WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 22-01**

Release Date: 04/04/2022

Effective Date: 04/04/2022

EFFECTIVE DATE		The following policy additions or changes are **effective 04/04/2022** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.1.2	**Subprograms of Medicaid**	Removed reference to TB Medicaid and updated reference links
1.1.3	**Financial Introduction**	Removed reference to TB Medicaid and updated reference links
2.7.2	**Changes**	Updated link for Income Maintenance Manual (IMM) decommission
5.5	**Reconsideration/Hearing**	Clarified policy and updated process information
7.2.7.3	**Individuals Without Verification and Effect on Household Eligibility**	Fixed a grammar error in the title
8.4.3	**Fraud**	Removed reference to IMM
15.3.26	**VA Allowances**	Updated VA information and added examples
15.3.35	**COLA Disregard for Social Security Recipients**	New Section
15.4.1	**Income From Trusts**	Updated a broken link
15.6.3.1	**Business Assets**	Clarified policy and updated process information
15.6.3.2	**Bank Accounts**	Clarified policy and updated process information
15.7.1	**Maintaining Home or Apartment**	Clarified deduction condition
16.5.3.1	**Irrevocable Assignment of Life Insurance-Funded Burial Contracts**	Updated a broken link
16.6.4.2	**Trust Established with Resources of the Individual or Spouse**	Updated links
16.7.2.2	**Loans and Other Contracts Exchanged for**	Updated links and clarified policy on homestead property and ABLE accounts

	Promissory Notes	
16.7.4.1.2	**Annuities that Cannot Be Surrendered (Effective March 1, 2009)**	Updated links and clarified policy on homestead property and ABLE accounts
16.7.9.2	**When to Count, When to Exempt**	Updated links and clarified policy on homestead property and ABLE accounts
16.7.30	**Achieving a Better Life Experience Accounts**	Updated links and clarified policy on homestead property and ABLE accounts
16.8	**Real Property**	Clarified policy on homestead property
16.9	**Non-home Property Exclusions**	Updated a broken link
17.2.6.11	**Transfer of Homestead Property**	Clarified policy on non-homestead property
17.2.6.12	**Non-homestead Property Given to Spouse or Certain Children**	Clarified policy on non-homestead property
17.3.2	**Calculating the Penalty Period**	Updated daily average nursing home pay rate
17.3.4	**Penalty Period Begin Date for Members**	Updated a link from IMM decommission
18.4.1	**Spousal Impoverishment Assets Introduction**	Clarified policy
18.4.2	**Asset Assessment**	Clarified policy
18.4.3	**Calculate the Community Spouse Asset Share**	Updated annual Cost of Living Adjustments numbers
18.6.2	**Community Spouse Income Allocation**	Updated annual Cost of Living Adjustments numbers
20.1.4	**Verification Rules**	Updated information for IMM decommission
20.2	**Collateral Contacts**	Updated information for IMM decommission
20.6	**Front End Verification**	Updated link from IMM decommission
22.1.2	**Recoverable Services**	Updated text to include note removed from another section
22.2	**Corrective Action**	Updated overpayment information
22.2.4	**Refer to District Attorney**	Updated link from IMM decommission
22.4.1	**Application of Policy**	Updated to remove obsolete link
22.4.8	**Fair Hearing Rights**	Updated link from IMM decommission
22.6	**Restoration of Benefits**	New Section
23.1	**Notification**	Updated information for IMMR decommission
24.1	**SSI Related Medicaid Introduction**	Added definitions and links and updated process information
24.5	**Calculating the Deductible**	Updated SSI-Related Medicaid categories
26.2	**Application**	Clarified information about MAPP application
26.4.1.1	**Independence Accounts**	Clarified independence accounts information and examples
26.4.2	**Income**	Added reference to new section
26.5.1	**Calculation**	Updated annual FPL numbers
27.3	**ILTC Facilities Not Medicaid Certified**	Updated a broken link

27.7.3.1	**Death**	Clarified information about MCO
32.1	**Medicare Savings Programs (MSP)**	Clarified information about MSP
32.2.3	**Income Limit**	Updated COLA increase information
32.3.2	**Income Limit**	Updated link
32.4.2	**Income Limit**	Updated link
32.5.2	**Income Limit**	Updated link
33.6.8.4	**Veterans Benefits**	Clarified information
39.4.1	**Elderly, Blind, or Disable Assets and Income Table**	Updated annual COLA and FPL amounts
39.4.2	**Elderly, Blind, or Disabled, Deductions and Allowances**	Updated annual COLA and FPL amounts
39.4.3	**Institutional Cost of Care Values**	Updated annual COLA and FPL amounts
39.5	**FPL Table**	Updated FPL table
39.6	**Cost-of-Living Adjustment**	Updated annual COLA amounts
39.11	**SeniorCare Income Limits**	Updated annual FPL amounts
40.1	**Worksheets**	Updated links

Contents

1.1 Introduction to Medicaid

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

Full-Benefit EBD Medicaid Programs

- SSI-Related Medicaid
- Medicaid Purchase Plan (MAPP)
- Katie Beckett Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)
- SSI Medicaid

Full-Benefit Long-Term Care Programs

- Institutional Medicaid
- Community Waivers Programs, which include:
    - Family Care
    - Family Care Partnership
    - Program of All-Inclusive Care for the Elderly (PACE)
    - Include, Respect, I Self-Direct (IRIS)
    - Children's Long-term Support Waiver Program (CLTS)

Limited-Benefit EBD Medicaid Programs

- ~~Tuberculosis-Related Medicaid (TB MA)~~
- Medicare Savings Program:
    - Qualified Medicare Beneficiary (QMB)
    - Specified Low-Income Medicare Beneficiary (SLMB)
    - Specified Low-Income Medicare Beneficiary Plus (SLMB+)
    - Qualified Disabled and Working Individual (QDWI)
- Emergency Medicaid
- SeniorCare

A person may qualify for one or more of the subprograms listed above, and will be found eligible if they meet all the requirements for a given subprogram. Individuals who do not qualify under a subprogram listed above may be eligible for BadgerCare Plus. See the BadgerCare Plus Handbook for more information.

People eligible for federal or state SSI are categorically eligible for SSI Medicaid and receive this form of Medicaid automatically. The Social Security Administration makes determinations of SSI eligibility for SSI recipients and receipt of SSI is the only eligibility criterion for SSI Medicaid.

1.1.3 Financial Introduction

See Section 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES for EBD asset limits. See Section 1.1.3.3 Disabled Minors to determine Medicaid eligibility for disabled minors who fail BadgerCare Plus financial tests.

1.1.3.4 Income

See SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES for EBD income limits. See SECTION 39.5 FEDERAL POVERTY LEVEL TABLE for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income ~~that you compare~~ to be compared with the income limits.

~~See Section 39.4.2 ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES for TB-related income limits.~~

2.7 Time Frames

2.7.2 Changes

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

~~For changes that occur after the confirmation date, follow the adequate and timely notice requirements outlined in Income Maintenance Manual Section 3.2 Adverse Action and Appeal Rights.~~

5.5 Reconsideration/Hearing

5.5.2 Reversed or Delayed Disability ~~Denial~~ Decision

When ~~DDB or DHA notifies the IM agency that~~ a disability denial decision ~~has been~~is reversed (approved) as a result of a reconsideration/hearing request or SSI or SSDI appeal, ~~the IM agency must redetermine~~or when a delayed approval is granted, the individual's Medicaid eligibility must be redetermined.

~~Use the~~The original Medicaid application filing date ~~that was~~ associated with the Medicaid Disability Application (MADA) decision ~~that has now been reversed (approved).~~(see Section 5.3 Disability Application Process) or the SSI or SSDI disability determination must be honored. A new application or signature is not required.

~~Re-evaluate the member's~~The individual's Medicaid eligibility must be re-evaluated for all months between the ~~Medicaid application~~ filing date (and ~~three-month backdate~~backdated period, if ~~appropriate~~backdating was requested) and the date of the DDB, SSI, or SSDI approval. For this retroactive period, ~~certify~~ the ~~member~~individual is only eligible for ~~those~~ Medicaid in the months ~~for~~in which ~~he or she~~they met all Medicaid eligibility requirements.

1. ~~Send the member a positive notice, advising him or her of the months of retroactive eligibility and current ongoing eligibility, if appropriate. If the member was ineligible for Medicaid for some of the prior months, send the member a negative notice, advising him or her of his or her retroactive ineligibility for those specific months.~~

~~For these types of cases, the IM worker is simply doing what ordinarily would have been done if the original DDB, SSI, or SSDI decision had been approved rather than denied.~~

~~Note~~Example:	~~If an SSI or SSDI disability determination is changed, the new determination is binding for Medicaid. The Medicaid filing date should be preserved as if DDB or DHA had reversed the MADA denial.~~Kate (47) originally applied for health care in January with a three month backdate request and was determined over income for BadgerCare Plus. She submitted a MADA, and her disability was initially denied. In May, her disability denial decision was reversed. Her disability onset date is December 15. The worker redetermines her health care eligibility as of October. Kate is ineligible for health care in October and November

	but eligible for EBD Medicaid for December and ongoing.

~~5.5.3 CARES Processing~~

~~Based on the assumption that the Medicaid CARES case has been closed for more than 30 days since the original denial decision date, you will now have to enter a new application in CARES using the application function. Do not require the member to file a new application. Use the recent DDB, SSI, or SSDI disability approval date as the Medicaid application filing date. You should now be able to use CARES to determine and certify the current month's Medicaid eligibility and up to three backdate months. If you need to go back any further than this, do the eligibility determination and certification manually.~~

~~When the disability denial decision is overturned by DHA, enter the disability approval and disability onset date established by DHA on the Disability page in CWW as if it was approved by DDB. Document in the case comments that this disability approval decision was actually made by DHA and not DDB and record the fair hearing case number. Run eligibility to determine Medicaid eligibility for current and future months and also for any past months in which the person was determined disabled.~~

7.2 Documenting Citizenship and Identity

7.2.7 Situations which Require Special Documentation Processing

7.2.7.3 Individuals without Verification and ~~Affect~~Effect on Household Eligibility

IM workers should not delay an individual household member's eligibility when awaiting another household members' citizenship or identity verification. The individual pending for citizenship or identity should be counted as part of the group when determining eligibility for other group members. See Process Help Section 68.2 Documentation and Verification Codes for processing instructions.

8.4 Cooperation Between IM & CSA

8.4.3 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action ~~(Income Maintenance Manual Section 11.1 Public Assistance Fraud Program).~~.

15.3 Exempt/Disregarded Income

15.3.26 VA Allowances

15.3.26.1 ~~Residents of a State Veterans Home~~Aid & Attendance (A&A) and Housebound Allowances

~~Eligibility: for any veteran~~For veterans and surviving spouses who ~~resides at a State Veterans Home at King, Chippewa Falls,~~need help with activities of daily living or ~~Union Grove, in the eligibility determination, exempt the amounts identified by the~~ are housebound due to disability, a Department of Veterans Affairs (VA) benefit may include a monetary amount referred to as ~~unreimbursed (sometimes called "unusual") medical expenses,~~ an "aid ~~and~~& attendance~~,~~" (A&A) or "housebound" allowance.

Disregard A&A and housebound allowances when determining eligibility for any category of Medicaid.

~~Post-eligibility: exempt $90 for those who meet all of the following conditions:~~

- ~~He or she receives aid and attendance, unusual medical expense, or housebound allowance payments in an amount greater than $90.~~
- ~~He or she is a veteran who currently has no spouse (i.e., he or she never married, or is divorced or widowed) or dependent child or is a childless surviving spouse of a veteran.~~

Disregard A&A and housebound allowances when determining the patient liability or cost share amount for Institutional Medicaid and Community Waivers. This rule does not apply to State Veterans Home residents without dependents (SEE SECTION 15.3.26.3 PATIENT LIABILITY CALCULATION FOR STATE VETERANS HOME RESIDENTS WITHOUT DEPENDENTS).

Example 5:	~~John~~Jack is a single veteran ~~residing at the State Veterans Home at King. His total~~living in his home. He receives a $2,051 monthly ~~income consists of a $90~~need-based VA pension ~~and a $55 annuity payment. The $90~~. His VA pension includes an A&A allowance of $821 per month. The A&A allowance is ~~totally~~ disregarded ~~in~~for Medicaid eligibility ~~and post-eligibility determinations. The personal needs allowance for institutionalized members is deducted from the $55 annuity payment. John's remaining~~.

	$2,051 VA pension - 821 A&A allowance (disregarded) = $1,230 budgetable income ~~in the Medicaid post-eligibility determination is $10, and that $10 will be applied to his patient liability.~~

Example 6:	~~Scott is a veteran residing at the State Veterans Home at King. His total monthly income consists of a $590 VA pension ($200 of which is for unusual medical expenses) and a $50 annuity payment. The portion of the VA pension for unusual medical expenses is totally disregarded in the Medicaid eligibility test. The $50 annuity payment and remaining $390 of the VA pension is non-exempt income. For the post-eligibility test, only $90 of the VA pension is disregarded. The patient liability calculation includes the personal needs allowance, so Scott will have to contribute $505 to his patient liability.~~ ~~Eligibility Calculation~~ ~~$590 VA Pension~~ ~~+ 50 Annuity~~ ~~$640~~ ~~-200 (exempt income)~~ ~~$440 countable income~~ ~~Liability Calculation~~ ~~$590 VA Pension~~ ~~+ 50 Annuity~~ ~~$640~~

	~~- 90 (exempt income)~~ ~~- 45 (personal needs)~~ ~~_____~~ ~~$505 patient liability~~Donald is a married veteran living with his spouse and two children. He is disabled (as determined by the VA) and receives VA disability compensation benefits in the amount of $1,963 per month. He does not receive A&A or housebound allowances and the VA did not consider any unreimbursed medical expenses when calculating the VA disability compensation benefit amount. The full $1,963 is budgetable income to the household.

When a single veteran or a surviving spouse without dependents is in a nursing home and enrolled in Medicaid, the VA is required to reduce the pension amount to no more than $90, except when the member is in a State Veterans Home. These reduced pensions of $90 or less are always considered A&A, so the full amount of these reduced pensions is disregarded for Medicaid eligibility as well as cost share or patient liability determinations.

Example 7:	Patrick is a single veteran with no dependents who is in a nursing home and open for Institutional Medicaid. He receives a $90 monthly VA pension. The entire $90 VA pension amount is A&A and is disregarded for both his Medicaid eligibility and patient liability determinations.

