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

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

Re: **Medicaid Eligibility Handbook Release 22-02**

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Effective Date: 08/01/2022

EFFECTIVE DATE		The following policy additions or changes are **effective 08/01/2022** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.1	**Applications Introduction**	Updated language for clarity.
2.2	**Application Methods**	Added two application methods.
2.5.1	**Valid Signature Introduction**	Updated with clarification on signature policy for applicants.
2.9.2	**Denial**	Added examples on application denials.
5.2.1	**Definition of Disability**	Updated reference link title.
7.3.3.3	**Iraqis and Afghans with Special Immigrant Status**	New section.
7.3.3.4	**Afghan Parolees**	New section.
7.3.8	**Immigration Status Chart**	Added a new registration code.
7.3.9	**Refugee Assistance Programs**	Updated Refugee Medical Assistance eligibility time period.
7.3.9.2	**Refugee Medical Assistance**	Updated Refugee Medical Assistance eligibility time period.
13.8.3	**Huber Law**	Added examples for Huber Law exemptions.
13.9	**State Correctional Institutions**	Updated counties of several facilities.
15.1.2	**Special Financial Rules for Disabled Children for SSI-Related Medicaid**	Updated section title and added details on parental income and updated examples.
15.3.30	**Certain Payment Types Related to the COVID-19 Pandemic**	Added payment types not counted as income.
15.3.31	**Cash and In-Kind Items Received in Conjunction with Medical and Social Services**	New section.
15.4.25	**Certain Payment Types Related to the COVID-19 Pandemic**	Added payment types counted as income.
15.4.26	**Virtual Currency**	New section.
15.5.19	**Virtual Currency**	New Section.
15.7.1	**Maintaining Home or Apartment**	Updated reference link.
16.2.2	**Real Property**	Removed cross reference link.
16.5.1	**Burial Trusts**	Section rewritten.

16.5.5	**Burial Funds**	Added clarification on when burial funds can be exempted.
16.7.1.3	**Other Personal Property**	Added a new personal property item type.
16.7.9.2	**When to Count, When to Exempt**	Updated reference link.
16.7.30	**Achieving a Better Life Experience (ABLE) Accounts**	Added clarification about ABLE account distributions.
16.9	**Property Essential to Self-Support**	Updated information on property essential to self-support and reorganized sections.
17.2.6.2	**Life expectancy of less than five years**	Updated grammar.
17.3.1	**Penalty Period Introduction**	Added clarification on length of penalty periods and examples.
17.3.2	**Calculating the Penalty Period**	
18.6	**Spousal Impoverishment Income Allocation**	Added clarification to dependent family member income allowance.
20.3.1	**Mandatory Verification Items Introduction**	Added clarification about Huber participation.
20.3.8.1	**Reasonable Compatibility for Income for Health Care**	Added threshold to reasonable compatibility policy.
20.3.8.1.2	**Reasonable Compatibility Thresholds**	
20.3.8.1.3	**Reasonable Compatibility Test**	
20.3.10	**Huber Law Exemption**	New section.
21.6	**HMO Enrollment**	Section rewritten.
22.2.1.1.1	**Date of Discovery and Look Back Period**	Added clarification about capitation fees.
22.2.1.1.2	**Overpayment Claims Minimum Threshold**	
22.2.1.1.3	**Recoverable Overpayment Types**	Added clarification to policy.
22.2.1.2.4	**Eligibility and Premium Determinations Based on Reasonable Compatibility**	New section.
22.3	**Interagency Case Transfer**	Removed obsolete information also removed from Process Help.
22.4.1	**Application of Policy**	Updated link.
22.5.1	**Authorized Representatives**	Updated link.
23	**Notices and Fair Hearings**	Update TOC label for chapter.
23.1	**Notices**	Updated language for clarity.
23.2	**Fair Hearings**	New section.
24.3	**Deductible Period**	Updated language for clarity.
26.4.2	**Income**	Updated language for clarity.
26.5.1	**Calculation**	Removed processing instructions that belong in Process Help.
26.5.3.1	**Payment Methods**	Section rewritten.
26.5.4	**Ongoing Cases**	Added clarification on ongoing premium payments.
26.5.5.2	**Between Adverse Action of the Benefit Month and the Last Day of Benefit Month**	Removed processing instructions that belong in Process Help.
26.5.5.3	**Anytime in Month After the Benefit Month**	
26.5.6	**Non-Payment**	
26.5.6.1	**Insufficient Funds**	
26.5.7	**Opting Out**	
27.5.4	**Instructions for Manual Eligibility Determinations**	Updated links.
27.7.6	**Personal Needs Allowance**	Updated link.
28.6.4.1	**Personal Maintenance Allowance**	Added information about EBD Maximum Personal Maintenance Allowance.
28.6.4.2.2	**Family Maintenance Allowance**	Updated reference link.

