
32.1.5	**Part B Enrollment Via the Medicare Savings Program Buy-In Program**	Moved section to Process Help 61.4.1
32.11	**Potential Adverse Effect of Medicare Savings Program Participation**	Moved section to Process Help 61.2.3
37.3	**HCBW Medicaid CARES Processing for the CLTS Waiver Program**	Moved process for this policy to Process Help 11.4 and updated CLTS policy

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2.9 DENIALS AND TERMINATIONS

2.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, Medicaid can be reopened without requiring a new application. The person may need to provide required verification.

If the person re-requests Medicaid after eligibility was terminated and the case is open for another program of assistance, do not require him or her to re-sign his or her application or sign a new application.

If more than a calendar month has passed since a member's enrollment was terminated, the applicant must file a new application to reopen his or her Medicaid.

If *EBD* Medicaid, *HCBW*, Institutional Medicaid, *MAPP*, or *MSP* eligibility closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the person may be reopened without filing a new application if he or she provides the necessary information within three months of the renewal date (see Section 3.1.6 Late Renewals).

2.9.2 Denial

If the ~~applicant~~person re-requests health care after the application was denied and the case is open for ~~any other~~another 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.

6.9 ~~INMATES~~RESERVED

Policy related to inmates has been moved to Chapter 13.

9.6 OTHER HEALTH INSURANCE

9.6.2 Policies Not To Report

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

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

13.1 ~~DEFINITIONS~~INTRODUCTION

When a Medicaid applicant or member is an inmate, they may be eligible for suspended Medicaid. Suspension is a type of eligibility in which an inmate continues to be enrolled in Medicaid while incarcerated, and does not have to complete a new application to regain benefits when released.

An inmate is someone who resides~~ing~~ in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

The following individuals are not considered to be inmates for the purposes of Medicaid:

- A staff person voluntarily residing in a public institution is not considered an inmate. ~~An inmate is a person residing in a *public institution* on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. A person~~
- An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to ~~his or her needs is not considered an inmate.~~the person's needs ~~is not considered an inmate~~.
- An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet~~, is not considered an inmate for the purposes of Medicaid~~.
- People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision) ~~are not considered inmates~~.

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see Section 27.1 Institutions), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which *Foster Care* maintenance payments are made under Title IV-E. People residing in these institutions are not inmates.

~~**Note:** The following are not publicly operated community residences, even though they may accommodate 16 or fewer residents:~~ Even though the following institutions may accommodate 16 or fewer residents, they are not considered to be publically operated community residences. People residing in these institutions may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

- Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

- Correctional or holding facilities for people who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

13.2 ~~INTRODUCTION~~COVERED SERVICES

~~People who are inmates of a public institution are not eligible for Medicaid, with two exceptions (outlined below). An inmate is a person who is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An person voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to his or her needs is not considered an inmate.~~

~~Inmates are ineligible for Medicaid services on any day in which they are residing in a public institution. Providers are prohibited from receiving payment for any services rendered to an inmate even if the inmate is still certified as eligible for Medicaid and has not received any negative notice. Inmates may never be considered temporarily absent from a household and receive Medicaid benefits. Temporary absence policies do not apply in the case of inmates.~~

Individuals who are inmates of a public institution ~~are not eligible for Medicaid with the following two exceptions:~~may be eligible for suspended SSI-related Medicaid or Wisconsin Well Woman Medicaid if they otherwise meet eligibility requirements. See Chapter 24 SSI Related Medicaid and Deductibles or Chapter 36 Wisconsin Well Woman Medicaid for information about these programs.

If a member of a different health care program becomes incarcerated, eligibility for that program will be terminated. However, the member will be evaluated for eligibility in a program that can be suspended.

During the suspension, Medicaid will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

While enrolled in suspended Medicaid, members are not eligible to enroll in an HMO.

Copay limits still apply to suspended members for any services they receive.

13.3 SUSPENSION START DATE

13.3.1 Applicants

If the applicant is already incarcerated and has been since at least the beginning of the application month, their suspension will start the first of the month of application.

> **Example 1:** Mark is incarcerated on January 17, 2021. He applies for health care on April 20, 2021, and is found eligible for suspended SSI-related Medicaid. Mark's suspension start date is April 1, 2021.

If the applicant was incarcerated after the first of the application month, the suspension will start the first of the month following the application month.

> **Example 2:** Jane is incarcerated on April 15, 2021. She applies for health care on April 20, 2021, and is found eligible. She is certified for full-benefit SSI-related Medicaid from April 1, 2021, until April 30, 2021. Jane's suspended SSI-related Medicaid starts on May 1, 2021.

13.3.2 Backdated Eligibility

If an applicant is determined eligible for a Medicaid backdate and was incarcerated during any of the backdated months, they will open in a suspended status for any backdated months in which they were incarcerated for the entire month. For any backdated months in which the person was not incarcerated for the entire month, they will open for full-benefit Medicaid.

The earliest a suspension can start is October 1, 2020. If an applicant is requesting backdated benefits for month(s) prior to October 1, 2020 and they were incarcerated during the entire backdated month, they would not be eligible for suspended or full-benefit Medicaid during that month.

> **Example 3:** Sophia is incarcerated on December 4, 2020. Her husband applies for health care for their household on May 21, 2021, and requests three months of backdated benefits. They are found eligible for SSI-related Medicaid. Sophia is open for suspended SSI-related Medicaid starting February 1, 2021. Her husband is open for full-benefit SSI-related Medicaid starting February 1, 2021.

> **Example 4:** Brady is incarcerated on February 9, 2021. He applies for health care on April 20, 2021, and requests three months of backdated benefits. He is found eligible for SSI-related Medicaid, and opens for full-benefit SSI-related Medicaid from January 1, 2021, until February 28, 2021. He is open for suspended SSI-related Medicaid starting March 1, 2021.

13.3.3 Existing Members

Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported. This policy applies even when the incarceration is reported untimely. See Section 12.1 Change Reporting Introduction. An untimely change report may result in an overpayment. See Section 22.2 Corrective Action.

> **Example 5:** Olivia is open for full-benefit SSI-related Medicaid. On December 23, 2020, Olivia reports she is incarcerated as of December 20, 2020. Olivia's SSI-related Medicaid is suspended starting January 1, 2021.

13.3.4 Deductibles

Suspended members who met a deductible before being incarcerated will maintain their existing certification period and renewal date, which is the end of the six-month deductible period.

> **Example 6:** Jordan has a Medicaid deductible period from April 1, 2021, until September 30, 2021. He meets his deductible on May 10, 2021, and becomes eligible for full-benefit Medicaid. He is incarcerated on June 19, 2021. His suspension starts July 1, 2021, and his certification period goes to September 30, 2021.