15.3.26.2 Unreimbursed Medical Expenses (UME)

When the VA determines the amount of a need-based benefit payment, it may consider any unreimbursed medical expenses incurred by the beneficiary or a member of their household that exceed 5% of the VA's basic Maximum Annual Pension Rate (MAPR). These expenses are sometimes referred to as "unreimbursed" or "unusual" medical expenses (UME). The VA deducts UME from countable income when computing the VA payment, resulting in a higher monthly payment.

Disregard any portion of a VA benefit that is for UME when determining eligibility for any category of EBD Medicaid.

Disregard any portion of a VA benefit that is for UME when determining the patient liability or cost share amount for Institutional or Community Waivers Medicaid. This rule does not apply to State Veterans Home residents without dependents (SEE SECTION

15.3.26.3 PATIENT LIABILITY CALCULATION FOR STATE VETERANS HOME RESIDENTS WITHOUT DEPENDENTS).

Example 8:	Allan is a veteran who resides in an assisted living facility. He receives a $1,200 monthly Social Security benefit and a monthly VA pension. His VA pension includes an A&A allowance of $883 per month. When calculating his pension amount, the VA also considered Allan's $42,000 annual ($3,500 monthly) assisted living fees as UME. The UME reduced his countable income (for VA purposes) to $0, resulting in a VA pension amount of $2,051 per month. The portion of the VA pension that is for A&A and UME is disregarded for Medicaid eligibility. Because Allan's $883 monthly A&A allowance plus the $3,500 monthly UME amount that the VA considered is greater than the total pension amount, the entire pension amount is for A&A and UME and must be disregarded for Medicaid eligibility. $ 1,200 Social Security + 2,051 VA pension - 2,051 amount of VA pension for A&A/UME (disregarded) _____ = $ 1,200 budgetable income

15.3.26.3 Patient Liability Calculation for State Veterans Home Residents Without Dependents

For any veteran without a spouse or dependents (or for a surviving spouse without dependents) who resides at a State Veterans Home at King, Chippewa Falls, or Union Grove:

- The portion of the VA pension that is an A&A or housebound allowance or is for UME is disregarded in the eligibility determination.
- If the member receives a VA pension in an amount less than or equal to $90, the total pension amount is exempt for the patient liability calculation.
- If the member receives a VA pension in an amount greater than $90, only $90 of the VA pension is exempt for the patient liability calculation. The portion of the

VA pension that is an A&A or housebound allowance or is for UME is included when calculating patient liability.

These special patient liability rules do not apply to State Veterans Home residents who have a spouse or other dependents.

If a veteran or surviving spouse in a State Veterans Home has dependents and receives a VA benefit, for Medicaid eligibility and patient liability, disregard any amount of the VA benefit that is an A&A or housebound allowance or is for UME.

Example 9:	John is a single veteran with no dependents residing at the State Veterans Home at King. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded for his Medicaid eligibility and patient liability calculation. John's budgetable income is $55. After deducting the $45 personal needs allowance, he has a $10 patient liability.

Example 10:	Scott is a single veteran with no dependents residing at the State Veterans Home at Chippewa Falls. His total monthly income consists of a $590 VA pension ($200 of which is for UME) and a $50 annuity payment. For his Medicaid eligibility determination, the $200 UME portion of his VA pension is disregarded. For his patient liability calculation, only $90 of the VA pension is disregarded. Eligibility Calculation $390 VA Pension ($590 gross VA pension – $200 UME) + 50 Annuity $440 gross countable income Patient Liability Calculation $ 440 gross countable income + 200 UME (counted) $ 640 adjusted gross income - 45 (personal needs allowance) - 90 (VA allowance)

	$ 505 patient liability amount

Example 11:	Melvin is a veteran residing at the State Veterans Home at King. He has a spouse residing in the community. His total monthly income consists of a $1,400 monthly Social Security benefit and a $410 monthly VA pension ($200 of which is for UME). The portion of the VA pension that is for UME is totally disregarded for both his Medicaid eligibility and patient liability calculation. $ 1,400 Social Security + 410 VA pension - 200 UME (disregarded) = $ 1,610 budgetable income

15.3.35 COLA Disregard for Social Security Recipients

The annual COLA increase to Social Security benefits is disregarded in certain months for the following programs and categories, which have income limits that are tied to the FPL:

- Medically Needy SSI-Related Medicaid (including deductibles)
- Medicaid Purchase Plan
- Medicare Savings Programs

The disregard begins the month of the COLA increase (usually January) and ends when the new FPL amounts are in effect (usually February 1 for new applications and March 1 for ongoing cases).

Example 12:	In December, Ed's Social Security payment was $875 per month. It increased to $900 in January. The current COLA disregard amount is calculated by subtracting Ed's previous Social Security payment amount from his current payment amount. Ed's current COLA disregard amount is $25, which is disregarded from January 1 until February 28. The disregard ends when the new FPL amounts go into effect on March 1.

15.4 Unearned Income

15.4.1 Income From Trusts

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term "trust" includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee, and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

- A Medicaid member.
- The spouse of a Medicaid member.
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse. This includes a power of attorney or guardian.
- A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member's spouse. This includes relatives, friends, volunteers, or authorized representatives.

All payments (including interest and dividends) from a trust to the beneficiary are unearned income to the beneficiary. See SECTION 15.4.9 INTEREST AND DIVIDEND INCOME for instructions on counting interest.

If the beneficiary does not receive payments (including interest and dividends) from the trust, but they are added back to the trust principal, do not count them as income to the beneficiary if the beneficiary is elderly, blind, or disabled.

Note:	If the grantor is an institutionalized person or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (~~see Section 17.13 Trusts).~~See SECTION 17.2 EVALUATION OF TRANSFERS FOR DIVESTMENT).

15.6 Self-Employment Income

15.6.3 Self-Employment Income Assets

15.6.3.1 Business Assets

~~Business assets are generally income producing~~The value of property ~~. Exclude assets directly related and~~ essential to ~~producing goods~~self-support and used in a trade or ~~services.~~

~~In EBD cases, all real and non-real~~ business ~~property~~ is ~~exempt~~excluded if the business is currently operating (see SECTION 15.6.1.3 OPERATING) for the self-support of the ~~EBD individual. There is no profitability test~~individual. This includes real and personal property (e.g., land, buildings, equipment, and supplies) used in a trade or business and liquid assets used as part of a trade or business.

~~Note:~~ ~~See Section 16.9 Non-Home Property Exclusions.~~

~~Ask the EBD person to furnish the documents needed to:~~

~~1. Describe the business, its properties, and its assets.~~
~~2. Show the number of years it has been operating.~~
~~3. Identify any co-owners.~~

~~4. Show the estimated gross and net earnings for the current tax year.~~

If the property is not currently operating, it is exempt ~~it~~ if there is a reasonable expectation it will resume operating within the next 12 months. ~~Base your~~The reasonable expectation should be based on the following information:

1. Date of last use~~.~~
2. Reason property is not in current use~~.~~
3. Estimated date the person expects to resume use~~.~~

If ~~he or she~~the individual decides not to resume operating, the property becomes a countable asset in the month after the decision is made not to resume.

~~Extend the~~The 12~~ months~~ ~~-~~month limit should only be extended when a disabling condition prevents the person from resuming business use of the property.

15.6.3.2 Bank Accounts

~~With corporations you can easily distinguish between personal and~~ The value of business ~~checking and savings~~bank accounts~~. A corporation~~ is ~~a separate legal entity and the accounts it owns must be in the corporation's name. Accounts in the name of the owners are personal accounts.~~

~~For partnerships and sole-proprietorships, a cash account is a business account if the person claims that it is a business account. Disregard a business account, if the~~

~~profitability test is passed~~disregarded, even if a partner or sole ~~-~~proprietor makes withdrawals from the account for personal use. ~~You don't need a profitability test for EBD cases~~A bank account is a business account if the individual claims that it is a business account.

15.7 Income Deductions

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from his or her income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the SSI payment level plus the E supplement for one person (see SECTION 39.4.1, ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLE). The amount is in addition to the personal needs allowance (see SECTION 39.4.2, ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES). It should be enough for mortgage, rent, property taxes (including special assessments), home or renters insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.

Make the deduction only when both the following conditions are met:

- A physician ~~certifies~~ provides a statement (verbally or in writing) certifying that the person is likely to return to the home or apartment within six months~~.~~
- The person's spouse is not living in the home or apartment~~.~~

Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six-month continuance. A physician must again certify that he or she is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time. It is not limited to the first six months the person resides in the medical institution.

Example 1:	Bob entered a nursing home in June 2013 as a private pay patient. In June 2014, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2014. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of care, starting in June 2014.

16.5 Burial Assets

16.5.3 Life Insurance-Funded Burial Contracts

16.5.3.1 Irrevocable Assignment of Life Insurance-Funded Burial Contracts

An irrevocably assigned LIFBC is an unavailable asset because the member no longer owns it.

If a member has chosen irrevocable assignment of his or her LIFBC, the burial space exemption (see SECTION 16.5.4 SPACES) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (see SECTION 16.5.5 BURIAL FUNDS).

If the face value of the burial funds portion of the contract exceeds $1,500, it offsets the burial fund exclusion described in SECTION 16.5.5 BURIAL FUNDS.

If the face value of the burial funds portion does not exceed $1,500, determine the CSV of the LIFBC at the time that it was assigned and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in SECTION 16.5.5 BURIAL FUNDS to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by 1. and 2. above, purchased at fair market value .

~~1. Apply divestment policy to any remaining CSV (see Section 17.13.2 Revocable Trusts).~~

4. Any remaining CSV must be evaluated for divestment (see SECTION 17.2.7.15 REVOCABLE TRUSTS).

Example 1:	Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see SECTION 16.5.5 BURIAL FUNDS), and so $1,500 of this LIFBC will be considered his exempt burial fund. The $1,300 casket does not reduce the burial fund exclusion (see SECTION 16.5.5 BURIAL FUNDS)

	and is not a countable asset because it is a purchase of a burial space. Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, ~~consider~~ the remaining $200 is evaluated for divestment (see ~~Section 17.13.2 Revocable Trusts).~~SECTION 17.2.7.15 REVOCABLE TRUSTS).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash surrender value (of the LIFBC at the time that it was assigned) and apply the divestment policy (see Section 17.13.2 Revocable Trusts). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the divested amount.

Example 2:	Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurred because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral

16.6 Non-Burial Trusts

16.6.4 Irrevocable Trusts

16.6.4.2 Trust Established With Resources of the Individual or Spouse

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

This treatment applies regardless of:

- Tthe purpose for which a trust is established~~;~~

- Wwhether the trustees have or exercise any discretion under the trust;
- Aany restrictions on when or whether distributions may be made from the trust; or,
- Aany restrictions on the use of distributions from the trust.

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

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

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

	brother Don as the trustee. Under the terms of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed. The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4:	In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution. The half of the generated income that is paid to Dave would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note:	If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (see ~~Section 17.13 Trusts and Section 17.13.4 Exceptions).~~SECTION 17.2.7.16 IRREVOCABLE TRUSTS ASSIGNED OR CREATED DURING OR AFTER THE LOOK BACK PERIOD and SECTION 17.2.6 ALLOWED DIVESTMENTS).

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts ~~described in~~ (see SECTION 16.6.5 SPECIAL NEEDS TRUST and SECTION 16.6.6 POOLED TRUSTS). The policies described above also do not apply to irrevocable trusts created by a will~~,~~ (also known as testamentary trusts), unless the terms of the trust permit the individual~~/~~ or beneficiary to require that the trustee distribute principal or income to ~~him or her~~them.

16.7 Liquid Assets

16.7.2 Loans (including Home Equity Loans), Reverse Mortgages, and Promissory Notes

16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes

The current market value of a promissory note or loan made by an AG member will be assumed to be equal to the outstanding balance, and the promissory note or loan will be a countable asset in a Medicaid eligibility determination unless it cannot be sold.

An applicant who disputes the value used by the IM worker must provide credible evidence from a knowledgeable source that the note is non-negotiable or has a different current market value.

Promissory notes or loans that cannot be sold because they are not negotiable, assignable, enforceable, or otherwise marketable are considered unavailable assets (see Section ~~17.12.2 Promissory Notes on or after January 1, 2009~~ 17.2.6.18 PROMISSORY NOTES, LOANS, LAND CONTRACTS, AND MORTGAGES regarding divestment policy).

16.7.4 Annuities

16.7.4.1 Annuities Purchased After March 1, 2004

16.7.4.1.2 Annuities That Cannot Be Surrendered (Effective March 1, 2009)

It has been established that a market exists for annuities that cannot be surrendered. Some companies have purchased such annuities. Check the annuity contract to see if it can be sold. If it is capable of being sold, consider it to be an available asset unless the applicant or member demonstrates that he or she has made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.

If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity, that amount will be considered an available asset.

The annuity will be considered to be an unavailable asset if documentation is provided from the company stating that it places no value on the annuity. Payments from an

annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must also be evaluated for possible divestment, in accordance with ~~Section 17.11 Annuities~~. SECTION 17.2.6.17 IRREVOCABLE ANNUITIES.

Example 2:	Cynthia is 83 years old and applying for Medicaid. She owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferable. The agency has the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia's annuity contract at $82,000. Cynthia's annuity is therefore considered to be an available asset with a value of $82,000, which is the amount used to determine Cynthia's Medicaid eligibility.

Example 3:	Sam is 66 years old and applying for Medicaid. He owns an annuity purchased for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility.

16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

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

- The equity value of any vehicle, other than the one wholly excluded, is a resource when it meets both of the following criteria:
  - It ~~I~~is owned by an eligible individual or couple. ~~and~~
  - It ~~C~~cannot be excluded under another provision (e.g., property essential to self-support, plan to achieve self-support, vehicles that are homes.)
- Do not apply the vehicle exclusion to the following vehicles:
  - A vehicle that has been junked
  - A vehicle that is used only for recreational purposes

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

Example 4:	George is applying for Medicaid. He has three vehicles: a car (equity value $2500), a truck (equity value $7500), and a snowmobile (equity value $750). He states that the snowmobile is used only for recreation in the winter. He uses the car and the truck interchangeably for transportation. The truck is excluded in the asset determination as it is used for transportation and has the highest equity value. While the car is also used for transportation, only one vehicle can be excluded. The equity value of the car counts in the asset determination. The equity value of the snowmobile also counts in the asset determination. Even if this was George's only vehicle, because he states that it is used for recreational purposes only, it would still be a counted asset.