	Calculation - EBD-Related	
29.1	**Katie Beckett**	Added clarification about qualifying for the program.
32.2.1	**Introduction**	Updated language for clarity.
32.2.2	**Entitled to Medicare**	
33.6.5	**Interest and Dividends**	Removed text to correct policy.
39.4	**Elderly, Blind, or Disabled Assets and Income Tables**	Section rewritten.
39.6	**COLA Disregard for DAC and 503 Assistance Groups**	Updated language for clarity and added a table.
40.1	**Worksheets**	Updated table.

2.1 Applications Introduction

Anyone has the right to apply for Medicaid. However, ~~individuals~~ people younger than 18 years old must have a parent, caretaker relative, or ~~a~~ legal guardian apply for Medicaid on their behalf unless they are living independently.

~~They~~ The applicant may be assisted by any person ~~he or she chooses~~ they choose in completing an application.

~~Encourage anyone~~Anyone who expresses interest in applying should be encouraged to file an application as soon as possible~~. When an application is requested:~~ (see Section 2.2 Application Methods).

1. ~~Suggest~~The agency must provide the ~~applicant use the ACCESS online application at the following site: access.wisconsin.gov/; or~~
2. ~~Mail in using the Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet, F-10101; or~~
3. ~~Schedule a telephone or face-to-face interview.~~

~~Provide any information, instruction, and/or materials needed to complete the application process. Provide a~~ Notice of Assignment~~: Child Support, Family Support, Maintenance and Medical Support form~~ (DWSP 2477) and Good Cause Notice (DWSP 2018) to ~~each applicant~~applicants with children applying for Medicaid or to anyone that requests either of these.

~~Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to www.dhs.wisconsin.gov/forms/index.htm.~~

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

~~Note:~~Example 1	~~An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, he or she is not eligible.~~Tim and Carrie are married. When Tim applies for health care, he indicates that he is requesting health care for himself, but Carrie is not requesting health care. Tim is determined eligible for Medicaid. Four months later, Carrie decides that she would also like to apply for health care. Carrie does not need to submit a new application or new signature. She can contact the IM agency to request health care.

Note:	An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, the person is not eligible.

2.2 Application ~~Types/~~Methods

Medicaid applicants have the choice of one of the ~~four~~ following application methods:

- ACCESS: access.wisconsin.gov/access/~~.~~
- Mail-in using the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet (F-10101~~).~~)
- Telephone interview
- Face-to-face interview~~. When a request for assistance is made by phone,~~
- Use of the ~~filing date is not set until a signed~~paper or online application ~~and/or registration form is received by~~available through the ~~agency.~~Marketplace
- Telephone application with the Marketplace
- ~~Face-to-face interview.~~

2.5 Valid Signature

2.5.1 Valid Signature Introduction

The applicant ~~or his or her~~, their representative (see below~~)~~), or the applicant's caretaker relative must sign one of the following:

- The paper application form
- The signature page of the Application Summary (by telephone, electronically, or ~~by providing~~with a handwritten signature)
- The ACCESS application with an electronic signature
- The online or paper Application for Health Coverage & Help Paying Costs from the FFM

2.5.1.1 Signatures From Representatives

~~An applicant's representative~~The following people can ~~be one~~sign the application with their own name on behalf of the ~~following~~applicant:

1. Guardian~~:~~

   When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the ~~person~~ individual claiming to be the applicant's guardian can file an application on ~~his or her~~their behalf. ~~Only the person designated as one of the following may sign the application:~~

   When someone has been designated as ~~the guardian of the estate, guardian of the person and the estate, or guardian in general~~one of the following, only the guardian, not the applicant, may sign the application or appoint ~~another representative.~~

   ~~If the applicant only has a legal **guardian of the person**, the applicant must sign the application unless the applicant has appointed his or her guardian of the person to be the~~an authorized representative~~.~~:

   - Guardian of the estate
   - Guardian of the person and the estate
   - Guardian in general

~~- authorized representative: The applicant may authorize someone to represent him or her. An authorized representative can be an individual or an organization. See SECTION 22.5 REPRESENTATIVES for more information.~~

~~If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or Organization F-10126B).~~

~~An authorized representative is responsible for submitting a completed, signed application and any required documents.~~

~~When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.~~

If the applicant only has a legal guardian of the person, the guardian can sign the application since they are acting responsibly for an incompetent or incapacitated person. However, a legal guardian of the person cannot appoint an authorized representative. The applicant must be the one to appoint an authorized representative if they choose to have one. The applicant may appoint their guardian of the person to be their authorized representative. If the applicant has appointed their guardian of the person to be their authorized representative, the guardian may sign the application as the authorized representative.

2. Conservator~~-~~ (Wis. Stat. 54.76(2~~)~~:))

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

~~For health care program purposes, conservators have the same powers as legal guardians. They can apply on behalf of the individual, report changes, renew benefits, and perform other benefit management activities. When someone has been appointed as the conservator, only the conservator, not the applicant may sign the health care application.~~

~~If both a conservator and a durable power of attorney (see below) have been appointed, the order of appointment determines who can sign:~~

- ~~If the durable power of attorney was executed before the conservator was appointed, the durable POA can sign.~~
- ~~If the durable power of attorney was executed after the conservator was appointed (or concurrently), either the conservator or the durable power of attorney can sign.~~

3. ~~Durable power of attorney (Wis. Stat. ch. 244):~~Authorized Representative

The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see Section 22.5 Representatives). If the applicant needs to appoint an authorized representative when applying by telephone or in person, the applicant must complete the Appoint, Change, or Remove an Authorized Representative form (F-10126).