13.4 SUSPENSION END DATE

When a member in a suspension is released from prison or jail and this information becomes known to the income maintenance agency, full-benefit Medicaid eligibility can be reinstated without a new application for benefits. Upon release, the suspended member's eligibility must be redetermined. If eligible, the member's Medicaid coverage will start the first of the month in which the member is released. The ~~regular~~member's health care certification renewal date will not change.~~align with the suspended health care renewal date.~~

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

The suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. However, this retroactive lifting may only go as far back as the last renewal. This is an exception to the normal backdating policy that only allows up to three months of backdated eligibility. See Section 2.8.2 Backdated Eligibility.

13.5 RENEWALS

Members in a health care suspension will go through the normal renewal process at the end of their certification period, including administrative renewals when applicable (see Chapter 3 Renewals). Members must complete the renewal and continue to meet program eligibility criteria in order to maintain their suspension. If the member does not complete the renewal or no longer meets program eligibility criteria, the member's suspension will end and Medicaid eligibility will be terminated.

Note: ~~**Prenatal Exception:**~~If a member has appointed the prison or jail or an employee of the prison or jail as their authorized representative, that entity can complete the renewal on the member's behalf. See Section 22.5 Representatives.

13.6 CHANGE REPORTING

Existing change reporting policy applies for members in a suspension (see Chapter 12 Change Reporting). The exception is a suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. See Section 13.4 Suspension End Date.

13.7 HOUSEHOLD COMPOSITION

If the individual who is incarcerated belongs to a household, the person will be considered "temporarily absent" from the household and remain a countable member of the household for Medicaid during the suspension. The other household members will also remain countable within the incarcerated member's suspended assistance group. There is no limit to how long inmates can be considered temporarily absent from the Medicaid household, as long as they continue to meet program rules.

Applicants and members are responsible for determining if an individual who is incarcerated is part of their household or not. They will be able to include this information in the application and when reporting a change. IM workers should accept this information that is provided by the applicant or member. Verification of this information is not required. Members can also report changes to the household status during the incarceration period.

Example: Quinton and Meg are married and both are enrolled in Medicaid. Quinton is the Primary Person on the case. Meg is incarcerated on January 3, 2021. Quinton reports Meg's incarceration and that she is still part of the household. Meg's suspension starts on February 1, 2021, and she continues to be on the same case as Quinton. On June 7, 2021, Quinton decides that Meg is no longer part of the household. He reports that Meg is still incarcerated but is no longer part of the same household as him. Meg is removed from the case and her suspension ends June 30, 2021. Meg must fill out a new application for herself if she wants to continue having suspended health care benefits going forward.

13.8 SPECIAL RULES

13.8.1 Children Whose Parent/Caretaker is an Inmate

If the only parent(s)/caretaker(s) in the household are incarcerated, any children on the case open for Medicaid will remain eligible for a three-month grace period. Eligibility for the children will end after the three-month grace period unless they open for health care on another case.

> **Example 1:** Faye and her 10-year-old daughter, Chantelle, are both enrolled in health care. Faye is enrolled in medically needy Medicaid and Chantelle is enrolled in BadgerCare Plus. On March 9, 2021, Faye is incarcerated. Faye's suspended Medicaid starts April 1, 2021. Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for the three-month grace period. Chantelle's BadgerCare Plus will end June 30, 2021. Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.

13.8.2 Pregnant Women ~~may apply for and receive~~

Pregnant women who are incarcerated will have their eligibility determined under the BadgerCare Plus Prenatal Program ~~benefits while they are an inmate.~~(see BadgerCare Plus Eligibility Handbook, Section 41.1 BadgerCare Plus Prenatal Program).

1. ~~When **Inpatient Exception:** If an inmate resides outside a public correctional institution for more than 24 hours at any one time, he or she can qualify for Medicaid during that time period if he or she meets all other eligibility criteria. For example, if an inmate of a public institution is admitted as an inpatient to a medical institution for 24 hours or more and is otherwise eligible, manually certify him or her for Medicaid from the admission date through the discharge date.~~

~~Procedures for processing inmates of state facilities are covered in 6.9.3 Inmates of State Correctional Institutions below.~~

~~6~~the pregnancy ends, BadgerCare Plus Prenatal Program members must have their health care eligibility redetermined for the next month. If determined eligible for Medicaid, the member will open for suspended Medicaid.

13.8.3 Huber Law

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

- They intend to return to the home.

- They continue to be involved in the planning for the support and care of their minor children.

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

13.8.4 Out-of-State Inmates

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

> **Example 2:** Oscar resides in Wisconsin. He commits a crime in Wisconsin and is incarcerated in a Wisconsin Department of Corrections facility. Due to a shortage of space, Oscar is transferred to a prison in Minnesota. Oscar remains a Wisconsin resident and may be eligible for suspended Medicaid or Medicaid while he is residing in the prison in Minnesota.

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

> **Example 3:** Connor resides in Wisconsin. He commits a crime in Illinois and is incarcerated in an Illinois correctional facility. Connor is an Illinois resident while he is residing in the facility in Illinois. He is not eligible for suspended or full-benefit Medicaid in Wisconsin since he is not a Wisconsin resident.

13.9 .3 GENERAL MEDICAID APPLICATION PROCESS FOR INMATES OF STATE CORRECTIONAL INSTITUTIONS

Use The following process for inmates is the list of state correctional institutions: administered by the Wisconsin Department of Corrections.

1. *DOC* staff submits an application using ACCESS, which will then be systematically routed to EM CAPO. Superintendents of state correctional facilities (wardens) or their designee may sign the application for the inmate. Refer to Section 6.9.5 State Correctional Institutions for the list of state correctional facilities at which the warden may sign the application.
2. Process the inmate as a one-person household with a living arrangement of "01 - Independent (Home/Apt/Trlr)" on the Current Demographics page.
3. If the inmate is 65 years old or older or ineligible for BadgerCare Plus due to excess income, collect asset information from DOC and test for *EBD*.
    a. If the inmate ineligible for BadgerCare Plus is younger than 65 years old and if there is no *disability* determination on file, instruct DOC to submit a Medicaid Disability Application (F-10112) along with the Medicaid application (F-10101 or through ACCESS) and the Authorization to Disclose Information to Disability Determination Bureau form (F-14014). Suppress the verification checklist for the Medicaid Disability Application.
    b. If the inmate is 65 years old or older, instruct DOC to submit the Medicaid application (F-10101 or through ACCESS).

If the individual is eligible, close the case in CARES by changing the Health Care Request page to "N." Suppress CARES-generated notices for Medicaid and any program that the person has not requested. Manually certify the person with the appropriate medical status code (see Process Help Section 81.5 Med Stat Code Chart for a list of medical status codes) from the hospital admission date through the date of discharge. If the person has not yet been discharged, certify the person from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility. For situations in which an inmate has multiple inpatient admissions, see Section 6.9.4 Medicaid Application Process for Inmates with Multiple Inpatient Admissions.