- For any vehicle that cannot be excluded for transportation reasons, consider excluding it under the provisions for property essential to self-support, plan to achieve self-support. If the vehicle does not qualify for the exclusion, count the equity value of the vehicle as a resource.
- If an individual owns a vehicle that is temporarily inoperable (e.g., needs repairs) and states that the vehicle will be repaired and used for transportation within the next 12 calendar months, exclude the total value of the vehicle until the repairs are completed. At that point, apply the rules for determining if the vehicle should be excluded.

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

16.7.30 Achieving a Better Life Experience (ABLE) Accounts

ABLE accounts are tax-sheltered money market savings accounts specifically designed for people with disabilities. Anyone may contribute to these accounts for the disabled beneficiary.

While Wisconsin does not offer residents a state-specific ABLE program, Wisconsin residents may open these accounts in any state where an ABLE program is offered. If an applicant or member has an ABLE account, treat the money in the account as follows:

1. Do not count the balance on the account as an asset.
2. Do not count contributions to the account, any interest or dividends earned, or other appreciation in value as income.

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

3. Exempt all distributions from these accounts to the beneficiary, as long as they are for qualified disability expenses. “Qualified disability expenses” means any expenses related to the eligible person’s blindness or disability that are incurred for the benefit of an eligible person who is the designated beneficiary. This includes the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses consistent with the purposes of the ABLE program. Unless the applicant or member reports that a distribution was used for non-qualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.
4. Disregard ABLE account distributions used for qualified disability expenses from a person’s total income when calculating cost of care for long-term care and home and community-based waivers.

ABLE account funds remaining after an applicant's or member's death are subject to estate recovery.

Note:	If a third party contributes to someone else's ABLE account, and then later applies for long-term care Medicaid, the contributed funds may be considered divestment.

16.8 Real Property

16.8.1 Home/Homestead Property

An individual's home is an excluded asset.

A home is ~~a~~defined as any property an individual has an ownership interest in and which serves as their primary place of ~~abode and lands used or operated in connection with it. In urban situations~~residence. An individual's primary place of residence is the ~~home usually consists of a house and lot. A~~property they consider their principal home and to which, if absent, they intend to return. It can ~~consist of a house~~be real or personal property, fixed or mobile, and located on land or water.

The home can include any of the following:

- The shelter in which they reside
- The land on which the shelter is located
- Related buildings on the land

The home can include more than one lot. ~~As~~ Land is considered part of the home as long as the lots adjoin one another~~, they are considered part of the home.~~

~~Homestead property may have more than one building or house on it. This applies to urban home owners as well as farm families. In farm situations the home consists of the house~~ and ~~buildings together with the total acreage property upon which they are located that is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the home.~~

~~Land should be considered part of the home property if it is~~ are not ~~completely~~ separated ~~from the home property~~ by land in which neither the individual nor ~~his or her~~their spouse has an ownership interest. Easements and public rights of way ~~(~~, such as utility lines~~,~~ and roads, ~~etc.)~~ do not separate other land from the home plot. For example, there are farms where the land is on both sides of a road and considered a part of the home. If land is completely separated from the home property by land in which neither the individual nor ~~his or her~~their spouse has ownership interest, it should not be considered part of the ~~homestead property~~home.

16.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered real property, regardless of whether or not the member owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (see SECTION 16.8.1 HOME/ HOMESTEAD PROPERTY) if the member currently lives in it or had lived in it before entering an institution~~, or~~ . If the member owns the land that the non-motorized trailer home is sitting on, consider it and any other buildings on that land as part of the homestead.
2. Non-home real property if the member does not live in it or had not lived in it prior to entering an institution.
   If the non-motorized trailer home is listed for sale, it is considered unavailable (see Section 16.2 Assets Availability).

16.8.1.7 Vehicles that are Homes

Vehicles such as motor homes and boats are considered home property for Medicaid purposes under certain circumstances. Consider a vehicle:

- Home property if the member currently lives in it as their primary dwelling or had lived in it as their primary dwelling before entering an institution. If the member owns the land that the vehicle is sitting on, consider the land and any other buildings on that land as part of the homestead. The member does not need to own the vehicle itself for the land on which the vehicle is located to be considered home property.
- Non-home vehicle property if the member does not live in it as their primary dwelling or had not lived in it as their primary dwelling prior to entering an institution.

16.9 Non-Home Property Exclusions

Non-home property is any countable asset other than a homestead. ~~See Section 17.4 Exceptions for divestment.~~See SECTION 17.2 EVALUATIONS OF TRANSFERS FOR DIVESTMENT for divestment. Exclusions of non-home property in EBD cases include:

1. Real property that is listed for sale with a realtor at a price consistent with its fair market value.
2. Property excluded regardless of value or rate of return. Property used in a trade or business is in this category (see SECTION 15.6.3.1 BUSINESS ASSETS). The property may be excluded as used in a trade or business when the ~~applicant/member~~individual is actively involved in the business operation on a day-to-day basis. The information reported on the Schedule E, Supplemental Income and Loss~~,~~ (if applicable), should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-Passive Income, the individual is actively engaged in the business.

   When determining if a trade or business exists in an LLC or other questionable situations workers should consider:
   a. Does the IRS regard this as a trade or business?
   b. Does the individual have documents to support the claim of trade or business such as licenses, permits, registration, etc.?
   c. Is the individual a member of a business or trade association?
3. Property excluded up to $6,000, regardless of rate of return. This category includes non-business property used to produce goods or services essential to self-support. Any portion of the property's equity value in excess of $6,000 is not excluded.

   Non-business property essential to self-support can be real or personal property. It produces goods or services essential to self-support when it is used, for example, to grow produce or livestock solely for personal consumption, or to perform activities essential to the production of food solely for home consumption.

Example 1:	John owns two acres of land that he uses to grow fruits and vegetables for his personal consumption. Up to $6,000 of the equity value of the property would be exempt.

4. Property excluded up to $6,000 if it is nonbusiness property that produces a net annual income (either cash or in-kind income) of at least 6 percent.

   Nonbusiness income producing property is land or non-liquid property which provides rental or other income but is not used as a part of a trade or business.

Nonbusiness income producing property includes, but is not limited to, the following:

a. Structures producing rental income

b. Land producing rent or other land use fees (non-liquid notes or mortgages, royalties for timber rights, mineral exploration, etc.)

Example 2:	James is applying for EBD Medicaid. He lives in a CBRF and is renting out his home which has an equity value of $20,000. He does not intend to return to the home. The income from the rent exceeds 6 percent of the equity value of the home, so $6,000.00 of the equity value is exempt. The remaining $14,000.00 is a counted asset.

Example 3:	Joan is applying for EBD Medicaid. She lives in her home but also owns a lake cottage in northern Wisconsin. She rents the cottage during the summer months. The income from the rent does not equal 6 percent of the equity value of the cottage. The entire equity value of the cottage is a countable asset.

5. If the excluded portion produces less than a six percent return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a six percent return, continue to consider the first $6,000 in equity as excluded.

Note:	Rental property cannot be exempt as a business property unless the property owner is in the business of renting and managing properties. If a person simply owns a piece of property and is renting it, he or she is not considered to be the owner of a trade or business (see 2. above for more information).

17.2 Evaluation of Transfers for Divestment

17.2.6 Allowed Divestments

17.2.6.11 Transfer of Homestead Property ~~Given to Spouse or Certain Children or Siblings~~

The transfer of homestead property by an institutionalized person or their spouse for less than FMV is an allowed divestment and doesn't result in a penalty period when the transfer is to:

- The institutionalized person's spouse.
- The institutionalized person's child ~~who~~, if the child meets at least one of the following criteria:
    - The child is under the age of 21.
    - The child is blind or permanently and totally disabled.
    - The child resided in the institutionalized person's home for at least two years immediately before the institutionalized person moved to a medical institution, and provided care that allowed the institutionalized person to reside at home rather than in the institution for the entire two years immediately before the institutionalized person moved to a medical institution. The child's provision of care must be verified by a notarized statement from the institutionalized person's physician or someone else who has personal knowledge of the circumstances. A notarized statement from the child is not sufficient.
    - ~~The child is younger than 21 years or~~
    - ~~The child is blind or~~
    - ~~The child is permanently and totally disabled or~~
        - ~~The child is at least 21 years old and meets all of the following:~~
        - ~~The child resided in the institutionalized person's home for at least two years immediately before the person moved to a medical institution; and,~~
        - ~~The child provided care to the institutionalized person, which permitted him or her to reside at home rather than in the institution; and, and~~
    - ~~The child provided care for the entire two years immediately before the person moved to a medical institution.~~
- The institutionalized person's sibling, if the sibling meets both of the following criteria:

- The sibling r~~R~~esided in the institutionalized person's home for at least one year immediately before the institutionalized person moved to a medical institution~~, and~~.
- The sibling h~~H~~as a verified equity or ownership interest in the home. The equity or ownership interest must be verified by documentation such as a copy of the deed or land contract. The sibling's name on the document is not sole proof, so other documentation such as canceled checks and receipts may be needed.

17.2.6.12 ~~Non-Homestead Property given~~Transfer of Assets to Spouse or ~~certain~~Blind or Disabled Children

~~A non-homestead~~ The transfer of any asset ~~that~~by an institutionalized person or their ~~community~~ spouse ~~transfers~~ for less than FMV is an allowed divestment and doesn't result in a penalty period ~~if~~when the transfer is to ~~either or both~~:

- A spouse~~.~~
- A child of ~~any age of either~~the institutionalized person or their spouse ~~who meets at least one~~, regardless of the ~~following criteria:~~
  - ~~Is~~child's age, if the child is blind or
- ~~Is~~ permanently and totally disabled

17.3 Penalty Period

17.3.2 Calculating the Penalty Period

The divestment penalty period is calculated in days using the average daily nursing home private pay rate. For divestments that occurred during or after the lookback period, the penalty period is calculated using the average daily nursing home private pay rate in effect at the time of application.

For subsequent divestments that occur when a person is already in a divestment penalty period, the additional penalty period is calculated using the average daily nursing home private pay rate currently in effect at the time the divestment penalty period is being determined. (see 17.3.6 DIVESTMENTS DURING A PENALTY PERIOD)

The rate effective January 1, ~~2021~~2022 is $~~303.38~~307.40. This rate may be updated annually (see SECTION 39.4.3 INSTITUTIONAL COST OF CARE VALUES).

Example 3:	Jeff moved to a nursing home and applied for Medicaid on 3/1/~~21~~22. One month earlier, Jeff transferred $18,500 in cash to his son, and it is determined to be a divestment. At the time of application, Jeff is otherwise eligible for LTC Medicaid. Since $18,500 divided by the average

	daily nursing home rate at the time Jeff applied ~~of $303.38~~($307.40) equals 60.~~97~~18 days, Jeff will have a divestment penalty period of 60 days.

17.3.4 Penalty Period Begin Date for Members

An enrolled member's penalty period begins on the first of the month after they are given timely notice~~. Timely notice is outlined in the Income Maintenance Manual,~~ (see SECTION ~~3.2~~ 23.1.4 TIMELY NOTICE OF ADVERSE ACTION ~~AND APPEAL RIGHTS~~).

Example 9:	Joe was determined eligible for institutional Medicaid effective March 1. On July 2, he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16, which impacted Joe's institutional Medicaid effective August 1. The penalty period begins August 1, the date the worker was able to give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after adverse action in July, the penalty period begin date would be September 1, the first day his LTC services could be impacted with timely notice. Joe will receive only Medicaid card services during the divestment penalty period.

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 2:	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 the person was first determined functionally eligible for HCBWs.

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).

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	Then the community spouse asset share is:
$~~260,760~~274,800 or more	$~~130,380~~137,400
Less than $~~260,760~~274,800 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

18.6 Spousal Impoverishment Income Allocation

18.6.2 Community Spouse Income Allocation

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

1. The community spouse maximum income allocation is one of the following:
    1. $2,903.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,~~259.50~~435.00.

        "Excess shelter allowance" means shelter expenses above $871.00. Subtract $871.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,903.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

        Community spouse shelter costs include the community spouse's expenses for:
        i. Rent
        ii. Mortgage principal and interest
        iii. Taxes (including special assessments) and insurance for principal place of residence. This includes renters insurance.
        iv. Any required maintenance fee if the community spouse lives in a condominium or cooperative.
        v. The standard utility allowance established under FoodShare:

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

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

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

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

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

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

20.1 Verification

20.1.4 ~~Verification~~ General Rules

1. ~~Avoid over~~Over-verification ~~(~~, including requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility~~).~~ ~~Do not require additional verification once~~, is prohibited. Once the accuracy of a written or verbal statement has been established~~.~~, additional verification can't be required. For example, once U.S. citizenship is verified, a member or applicant never has to verify it again (see SECTION SECTION 7.2 DOCUMENTING CITIZENSHIP AND IDENTITY).
2. ~~Do not verify~~ If information has already been verified ~~unless there~~, the applicant or member does not need to verify it again except in the following situations:
   a. There is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made~~.~~ (see SECTION SECTION 20.6 FRONT END VERIFICATION).
   b. ~~Do not exclusively require one~~The member reported a change to information that is subject to mandatory verification rules or is questionable.
   c. At renewal, information is subject to mandatory verification rules or is questionable.

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

~~3.~~4. Verification need not be presented in person. Verification may be submitted by mail, fax, email, or another electronic device, or through an authorized representative.

4.5. Do not target specialSpecial groups or persons can't be targeted based on the basis of race, religioncolor, national origin, age, disability, sex, religion, or migrant status for special verification requirements.

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

6.7. Do not require verificationVerification of information that is not used to determine eligibility can't be required.

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

The applicant or member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the applicant to provide it., unless the information from the data source is not reasonably compatible with what the applicant or member has reported (see Section 20.3.8.1 Reasonable Compatibility for Income for Health Care and Section 20.3.5.2 Reasonable Compatibility for Assets).

AssistIM agencies must assist the applicant or member in obtaining verification if he or she requeststhey request help or has have difficulty in obtaining it.

Use theThe best information available should be used to process the application or change within the time limit and issue benefits when both of the following two conditions exist:

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

Do not denyApplicants meeting the health care program eligibility in criteria based on this situation, but best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in yourtheir attempts to obtain verification. When you have received the verification, you is received, benefits may need to adjustbe adjusted or recover benefitsrecovered based on the new information. Explain thisThis will be explained to the applicant/ or member when requesting verification. The agency must explain this to the applicant or member when requesting verification.

20.2 Collateral Contacts

Collateral contacts consist of oral confirmations of circumstances by persons other than members of the health care assistance group. A collateral contact may be made either in person or over the telephone.