~~3.~~4. Durable Power of Attorney (Wis. Stat. ch. 244)

A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated.

When a submitted application is signed by someone claiming to be the applicant's durable power of attorney~~:~~, the agency must do both of the following:

- Obtain a copy of the document the applicant used to designate the signer of the application as the ~~durable power~~durable power of ~~attorney~~attorney.
- Review the document for a reference that indicates the power of attorney authority continues notwithstanding any subsequent disability or incapacity of the applicant.

Do not consider the application properly signed unless both of ~~these~~the above conditions are met. An individual's ~~durable power~~durable power of ~~attorney~~attorney may appoint an authorized representative for purposes of making a ~~Medicaid~~health care application, if authorized on the ~~Durable Power~~power of ~~Attorney~~attorney form.

The d~~D~~urable p~~P~~ower of a~~A~~ttorney form will specify what authority is granted. The appointment of a ~~durable power~~durable power of ~~attorney~~attorney does not prevent an ~~applicant~~individual

from filing ~~his or her~~their own ~~Medicaid~~ application, nor does it prevent the ~~applicant~~individual from granting authority to someone else to apply for public assistance on ~~his or her~~their behalf.

~~4.~~5. Someone acting responsibly for an incompetent or incapacitated person~~.~~

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

~~5.~~6. A superintendent of a state mental health institute or center for the developmentally disabled~~.~~

~~6.~~7. A warden or warden's designee

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

~~7.~~8. The superintendent of a county psychiatric institution~~, who has been designated by~~ The superintendent of a country psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director~~,~~ has delegated to them (in writing) the authority to sign and witness applications for residents of the institution. Retain a copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.9 Denials and Terminations

2.9.2 Denial

If the person ~~re-requests~~applied for health care ~~after the~~and the IM agency denied the health care application ~~was denied and the case is open for another program of assistance, do not require him~~ 30 or ~~her to re-sign his or her application or sign~~fewer days ago, the person can re-request health care without submitting a new application~~.~~

~~If the applicant is not open for any other program of assistance and less than 30 days has passed since~~ or a new signature. The date of the ~~applicant's eligibility was denied, allow~~ new health care request is the ~~applicant or his or her representative to do one of the following:~~

- ~~Re-sign and date the original application~~
- ~~Sign Section 22 - Signature of the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet~~
- ~~Sign the signature page of the application summary~~

~~Call the agency to submit a telephonic signature to set a new~~ new filing date.

~~Note:~~Example 1	~~Individuals eligible for an un-met Medicaid Deductible only are not considered open for a program of assistance and must file a new application to reopen Medicaid.~~Keisha applied for health care on August 15. The IM agency processed the application on September 8 and denied health care for Keisha. Keisha calls the IM agency on September 20 to re-request health care. The new filing date for health care is September 20. The IM agency cannot require Keisha to submit a new application or a new signature since it is within 30 days of the denial date of her application.

If the ~~applicant is not open~~person applied for ~~any other programs of assistance~~health care and ~~more than 30 days has passed since an applicant's eligibility was~~the IM agency initially denied the health care application (or ~~was only~~ determined the person was only eligible for an unmet deductible) more than 30 days ago, the person must ~~file~~submit and sign a new application in order to ~~reopen his or her Medicaid~~re-request health care, regardless of the other non-health care programs the person is enrolled in.

Example 2	James applied for health care and FoodShare on September 13. The IM agency processed the application on September 20 and denied health care for James, but approved FoodShare. James calls the IM agency on October 25 to re-request health care. James must submit a new application for health care since it is more than 30 days since the denial date of his application.

The person may need to provide verification if required to complete the eligibility determination.

5.2 Determination of Disability

5.2.1 Definition of Disability

The law defines disability for Medicaid as: "The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." See ~~SECTION 39.4.1 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLE~~Section 39.4.7 SSI Reference Values for the current SGA limits.

One exception to this is that a MAPP disability determination does not involve the SGA test. See Section 26.1 Medicaid Purchase Plan Introduction for the MAPP disability definition.

Disability and blindness determinations are made by the DDB. The IM agency should submit an application for a disability determination even if the applicant/member has already applied for SSI or SSDI (see Section 5.3 Disability Application Process), except for children applying for home and community-based waivers. An application for a disability determination should only be submitted for these children at the parent's request.

Note that for some long-term care programs, eligibility is based on level of care determinations rather than on a disability determination. For example, there is no disability determination required for children to be eligible for home and community based waivers. The appropriate level-of-care determination as established by the functional screen is used as an indicator of the child's need for services. This is also true for some adults. See Section 28.1 Adult Home and Community-Based Waivers Long-term Care Introduction and Chapter 37 Home and Community-Based Services: The Children's Long-Term Support Waiver Program.