Note: It is not necessary to provide a 10-day notice of termination for Medicaid when the reason for termination is the return of a person to prison.

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

6.9.4 Medicaid Application Process for Inmates with Multiple Inpatient Admissions

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

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

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

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

~~6.9.5 State Correctional Institutions~~

Brown
Green Bay Correctional Institution (GBCI)
Sanger Powers Correctional Institution (SPCI)

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

Columbia
Columbia Correctional Institution (CCI)

Crawford
Prairie du Chien Correctional Institution (PDCI)

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

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

Waupun Correctional Institution (WCI)

Douglas
Gordon Correctional Center (GCC)

Fond du Lac
McNaughton Correctional Center (MCC)
Taycheedah Correctional Institution (TCI)
~~Wisconsin's Women Correctional System (WWCS)~~

Grant
Wisconsin Secure Program Facility (WSPF)

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

Kenosha
Kenosha Correctional Center (KCC)

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

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

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

St. Croix
St. Croix Correctional Center (SCCC)

Sauk
New Lisbon Correctional Institution (NLCI)

Sawyer
Flambeau Correctional Center (FCC)

Sheboygan

Kettle Moraine Correctional Institution (KMCI)

Waushara
Redgranite Correctional Institution (RCI)

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

~~6.9.6 Department of Corrections Pre Release Applications from Offenders~~

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

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

~~Eligibility begins the first of the month in which the applicant is released, but providers are prohibited from billing BadgerCare Plus for any services while the applicant is still incarcerated. The first day that a member can receive BadgerCare Plus-covered services is the day of release.~~

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

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

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

~~When processing an application with DOC assistance, the DOC staff may verbally verify the release date of the applicant. If the release date is not verbally confirmed by a DOC~~

~~staff member as part of an assisted application, the worker will verify the discharge date by searching for the applicant on the WI DOC Offender Locator site.~~

~~See Process Help, Section 9.8 Processing Telephonic HC Applications from Offenders for more information on processing these applications.~~

~~Medicare (enter in CWW on the Medicare page).~~

~~1. *IHS*. on CARES.~~

~~13-14 RESERVED~~

15.3 EXEMPT/DISREGARDED INCOME

15.3.5 Disaster and Emergency Assistance

Disregard major disaster and emergency assistance payments made by federal, state, county, ~~and~~tribal, or local government agencies, ~~and other~~or disaster assistance organizations.

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims
3. Payments under the Alaskan Native Claims Settlement Act
4. Payments under the Maine Indian Claims Settlement Fund
5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000
7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge-Munsee Indian Community of Mohicans
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot
10. For EBD Medicaid cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, Minnesota reservations
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe
15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000
16. Payments under the settlement of the Cobell v. Salazar class-action trust case
17. Non-gaming tribal income from the following sources:
    - Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from one of the following:

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

18. Disregard Tribal Per Capita payments from gaming revenue up to the first $500 of the monthly payment per individual. If the payments are received less than monthly, prorate the gross payment amount over the months it is intended to cover and disregard $500 from the monthly amount.

This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons **except** the following:

- SeniorCare
- *LTC* programs, such as the following:
    - Institutional Medicaid
    - *HCBW*
    - Managed LTC or *IRIS*

For these subprograms, which are treated differently because they are covered under a different section of federal law, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

19. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
20. Payment from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
21. Money from selling things that have cultural significance
22. Tribal general welfare payments that are based on the individual's demonstration of need, even if the source of the payment is gaming revenue

15.3.30 Federal Coronavirus Recovery Rebates (Stimulus Payments)

Do not count Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments) received as part of the federal CARES Act.

Note: These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.

15.3.31 Federal Pandemic Unemployment Compensation (FPUC)

Do not count Federal Pandemic Unemployment Compensation (FPUC) payments.

Note: These were the $600 checks issued weekly from late April through July 2020, and were in addition to regular unemployment insurance benefits.

15.3.32 Retroactive Pandemic Unemployment Assistance (PUA)

Disregard retroactive Pandemic Unemployment Assistance (PUA) payments.

15.3.33 Retroactive Pandemic Emergency Unemployment Compensation (PEUC)

Disregard retroactive Pandemic Emergency Unemployment Compensation (PEUC) payments.

15.4 UNEARNED INCOME

15.4.23 Rental Income

When a Medicaid group member reports rental income to the *IRS* as self-employment income, see Section 15.6.4 Self-Employed Income Sources.

If he or she does not report it as self-employment income, the net rental income is counted as unearned income. Determine net rental income as follows:

A. When the owner is not an occupant, net rental income is the total rent payment(s) received minus the interest portion of the mortgage payment(s) and other verifiable operational costs.
    - Operational costs include ordinary and necessary expenses, such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.
    - Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include such improvements as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.

    If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

    When a life estate (see Section 16.8.1.6 Life Estate) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. The operational costs are the same as the costs the holder was liable for when living on the property.

B. When the owner is an occupant (of a duplex, triplex, etc.) and lives in one of the units, determine net rental income as follows:
    1. Add together the annual interest portion of the mortgage payment and other annual verifiable operational costs common to the entire operation to get the total annual expenses.
        - Operational costs include ordinary and necessary expenses, such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses, such as repainting, fixing gutters or floors, plastering, and replacing broken windows.
        - Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value

of the property. It would include such improvements as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.

2. Divide the result in step 1 (the total annual expenses) by the total number of units to get the proportionate annual share of expenses.
3. Multiply the amount in step 2 (the proportionate annual share of expenses) by the number of rental units (rental units means the total number of units minus the unit the owner lives in) to get the member's total annual expenses.
4. Subtract the result in step 3 (the member's total annual expenses) from the total annual rental income to get the member's net annual rental income.
5. Divide the result of step 4 (the member's net annual rental income) by 12 to get the member's net monthly rental income. Budget this amount.

Example 4: George owns a four unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is $9,765. His operational expenses, including taxes on the building, from the most recent taxes is $12,359. This totals $22,124. This amount divided by four units equals a proportionate share of $5,531.

$5,531 multiplied by three rental units equals $16,593. This represents his total budgetable annual expenses. His total annual rental income equals $28,800 ($800 per unit per month).

$28,800
–$16,593
$12,207

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

15.5 EARNED INCOME

15.5.3 Rental Income

When a Medicaid group member reports rental income to the *IRS* as self-employment income, see Section 15.6.~~3~~4 Self-~~Employment~~Employed Income~~ and Assets~~.

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

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

- ~~Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements, such as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.~~

- ~~If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.~~

~~When a life estate (see Section 16.8.1.6 Life Estate) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. The operational costs are the same as the costs the holder was liable for when living on the property.~~

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

  1. ~~Add the interest portion of the mortgage payment and other verifiable operational costs common to the entire operation.~~
  2. ~~Multiply the number of rental units by the total in 1.~~
  3. ~~Divide the result in 2. by the total number of units. This is the proportionate share.~~

~~4. Add the proportionate share (the result of 3.) to any operational costs paid by the member that are unique to any rental unit. The result is the total member expense.~~

~~Subtract the total member expense (the result of~~ see Section 15.4~~.) from the total rent payments to get "net rent."~~.23 Rental Income.