20.2.1 Third-Party Cooperation

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

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

20.6 Front End Verification

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. ~~Refer a~~A group should be referred for FEV only when its characteristics meet a designated profile (see Process Help Section ~~12~~31.3.4 FEV ~~Case Application of the Income Maintenance Manual~~/Fraud Referral vs. Claim Referral).

22.1 Estate Recovery

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the member's age and residence when he or she received the benefit. If a member's services do not meet the criteria listed below, they are not subject to estate recovery.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members age 55 or older on or after April 1, 2000.

Example	Josie is 12 years old and is enrolled in Katie Beckett Medicaid. She receives home health care services that include skilled nursing services, home health therapy, and speech pathology. Because she was not 55 years or older when she received the home health care services, they are not subject to estate recovery.

4. All HCBW services (COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:
    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.
5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:
    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.

Note:	The Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from members who received benefits under this program prior to May 1, 2003.

6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All IRIS services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.
8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014.
   LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and PACE). The capitation payment made to the MCO on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.
9. Costs that may be recovered through a lien are:
   a. Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
   b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

22.2 ~~Corrective Action~~Overpayments

22.2.1 Overpayments Introduction

In addition to benefits subject to Estate Recovery, incorrectly overpaid benefits are subject to recovery.

An overpayment occurs when:

- Medicaid benefits are incorrectly paid for a person who was not eligible for them,
- A MAPP member should have paid a higher premium, or
- A long-term care member did not pay as much as they should have for their nursing home patient liability or ~~when Medicaid payments are made in an incorrect amount.~~ waiver cost share

The dollar amount of ~~recovery~~an overpayment may not exceed the amount of the Medicaid benefits incorrectly provided~~. Some examples of how overpayments occur are:~~, the amount of underpaid premiums, or the patient liability or cost share, whichever is less.

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

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

~~Note:~~	~~Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from those who received benefits under this program prior to May 1, 2003.~~

Overpayments not caused by the member, which includes overpayments caused by the agency, system issues, or timely notice requirements, may not be recovered, although they may be subject to estate recovery (see SECTION 22.1 ESTATE RECOVERY).

Use the best available information to determine whether an overpayment exists in situations where verification has been requested but has not been provided (see SECTION 20.1.4 GENERAL RULES for more information on best available information).

22.2.1.1 Recoverable Overpayments

22.2.1.1.1 Recoverable Overpayment Types

Initiate recovery for a Medicaid overpayment if the incorrect payment resultedoverpayments resulting from oneany of the followingthese reasons are subject to recovery:

- Applicant or Member Error
. Applicant or member error existsoccurs when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates (financial or nonfinancial) or omits facts, which at application or renewal, and this results in the member receiving a benefit that he or she isthey are not entitled to or more benefits than he or she is entitled to.

Failure to report nonfinancial facts that impact eligibility. This can include having lower premiums, patient liability, or cost share amounts is a recoverable overpaymentthan the member should have had.

Applicant or member error also occurs when there is a: A Medicaidthe member is, or any person responsible for notifying his or her IM agency of giving information on the member's behalf, fails to report changes within 10 days of the occurrence.

An overpayment occurs if the change in financial or nonfinancial information (see Section 12.1 Change Reporting Introduction) that would have adversely affected eligibility benefits, the benefit plan, or premium, patient liability, or the post-eligibility contribution amount (cost share, patient liability). amounts.

Example 13:	Ed applied for EBD Medicaid and was found eligible effective November 1, 20132020. Ed originally reported $1,800 of nonexempt assets (checking and savings accounts), which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several nonexempt vehicles with an equity value of $1,000. The agency discovers Ed's ownership of these vehicles on February 10, 20142021. On February 20, 20142021, the agency receives verification that the equity value of Ed's nonexempt vehicles and other nonexempt assets has continuously exceeded the $2,000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Decision on February 22, 20142021, advising him that his eligibility is being discontinued effective March 31, 20142021. The overpayment amount that is subject to recovery is the total of all

	~~Medicaid benefits that were received by Ed from November 1, 20132020, through March 31, 20142021, as long as they exceed the minimum threshold of $500.~~

~~Example 24:~~	~~Sally, was determined eligible for a HCBW in January with a cost share, . She experienced a reduction in her health insurance expense as of July 1., but did not report that to her worker until her November review. The worker made the changes in CARES and increased her cost share for December.~~ ~~Had Sally reported timely, her cost share would have increased beginning in August. The overpayment is the difference between the new cost share and the old cost share for August, September, October, and November.~~

~~Example 35:~~	~~Shana was determined eligible for WWWMA in February. She had private insurance that covered treatment of breast or cervical cancer, but due to a waiting period for preexisting conditions, her treatments were not covered. The waiting period ended July 31, and the private insurance began to cover Shana's treatment effective August 1. Shana did not report this to her worker, so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30.~~ ~~Since her case would have closed August 31 if she had reported the change timely, Shana has an overpayment for September through November. The fee-for-service claims paid for September, October, and November are recoverable.~~

~~Example 46:~~	~~Joe has been a Medicaid member since January 1, 20122021. During a December 20132022 eligibility review, the agency discovered that Joe won a $10,000 lottery that was paid to him on June 12, 20132021. Joe never reported the receipt of these~~

	lottery winnings and still has about $8,000 from the lottery proceeds. The agency verified that Joe's nonexempt assets have been in excess of the $2,000 Medicaid asset limit since June 12, 20132021, and sent him a Notice of Decision, advising him that his Medicaid eligibility is being discontinuedending effective January 31, 20142023. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 20132021, through January 31, 20142023. June 2013 and July 2013of 2021 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe would havehad reported this change timely (no later than June 22, 20132021), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 20132021.

- Misstatement or omission of facts by an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf at a Medicaid application or renewal.
- Failure on the part of the member, or any person responsible for giving information on the member's behalf, to report required changes in financial (income, assets, expenses) or nonfinancial information that affects eligibility, premium, patient liability, or cost share amount.

- Fraud
. Fraud exists when an applicant, member, or any other person responsible for giving information on the member's behalf does any of the following:
  - Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
  - Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
  - Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
  - Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

If there is suspicion that fraud has occurred, the case may need to be referred to the District Attorney (DA) (see SECTION 22.2.4 REFER TO DISTRICT ATTORNEY).

Overpayments based on fraud convictions or a signed Intentional Health Care Program Violation Acknowledgement form have a lookback period of six years preceding the date of discovery, and the minimum threshold does not apply.

- ~~Member Loss of an Appeal.~~
  ~~Benefits a member receives as a result of a fair hearing request order can be recovered if the member loses the appeal.~~

  ~~A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount or the amount of claims and HMO capitation payments the state paid for each month (whichever is less).~~ the overpayment amount is the lesser of:

  - ~~The difference between the initial amount and the new amount~~
  - ~~The amount of claims and HMO capitation payments the state paid for each month~~

22.2.1.1.1 Date of Discovery and Lookback Period

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

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

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

~~Note~~Example 1:	~~As of February 1, 2002, there should be no compromise of overpayment claims. If it is determined that a recoverable overpayment exists, recovery may not be waived.~~Max applied for MAPP and was determined eligible starting April 1, 2022. In October 2022, Max started a new job but did not report this to his IM agency. Max did not complete his renewal, so his MAPP ended on March 31, 2023. In August 2024, the IM agency discovered his job that was not reported and that his income was over the income limit for MAPP. However, the IM agency found that Max misunderstood the change reporting requirements and there was no intention to commit fraud. There is no fraud conviction, and Max did not sign the Intentional Health Care Program Violation Acknowledgement

	form. The 12 month lookback period applies in this situation. Since the overpayment period is more than 12 months prior to the date of discovery, the overpayment is not recoverable.

22.2.1.1.22 ~~Nonrecoverable Overpayments~~Overpayment Claims Minimum Threshold

~~Do not initiate recovery for a Medicaid overpayment if it resulted from a non-member error, including the following situations:~~

- ~~The member reported the change timely, but the worker could not close the case or reduce the benefit due to the 10-day notice requirement.~~
- ~~Agency error (keying error, math error, failure to act on a reported change).~~
- ~~Normal prospective budgeting projections based on the best available information.~~

~~A change in the Medicaid category if the~~The minimum threshold for each claim is $500 for recoverable health care overpayments. If the overpaid amount is less than $500, no claim will be established unless it meets one of the following criteria:

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

Duplicate benefits are ~~the same~~defined as ~~the original~~situations in which a member moved out of state, enrolled in another state's Medicaid program, and ~~the post-eligibility contribution, if any, remains the same.~~received services under BadgerCare Plus or Wisconsin Medicaid more than two months after the move occurred.

Example ~~5~~2:	~~A Medicaid EBD member reports on March 25, 2014, that he received a $50,000 inheritance on March 23, 2014. The agency sends the member the required Notice of Decision discontinuing his eligibility effective April 30, 2014. Even though the member had excess assets during March and April 2014, there is no Medicaid overpayment for those months because the change was reported timely, and the agency was required to provide appropriate and timely notice before discontinuing the member's eligibility. Benefits issued only because of the timely notice requirements are not overpayments and are not subject to recovery.~~John was determined eligible for SSI-Related Medicaid starting January 1. John moved to South Carolina on July 20. Since John was no longer a Wisconsin resident, he was no longer eligible for Medicaid. John enrolled in Medicaid in

	South Carolina starting August 1. John did not report his move to South Carolina to his IM agency in Wisconsin, so capitation payments continued to be made for John. John did not complete a Medicaid renewal, so Medicaid closed December 31. His case would have closed August 31 if he had reported the move timely. Two years later, the IM agency discovered that John had duplicate benefits in Wisconsin and South Carolina for more than two months after the move. Since this is a duplicate benefits situation, the lookback period is six years, and the minimum threshold does not apply. Fee-for-service claims and any HMO capitation payments for September, October, November, and December are recoverable.

22.2.1.1.3 Recoverable Overpayment Types

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

- Applicant or member error

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

  Applicant or member error also occurs when the member, or any person responsible for giving information on the member's behalf, fails to report changes in financial or nonfinancial information (see Section 12.1 Change Reporting Introduction) that would have adversely affected eligibility, the benefit plan, or premium, patient liability, or cost share amounts.

Example 3:	Ed applied for EBD Medicaid and was found eligible effective November 1, 2020. Ed originally reported $1,800 of nonexempt assets (checking and savings accounts), which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several nonexempt vehicles with an equity value of $1,000. The agency discovers Ed's ownership of these vehicles on February 10, 2021. On February 20, 2021, the agency receives verification that the equity value of Ed's nonexempt vehicles and other nonexempt assets has

	continuously exceeded the $2,000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Decision on February 22, 2021, advising him that his eligibility is being discontinued effective March 31, 2021. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Ed from November 1, 2020, through March 31, 2021, as long as they exceed the minimum threshold of $500.

Example 4:	Sally was determined eligible for a HCBW in January with a cost share. She experienced a reduction in her health insurance expense as of July 1 but did not report that to her worker until her November review. The worker made the changes in CARES and increased her cost share for December. Had Sally reported timely, her cost share would have increased beginning in August. The overpayment is the difference between the new cost share and the old cost share for August, September, October, and November.

Example 5:	Shana was determined eligible for WWWMA in February. She had private insurance that covered treatment of breast or cervical cancer, but due to a waiting period for preexisting conditions, her treatments were not covered. The waiting period ended July 31, and the private insurance began to cover Shana's treatment effective August 1. Shana did not report this to her worker, so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30. Since her case would have closed August 31 if she had reported the change timely, Shana has an overpayment for September through November. The fee-for-service claims paid for September, October, and November are recoverable.

Example 6:	Joe has been a Medicaid member since January 1, 2021. During a December 2022 eligibility review, the agency discovered that Joe won a $10,000 lottery that was paid to him on June 12, 2021. Joe never reported the receipt of these lottery winnings and still has about $8,000 from the lottery proceeds. The agency verified that Joe's nonexempt assets have been in excess of the $2,000 Medicaid asset limit since June 12, 2021, and sent him a Notice of Decision, advising him that his Medicaid eligibility is ending effective January 31, 2023. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 2021, through January 31, 2023. June and July of 2021 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe had reported this change timely (no later than June 22, 2021), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 2021.

- Fraud

  Fraud exists when an applicant, member, or any other person responsible for giving information on the member's behalf does any of the following:

  - Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
  - Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
  - Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
  - Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

  If there is suspicion that fraud has occurred, the case may need to be referred to the District Attorney (DA) (see SECTION 22.2.4 REFER TO DISTRICT ATTORNEY).

  Overpayments based on fraud convictions or a signed Intentional Health Care Program Violation Acknowledgement form have a lookback period of six years preceding the date of discovery, and the minimum threshold does not apply.

- Member loss of an appeal

  Benefits a member receives as a result of a fair hearing request order can be recovered if the member loses the appeal.

A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, the overpayment amount is the lesser of:

. The difference between the initial amount and the new amount
. The amount of claims and HMO capitation payments the state paid for each month

~~Do not initiate recovery for a Medicaid overpayment~~22.2.1.2 Unrecoverable Overpayments

22.2.1.2.1 Date of Discovery and Lookback Period

Overpayments for periods prior to the lookback period are not recoverable (see SECTION 22.2.1.1.1 DATE OF DISCOVERY AND LOOKBACK PERIOD).

22.2.1.2.2 Overpayment Claims Minimum Threshold

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

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

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

22.2.1.2.3 Non-Member Errors

Overpayments resulting from a non-member error are not recoverable, including the following situations:

- The member reported the change timely, but the case could not be closed or the benefit reduced due to the 10-day notice requirement
- Agency error (keying error, math error, failure to act on a reported change, etc.)
- Normal prospective budgeting projections based on best available information

Example 1:	Susan is open for HCBW. Susan reported a change in income on April 1. The worker didn't process the change until April 28, so it wasn't effective until June 1. There is no overpayment for May since the change was reported timely but not acted on by the worker until after adverse action.

Overpayments for any months when rules preventing health care terminations during the COVID-19 public health emergency were in effect~~.~~ are not recoverable. This means benefits issued March 2020 and any months after March 2020 for which ~~the policy~~continuous coverage due to the COVID-19 public health emergency is in effect~~. This includes~~ for that member. This includes individuals whose health care was ~~extended~~granted, extended, or both due to agency or state error~~. The only exception to recovering overpayments during this time period is when there is a fraud conviction~~.