7.3 Immigrants

"Immigrants" refers to all people who reside in the U.S., but are not U.S. citizens or nationals. Immigrants may be eligible for Medicaid and other categories of health care benefits if they meet all eligibility requirements and, in addition, declare that they have a satisfactory immigration status (see Section 7.3.1), and they are:

- "Qualified Immigrants" (see Section 7.3.3.1), or
- "Lawfully Present" (see Section 7.3.3.2), and
    - Are under age 19,
    - Are under age 21 and residing in an IMD, or
    - Are pregnant.

Immigrants who do not meet these additional requirements may still be eligible for the BadgerCare Plus Prenatal Program or Emergency Services.

Before health care benefits may be issued to immigrants, their immigration status must be verified with the Department of Homeland Security through the Federal Data Sources Hub or SAVE (See Section 7.3.2). Prior to verification of immigration status, benefits may also be issued for a temporary period under a Reasonable Opportunity Period (see Section 7.3.2.2).

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for Medicaid if they meet all other eligibility requirements and are either Qualifying Immigrants or are Lawfully Present as described below.

7.3.3.3 Iraqis and Afghans with Special Immigrant Status

Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI-1, 2, 3, 6, 7, and 8) are to be treated like they are refugees when determining their eligibility for Medicaid for as long as they have this Special Immigrant status. This policy applies to these immigrants regardless of when they received this status.

Class of Admission Code	Description	CARES Alien Registration Status Code
SI1	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI2	Spouses of an SI1	Code 04
SI3	Children of an SI1	Code 04
SI6	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI7	Spouses of an SI6	Code 04
SI8	Children of an SI6	Code 04

In addition, immigrant Afghan spouses and children of former Special Immigrants who have become United States citizens are also to be treated like they are refugees when determining their eligibility for Medicaid. This treatment is to continue for as long as they have a status of Special Immigrant

Conditional Permanent Resident (SI CPR). The Class of Admission codes for SI CPRs are CQ1, CQ2 and CQ3.

7.3.3.4 Afghan Parolees

Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States between July 31, 2021, and September 30, 2022, are to be treated like they are refugees when determining their eligibility for Medicaid.

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

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

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

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

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

7.3.8 Immigration Status Chart

Please see Process Help, ~~SECTION~~Section 82.6 VIS SAVE ~~VERIFICATION RESPONSES TABLE~~Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

CARES Registration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran * Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran * Arrived On or After August 22, 1996	Children Under 19 and Pregnant Women; Arrived on or after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
04	Lawfully present under Section	Eligible	Eligible	Eligible	Eligible	Eligible

	207(c)					
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking **	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Bar	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible
22	Citizens of	Eligible	Eligible	Eligible	Eligible	Eligible

	Compacts of Free Assoc (COFA)					

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.
**Some victims of trafficking may need to provide certain verification to be exempt from the five-year bar. See Section 7.3.11 ~~VICTIMS OF TRAFFICKING~~Victims of Trafficking for more information.

7.3.9 ~~Iraqis~~Refugee Assistance Programs

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

~~Beginning December 19, 2009, Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI-1, 2, 3, 6, 7, and 8) are to be treated like they are refugees when determining their eligibility for BadgerCare Plus for as long as they have this Special Immigrant status. This policy applies to these immigrants regardless of when they received this status.~~

~~Class of Admission Code~~	~~Description~~	~~CARES Alien Registration Status Code~~
~~SI1~~	~~Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces~~	~~Code 04~~
~~SI2~~	~~Spouses of an SI1~~	~~Code 04~~
~~SI3~~	~~Children of an SI1~~	~~Code 04~~
~~SI6~~	~~Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces~~	~~Code 04~~
~~SI7~~	~~Spouses of an SI6~~	~~Code 04~~
~~SI8~~	~~Children of an SI6~~	~~Code 04~~

7.3.9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, ~~he or she~~they may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. Refugee Medical Assistance is considered a separate benefit from Medicaid but provides the same level of benefits. Refugee Medical Assistance is available only in the first ~~eight~~ 12 months after a special immigrant's date of entry. If it is not applied for in that ~~eight~~12-month period, it cannot be applied for later~~. Iraqi immigrants may be eligible for Refugee Medical Assistance for eight months and Afghan immigrants may be eligible for Refugee Medical Assistance for six months~~.

While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in Wisconsin Works (W-2) Manual, ~~SECTION~~Section 18.3 ~~REFUGEE MEDICAL ASSISTANCE~~Refugee Medical Assistance.

Note:	The federal Medicaid eligibility for all other refugees admitted under ~~Alien~~Registration Status

	Code 04 remains the same.

13.8 Special Rules

13.8.3 Huber Law

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

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

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

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

Example 3	Dennis is incarcerated in jail. During his incarceration, his 3-year-old and 5-year-old children live with his wife, Brenda. Dennis is allowed to leave jail under the Huber Law to attend school and care for his children while Brenda is at work. Dennis is eligible for the Huber Law exemption because his court documents list attending to the needs of his family as a reason for his participation in the Huber Program.