15.5.18 Prison or Jail Job

Count income that an inmate earns from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). This income does not need to be verified.

15.6 SELF-EMPLOYMENT INCOME

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.

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

Self-employment income sources are:

1. **Business**. Income from operating a business.
2. **Capital Gains**. Business income from selling securities and other property is counted. Personal capital gains are not counted as income.
3. **Rental**. Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. ~~It~~If rental income is ~~unearned when the owner reports it~~not reported to the IRS~~ as other than self-employment~~, see Section 15.4.23 Rental Income.

~~Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.~~

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

~~When a life estate (see Section 16.8.1.6 Life Estate) holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.~~

~~When the owner lives in one of the units of a multiple unit dwelling, compute the annual net rental income as follows:~~

~~1. Add the annual interest portion of the mortgage payment and other annual operational costs (including taxes) common to the entire operation.~~
~~2. Divide the result in step 1 by the *total* number of units to get the proportionate share.~~
~~3. Multiply the amount in step 2 (the proportionate share) by the number of *rental* units. Rental units means the total number of units minus the unit the owner lives in.~~
~~4. This equals total expenses.~~
~~5. Subtract total annual expenses from the total annual rental income to get net annual rental income.~~

1. Divide the net annual rental income by 12 to get the net monthly rental income. Budget this amount.

Example 1: George owns a 4 unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is $9,765. His operational expenses, including taxes on the house from the most recent taxes is $12,359. This totals $22,124. This amount divided by 4 units = a proportionate share of $5,531.

$5,531 * 3 rental units = $16,593. This represents his total budgetable annual expenses. His total annual rental income = $28, 800 ($800 per unit per month).

$28,800
-$16,593
$12,207

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

Royalties. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials, or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

16.2 ASSETS AVAILABILITY

16.2.2 Real Property

Non-exempt *real property* (see Section 16.8 Real Property) is unavailable when:

1. The person who owns the property lists it for sale with a realtor (see Section 16.9 Non-home Property Exclusions).

   If an institutionalized person owns property that is unavailable because it is listed for sale, he or she can use some of his or her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. Do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.

   ~~Allow these~~The non-exempt real property is unavailable and minimal maintenance costs ~~for~~are allowed as long as the person is making a good faith effort to sell the property at current market value.

   If the member refuses a fair market value offer(s) while the property is listed for sale with a realtor, the member is no longer making a good faith effort to sell the property. In this case, the property is an available asset and minimal maintenance costs will no longer be allowed.

2. A joint owner who is outside the fiscal test group refuses to sell the property.

When the member is a co-owner of the property with someone outside the fiscal group, you must determine whether it is owned as a joint tenancy or tenancy-in-common.

Joint tenants have a right of survivorship. That is, upon the death of one joint tenant, the other inherits the share of the deceased. A joint tenant's interest may not be sold without forcing the sale of the entire property.

Tenants-in-common has no right of survivorship. A tenant-in-common may bequeath his or her share of the property to anyone he or she chooses. He or she may also sell his or her share during his or her lifetime.

16.5 BURIAL ASSETS

16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include all the following, if they have been paid for or are included in a contract to purchase with burial insurance that meets the criteria of Section 16.5.2 Burial Insurance or a LIFBC that meets the criteria in Section 16.5.3 Life Insurance-Funded Burial Contracts:

- Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons
- Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques
- Arrangements for opening and closing the grave site

Exempt multiple spaces of any value under the following conditions:

- The space(s) must be owned by the elderly, blind, or disabled person, that person's *spouse*, or, when the EBD person is a *minor*, by the minor's parents.
- Both a plot and a mausoleum space cannot be exempted for the same person.
- Each person may have more than one type of space.
- The space(s) must be for the use of the elderly, blind, or disabled member or one of the following:
    - Spouse.
    - Minor or *adult* natural, adoptive, or stepchild.
    - Brother or sister.
    - Natural or adoptive parent.
    - Spouse of any of the above.

If the burial space expenses are being paid for through ~~an~~burial insurance or a LIFBC for a relative with a qualifying relationship (other than the EBD person and that person's spouse), allow only those expenses listed above ~~in Section 16.5.3~~ as exemptions. Any other goods or services purchased through the burial insurance or LIFBC would be a divestment.

Example 5: Bob, who is 12 years old, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: the first is for Bob, the second and third are for his parents, the fourth is for his older brother, who does not live at home, and the fifth is for Bob's uncle. All the plots and spaces are exempt except for the fifth.

Example 6: Harry is applying for HCBW. Last year he used his life insurance policy with a face value of $10,000 and a cash value of $8,000 to set up a LIFBC for his son. On the Statement of Goods and Services, $4,000 is designated for a casket,

$1,000 for a vault, and $500 for the cemetery plot, for a total of $5,500 that is exempt burial space expenses. The remaining $2,500 that was put in to the LIFBC is considered divestment.

16.7 LIQUID ASSETS

16.7.11.3 Reimbursement of Cost Share or Patient Liability Payments

To prevent the loss of eligibility due to counting a lump sum reimbursement of cost share or patient liability as an asset, the payment must be excluded as an asset in the month of its receipt, and for the next nine months. At the end of this period, any remaining available portion will be counted as an asset for purposes of determining eligibility. This time period gives members time to use these assets while also maintaining their Medicaid eligibility. This policy aligns with the treatment of lump sum payments received by members for retroactive Social Security payments (see Section 16.7.11.1, Retroactive SS Payments).

Example 5: Michelle is a former SSI recipient and now receives Social Security Disability Income and a surviving child benefit. She is considered a Disabled Adult Child (DAC) by the Social Security Administration. She applies for Medicaid but does not know when she stopped receiving SSI. Instead of being determined eligible for Medicaid as a DAC with no premium or cost share, she is determined eligible for Waiver Medicaid as a Group B with a cost share, which she pays each month. When her previous receipt of SSI is discovered, Michelle is owed the money that she paid towards her cost share and must be reimbursed that amount. Michelle has nine months after the month of receipt in which the reimbursed amount will not be considered an asset. If she receives the reimbursement in January, any remaining amount from the reimbursement will be counted as an asset in November.

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.

16.7.33 Federal Coronavirus Recovery Rebates (Stimulus Payments)

Federal Recovery Rebates (sometimes referred to as Coronavirus stimulus payments) received as part of the federal CARES Act should be disregarded as assets for 12 months from the date the payment was received.

Note: These payments were tax rebates from the IRS issued in 2020 and amounted to a maximum of $1,200 per taxpayer, and $500 per qualifying child.