22.2.2 Overpayment Calculation

22.2.2.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial Medicaid application or renewal, ~~determine~~ the period for which the benefits were determined incorrectly and ~~determine~~ the appropriate overpayment amount ~~(SECTION 22.2.2.2 OVERPAYMENT AMOUNT). The ineligibility~~must be determined (see SECTION 22.2.2.2 OVERPAYMENT AMOUNT) within the applicable lookback period ~~could begin as early as the first month of eligibility, including any backdated benefits.~~(see SECTION 22.2.1.2.1 DATE OF DISCOVERY AND LOOKBACK PERIOD).

Failure to Report

For ineligible cases, if the overpayment is a result of failure to report a required change, ~~calculate~~ the date the change should have been reported and the month the case would have closed or been adversely affected if the change had been reported timely must be calculated.

Fraud

For ineligible cases, if the overpayment was the result of fraud, ~~determine~~ the date the fraudulent act occurred must be determined. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice~~. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.~~, within the applicable lookback period (see SECTION 22.2.1.2.1 DATE OF DISCOVERY AND LOOKBACK PERIOD).

22.2.2.2 Overpayment Amount

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

If a case was ineligible due to excess income, ~~recover whichever is less~~the overpayment amount is the lesser of the following:

- Fee-for service claims and any HMO capitation payments Medicaid paid~~, or~~. Any contributions made by the member (such as premiums) for each month in which an overpayment occurred are deducted from the overpayment amount.
- The amount the member would have paid toward a deductible (if eligible for a deductible)

~~To calculate the overpayment amount, use ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). The overpayment amount depends on the Medicaid category and whether the case is fee-for-service or enrolled in an HMO or MCO.~~

If a case or person was ineligible for reasons other than excess income or ~~not~~wasn't eligible for a deductible, ~~recover~~the overpayment amount is the amount of fee-for-service claims paid by the state and any HMO and MCO capitation rates the state paid. ~~Use ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). Deduct any contribution~~Any contributions made by the member (for example, ~~premium~~premiums or cost share) for each month in which an overpayment occurred are deducted from the overpayment amount.

~~For the overpayment amounts for institutional (SECTION 22.2.2.1 OVERPAYMENT PERIOD), home and community-based waivers (SECTION 22.2.2.2.1.2 FAMILY CARE, FAMILY CARE PARTNERSHIP, PACE, AND IRIS),~~ For the overpayment amounts for long-term care (SECTION 22.2.2.2.1 LONG TERM CARE OVERPAYMENTS), MAPP (SECTION 22.2.2.2.4 OVERPAYMENTS FOR QUALIFIED MEDICARE BENEFICIARY CASES), and deductible (SECTION 22.2.2.2.2 DEDUCTIBLE-RELATED OVERPAYMENTS) cases, see the appropriate sections.

Medicaid Purchase Plan ~~(SECTION 22.2.2.2.4 [MAPP]), and deductible (SECTION 22.2.2.3 DEDUCTIBLE) cases see the appropriate sections.~~

22.2.2.2.1 ~~Institutional~~Long Term Care Overpayments

~~The overpayment amount for an institutional case is the amount Medicaid paid.~~

If a member is still eligible for long-term care benefits but a misstatement or omission of fact resulted in a patient liability or waiver cost share that is lower than it should be, the overpayment amount is the difference between the correct patient liability or cost share amount and the one the member originally paid. See Process Help, Section 31.3.6.1 for instructions on how to complete the forms reporting the overpayment amount.

Note:	Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount. Nursing Home bills paid by Medicaid are already reduced by the patient liability amount.

If a member failed to report a divestment that would have resulted in a penalty period and the member is still otherwise eligible for long-term care, ~~do not recover~~any benefits Medicaid paid during the time in which the penalty period would have been served~~.~~ are not recovered. Instead, ~~impose the~~a penalty period is imposed for ongoing eligibility as outlined in ~~Section 17.5.4 Penalty Period Begin Date for Members.~~SECTION 17.3.4 PENALTY PERIOD BEGIN DATE FOR MEMBERS.

~~Note:~~	~~Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.~~

~~22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact~~

~~If a member is still eligible for long-term care benefits but a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability or cost share amount and the one the member originally paid is the overpayment amount.~~

~~Do not send a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) to retroactively increase the patient liability on MMIS.~~

~~22.2.2.2.1.2 Family Care, Family Care Partnership, PACE, and IRIS~~

~~For Family Care, Family Care Partnership, PACE, or IRIS cases in which an omission of fact results in either of the following conditions:~~

- ~~The individual's income has been underreported, which has resulted in CARES calculating a cost share that is less than it should be.~~
- ~~The individual's income has been underreported, which has resulted in CARES calculating no cost share for the individual when there should be a cost share.~~

~~Follow the instructions in Process Help, Section 31.3.6.1.~~

~~An individual may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the individual was ineligible, the benefits received while awaiting the decision can be recovered.~~

22.2.2.2.2 Deductible-Related Overpayments

If a member error increases the deductible before the deductible is met, there is no overpayment. ~~Recalculate eligibility and notify the member of the new deductible amount.~~

If the member met the incorrect deductible and Medicaid paid for services after the deductible had been met, there is an overpayment. Recover the ~~lessor~~lesser of:

- The difference between the correct deductible amount and the previous deductible amount~~.~~

- The difference between the correct deductible amount and any fee-for-service claims and HMO capitation payments Medicaid paid over the six-month period~~.~~

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

Example 6:	Sean had a deductible of $2,000 for a six-month period. He met the deductible by paying $1,000 and sending in verification of $1,000 in outstanding medical bills. An IM worker discovers an undisclosed bank account that puts Sean over the asset limit for the program. After determining his overpayment amount, the IM worker must decrease the amount overpaid by the $1,000 that Sean prepaid toward his deductible. The IM worker will not decrease the overpayment amount by any of the medical bills that helped Sean meet his deductible.

If ~~the~~a deductible ~~was~~is prepaid with a check that is returned for insufficient funds, ~~an overpayment may have occurred. Discontinue the~~ the member's eligibility~~, determine whether~~ is terminated. The overpayment amount is any fee-for-service claims and HMO capitation payments Medicaid paid ~~for any benefits on behalf of the member and, if so, establish a claim for benefit recovery~~during the deductible period.

22.2.2.2.3 Medicaid Purchase Plan

If a person was ineligible for MAPP, ~~recover~~the overpayment amount is the amount of fee-for-service claims and any HMO capitation payments paid by the state. Deduct any amount the person paid in premiums for each month in which an overpayment occurred from the overpayment amount.

If a MAPP member was still eligible for the time frame in question, but there was an increase in the premium, there is an overpayment. ~~Recover~~The overpayment amount is the ~~lessor~~lesser of:

- The difference between the premiums paid and the premium amount owed~~.~~
- The difference between the premiums paid and the amount of any fee-for-service claims and HMO capitation payments Medicaid paid for each month in question~~.~~

Premium adjustments are only made on months where there is an overpayment. If there is a month without an overpayment, then the premium calculation for that month should not be adjusted.

Example 7:	Stephanie was eligible for MAPP with a premium of $50. She forgot to report a part-time job that would have increased her MAPP premium to $75 a

	month. During the overpaid months, the state paid a monthly capitation rate of $200. For the months during the overpayment time period, the overpayment each month is $~~25 because~~ 150, which is the difference between the ~~premium paid and the premium owed each month is $25, and $25 is less than the~~$200 monthly capitation ~~rate of $200~~payment and the $50 monthly premium payment.

22.2.2.3 Liable Individual

~~Except for minors, collect~~Collect overpayments from the Medicaid member, even if the member has authorized a representative to complete the application or renewal for him or her. Join liability for married couples is as follows:

- Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments.
- For cases for which spousal impoverishment rules have been applied, the legally married spouses who signed the application or renewal are jointly liable even though one of the spouses may be institutionalized.

Example 8:	Sofie applied for Medicaid in December and at that time designated her daughter, Lynn, as her authorized representative. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for Medicaid. Sofie was determined to be ineligible for Medicaid from December~~–~~ through March. ~~Recover from Sofie any benefits~~Benefits that were provided to ~~her~~Sofie from December~~–~~ through March are recovered. Even though Lynn failed to report the information as the authorized representative, Lynn is not liable.

Example 9:	Mary and Herman are married, living together, and eligible for SSI-related Medicaid without a deductible. At their annual renewal, the IM worker discovers an undisclosed pension that would have pushed the couple above the income limit for the program, requiring them to meet a deductible before being eligible. Because they are married and were living in the same household at the time of the overpayment, Mary and Herman will be jointly liable for the entire overpayment that is

	calculated for the time period in question.

Example 10:	Jill and Samuel are married and living together. Jill is eligible for SSI-related Medicaid. Samuel receives federal and state SSI. At renewal, the IM worker discovers that Jill receives disability income from her former employer. This income was not disclosed at application. Because they are married and were living in the same household at the time of the overpayment, both Jill and Samuel are jointly liable for any overpayment calculated for the benefits incorrectly paid to Jill.

Members under age 18 are not liable for overpayments. Dependent 18-year-olds are not liable for overpayments in cases where their parent or other caretaker relative is the primary person for the case.

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

Other household members who were not enrolled in Medicaid on the same case during the time the overpayment occurred are not jointly liable for overpayments.

22.2.3 Member Notices ~~Overpayment Process~~

~~22.2.3.1 Overpayment Process Introduction~~

~~Follow the instructions in Chapter VIII of the CARES Member Assistance for Re-employment & Economic Support Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered. You are responsible to:~~

1. ~~Enter the claim into CARES.~~

~~Send a manual Medicaid Overpayment (F-10093) indicating the reason for the overpayment and the period of ineligibility.~~

2. ~~Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.~~
3. ~~Record payments on CARES screen BVCP within five days of receipt.~~

~~CARES will:~~

1. ~~Track the issuance of notices of non-payment and send automated dunning notices (i.e., past due notices).~~
2. ~~Refer past due claims for further collection action (i.e., tax intercept) to the Central Recoveries Enhanced System.~~

3. Close the claim when the balance is paid.

22.2.3.2 Member Notice

Notify theThe member or the member's representative must receive a notice of the period of ineligibility,overpayment that includes the period of eligibility, the reason for his or hertheir ineligibility, and the amounts incorrectly paid, and request arrangement ofinformation on arranging for repayment within a specified period of time.

22.2.4 Refer to District Attorney

See Income Maintenance Manual Chapter 13, Public Assistance Fraud for referral criteria when fraud isOverpayments involving suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the member is suspected.may be referred to the Department of Health Services (DHS) Office of the Inspector General (OIG). If the investigation reveals a member may have committed fraud, refer the case may be referred to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

22.2.6 Agency Retention

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

22.2.7 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his or her Medicaid from the date of the incorrect denial or termination through the time period that he or she would have remained eligible.

If the member was incorrectly denied or terminated for BadgerCare Plus or MAPP (MAPP offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through Wisconsin Medicaid.) with a premium obligation, allow the member to pick the months in which he or she would like to receive benefits. Collect all premiums owed for all prior months before certifying the member for the months he or she chose.

If a member already paid for a Medicaid covered service, inform the member that he or she will need to contact his or her provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

~~22.2.8 Incorrect Member Contribution~~

~~22.2.8.1 Premiums~~

~~If a MAPP premium is calculated in an amount that is incorrect and higher than it should have been, the excess amount must be refunded to the member when the error is discovered. See Process Help Section 25.4.3 .~~

22.6 Restoration of Benefits

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

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

If a member already paid for a Medicaid covered service, the member will need to contact their provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

22.6.1 Incorrect Member Contribution

22.6.1.1 Premiums

If a MAPP premium is calculated in an amount that is incorrect and higher than it should have been, the excess amount must be refunded to the member when the error is discovered (see SECTION 26.5.3.3 REFUNDS and Process Help Section 25.4.3).

23.1 Notices

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

23.1.1 Notice Requirements

Applicants and members must be provided with written notice of:

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

23.1.2 Notice of Approval

Any notice of approval of eligibility must include:

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

23.1.2.1 Notice of Denial

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

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

23.1.3 Notice of Adverse Action

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

23.1.3.1 Adequate Notice of Adverse Action

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

- A statement describing the intended action
- The reason(s) for the intended action, including a citation to the law, regulation, rule, or policy that supports or requires the action
- An explanation of the right to a fair hearing and how to request one
- A statement on the availability of free representation
- A statement that if a hearing is requested before the action's effective date, benefits will continue until the hearing decision is made
- A statement that the member may have to repay any benefits continued during the appeal if the hearing decision isn't in their favor or they abandon or withdraw the hearing request
- The telephone number of the income maintenance agency to contact for more information

23.1.4 Timely Notice of Adverse Action

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

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

24.1 SSI Related Medicaid Introduction

SSI-related Medicaid is the ~~original,~~ basic Medicaid program for individuals who are elderly, blind, or disabled~~.~~ and who are not receiving SSI. SSI-related individuals must meet ~~all appropriate~~ Medicaid nonfinancial eligibility requirements~~.~~ (see SECTION 4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?). SSI-related Medicaid has the lowest income and asset limits of all EBD Medicaid programs/categories. It has two income limits which are referred to as the "categorically needy" limit and the "medically needy" limit (see SECTION 39.4.1 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLE for the SSI-related categorically needy and medically needy income limits).

Categorically Needy

A fiscal test group with countable net income that does not exceed the categorically needy income limit passes the SSI-related Medicaid categorically needy income test.

Medically Needy

If a fiscal test group's countable net income exceeds the categorically needy income limit, their income is then compared to the medically needy limit of 100% FPL. If the fiscal group's countable net income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

Deductible

If a fiscal group's countable net income exceeds the medically needy income limit, they can still qualify for Medicaid by meeting a deductible, if otherwise eligible (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION and SECTION 24.5 CALCULATING THE DEDUCTIBLE).

24.5 Calculating the Deductible

24.5.1 ~~Fiscal Test Groups~~Deductible Amount

~~Determine~~To calculate the dollar amount of a Medicaid deductible for an SSI-related fiscal test group:

Determine the fiscal test group's total income for each month of the deductible period (see Section 24.3 Deductible Period~~) for this fiscal test group.~~

~~Find the fiscal test group's total net income for each month in the deductible period.~~

1. ~~For~~). Subtract the ~~months after the month of application, subtract the~~ applicable income disregards and deductions (see ~~SECTION 15.7 INCOME DEDUCTIONS), including any applicable special exempt~~SECTION 15.3 EXEMPT/DISREGARDED INCOME and SECTION 15.7 INCOME DEDUCTIONS).

   Certain income~~, IRWE, the $65 and ½ earned income deduction, and the $20 disregard, from the applicant's gross income to get the monthly countable net income. Some of the income~~ disregards and deductions allowed in other forms of Medicaid, such as the COLA and OASDI disregards for Special Status Medicaid ~~or~~and medical/remedial expenses for MAPP, are not deducted when calculating a deductible.