13.9 State Correctional Institutions

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

Brown
Green Bay Correctional Institution (GBCI)
~~Sanger Powers Correctional Institution (SPCI)~~
Chippewa
Chippewa Valley Correctional Treatment Facility (CVCTF)
Stanley Correctional Institution (SCI)
Columbia
Columbia Correctional Institution (CCI)
Crawford
Prairie du Chien Correctional Institution (PDCI)
Dane
Oakhill Correctional Institution (OCI)
Oregon Correctional Center (OCC)
Thompson Correctional Center (TCC)
Mendota Juvenile Treatment Center (MJTC)
Dodge
John Burke Correctional Center (JBCC)
Dodge Correctional Institution (DCI)
Fox Lake Correctional Institution (FLCI)
Waupun Correctional Institution (WCI)
Douglas
Gordon Correctional Center (GCC)
Fond du Lac
~~McNaughton Correctional Center (MCC)~~
Taycheedah Correctional Institution (TCI)
Grant
Wisconsin Secure Program Facility (WSPF)
Jackson
Black River Correctional Center (BRCC)
Jackson Correctional Institution (JCI)
Juneau
New Lisbon Correctional Institution (NLCI)
Kenosha
Kenosha Correctional Center (KCC)
Lincoln
Copper Lake School (CLS)
Lincoln Hills School (LHS)
Milwaukee
Marshall E. Sherrer Correctional Center (MSCC)
Milwaukee Secure Detention Facility (MSDF)

Milwaukee Women's Correctional Center (MWCC)
Felmers O. Chaney Correctional Center (FCCC)
Oneida
McNaughton Correctional Center (MCC)
Outagamie
Sanger Powers Correctional Institution (SPCI)
Racine
Robert E. Ellsworth Correctional Center (RECC)
Racine Correctional Institution (RCI)
Racine Youthful Offender Correctional Facility (RYOCF)
Sturtevant Transitional Facility (STF)
St. Croix
St. Croix Correctional Center (SCCC)
~~**Sauk**~~

~~New Lisbon Correctional Institution (NLCI)~~
Sawyer
Flambeau Correctional Center (FCC)
Sheboygan
Kettle Moraine Correctional Institution (KMCI)
Waushara
Redgranite Correctional Institution (RCI)
Winnebago
Drug Abuse Correctional Center (DACC)
Oshkosh Correctional Institution (OSCI)
Winnebago Correctional Center (WCC)
Wisconsin Resource Center (WRC)

15.1 Income Introduction

15.1.2 Special Financial ~~Tests~~Rules for Disabled ~~Minors~~Children for SSI-Related Medicaid

~~A~~Some amount of parental income may be deemed to a blind or disabled minor ~~(~~child or dependent 18-year-old~~) must have his or her Medicaid eligibility determined according to the following special procedures. This process deems parental income to the disabled minor. The deemed parental income is added to the disabled minor's income~~ when determining the ~~disabled minor's~~child's financial eligibility for ~~EBD~~SSI-Related Medicaid and Medicare Savings Programs.

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

An ~~ineligible~~"eligible child" in this section is defined as a minor child or dependent 18-year-old who is ~~neither~~blind or disabled ~~nor blind~~.

An ~~eligible~~"ineligible child" in this section is defined as a minor child or dependent 18-year-old who lives in the same household as the eligible child and is neither blind nor disabled.

Children who ~~is disabled or blind or both~~receive SSI are not counted as household members for purposes of this deeming process.

~~Calculate the countable~~To determine how much parental income ~~of everyone~~must be deemed to each eligible child:
Determine how much parental income to allocate to any ineligible children in the household ~~using the following six steps.~~

~~1. For~~. To do this, for each ineligible child ~~in~~, subtract the ~~household:~~

1. ~~Subtract the ineligible child's~~child's unearned and earned income from the ~~EBD~~SSI-Related Deeming Amount to an Ineligible Minor ~~(see Section 39.4.2 ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES).~~ This amount is updated annually and can be found in SECTION 39.4.2 DISABLED MINORS DEEMING AND ALLOWANCES.
2. ~~The remainder is the amount to be allocated to~~ Determine the remaining total parental income as follows:
    1. Subtract the ineligible child allocation amount (Step 1) from the parental ~~gross~~ unearned income. ~~Subtract this amount from the parental unearned income.~~

       If there is not enough parental unearned income to ~~allocate~~subtract the whole amount, ~~allocate~~subtract the rest from parental ~~gross~~ earned income.
    2. If there ~~was~~is any remaining parental unearned income from ~~step 1(b~~Step 2(a), subtract the $20~~, the~~ general income ~~exclusion,~~disregard from the ~~amount.~~remaining unearned

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

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

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

~~2.~~ Determine the ~~total~~amount of parental income~~.~~

~~2.~~3. ~~From the total parental income, subtract~~ that must be deemed to the eligible children by subtracting the appropriate Parental Living Allowance ~~(see SECTION 39.4.2 ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES).~~from the remaining total parental income determined in Step 2. Use the Parental Living Allowance amount for ~~an individual~~ one parent if only one parent lives in the ~~home or~~household. Use the amount for ~~a couple~~two parents if both parents~~,~~ (or one parent and a spouse~~,~~) live in the household.