16.7.34 Retroactive Federal Pandemic Unemployment Assistance (PUA)

Retroactive Pandemic Unemployment Assistance payments are counted as an asset the month they are received.

16.7.35 Retroactive Federal Pandemic Emergency Unemployment Compensation (PEUC) Payments

Retroactive Pandemic Emergency Unemployment Compensation payments are counted as an asset the month they are received.

16.7.36 Retroactive Federal Pandemic Unemployment Compensation (FPUC) Payments

Retroactive Federal Pandemic Unemployment Compensation (FPUC) payments are counted as an asset the month they are received.

16.8 REAL PROPERTY

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (see Section 17.2.3.1 Homestead Property).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while he or she continues to reside there.

Institutionalized Person. When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His or her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.

2. The institutionalized person expresses his or her intent to return to the home. If he or she is able to form an intent but unable to express it, determine his or her intent through other available evidence. Other evidence includes:
    a. His or her written statements.
    b. His or her oral statements made before incapacitation. Accept reports of these statements made by family members.
    c. Accept reports of his or her intent made by an *authorized representative*. If there is no evidence he or she disagrees with the statement, accept the authorized representative's statement.

If he or she appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his or her intent.

If he or she has been judged incompetent, accept the intent statement of his or her guardian. Use the guardian's intent statement even if it differs from the member's.

If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

Refer to Section 18.4 Spousal Impoverishment Assets and Section 18.4.1 Spousal Impoverishment Assets Introduction for the definition of institutionalized spouse and home exemptions when Spousal Impoverishment policies apply.

17.4 EXCEPTIONS

A divestment that occurred in the look-back period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment was not made with the intent of receiving Medicaid.

   The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that he or she was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

   Any of the following circumstances are sufficient to establish that the *applicant*/*member* transferred resources without an intent to qualify for Medicaid.

   - The applicant/member had made arrangements to provide for his or her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

     An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his or her long term care services for his or her remaining life expectancy.

     To measure "sufficient resources," use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets, and insurance held by the individual at the time of the divestment, **or**

   - Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**

- If an individual or couple had a pattern of charitable gifting or gifting to family members (i.e., birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15 percent of the individual's or couple's annual gross income. If the yearly gifted amount exceeds 15 percent of the individual's or couple's annual gross income, and/or there is a gap in the years the gifts occurred, the total amounts gifted for the years in the look-back period shall be considered divestment. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals, or

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for *IRS* tax purposes, or otherwise provide more than 50 percent of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

2. The community spouse divested assets that were part of the community spouse asset share **and** this transfer occurred more than five years after the institutionalized spouse was determined eligible. If it is more than five years after the institutionalized person is determined eligible, the community spouse can divest assets.

Example 1: When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. Six years after Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share, as long as it is more than five years after Ralph was determined eligible. If Edith applies for long-term care services within five years though, the gift to her nephew may be considered divestment when determining her eligibility.

Example 2: When Ralph went into the nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. One year after Ralph became eligible, Edith gave $30,000 to a favorite nephew. This divestment will result in a divestment penalty period for Ralph because it occurred within the first five years of his eligibility.

The transfer of *homestead* property to the community spouse and then to another person is treated as a divestment depending on when the transfers occur. If the institutionalized person transfers the homestead to the community spouse, and then the community spouse transfers it to someone else within five years of the institutionalized person becoming eligible for long-term care Medicaid, this would be considered a divestment, and it would affect the institutionalized person's eligibility. However, if five years have passed since the institutionalized person became eligible for long-term care Medicaid, the community spouse can transfer the homestead property without affecting the institutionalized person's eligibility.

Example 3: When Ralph applied for Institutional Medicaid, he and Edith owned a home together. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. After five years have passed, Edith can transfer the part of the homestead Ralph gave her without Ralph's eligibility being affected.

Note: While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination do not affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if he or she later enters an institution and applies for Medicaid.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession are not divestment. An exception to this is if someone voluntarily signs the property deed over to the bank rather than trying to sell the property or foreclosing due to defaulting on their loan. Banks may refer to this as a "voluntary foreclosure," which would be considered divestment.

5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 4: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7,300. When Gary applies for Medicaid, this divestment will be disregarded.

6. The agency determines that denial of eligibility would result in undue hardship for the person (see Section 22.4 Undue Hardship).

7. The institutionalized person or his or her spouse divests homestead property to his or her:

    a. Spouse
    b. Child who meets at least **one** of the following conditions/situations:

        - Is younger than 21 years old
        - Is blind
        - Is permanently and totally disabled
        - Has been residing in the institutionalized person's home for at least two years immediately before the person moved to a medical institution, and provided care to him or her which permitted him or her to reside at home rather than in the institution. This care must have been provided for the entire two years immediately before the person moved to a medical institution. Get a notarized statement that the person was able to remain in his or her home because of the care provided by the child.

            Note: The statement must be from his or her physician or from someone else who has personal knowledge of his or her living circumstances. A notarized statement from the child does not satisfy these requirements.

    c. Sibling who:

        - Was residing in the institutionalized person's home for at least one year immediately before the date the person moved to a medical institution.

        Verify that the sibling was residing in the institutionalized person's home for at least one year immediately before the person moved to a medical institution. Do not require a specific type of verification. Some examples of verification are written statements from ~~nonrelatives~~non-relatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

        and

        - Has a verified equity interest in the home.

"Equity interest" means an ownership interest in a homestead.

Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

8. The institutionalized person or his or her community spouse divests a non-homestead asset or assets to:

a. A spouse

b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

9. The institutionalized person gives away an exempt asset. This includes an asset that is temporarily disregarded, but only during the time that it is being disregarded. This would include, but is not limited to, giving away funds from the following:
    a. Retroactive Social Security payments during the nine months after the payment was received,
    b. Patient liability or cost share refunds during the nine months after the refund was received, or
    c. Federal Coronavirus Recovery Rebate during the 12 months after the payment was received.

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. This includes burial assets owned by the applicant/member and/or the community spouse for a child(ren).
- 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).

18.4.2 Asset Assessment

The *IM* agency must make an assessment of the total countable assets of the couple at one of the following, whichever is earlier:

- The beginning of the person's first continuous period of institutionalization of 30 days or more.
- The date ~~a functional screen was completed and~~ the person was determined functionally eligible for *HCBW*s.

Complete an asset assessment when a person applies, even if he or she had one done in the past, to get the most current asset share.

If a member was not married on the first date of institutionalization or waivers request, apply the policy from the point he or she is married. If he or she has remarried since the first date of institutionalization or waivers request, apply the policy from the date he or she married his or her current spouse.

The IM agency should inform the person for whom an assessment is being made what documentation is required. He or she must document ownership interest in and the value of any available assets the couple had at the time of his or her first period of

continuous institutionalization. The same documentation procedures are used as when an application is filed (see Section 20.1 Verification Introduction).