Compare the total ~~net~~countable income of each month ~~with~~to the ~~group's~~SSI-related medically needy income limit~~. If the group is an:~~

2. ~~SSI-related fiscal test group, (~~see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).
   - If a given month's income is less than or equal to the medically needy limit, ignore it.
   - If a given month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net ~~income~~income of that month.

3. Add together the excess income of the months in the deductible period. The result is the Medicaid deductible.

26.2 Application

26.2.1 MAPP Application Introduction

~~26.2.1 Begin Month~~

~~Certify applicants~~ When someone who has a disability applies for health care (see Section 2.1 Applications Introduction), the request for health care is also a request for MAPP ~~retroactively for any or all,~~.

Eligibility for MAPP will be determined if the member is not eligible for another form of full-benefit Medicaid.

26.2.2 Begin Month

MAPP eligibility can be backdated up to three months prior ~~months, if he or she met all of the eligibility criteria at that time.~~to the month of application (see Section 2.8.2 Backdated Eligibility). The member may be certified for MAPP for any backdate month in which they would have been eligible for MAPP had they applied in that month. The member is responsible for any ~~premium~~premiums due for the previous months in which ~~he or she elects~~they elect coverage.

~~Clients~~ MAPP applicants can also choose to begin ~~MAPP~~their eligibility ~~during any future~~:

- The month ~~that can be~~of application
- The month after the month of application
- Two months after the month of application (if processed ~~in CARES.~~after adverse action)

Example 1:	Jack applies for MAPP on September 30th and requests a retroactive determination of eligibility. His application is processed on October 21st. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November or December.

26.2.~~2~~ 3 Fiscal Test Group

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (AG). Enter them in CARES on the same application. The member's spouse is a countable member of the FTG. A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP applicant chooses not to disclose or verify assets, a case may fail for a higher Medicaid eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the member's spouse and test children in the FTG. Test children include the member's minor natural or adoptive children. Do not include the member's stepchildren in the FTG. Do not count the income or assets of the test children.

26.4 MAPP Financial Requirements

26.4.1 Assets

26.4.1.1 Independence Accounts

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

Only 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:

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

- For non-retirement/pension accounts that were registered as Independence Accounts prior to August 1, 2020, any existing amount entered in the Pre-Independence Account Balance field will continue to count for all Medicaid programs, and the Independence Account Balance will be exempt for all Medicaid programs that have an asset test. However, no new funds may be deposited in non-retirement/pension accounts during months when the member is ineligible for MAPP. If new funds are deposited during months when the member is ineligible, the entire asset will be counted.

Example 1:	Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was considered a countable asset during her eligibility determination. Sheila registers the retirement account as an Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance will continue to be a countable asset.

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

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

	those months, the Independence Account's entire balance will be considered a non-exempt asset.

Example 4:	Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

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

1. Registered with the IM Agency.
    a. Completing the F-10121 Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency.
    b. Scan the completed F-10121 to ECF and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the following exceptions:
    a. Pension and retirement accounts (see SECTION 26.4.1.3 PENSION OR RETIREMENT ACCOUNTS)
    b. Non-retirement accounts that were registered as Independence Accounts before August 1, 2020 during a member's previous period of MAPP eligibility

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

A member's deposits ~~(~~of earned or unearned income~~) in~~ into an ~~independence account~~ Independence Account may total ~~up to~~no more than 50% of the member's gross earnings over ~~a~~ the 12-month certification period~~, without penalty.~~. If the member's deposits~~, from actual (earned or unearned income),~~ exceed 50% of ~~his or her~~

their actual gross earnings over the same twelve-month period, a penalty is assessed (~~See~~see ~~26.5.1.1 PENALTY~~SECTION 26.5.1.1 INDEPENDENCE ACCOUNT PENALTY).

Amounts withdrawn from a MAPP Independence Account during ~~a twelve~~ the 12-month certification period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 5:	~~Fred earns $5000 gross from January - December. Total deposits into~~ The agency is processing Fred's MAPP renewal. During the ~~independence account were $3000 for the same~~previous 12-month certification period~~. Although a $500 withdrawal was made~~, Fred earned $5,000 from his job and received $12,000 in ~~December of~~ unearned income. During that same ~~year~~period, he deposited $3,000 into his Independence Account. At one point he withdrew $500 from his Independence Account to pay for car repairs. ~~$500 withdrawal is irrelevant when determining the penalty.~~ The penalty is based solely on total deposits ~~which exceeded~~ in excess of 50% of gross earnings over ~~a~~the twelve-month period. ~~The result in~~Withdrawals are irrelevant when determining the penalty. In this example ~~would be a $500 penalty (~~, 50% of ~~$5000 = $2500.~~Fred's $5,000 earned income = $2,500. The $~~3000~~3,000 in deposits - $~~2500~~2,500 = $500 penalty~~). (See 26.4.1.3 PENSION OR RETIREMENT ACCOUNTS)~~.

26.4.2 Income

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

1. Determine earned income. Count the member and his or her spouse's income if residing together.
2. Deduct the $65 and ½ of the earned income disregard from the spouse and member's earnings ~~(15.7.5 $65 AND ½ EARNED INCOME DEDUCTION~~(see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).
3. Deduct the member's and spouse's IRWEs ~~(15.7.4 IMPAIRMENT RELATED WORK EXPENSES (IRWE)~~(see SECTION 15.7.4 IMPAIRMENT RELATED WORK EXPENSES (IRWE)). The result is the adjusted earned income.

4. Determine unearned income. Count the applicant or member's unearned income and his or her spouse's unearned income if residing together.
5. Add the adjusted earned and unearned income together.
6. Deduct $20 from the combined income.
7. Deduct special exempt income ~~(15.7.2 SPECIAL EXEMPT INCOME~~(see SECTION 15.7.2 SPECIAL EXEMPT INCOME).
8. Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (~~or his or her~~ their spouse, if living together), if the monthly total of those expenses is above $500.
9. If a MAPP member receives Social Security payments, subtract the current COLA disregard between January 1st and the date the FPL is effective in CARES for that year~~.~~ (see SECTION 15.3.35 COLA DISREGARD FOR SOCIAL SECURITY RECIPIENTS).

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

10. Subtract the historical COLA Disregard Amount ~~(39.6 COLA~~(see SECTION 39.6 COLA) for MAPP members who are also determined to be a 503 ~~(~~see (see Section 25.1 503 Eligibility) or Disabled Adult Child (DAC) (see Section 25.2 DAC).
11. Compare the result to 250% of the FPL ~~(39.5 FPL TABLE~~(see SECTION 39.5 FPL TABLE). Include the member's minor dependent children (natural or adoptive) when determining fiscal test group size. Include the member's dependent 18-year-old child(ren) in the FTG. Do not include the member's stepchildren in the fiscal test group size.

26.5 MAPP Premiums

26.5.1 Calculation

Calculate premiums using only the member's income. Calculate a premium if the member's monthly Premium Gross Income exceeds 100 percent of the FPL (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE) for a group of one.

To calculate monthly premium amount:

1. Determine the member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income.
2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:
    a. The member's own verified monthly impairment-related work expenses (any amount)
    b. The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    c. The current COLA disregard from January 1 through the date the FPL is effective in CARES for that year, if applicable
3. Determine Premium Net Income by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number, change it to zero.
4. Multiply the premium net income by three percent (0.03).
5. Add the $25 Base Premium Amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount (see the Medicaid Eligibility Handbook, Section 26.5.1.1 Independence Account Penalty).

The result is the member's monthly premium amount.

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

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

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

Example 3:	Susan is a MAPP member whose Premium Gross income is ~~206 percent~~194% of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below: $2,200 Premium Gross Income – $300 monthly IRWE deduction – $150 monthly medical/remedial deduction ---------- $1,750 Countable Net Income – $1,~~063.33~~ 132.50 (100% of the FPL) ---------- $~~686.67 Premium Net Income~~ ~~$686.67~~ 617.50 Premium Net Income X 0.03 (3%) ---------- $~~20.60~~18.53 +$25 Base Premium Amount ---------- $~~45.60~~ 43.53 (round down to nearest whole dollar) Susan's monthly MAPP premium is $~~45~~43.

27.3 ILTC Facilities Not Medicaid Certified

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. Medicaid will not pay cost of care for these persons, but they may still be eligible for Medicaid card services (~~17.15~~see Section 21.4.1.1 Medicaid Card Services).

32.1 Medicare Beneficiaries Introduction

32.1.1 Medicare Savings Programs Introduction

Medicare is the health insurance program administered by ~~CMS~~the Centers for Medicare & Medicaid Services for people 65 years old or older, people determined disabled for two years or more, or people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or amyotrophic lateral sclerosis (ALS). People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into four types of health coverage:

- Hospitalization insurance (Part A), which pays hospital bills and certain skilled nursing facility, home health care, and hospice expenses~~.~~
- Medical insurance (Part B), which pays doctor bills and certain other charges~~.~~
- Medicare Advantage (Part C), which allows private health insurance companies to provide Medicare benefits~~.~~
- Drug insurance (Part D), which pays for prescription drug charges
- Medicare charges monthly premiums, and Medicare beneficiaries are responsible for deductibles and coinsurance payments to providers. These out-of-pocket charges are generally referred to as Medicare cost-sharing.

Medicare charges monthly premiums, and Medicare beneficiaries are responsible for deductibles and coinsurance payments to providers. These out-of-pocket charges are generally referred to as Medicare cost-sharing.

Wisconsin Medicaid may pay some or all of the member's Medicare cost-sharing for certain Medicare beneficiaries participating in the following programs:

- QMB
- SLMB
- SLMB+
- QDWI

These programs are called Medicare Savings Programs (MSP). ~~(~~They may also be referred to as Medicare Premium Assistance or Medicare Buy-In programs~~.)~~.

A request for health care is also considered a request for MSP, unless the member specifically states otherwise. Any Medicaid applicant or member who has or becomes eligible for Medicare should have their eligibility determined for MSP without requiring an additional request.

When determining eligibility for MSP, ~~IM workers should use~~ the same rules for determining financial eligibility ~~as~~for Medicaid are used ~~for Medicaid~~ with the exception of using the MSP asset limits in Section 32.6 Medicare Savings Programs Asset Limits

and the MSP income limits in ~~SECTION 39.5 FEDERAL POVERTY LEVEL TABLE.~~SECTION 39.5 FEDERAL POVERTY LEVEL TABLE. Nonfinancial eligibility is available as follows:

- ~~For QMB, see SECTION 32.2 QUALIFIED MEDICARE BENEFICIARY.~~
- ~~For SLMB, see SECTION 32.3 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY.~~
- For QMB (see SECTION 32.2 QUALIFIED MEDICARE BENEFICIARY)
- For SLMB (see SECTION 32.3 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY)
- For SLMB~~+,~~ + (see SECTION 32.4 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PLUS~~.~~
- ~~For QDWI, see SECTION 32.5 QUALIFIED DISABLED AND WORKING INDIVIDUAL.~~
-)
- For QDWI (see SECTION 32.5 QUALIFIED DISABLED AND WORKING INDIVIDUAL)

QMB members will receive a ForwardHealth card even if the member is not eligible for any other subprograms of Medicaid since Medicaid pays the Medicare copayments and deductibles for members enrolled in QMB.

32.2 QMB

32.2.3 Income Limit

The QMB income limit is 100% of the FPL~~. See 39.5~~ (see ~~39.5 FPL TABLE.~~SECTION 39.5 FPL TABLE).

The method of counting income is based on the SSI method, not on the spousal impoverishment method~~. (See~~ (see Section 28.1 ~~Adult Home and Community-Based Waivers Long-Term Care Introduction).~~ADULT HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION). Calculate QMB net income as follows:

$ Earned income (~~See~~see Section 15.5 Earned Income)
- $65 and ½ earned income deduction ~~(15.7.5 $65 AND ½ EARNED INCOME DEDUCTION~~(see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION)
+ Unearned income (Social Security income, etc.) ~~(15.4 UNEARNED INCOME~~(see SECTION 15.4 UNEARNED INCOME)
- Special exempt income ~~(15.7.2 SPECIAL EXEMPT INCOME~~(see SECTION 15.7.2 SPECIAL EXEMPT INCOME)
- $20 standard deduction
= Net income used to determine QMB eligibility

When counting Social Security income, use the gross Social Security income. Gross Social Security income:

1. Of a self-payer = the Social Security check amount + Medicare premiums he or she has paid.
2. Of someone for whom the state is paying the premiums = the Social Security check amount.

~~Disregard the~~The COLA increase is disregarded for the current year until the month after the new federal poverty limits become effective.

Example 5:	Al is a QMB member. He has income of 99% of the FPL. In January, a COLA increase of $15.00 increases Al's income above 100% of the FPL. ~~Disregard the~~The COLA increase is disregarded in any determination of Al's continuing QMB eligibility. On April 1, new QMB income limits are published. Redetermine Al's QMB eligibility in May using the new QMB income limits. At this redetermination, ~~do not disregard~~ the January COLA increase is applied.

32.3 SLMB

32.3.2 Income Limit

The SLMB income limit is at least 100% of the FPL, but less than 120%. See 39.5 FPL TABLE.% (see SECTION 39.5 FPL TABLE).

Calculate SLMB net income in the same way as QMB net income including the temporary disregard of the . The annual COLA increase. (See is temporarily disregarded until the new income limits take effect (see 32.2.2 QMB INCOME LIMITSECTION 32.2.3 INCOME LIMIT).

32.4 SLMB+

32.4.2 Income Limit

SLMB+ income must be at least 120% of the FPL, but less than 135% (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE).

Calculate SLMB+ net income in the same way as QMB net income ~~including the temporary disregard of the annual COLA increase (see SECTION 32.2.2 INCOME LIMIT~~. The annual COLA increase is temporarily disregarded until the new income limits take effect (see SECTION 32.2.3 INCOME LIMIT).

32.5 QDWI

32.5.2 Income Limit

The QDWI income limit is 200% of the FPL~~. See 39.5 FPL TABLE.~~ (see SECTION 39.5 FPL TABLE).

Calculate QDWI net income in the same way as QMB net income ~~including the temporary disregard of the~~. The annual COLA increase~~.~~(is temporarily disregarded until the new income limits take effect (See ~~32.2.2 QMB INCOME LIMIT~~SECTION 32.2.3 INCOME LIMIT).