The ~~remainder is the total parental income to be deemed to the eligible child(ren).~~Parental Living Allowance amounts are updated annually and can be found in SECTION 39.4.2 DISABLED MINORS DEEMING AND ALLOWANCES.

~~3.~~4. Divide the parental deemed income equally among the eligible children. ~~Use the EBD-Related Determination Worksheet (Worksheet 06) (see Section 40.1 WORKSHEETS TABLE OF CONTENTS) to calculate each child's Medicaid eligibility.~~

Example 1:	Mr. and Mrs. Darwin ~~have~~live with their two minor children~~.~~, Matthew~~, eight years old, is disabled,~~ and ~~is the eligible child.~~ Jenny~~, 10 years old, is the ineligible child.~~. Matthew is disabled and applying for Medicaid in 2022. Jenny is neither blind nor disabled. Neither child has income. ~~The Darwins~~ Mr. and Mrs. Darwin have no unearned income~~. Parental~~ and their gross earned income is $3,~~006~~800 a month. ~~EBD deeming~~In 2022, the SSI-Related Deeming Amount to an Ineligible Minor is $420 and the Parental Living Allowance for two parents is $1,261. --- 1. Determine amount ~~to an~~ allocated for ineligible ~~minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) = $392~~child ($420 - $0) = $420 ~~_____~~ 2. ~~Remaining~~Determine total parental income: 1. Start with $3,800 gross parental earned income ~~$2,614~~ 2. ~~General~~Subtract $420 allocated for Jenny = $3,380 ~~2.~~3. Subtract $20 general income ~~exclusion $20~~disregard = $3,360 ~~3.~~4. ~~Remaining~~Subtract $65 earned income ~~$2,594~~disregard = $3,295 ~~Earned income exclusion -$65~~ ~~_____~~ ~~Remaining earned income $2,529~~ ~~4.~~5. ~~1/2~~Subtract half of remaining earned income ~~-$~~= $1,~~264~~647.50 ~~_____~~ ~~2.~~3. ~~Parental~~Subtract parental living allowance ~~-$~~for two parents ($1,~~157~~261) from total parental income ($1,647.50) = $386.50 ~~_____~~

	~~3.~~4. ~~Income~~Divide by the number of eligible children (1) = $386.50 deemed to ~~eligible child = $107.50~~Matthew

Example 2:	Lawrence ~~has~~is a single parent with three minor children~~. One~~, Abel, Maris, and Dean. Dean is disabled~~.~~ and applying for Medicaid in 2022. Abel and Maris are neither blind nor disabled. None of the children have any income. ~~His~~Lawrence has $600 monthly unearned income ~~is~~and $2,050 monthly earned ~~and $402 unearned.~~ ~~Unearned~~ income ~~= $402.00~~. ~~EBD~~In 2022, the SSI-Related Deeming Amount ~~for two~~to an Ineligible Minor is $420 and the Parental Living Allowance for one parent is $841. ~~----------~~ 1. Determine amount allocated for ineligible ~~minors (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) $784.00~~children ($420 - $0) + ($420 - $0) = $840 2. ~~After subtracting this from~~ Determine total parental income: 1. Start with $600 gross unearned income~~, there is $382~~ ~~1.~~2. Subtract $840 allocated for Abel and Maris = -$240 remaining allocation ~~that can be applied to earned income.~~ 3. ~~Lawrence's~~Subtract $240 remaining allocation from gross parental earned income ($2,050) = $1,810 4. Subtract $20 general income disregard = $1,790 ~~2.~~5. Subtract $65 earned income ~~$2,050~~disregard = $1,725 ~~Excess allocation -$382~~ ~~----------~~ ~~Remaining~~Subtract half of remaining earned income ~~$1,668~~ ~~General income exclusion -$20~~ ~~----------~~ ~~Remainder $1,648~~ ~~Earned income exclusion -$65~~ ~~Remainder $1,583~~ ~~3.~~6. ~~1/2 remaining earned income -$791~~= $862.50 ~~2.~~3. ~~Parental~~ Subtract parental living allowance ~~-$771~~for one parent ($841) from total parental income ($862.50) = $21.50 ~~----------~~ ~~3.~~4. ~~Income~~Divide by the number of eligible children (1) = $21.50 deemed to ~~eligible child $20.50~~Dean

15.3 Exempt/Disregarded Income

"Disregard" and "exempt" in this section mean "do not count." When calculating the total amount of income a person has received, disregard the following kinds of income:

15.3.30 Certain Payment Types Related to the COVID-19 Pandemic

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

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

The payment types that do not count as income include but are not limited to:

- Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency~~.~~
- Federal Pandemic Unemployment Compensation (FPUC) payments~~.~~
- Retroactive Pandemic Unemployment Assistance (PUA) payments~~.~~
- Retroactive Pandemic Emergency Unemployment Compensation (PEUC) payments~~.~~
- Retroactive Extended Benefits (EB) unemployment compensation payments
- We're All In Small Business Grants~~.~~
- Child Care Counts supplementary payments. These payments are awarded to child care providers~~.~~
- Wisconsin Emergency Rental Assistance (WERA) payments~~.~~
- COVID-19 Funeral Assistance~~.~~
- Emergency Assistance for Rural Housing/Rural Rental Assistance~~.~~
- Homeowner Assistance Fund~~.~~
- Housing Assistance and Supporting Services Programs for Native Americans~~.~~
- Higher Education Emergency Relief Fund (HEERF) payments~~.~~
- Economic relief payments paid directly from a tribal government to a tribal member using local government relief funds provided through the CARES Act.
- A Paycheck Protection Program (PPP) loan. The loan itself is not counted as income. However, if the loan is being used to pay employee wages, the wages are counted as income for the employee who receives them.

See ~~SECTION 15.4.25 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC~~Section 15.4.25 Certain Payment Types Related to the COVID-19 Pandemic for countable types of pandemic-related unemployment compensation benefits.

~~15.3.31 Reserved~~

15.3.31 Cash and In-Kind Items Received in Conjunction with Medical and Social Services

The treatment of cash and in-kind items received in conjunction with medical and social services depends on whether they are provided by a governmental or nongovernmental organization.

To be considered governmental, the program must be authorized by federal, state, or local law, statute, or ordinance to provide medical or social services. An example of a governmental medical and social services program is a managed care organization for Medicaid for dual eligible special needs plans (D-SNPs).

Disregard any cash provided by a governmental medical or social services program. Disregard in-kind items (including food or shelter) provided by a governmental medical or social services program unless the items are provided as payment for sheltered employment or as incentive payments.

Example 10	Mariel received a prepaid debit card from her D-SNP plan as a "wellness benefit" that she can use to purchase healthy food and over-the-counter medications. The funds on the debit card are disregarded.

For cash and in-kind items provided by a nongovernmental medical or social services organization, disregard the following:

- Room and board provided during an inpatient stay.
- In-kind items (other than food or shelter) provided for medical or social services purposes. Food or shelter is not exempt unless excluded under some other provision (such as room and board provided during an inpatient stay).
- Cash, if either of the following conditions is met:
    - The cash is for approved medical or social services already received.
    - The cash is only for the future purchase of medical- or social service-related items.

15.4 Unearned Income

Unearned income is income that a member receives from sources other than employment. Unless it is disregarded income (see ~~SECTION 15.3 EXEMPT AND DISREGARDED INCOME) or an income deduction (see SECTION 15.7 INCOME DEDUCTIONS~~Section 15.3 Exempt and Disregarded Income) or an income deduction (see Section 15.7 Income Deductions), count gross unearned income in a person's income total. When two payments from the same income source are received the same month due to mailing cycle adjustments, count each payment only for the month it is intended. Income sources commonly affected by such mailing cycle fluctuations include general assistance, other public assistance programs, SSI, and SSA benefits.

Note: Occasionally, a regular periodic payment (e.g., Title II or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.4.25 Certain Payment Types Related to the COVID-19 Pandemic

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

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

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

- Workforce Retention and Recognition Stipend Program payments. These payments are awarded to child care professionals.
- USDA Coronavirus Food Assistance Program – Direct Payments to Farmers and Ranchers.
- Child Care Counts Stabilization Payments.

See section ~~15.3.30 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC~~15.3.30 Certain Payment Types Related to the COVID-19 Pandemic for non-countable types of pandemic-related income.

15.4.26 Virtual Currency

If virtual currency is sold, income received from the sale is counted as income. See SECTION 15.5.19 VIRTUAL CURRENCY for information about treatment of virtual currency that the applicant or member has earned through work.

15.5 Earned Income

15.5.19 Virtual Currency

Virtual currency is counted as income when it is:

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

See SECTION 15.4.26 VIRTUAL CURRENCY for information about the sale of virtual currency.

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~~their 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).~~Institutions Home Maintenance Allowance Maximum (see Section 39.4.3 LTC Post-Eligibility Allowances). The amount is in addition to the $45 personal needs allowance. It should be enough for mortgage, rent, property taxes (including special assessments), home or ~~renters~~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 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.

16.2 Assets Availability

16.2.2 Real Property

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

1. The person who owns the property lists it for sale with a realtor ~~(see SECTION 16.9 NON-HOME PROPERTY EXCLUSIONS)~~.

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

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

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

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

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

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

16.5 Burial Assets

16.5.1 Irrevocable Burial Trusts

~~Exempt all~~ Per Wisconsin law, when a person makes a pre-need agreement with a funeral provider to purchase funeral or burial products and services (not including burial spaces), all payments made under the agreement are trust funds, including interest and dividends, until the person's death. For Medicaid purposes, Wisconsin law stipulates that such trusts may be made ~~in Wisconsin that are~~ irrevocable ~~by Wisconsin law,~~ as ~~noted in the trust agreement.~~ to the first $4,500 of the funds paid under the agreement. The irrevocable amount of such a trust is referred to as an irrevocable burial trust and is an exempt asset. If ~~made~~ the total value of an otherwise irrevocable pre-need agreement with a funeral provider exceeds $4,500, the amount over $4,500 is revocable and is a countable asset. Interest and dividends, if any, are exempt only if they accrue to irrevocable burial trusts and the trust agreement specifies that they are irrevocable.