18.8 SPOUSAL IMPOVERISHMENT NOTICES

After the institutionalized person has been determined Medicaid eligible, the worker must send the following manual notices to both spouses:

1. Notice of Medicaid Income Allocation (F-10097). This notice contains the amount of income allocated to the *community spouse* and the amount of the institutionalized person's cost of care contribution. This notice must also be completed any time there is a change in the allocated amount.
2. Medicaid Recipient Asset Allocation Notice (F-10098). This notice specifies the amount of assets the member must transfer to the community spouse in order to retain Medicaid eligibility. It also specifies the date by which the transfer must be made.

Note: The Notice of Medicaid Income Allocation (F-10097) and Medicaid Recipient Asset Allocation Notice (F-10098) are not required to be sent for Group A eligible Waiver cases.

18.9 COMMUNITY SPOUSE'S MEDICAID APPLICATION

~~*Community spouses* who apply for Medicaid must apply on a separate application from that of the institutionalized person.~~ Count assets and income allocated and transferred to ~~them~~the *community spouse* by the institutionalized person when determining the community spouse's Medicaid eligibility. Beyond these, count only the assets and income belonging to the community spouse.

20.3 MANDATORY VERIFICATION ITEMS

20.3.8 Income

Verify all sources of nonexempt income for EBD Medicaid applicants and members. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/member is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e., checkstubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

a. Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member);
b. Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.
c. Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment, pensions, retirement income, etc.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e. check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and

2. Information is not obtainable timely even with your assistance. In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

Note: Accept a member's or suspended member's statement and do not require verification of income earned by an inmate from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). See Section 15.5.18 Prison or Jail Job.

20.3.8.1 Reasonable Compatibility for Income for Health Care

This section addresses reasonable compatibility for income. Reasonable compatibility for assets can be found in Section 20.3.5.2 Reasonable Compatibility for Assets.

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see Section 15.5.18 Prison or Jail Job), or information from the data source is not "reasonably compatible" with what the applicant has reported. Information from the data source is "reasonably compatible" if it results in the same eligibility outcome as member-reported information:

- If both the electronic data source and the member-reported information put the individual's total countable income below a given income threshold, the two data sources are considered to be reasonably compatible and **further verification may not be requested or required.**

- If the electronic data source puts the individual's total countable income above a given income threshold, but the member-reported information puts the individual's total countable income below that same threshold, the two data sources are not reasonably compatible and **further verification is required as a condition of eligibility.**

- If the member reports income that is above a given threshold, the member-reported income information will be used to deny or terminate health care benefits, regardless of what the outcome would be using information from the electronic data source. In this scenario, **verification is not required.**

The reasonable compatibility test will only be applied to job earnings that have not otherwise been verified (for example, as part of another program's verification process). It can only be applied when earnings information is available through the State Wage Information Collection Agency (SWICA) or through Equifax from the Federal Data Services Hub (FDSH).

Unearned income (as defined in Section 15.4) will continue to be verified as outlined in this chapter and in Process Help Chapter 44. If there is an electronic data source available to use for verifying a type of unearned income, it should be used as verification for that income. If no data source is available, the applicant or member must provide verification of the unearned income.

Self-employment and in-kind job income will continue to be verified as outlined in Section 15.6 and 15.5.1 and Process Help Sections 16.2 and 16.6

20.3.8.1.1 Programs for Which Reasonable Compatibility Will Apply

The reasonable compatibility test will be performed as part of any eligibility determination for the following categories of Medicaid:

- Elderly, Blind or Disabled Medicaid (EBD MA), except deductibles
- Medicaid Purchase Plan (MAPP)
- Medicare Savings Program (QMB/SLMB/SLMB+)

20.3.8.1.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each AG for which earned income is reported, has not been already been verified, and for which SWICA and/or Equifax data is available. Because different AGs are subject to different income and premium thresholds, the thresholds described below will be used by population to determine whether reported information is reasonably compatible. Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

- EBD Categorically Needy SSI-Related MA and Medically Needy MA thresholds are based on the income limits shown in Section 39.4.1.
- MAPP and MSP thresholds are based on the income limits shown in Section 39.5.
- MAPP Premium thresholds are based on 100% FPL for a group of one as shown in Section 39.5. and described in the table below.

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	**And total gross income using the monthly earnings reported by SWICA or Equifax is:**	**Is it reasonably compatible?**

Below the MAPP premium threshold (100 percent of the FPL)	Below the MAPP premium threshold (100 percent of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
Below the MAPP premium threshold (100 percent of the FPL)	At or above the MAPP premium threshold (100 percent of the FPL)	No. Further verification must be requested.
At or above the MAPP premium threshold (100 percent of the FPL)	At or above the MAPP premium threshold (100 percent of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
At or above the MAPP premium threshold (100 percent of the FPL)	Below the MAPP premium threshold (100 percent of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

20.3.8.1.3 Reasonable Compatibility Test

The reasonable compatibility test is based on whether using member-reported information about earnings and information about earnings from data exchanges results in the same eligibility outcome when all other countable income is taken into account.

Reasonable compatibility will first be tested based on the household's total countable income as reported to the agency or verified through other sources. This test will determine whether the member is required to provide verification of earnings.

If the member-reported earnings amount is not reasonably compatible (based on the household's total reported income), verification of earnings will be required at the same time that verification is required for unearned income, self-employment, and/or tax deductions.

A second verification request will be required if the initial test leads to a determination of reasonable compatibility but the earnings are no longer reasonably compatible after other income types or deductions have been verified.

If earnings are determined to be reasonably compatible, the amount reported by the member should be used to determine eligibility and premium amounts for health care.

If the earnings are later verified (for example, because verification is required for another program), the verified earnings should then be used to determine eligibility and premium amounts for health care.

In this situation, members are not liable for overpayments because the initial determination was based on income that was reasonably compatible with a data exchange.

Members with eligibility determinations that were based on income that was reasonably compatible are subject to regular change reporting rules and can be subject to benefit recovery if they fail to report income that exceeds their reporting threshold.

20.3.8.1.4 Use of Equifax Data for Verification of Income

Agencies may not consider Equifax data to be the final "verified" income amount unless the Equifax data is the same as what the member reported. Agencies may not deny or terminate health care benefits based on earned income data received from Equifax without giving the applicant or member an opportunity to verify their reported earned income amount.

If the member reports that he or she is unable to obtain the requested verification, the worker should assist the member in obtaining verification (see Section 20.1.4). If the applicant and/or worker have made reasonable efforts to obtain verification and are not able to do so, then the agency should determine the income amount based on "best available" information, and then document how this amount was determined.

Note: The same policies for use of Equifax data apply when a member is reporting a change in income. Equifax data can be used for verification if it is the same as what the member has reported. If it is not the same, health care will apply a reasonable compatibility test to determine whether further verification is required.