33.6 SeniorCare Financial Requirements

33.6.8 Other Income

33.6.8.4 Veterans ~~Disability~~Benefits

Veterans ~~disability~~benefit payments should be reported as income.

~~Do not~~Don't count as income ~~the~~any portion of a veterans ~~disability payment~~benefit that is ~~for unusual medical expenses,~~an aid ~~and~~& attendance~~,~~ (A&A) or ~~a~~ housebound allowance~~.~~ or is intended to help the beneficiary pay for their unreimbursed medical expenses (see SECTION 15.3.26 VA ALLOWANCES).

An applicant should check with the Department of Veterans ~~Administration~~Affairs (VA) at 1-800-827-1000 to determine what (if any ~~portion of the payment~~) amount of their veterans benefit is considered an ~~allowance for unusual medical expenses, aid and attendance,~~A&A or housebound allowance or is for unreimbursed medical expenses.

Reimbursement from the VA for medical costs does not count as income.

39.4 Elderly, Blind, or Disabled Assets and Income Tables

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

The values in the following table were effective January 1, ~~2021~~2022.

Group Size				
Category		1		2
SSI-Related Categorically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$~~877~~924.78	Income	$1,~~323~~393.05
SSI-Related Medically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$1,~~073.33~~132.50 (effective 2/1/~~2021~~2022)	Income	$1,~~451.67~~525.83 (effective 2/1/~~2021~~2022)
SSI Payment Level				
Federal SSI Payment Level	Income	$794.00	Income	$1,191.00
SSP	Income	$83.78	Income	$132.05
Total	Income	$877.78	Income	$1,323.05
SSI Payment Level + E Supplement	Income	$~~973~~1,020.77 (Home Maintenance Maximum Allowance)		$1,668.41
SSI E Supplement	Income	$95.99		$345.36
Community Waivers Special Income Limit	Income	$2,~~382~~523.00		

Institutions Categorically Needy Income Limit	Income	$2,~~382~~523.00		
Substantial Gainful Activity Limit (non-blind individuals)	Income	$1,310.00		
Substantial Gainful Activity Limit (blind individuals)	Income	$2,190.00		
Medicaid Savings Programs				
QMB	Income	~~AT OR BELOW 100% FPL~~AT OR BELOW 100% FPL		
SLMB	Income	~~AT LEAST 100% FPL BUT LESS THAN 120% FPL~~AT LEAST 100% FPL BUT LESS THAN 120% FPL		
SLMB+	Income	~~AT LEAST 120% FPL BUT LESS THAN 135% FPL~~AT LEAST 120% FPL BUT LESS THAN 135% FPL		
QMB, SLMB, SLMB+	Assets	$~~7,970~~8,400.00		$~~11,960~~12,600.00
QDWI	Income	~~AT OR BELOW 200%~~AT OR BELOW 200%		
	Assets	$4,000.00		$6,000.00

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, ~~2021~~2022.

Description	Amount

Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,~~382~~523.00
EBD Deeming Amount to an Ineligible Minor		$~~397~~420.00
Community Waivers Basic Needs Allowance		$~~974~~1,021.00
Parental Living Allowance for Disabled Minors	1 Parent 2 Parent	$~~794~~841.00 $1,~~191~~261.00

The spousal impoverishment values in the following table were effective July 1, 2021.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,903.34
Community Spouse Excess Shelter Cost Limit	$871.00
Community Spouse Maximum Income Allocation (monthly)	The lesser of $3,~~259.50~~435.00 (as of 1/~~2021~~2022) or the Lower Income Allocation Limit plus excess shelter expenses
Family Member Income Allowance	$725.84
Community Spouse asset share (CSAS) maximum	$~~130,380~~137,400.00 as of 1/~~2021~~2022

39.4.3 Institutional Cost of Care Values

The values in the following table were effective January 1, 2021.

Description	Amount
Daily Average Private Pay Nursing Home Rate	$~~303.38~~307.40
Monthly Average Private Pay Nursing Home Rate	$9,~~227.81~~350.08

Monthly Rate for State Centers for Persons with Developmental Disabilities	$~~25,709.69~~28,028.96

39.5 FPL Table

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL	160% FPL	185% FPL	191% FPL	200% FPL	201% FPL	240% FPL	250% FPL	300% FPL	306% FPL	30% of 200% FPL
1	~~$12,880~~ $13,590	~~$1,073.33~~ $1,132.50	~~$1,288.00~~ $1,359.00	~~$1,427.53~~ $1,506.23	~~$1,449.00~~ $1,528.88	~~$1,610.00~~ $1,698.75	~~$1,674.39~~ $1,766.70	~~$1,717.33~~ $1,812.00	~~$1,985.66~~ $2,095.13	~~$2,050.06~~ $2,163.08	~~$2,146.66~~ $2,265.00	~~$2,157.39~~ $2,276.33	~~$2,575.99~~ $2,718.00	~~$2,683.33~~ $2,831.25	~~$3,219.99~~ $3,397.50	~~$3,284.39~~ $3,465.45	
2	~~$17,420~~ $18,310	~~$1,451.67~~ $1,525.83	~~$1,742.00~~ $1,831.00	~~$1,930.72~~ $2,029.35	~~$1,959.75~~ $2,059.87	~~$2,177.51~~ $2,288.75	~~$2,264.61~~ $2,380.29	~~$2,322.67~~ $2,441.33	~~$2,685.59~~ $2,822.79	~~$2,772.69~~ $2,914.34	~~$2,903.34~~ $3,051.66	~~$2,917.86~~ $3,066.92	~~$3,484.01~~ $3,661.99	~~$3,629.18~~ $3,814.58	~~$4,355.01~~ $4,577.49	~~$4,442.11~~ $4,669.04	$~~871.00~~ $915.50
3	~~$21,960~~ $23,030	~~$1,830.00~~ $1,919.17	~~$2,196.00~~ $2,303.00	~~$2,433.90~~ $2,552.50	~~$2,470.50~~ $2,590.88	~~$2,745.00~~ $2,878.76	~~$2,854.80~~ $2,993.91	~~$2,928.00~~ $3,070.67	~~$3,385.50~~ $3,550.46	~~$3,495.30~~ $3,665.61	~~$3,660.00~~ $3,838.34	~~$3,678.30~~ $3,857.53	~~$4,392.00~~ $4,606.01	~~$4,575.00~~ $4,797.93	~~$5,490.00~~ $5,757.51	~~$5,599.80~~ $5,872.66	
4	~~$26,500~~ $27,750	~~$2,208.33~~ $2,312.50	~~$2,650.00~~ $2,775.00	~~$2,937.08~~ $3,075.63	~~$2,981.25~~ $3,121.88	~~$3,312.50~~ $3,468.75	~~$3,444.99~~ $3,607.50	~~$3,533.33~~ $3,700.00	~~$4,085.41~~ $4,278.13	~~$4,217.91~~ $4,416.88	~~$4,416.66~~ $4,625.00	~~$4,438.74~~ $4,648.13	~~$5,299.99~~ $5,550.00	~~$5,520.83~~ $5,781.25	~~$6,624.99~~ $6,937.50	~~$6,757.49~~ $7,076.25	
5	~~$31,040~~ $32,470	~~$2,586.67~~ $2,705.83	~~$3,104.00~~ $3,247.00	~~$3,440.27~~ $3,598.75	~~$3,492.00~~ $3,652.87	~~$3,880.01~~ $4,058.75	~~$4,035.21~~ $4,221.09	~~$4,138.67~~ $4,329.33	~~$4,785.34~~ $5,005.79	~~$4,940.54~~ $5,168.14	~~$5,173.34~~ $5,411.66	~~$5,199.21~~ $5,438.72	~~$6,208.01~~ $6,493.99	~~$6,466.68~~ $6,764.58	~~$7,760.01~~ $8,117.49	~~$7,915.21~~ $8,279.84	
6	~~$35,580~~ $37,190	~~$2,965.00~~ $3,099.17	~~$3,558.00~~ $3,719.00	~~$3,943.45~~ $4,121.90	~~$4,002.75~~ $4,183.88	~~$4,447.50~~ $4,648.76	~~$4,625.40~~ $4,834.71	~~$4,744.00~~ $4,958.67	~~$5,485.25~~ $5,733.46	~~$5,663.15~~ $5,919.41	~~$5,930.00~~ $6,198.34	~~$5,959.65~~ $6,229.33	~~$7,116.00~~ $7,438.01	~~$7,412.50~~ $7,747.93	~~$8,895.00~~ $9,297.51	~~$9,072.90~~ $9,483.46	
7	~~$40,120~~ $41,910	~~$3,343.33~~ $3,492.50	~~$4,012.00~~ $4,191.00	~~$4,446.63~~ $4,645.03	~~$4,513.50~~ $4,714.88	~~$5,015.00~~ $5,238.75	~~$5,215.59~~ $5,448.30	~~$5,349.33~~ $5,588.00	~~$6,185.16~~ $6,461.13	~~$6,385.76~~ $6,670.68	~~$6,686.66~~ $6,985.00	~~$6,720.09~~ $7,019.93	~~$8,023.99~~ $8,382.00	~~$8,358.33~~ $8,731.25	~~$10,029.99~~ $10,477.50	~~$10,230.59~~ $10,687.05	
8	~~$44,660~~ $46,630	~~$3,721.67~~ $3,885.83	~~$4,466.00~~ $4,663.00	~~$4,949.82~~ $5,168.15	~~$5,024.25~~ $5,245.87	~~$5,582.51~~ $5,828.75	~~$5,805.81~~ $6,061.89	~~$5,954.67~~ $6,217.33	~~$6,885.09~~ $7,188.79	~~$7,108.39~~ $7,421.94	~~$7,443.34~~ $7,771.66	~~$7,480.56~~ $7,810.52	~~$8,932.01~~ $9,325.99	~~$9,304.18~~ $9,714.58	~~$11,165.01~~ $11,657.49	~~$11,388.31~~ $11,890.64	
9	~~$49,200~~ $51,350	~~$4,100.00~~ $4,279.17	~~$4,920.00~~ $5,135.00	~~$5,453.00~~ $5,691.30	~~$5,535.00~~ $5,776.88	~~$6,150.00~~ $6,418.76	~~$6,396.00~~ $6,675.51	~~$6,560.00~~ $6,846.67	~~$7,585.00~~ $7,916.46	~~$7,831.00~~ $8,173.21	~~$8,200.00~~ $8,558.34	~~$8,241.00~~ $8,601.13	~~$9,840.00~~ $10,270.01	~~$10,250.00~~ $10,697.93	~~$12,300.00~~ $12,837.51	~~$12,546.00~~ $13,094.26	
10	~~$53,740~~ $56,070	~~$4,478.33~~ $4,672.50	~~$5,374.00~~ $5,607.00	~~$5,956.18~~ $6,214.43	~~$6,045.75~~ $6,307.88	~~$6,717.50~~ $7,008.75	~~$6,986.19~~ $7,289.10	~~$7,165.33~~ $7,476.00	~~$8,284.91~~ $8,644.13	~~$8,553.61~~ $8,924.48	~~$8,956.66~~ $9,345.00	~~$9,001.44~~ $9,391.73	~~$10,747.99~~ $11,214.00	~~$11,195.83~~ $11,681.25	~~$13,434.99~~ $14,017.50	~~$13,703.69~~ $14,297.85	
11	~~$58,280~~ $60,790	~~$4,856.67~~ $5,065.83	~~$5,828.00~~ $6,079.00	~~$6,459.37~~ $6,737.55	~~$6,556.50~~ $6,838.87	~~$7,285.01~~ $7,598.75	~~$7,576.41~~ $7,902.69	~~$7,770.67~~ $8,105.33	~~$8,984.84~~ $9,371.79	~~$9,276.24~~ $9,675.74	~~$9,713.34~~ $10,131.66	~~$9,761.91~~ $10,182.32	~~$11,656.01~~ $12,157.99	~~$12,141.68~~ $12,664.58	~~$14,570.01~~ $15,197.49	~~$14,861.41~~ $15,501.44	
12	~~$62,820~~ $65,510	~~$5,235.00~~ $5,459.17	~~$6,282.00~~ $6,551.00	~~$6,962.55~~ $7,260.70	~~$7,067.25~~ $7,369.88	~~$7,852.50~~ $8,188.76	~~$8,166.60~~ $8,516.31	~~$8,376.00~~ $8,734.67	~~$9,684.75~~ $10,099.46	~~$9,998.85~~ $10,427.01	~~$10,470.00~~ $10,918.34	~~$10,522.35~~ $10,972.93	~~$12,564.00~~ $13,102.01	~~$13,087.50~~ $13,647.93	~~$15,705.00~~ $16,377.51	~~$16,019.10~~ $16,705.06	
13	~~$67,360~~ $70,230	~~$5,613.33~~ $5,852.50	~~$6,736.00~~ $7,023.00	~~$7,465.73~~ $7,783.83	~~$7,578.00~~ $7,900.88	~~$8,420.00~~ $8,778.75	~~$8,756.79~~ $9,129.90	~~$8,981.33~~ $9,364.00	~~$10,384.66~~ $10,827.13	~~$10,721.46~~ $11,178.28	~~$11,226.66~~ $11,705.00	~~$11,282.79~~ $11,763.53	~~$13,471.99~~ $14,046.00	~~$14,033.33~~ $14,631.25	~~$16,839.99~~ $17,557.50	~~$17,176.79~~ $17,908.65	
14	~~$71,900~~ $74,950	~~$5,991.67~~ $6,245.83	~~$7,190.00~~ $7,495.00	~~$7,968.92~~ $8,306.95	~~$8,088.75~~ $8,431.87	~~$8,987.51~~ $9,368.75	~~$9,347.01~~ $9,743.49	~~$9,586.67~~ $9,993.33	~~$11,084.59~~ $11,554.79	~~$11,444.09~~ $11,929.54	~~$11,983.34~~ $12,491.66	~~$12,043.26~~ $12,554.12	~~$14,380.01~~ $14,989.99	~~$14,979.18~~ $15,614.58	~~$17,975.01~~ $18,737.49	~~$18,334.51~~ $19,112.24	
15	~~$76,440~~ $79,670	~~$6,370.00~~ $6,639.17	~~$7,644.00~~ $7,967.00	~~$8,472.10~~ $8,830.10	~~$8,599.50~~ $8,962.88	~~$9,555.00~~ $9,958.76	~~$9,937.20~~ $10,357.11	~~$10,192.00~~ $10,622.67	~~$11,784.50~~ $12,282.46	~~$12,166.70~~ $12,680.81	~~$12,740.00~~ $13,278.34	~~$12,803.70~~ $13,344.73	~~$15,288.00~~ $15,934.01	~~$15,925.00~~ $16,597.93	~~$19,110.00~~ $19,917.51	~~$19,492.20~~ $20,315.86	
16	~~$80,980~~ $84,390	~~$6,748.33~~ $7,032.50	~~$8,098.00~~ $8,439.00	~~$8,975.28~~ $9,353.23	~~$9,110.25~~ $9,493.88	~~$10,122.50~~ $10,548.75	~~$10,527.39~~ $10,970.70	~~$10,797.33~~ $11,252.00	~~$12,484.41~~ $13,010.13	~~$12,889.31~~ $13,432.08	~~$13,496.66~~ $14,065.00	~~$13,564.~~ $14,135.33	~~$16,195.99~~ $16,878.00	~~$16,870.83~~ $17,581.25	~~$20,244.99~~ $21,097.50	~~$20,649.89~~ $21,519.45	
17	~~$85,520~~ $89,110	~~$7,126.67~~ $7,425.83	~~$8,552.00~~ $8,911.00	~~$9,478.47~~ $9,786.35	~~$9,621.00~~ $10,024.87	~~$10,690.01~~ $11,138.75	~~$11,117.61~~ $11,584.29	~~$11,402.67~~ $11,881.33	~~$13,184.34~~ $13,737.79	~~$13,611.94~~ $14,183.34	~~$14,253.34~~ $14,851.66	~~$14,324.61~~ $14,925.92	~~$17,104.01~~ $17,821.99	~~$17,816.68~~ $18,564.58	~~$21,380.01~~ $22,277.49	~~$21,807.61~~ $22,723.04	
18	~~$90,060~~ $93,830	~~$7,505.00~~ $7,819.17	~~$9,006.00~~ $9,383.00	~~$9,981.65~~ $10,399.50	~~$10,131.75~~ $10,555.88	~~$11,257.50~~ $11,728.76	~~$11,707.80~~ $12,197.91	~~$12,008.00~~ $12,510.67	~~$13,884.25~~ $14,465.46	~~$14,334.55~~ $14,934.61	~~$15,010.00~~ $15,638.34	~~$15,085.05~~ $15,716.53	~~$18,012.00~~ $18,766.01	~~$18,762.50~~ $19,547.93	~~$22,515.00~~ $23,457.51	~~$22,965.30~~ $23,926.66	
19	~~$94,600~~ $98,550	~~$7,883.33~~ $8,212.50	~~$9,460.00~~ $9,855.00	~~$10,484.83~~ $10,922.63	~~$10,642.50~~ $11,086.88	~~$11,825.00~~ $12,318.75	~~$12,297.99~~ $12,811.50	~~$12,613.33~~ $13,140.00	~~$14,584.16~~ $15,193.13	~~$15,057.16~~ $15,685.88	~~$15,766.66~~ $16,425.00	~~$15,845.49~~ $16,507.13	~~$18,919.99~~ $19,710.00	~~$19,708.33~~ $20,531.25	~~$23,649.99~~ $24,637.50	~~$24,122.99~~ $25,130.25	
20	~~$99,140~~ $103,270	~~$8,261.67~~ $8,605.83	~~$9,914.00~~ $10,327.00	~~$10,988.02~~ $11,445.75	~~$11,153.25~~ $11,617.87	~~$12,392.51~~ $12,908.75	~~$12,888.21~~ $13,425.09	~~$13,218.67~~ $13,769.33	~~$15,284.09~~ $15,920.79	~~$15,779.79~~ $16,437.14	~~$16,523.34~~ $17,211.66	~~$16,605.96~~ $17,297.72	~~$19,828.01~~ $20,653.99	~~$20,654.18~~ $21,514.58	~~$24,785.01~~ $25,817.49	~~$25,280.71~~ $26,333.84	
21	~~$103,680~~ $107,990	~~$8,640.00~~ $8,999.17	~~$10,368.00~~ $10,799.00	~~$11,491.20~~ $11,968.90	~~$11,664.00~~ $12,148.88	~~$12,960.00~~ $13,498.76	~~$13,478.40~~ $14,038.71	~~$13,824.00~~ $14,398.67	~~$15,984.00~~ $16,648.46	~~$16,502.40~~ $17,188.41	~~$17,280.00~~ $17,998.34	~~$17,366.40~~ $18,088.33	~~$20,736.00~~ $21,598.01	~~$21,600.00~~ $22,497.93	~~$25,920.00~~ $26,997.51	~~$26,438.40~~ $27,537.46	