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21.6 HMO ENROLLMENT

21.6.3 Change of Circumstances

Members who lose Medicaid eligibility but become eligible again may be automatically re-enrolled in their previous HMO.

If the member's eligibility is re-established after ~~the six month~~a restrictive re-enrollment period~~,~~ (RRP), he or she will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, ~~or~~ if the HMO is no longer accepting reassignments, or if the HMO has exceeded its enrollment level, he or she will receive an enrollment packet, and the enrollment process will start over.

Note: The policies in this section also apply to members whose Medicaid was suspended due to incarceration but have regained full Medicaid eligibility upon release from jail or prison.

21.6.4 Disenrollment

Members are automatically disenrolled from the HMO program if:

- Their medical status code changes to a BadgerCare Plus or Medicaid subprogram that does not require enrollment in an HMO.
- They enroll in an Adult LTC program.
- They become eligible for Medicare.
- They lose eligibility.
- They move out of the HMO's service area.
- Their Medicaid is suspended due to incarceration in jail or prison.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member's new area, he or she remains *fee-for-service*.

22.2 CORRECTIVE ACTION

22.2.8 Incorrect Member Contribution

22.2.8.1 Premiums

If ~~it is determined that~~ a MAPP premium ~~amount was incorrectly~~ is calculated ~~for BadgerCare Plus or MAPP~~ in an amount that is incorrect and higher than it should have been, the excess amount must be refunded to the member ~~should receive a refund.~~when the error is discovered. See ~~PH~~ Process Help Section 25.~~1.7~~4.3 ~~for how to calculate and process a refund~~.

22.5 REPRESENTATIVES

22.5.3 Community Spouse as Representative

In Spousal Impoverishment cases, when a Community Spouse cooperates with providing his/her signature at application and/or renewal (Section 2.5.3), the Community Spouse can act on the applicant's/member's behalf without requiring the completion of the Appoint, Change, or Remove an Authorized Representative form (F-10126A). The act of signing the application/renewal allows the Community Spouse to do the following on the applicant's/member's behalf:

- Provide information for the member's application and/or renewal
- Report changes in the applicant's/member's circumstances or demographic information
- Receive copies of the applicant's/member's notices and other communication from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant's/member's eligibility

Note: In Spousal Impoverishment cases, the applicant or member's signature and the community spouse's signature are **both required** at application and renewal.

24.7 MEETING THE DEDUCTIBLE

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant /member's FTG.

Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example 2: Sally's spouse died of leukemia in April 2014. In September 2014, Sally requests that a medical bill incurred for her spouse be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in (24.7.1.1 Countable Expenses)

3. Meet one of the following four conditions

    a. Still be owed to the medical service provider sometime during the current deductible period.

    Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a Medicaid deductible.

    - The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
        - If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
    - Many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 3: From May- July 2013 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2014, Helen has

not paid this bill. In October Helen's social worker, Ruth, applies for Medicaid on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the member would never be billed for the charges, but if he or she happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can use this "deferred" charge toward her deductible.

Example 4: Lestat applies for Medicaid in July, 2014. An Medicaid deductible of $700 is calculated for him. In 2013 he had a blood transfusion. The bill for the transfusion was $800. He never paid it and still owes it to the service provider. He can use the unpaid bill to meet his Medicaid deductible, but must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

b. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 5: Frank and Estelle apply for Medicaid on March 1, 2014, requesting that their deductible period begin January 1, 2014. Their deductible for the period January 1 - June 30th is $340. In April, they had a ten-year-old medical bill of $300 written off. They can count the $300 toward the January - June 2014 deductible because it was written off during the deductible period.

c. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 6: Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 7: Malcolm is in his second deductible period which began March 1, 2014. He did not meet his deductible in the prior deductible period, which

immediately preceded the current deductible period. He has a medical bill that he paid in February 2013. He may not apply this toward his current deductible.

Example 8: Norah is in her second deductible period which began in September 2014. In June 2014, Norah met her first deductible period and was certified for Medicaid through August. After certification, and before the first deductible period ended in August, Norah paid for medical services that were not Medicaid covered services. Norah can apply these paid bills to the second deductible period that began in September 2014.

d. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 9: Sierra and Skyler apply for Medicaid on August 10, 2014, requesting that their deductible period begin on August 1, 2014. Their deductible for the period from August through January is $1500. On May 10th the couple had paid off a $2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining $500 cannot be applied to future deductible periods.

Example 10: Anna applied for Medicaid on July 25, 2020, with no request for any backdated months. Her deductible period is from July 2020 through December 2020. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May, and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.

Example 11: Anna applied for Medicaid on July 25, 2020, requesting a one month backdate. Her deductible period is from June 2020 through November 2020. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.

~~1. Medicare Supplemental Medical Insurance (Plan B) premiums if they have already been deducted from the gross social security check.~~

2. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

> **Example 14:** Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.

3. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in 24.7.~~1Countable~~1 Countable Costs.

> **Example 15:** An applicant incurs a $300 medical bill. She applies the $300 toward her deductible even though he or she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the $300 bill. But she cannot use it to meet her current deductible because she already used it to meet the prior deductible.

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26.3 NONFINANCIAL REQUIREMENTS

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. ~~Do not take action to terminate eligibility~~Eligibility cannot be terminated until one full calendar month has passed since employment ended.

> **Example 1:** Kerrie reported on March 15 that her employment ended March 5. She has until April 30 to become employed again, and her eligibility cannot be terminated due to not having employment before then.

26.3.8 Institutionalization

Members in an institution may qualify for MAPP if they ~~fail~~do not qualify for institutional Medicaid. If the member's income ~~equals or~~ exceeds ~~150~~100 percent of the *FPL* for a group of one (see Section 39.5 Federal Poverty Level Table), he or she is responsible to pay a monthly premium instead of a patient liability or cost share (see Section 27.7 Cost of Care Calculation and Section 27.7.3 Partial Months).

26.3.9 Community Waivers

~~MAPP is a full-benefit Medicaid subprogram for community waiver participation (see Section 21.2 Full-Benefit Medicaid).). If the member's monthly income equals or exceeds 150 percent of the FPL (see Section 39.5 Federal Poverty Level Table), he or she is responsible to pay a monthly premium instead of a cost share.~~

MAPP is a full-benefit Medicaid subprogram for community waiver participation (see Section 21.2 Full-Benefit Medicaid). If the member's monthly income exceeds 100 percent of the FPL for a group of one (see Section 39.5 Federal Poverty Level Table), he or she is responsible to pay a monthly MAPP premium instead of a cost share.

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~~6.4 Cost Share Amount.
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.

28.1 ADULT HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION

28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy

To be eligible for *EBD* Medicaid or LTC Medicaid, a person must be elderly, blind, or disabled.

Adults over age 18 and younger than 65 years old must have a disability determination unless the person is eligible for BadgerCare Plus, *WWWMA*, Foster Care, or Adoption Assistance. If a person later loses eligibility for that program and must be tested for EBD Medicaid or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care, Family Care Partnership, PACE, or IRIS.

A disability finding made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirements for managed LTC or IRIS until the first of the following:

- An adult disability determination can be completed
- The child disability determination ~~is~~was redetermined and the child was found to no longer ~~in effect~~be disabled.

Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

28.5 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE EFFECTIVE DATE

28.5.1 Urgent Services

Applicants who have been determined functionally eligible for Family Care or Family Care Partnership may receive services from the MCO while Medicaid financial eligibility is being determined if they have been determined by the ADRC to be in need of urgent services. See Process Help Section 11.3.4 Urgent Services for more information on how to process these requests.

~~For such individuals, the ADRC will send IM a referral for a "priority" Medicaid eligibility determination along with:~~

1. ~~A copy of a signed Family Care Program Enrollment (F-00046) or PACE/Partnership Programs Enrollment (F-00533) form; and~~
2. ~~A copy of a signed Urgent Services Agreement (F-02140).~~

~~IM will then (1) confirm with the ADRC that it has received the Urgent Services referral; (2) conduct the financial eligibility determination on a priority basis; and (3) notify the ADRC and MCO of the outcome of the financial eligibility determination as soon as possible. A financial eligibility determination for Medicaid must be made within 30 calendar days from the date an individual, or their legal guardian, conservator, or activated power of attorney, signs the Urgent Services Agreement.~~

The effective date of enrollment into Family Care or Family Care Partnership shall be no earlier than the date the Urgent Services Agreement is signed and the Medicaid application is submitted.

~~**28.10 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE NOTICES**~~

~~CARES generates a Notice of Decision each time the *IM* worker confirms a case.~~

28.10 RESERVED

32.1 MEDICARE SAVINGS PROGRAMS

32.1.5 Part B Enrollment Via the Medicare Savings Programs Buy-In Program

Members receiving Medicare Part A coverage who chose not to enroll in Part B may be eligible to enroll in Part B via the MSP process with the state. ~~The MSP eligibility should be determined in CWW. If the member is eligible for MSP, the worker must contact the ForwardHealth Medicare buy-in analyst by phone at 608-224-6126 or by filling out a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) stating when the member will begin their Medicare buy-in eligibility. The Medicare buy-in analyst will create a manual transaction to send to CMS with the appropriate MSP information. Once CMS processes the record, the member should be enrolled into Part B with coverage beginning the first month of MSP eligibility~~See Process Help 61.4 Manual Updates to MSP On Forward Health iChange.

> ~~**Example 1:** In January, the member applies for QMB benefits and is only receiving Part A Coverage. The case worker determines the member qualifies for QMB starting February. After the confirmation is done in CARES in January, the worker contacts the ForwardHealth Medicare buy-in analyst to report the enrollment. The buy-in analyst creates a transaction with the QMB information. This transaction is sent to CMS in February.~~
>
> ~~Once CMS processes the record and bills the state, the member will show Part B coverage starting in February.~~

32.11 POTENTIAL ADVERSE EFFECT OF MEDICARE SAVINGS PROGRAM PARTICIPATION

When a member is found eligible for one of the *MSP* programs and the state pays a person's Part B premium, his or her Social Security payment will increase by the same amount as the Medicare Part B premium. This increase in the Social Security payment may result in the person either losing Medicaid eligibility, or ~~being reduced from categorically needy to medically needy~~experiencing a reduction in benefits.

When a person would be adversely affected in this way, he or she is allowed to choose between ~~either losing his or her~~ Medicaid ~~current benefits and keeping free Medicare~~ enrollment~~,~~ or ~~giving up the free Medicare~~MSP enrollment~~ and keeping his or her Medicaid benefits. All but 503, DAC's and widow/widowers can opt out of the *QMB* buy-in through CARES.~~

~~When a 503, DAC, or widow/widower requests~~. Refer to ~~not have the state pay the Part B premium, contact the buy-in analyst at 608-224-6126. The buy-in analyst will update MMIS with the appropriate information to prevent the automatic buy-in~~Process Help Section 61.2.3 Reason for Not Requesting.

37.3 HCBW MEDICAID CARES PROCESSING FOR THE CLTS WAIVER PROGRAM

When a child who is functionally eligible for the CLTS program is referred to IM, he or she must first be tested for eligibility using *HCBW* rules. To be eligible for HCBW Medicaid, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW, only the child's income is counted. Effective 10/01/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

~~HCBW requests must be processed differently depending on whether there are any other people on the case who are requesting health care.~~ If the CLTS applicant is the only household member applying for healthcare, the packet provided by the CWA is all that is required to be submitted ~~(see Sections 37.3.1 and 37.3.2).~~. When the CWA submits the signed F-10129 to the IM agency, the primary person is required to provide a second signature. The primary person can ~~chose~~choose to call the IM agency to provide a telephonic signature or mail a signed Application Summary (see ~~Section~~Section 2.5.1 Valid Signature Introduction). ~~See Process Help Section 9.7 Home and Community Based Waiver Medicaid for Children's Long Term Support for processing instructions.~~

~~37.3.1 HCBW CARES Processing for Minor Children~~

~~To facilitate the application and renewal process and reduce the duplication of verification requests that could cause a burden to families who are applying for multiple programs, CWA staff working with a family whose child is functionally eligible and requesting HCBW will submit the following information to the IM agency.~~

~~For initial applications, CWAs work with families to complete and submit:~~

- ~~A valid application for health care (see Section 2.4 Valid Application), including the Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application, F-10129~~
- ~~Home and Community Based Waiver Medicaid Enrollment for the Children's Long Term Support Waiver Program, F-02319~~
- ~~Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919~~
- ~~Verification of the child's income, if any~~

For annual HCBW renewals, the family must submit a completed health care renewal (for example, a PPRF) and CWA staff will submit:

- Home and Community-Based Waiver Medicaid Enrollment for the Children's Long-Term Support Waiver Program, F-02319
- Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the child's income, if any

37.3.2 HCBW CARES Processing for Young Adults 18–21

Individuals can be eligible for the CLTS Waiver Program and HCBW Medicaid through age 21. When a CLTS Waiver Program applicant or member reaches 18 years old and their source of Medicaid is HCBW, they must apply for HCBW Medicaid as the primary person. Federal and state privacy and confidentiality protections prevent the parents of adults from automatically having access to protected information; therefore, these young adults must apply as the head ofseparately from their own IM caseparents.

When individuals ages 18–21 require HCBW Medicaid, CWA staff submits the following to IM:

- Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application, F-10129
- See Process Help Section 11.4 Home and Community-Based Waiver Medicaid Enrollment for the Children'sChildren's Long-Term Support Waiver Program Form, F-02319
- Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the young adult's income, if any.

The renewal process is the same for all HCBW members (see Section 37.3.1 HCBW CARES Processing for Minor Children).processing instructions.