22	~~$108,220~~ $112,710	~~$9,018.33~~ $9,392.50	~~$10,822.00~~ $11,271.00	~~$11,994.38~~ $12,492.03	~~$12,174.75~~ $12,679.88	~~$13,527.50~~ $14,088.75	~~$14,068.59~~ $14,652.30	~~$14,429.33~~ $15,028.00	~~$16,683.91~~ $17,376.13	~~$17,225.01~~ $17,939.68	~~$18,036.66~~ $18,785.00	~~$18,126.84~~ $18,878.93	~~$21,643.99~~ $22,542.00	~~$22,545.83~~ $23,481.25	~~$27,054.99~~ $28,177.50	~~$27,596.09~~ $28,741.05	
23	~~$112,760~~ $117,430	~~$9,396.67~~ $9,785.83	~~$11,276.00~~ $11,743.00	~~$12,497.57~~ $13,015.15	~~$12,685.50~~ $13,210.87	~~$14,095.01~~ $14,678.75	~~$14,658.81~~ $15,265.89	~~$15,034.67~~ $15,657.33	~~$17,383.84~~ $18,103.79	~~$17,947.64~~ $18,690.94	~~$18,793.34~~ $19,571.66	~~$18,887.31~~ $19,669.52	~~$22,552.01~~ $23,485.99	~~$23,491.68~~ $24,464.58	~~$28,190.01~~ $29,357.49	~~$28,753.81~~ $29,944.64	
24	~~$117,300~~ $122,150	~~$9,775.00~~ $10,179.17	~~$11,730.00~~ $12,215.00	~~$13,000.75~~ $13,538.30	~~$13,196.25~~ $13,741.88	~~$14,662.50~~ $15,268.76	~~$15,249.00~~ $15,879.51	~~$15,640.00~~ $16,286.67	~~$18,083.75~~ $18,831.46	~~$18,670.25~~ $19,442.21	~~$19,550.00~~ $20,358.34	~~$19,647.75~~ $20,460.13	~~$23,460.00~~ $24,430.01	~~$24,437.50~~ $25,447.93	~~$29,325.00~~ $30,537.51	~~$29,911.50~~ $31,148.26	
each additional person	~~$4,540~~ $4,720	~~$378.33~~ $393.33	~~$454.00~~ $472.00	~~$503.18~~ $523.13	~~$510.75~~ $531.00	~~$567.50~~ $590.00	~~$590.19~~ $613.59	~~$605.33~~ $629.33	~~$699.91~~ $727.66	~~$722.61~~ $751.26	~~$756.66~~ $786.66	~~$760.44~~ $790.59	~~$907.99~~ $943.99	~~$945.83~~ $983.33	~~$1,134.99~~ $1,179.99	~~$1,157.69~~ $1,203.59	
		QMB BC+ Extensions trigger limit BC+ Adults limit MAPP premium limit	SLMB	BC+ adult premium limit	QI-1 (SLMB+)		MAGI/BC+ Limit for kids 6-18 subject to access / backdate / EE	SeniorCare tier one limit	BC+ EE for kids ages 1-5	MAGI/BC+ limit for kids 1-5 subject to access / backdate / EE	QDWI & lower SI Inc Alloc BC+ kids premiums BC+ adults limit	MAGI/BC+ kids premiums	SeniorCare tier three limit	MAPP	BC+ pregnant women kids limit	MAGI/BC+ pregnant women kids limit	excess shelter allowance

	Annual figures for SeniorCare		~~$20,608.00~~ $21,744.00		~~$25,760.00~~ $27,180.00		~~$30,912.00~~ $32,616.00	
			$29,296.00		$36, 620.00		$43,944.00	

39.6 Cost-of-Living Adjustment

To calculate the COLAdisregard amount, do the following:

1. Find the AG's current gross OASDI Benefits income. The gross OASDI income is the sum of the following:
    a. OASDI check.
    b. Any amount that has been withheld for a Medicare premium.
    c. Any amount withheld to repay an earlier overpayment.
2. Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.
3. On the COLA Disregard Amount Table below, find the last month in which the person was eligible for and received a check for both OASDI and SSI.
4. Find the decimal figure that applies to this month.
5. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount	
January to December 2021	0.055713
January to December 2020	0.~~012833~~067831
January to December 2019	0.~~028379~~082511
January to December 2018	0.~~054843~~107501
January to December 2017	0.~~073376~~125001
January to December 2016	0.~~076148~~127618
January to December 2015	0.~~076148~~127618
January to December 2014	0.~~091590~~142201
January to December 2013	0.~~105015~~154877
January to December 2012	0.~~119976~~169004
January to December 2011	0.~~150556~~197881
January to December 2010	0.~~150556~~197881
January to December 2009	0.~~150556~~197881
January to December 2008	0.~~197123~~241853
January to December 2007	0.~~215174~~258899
January to December 2006	0.~~240245~~282574

January to December 2005	0.~~270169~~310830
January to December 2004	0.~~289356~~328948
January to December 2003	0.~~303973~~342750
January to December 2002	0.~~313582~~351825
January to December 2001	0.~~330977~~368250
January to December 2000	0.~~353601~~389614
January to December 1999	0.~~368751~~403920
January to December 1998	0.~~376852~~411569
January to December 1997	0.~~389669~~423672
January to December 1996	0.~~406870~~439915
January to December 1995	0.~~421900~~454108
January to December 1994	0.~~437646~~468976
January to December 1993	0.~~451897~~482433
January to December 1992	0.~~467861~~497508
January to December 1991	0.~~486848~~515437
January to December 1990	0.~~513138~~540263
January to December 1989	0.~~534993~~560900
January to December 1988	0.~~552878~~577789
January to December 1987	0.~~570900~~594807
January to December 1986	0.~~576407~~600007
January to December 1985	0.~~589144~~612034

January to December 1984	0.~~603037~~625153
July 1983 to December 1983	0.~~616461~~637829
July 1982 to June 1983	0.~~642888~~662783
July 1981 to June 1982	0.~~678856~~696748
July 1980 to June 1981	0.~~719034~~734687
July 1979 to June 1980	0.~~744344~~758587
July 1978 to June 1979	0.~~759947~~773321
July 1977 to June 1978	0.~~773321~~785950
July 1976 to June 1977	0.~~786956~~798825
July 1975 to June 1976	0.~~802737~~813727

39.11 SeniorCare Income Limits

39.11.1 SeniorCare Income Limits Introduction

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

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

The participation levels are:

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

Note:	The FPL may be adjusted annually~~.~~ ~~See~~ (see ~~39.5 FEDERAL POVERTY LEVEL TABLE~~SECTION 39.5 FPL TABLE for current FPLs~~.~~). If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	Annual Out-of-Pocket Expense Requirements and Benefits
Level 1 Income at or below 160% of FPL At or below $~~20,608~~21,744 per individual or $~~27,872~~29,296 per couple annually.*	• No deductible or spenddown. • $5 co-pay for each covered generic prescription drug. • $15 co-pay for each covered brand name prescription drug.
Level 2a	• $500 deductible per person.

Income above 160% and at or below 200% FPL $~~20,609~~21,745 to $~~25,760~~27,180 per individual and $~~27,873~~29,297 to $~~34,840~~36,620 per couple annually.*	• Pay the SeniorCare rate for drugs until the $500 deductible is met. • After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b Income above 200% and at or below 240% of FPL $~~25,761~~27,181 to $~~30,912~~32,616 per individual and $~~34,841~~36,621 to $~~41,808~~43,944 per couple annually.	• $850 deductible per person. • Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 Annual income is above 240% of the FPL $~~30,913~~32,617 or higher per individual and $~~41,809~~43,945 or higher per couple annually.*	• Pay retail price for drugs equal to the difference between the member's income and $~~30,913~~32,616 per individual or $~~41,809~~43,944 per couple. This is called “spenddown.” • Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. • After spenddown is met, meet an $850 deductible per person. • Pay SeniorCare rate for most covered drugs until the $850 deductible is met. • After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each

	covered brand name prescription drug.

* These income amounts are based on the ~~2021~~ 2022 federal poverty guidelines, which typically increase by a small amount each year.

39.11.2 Level 1: Copayment

SeniorCare will pay for covered prescription drugs purchased from participating pharmacies except for participant copayments.

Level 1 participants are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

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

If a participant has private insurance with a higher copayment per prescription than SeniorCare, the SeniorCare copayment rules will apply, and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services at 1-800-947-9627.

Residents of nursing homes and community-based residential facilities will have to pay the usual SeniorCare copayment even when they are required to purchase drugs on less than a monthly basis.

39.11.3 Level 2a: Deductible

~~Participant has~~ Level 2a participants have an annual deductible of $500. ~~Participant~~The participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 copayment for each covered generic prescription drug ~~,~~ and a $15 ~~co-payment~~copayment for each covered brand name prescription drug.

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

39.11.4 Level 2b: Deductible

Level 2b participants have an annual deductible of $850. The participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

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

Note:	If married persons in the same FTG with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the spouse who applies later (see Section 33.9.3.1 FTG Changes at Level 2a and 2b)

39.11.4 Level 2b: Deductible

~~Participant has an annual deductible of $850. Participant~~ will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

~~After this deductible is met, a level 2b participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.~~

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

~~Note:~~	~~If married persons in the same FTG with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the spouse who applies later. (See 33.9.3.1 FTG Changes at Level 2a and 2b)~~

39.11.5 Level 3: Spenddown

39.11.5.1 Level 3: Fiscal Test Group of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, ~~he or she is~~ they are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name ~~copayment~~copay.

Example 1:	Dorothy's annual income is $~~31,624~~33,616. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount. If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible. After this deductible is met, Dorothy purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

39.11.5.2 Level 3: Fiscal Test Group of Two

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

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

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

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

Example 2:	Bob and Alice's annual income is $~~43,376~~45,944, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the

	12-month benefit period, their joint spenddown amount is $2,000. Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement. After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible. Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

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

Example 3:	Tracy and Dave's annual income is $~~43,376~~45,944, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000. Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement. After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period.

40.1 Worksheets

The following is a list of Medicaid worksheets. Workers should come here each time a worksheet is needed to insure they are using the most up to date worksheets.

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

Wkst 14	AFDC-Related Determination Worksheet