For burial trusts established in another state, ~~exempt~~ all amounts that are irrevocable by the laws of that state~~. Refer any~~ are exempt. Any question about any state's law ~~to your~~should be referred to corporation counsel.

~~Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, they are a countable asset.~~

~~In non-spousal impoverishmentEBD~~Each Medicaid ~~cases, each~~ fiscal test group member may have one or more irrevocable burial trusts~~, of which the total Face Value may not exceed $4,500. Any principal amount over $4,500 is a countable asset. Although Wisconsin law allows $3,000 to be irrevocable, Wisconsin's Medicaid state plan allows an additional $1,500 to be~~ .

The following are not considered ~~as though it were~~ irrevocable ~~by law~~burial trusts for ~~these burial trusts. This is why $4,500 is allowed. (See Section 18.4 Spousal Impoverishment Assets~~Medicaid purposes. These are subject to the burial fund provisions described in SECTION 16.5.5 BURIAL FUNDS:

- A revocable pre-need agreement with a funeral provider to purchase funeral or burial products and services
- An irrevocable pre-need agreement with a funeral provider to purchase funeral or burial products and services, if the applicant or member has established a revocable trust to fund the burial agreement
- A revocable or irrevocable trust account for ~~information about burial~~ burial purposes, established with the applicant or member's own assets ~~for persons~~, that is not a pre-need agreement with a ~~community spouse.)~~funeral provider

16.5.5 Burial Funds

Burial fund exemptions apply only to EBD Medicaid fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD Medicaid members and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add together the following:

1. The face value of the person's irrevocable burial trusts~~.~~ (see Section 16.5.1 Irrevocable Burial Trusts)

2. The face value of all of ~~his or her~~their life insurance policies whose cash value is exempt~~.~~ (see Section 16.7.5 Life Insurance)
3. The face value of ~~his or her~~their exempt burial insurance (see ~~SECTION 16.5.2 BURIAL INSURANCE).~~Section 16.5.2 Burial Insurance)
~~1. The CSV of revocably assigned LIFBC (see SECTION 16.5.3.2 REVOCABLE ASSIGNMENT OF LIFE INSURANCE-FUNDED BURIAL CONTRACTS).~~
4. The cash surrender value of revocably assigned LIFBC (see Section 16.5.3.2 Revocable Assignment of Life Insurance-Funded Burial Contracts)
~~4.~~5. The burial funds portion of irrevocably assigned LIFBC (see ~~SECTION 16.5.3.1 IRREVOCABLE ASSIGNMENT OF LIFE INSURANCE-FUNDED BURIAL CONTRACTS).~~Section 16.5.3.1 Irrevocable Assignment of Life Insurance-Funded Burial Contracts)

~~If the total value of the above items is $1,500 or more, do not exempt any more burial funds.~~

If the total value of the exemptions above is $1,500 or more, no additional burial assets are exempt.

~~-~~If the total is less than $1,500, subtract the total from $1,500. The result is the amount of ~~his or her~~the person's burial fund total that is ~~exempt~~exempted.

Example 7:	Mrs. Smith, who is 74 years old, applies for EBD Medicaid. She has a $1,600 savings account designated as a burial fund, a $1,300 irrevocable burial trust, and two life insurance policies. The combined face values of the life insurance policies total $900. ~~Add the values of exempted assets.~~ The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed $1,500. $1,300 Irrevocable burial trust +900 Face value life insurance _____ $2,200 The total is more than $1,500, so no portion of the burial fund (savings account) is exempt.

Example 8:	This time, Mrs. Smith, in addition to her $1,600 savings account designated as a burial fund, has a $300 irrevocable burial trust and two life insurance policies with a combined face value of $900. $ 300 Irrevocable trust + 900 Face value life insurance _____ $1,200 The total is less than $1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund. $1,500 Maximum burial fund exclusion - 1,200 _____ $ 300 Mrs. Smith can exempt $300 from her savings account as a burial fund. The remaining $1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which ~~he or she~~they first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.
The fund set aside for burial must be identifiable, but not necessarily segregated, from other funds.

16.7 Liquid Assets

16.7.1 Personal Property

16.7.1.3 Other Personal Property

Both the following are true of personal property that an individual acquires or holds because of its value or as an investment:

- It is a countable resource (asset).
- It is not considered to be a household good or personal effect.

Other personal property items include, but are not limited to, the following:

- Gems acquired or held because of their value or as an investment
- Jewelry that is not worn or held for family significance
- Collectibles acquired or held because of their value or as an investment
- Virtual currency

Example 1:	Mr. Hollenback received $10,000 from an insurance settlement. Mr. Hollenback paid back creditors with $7,000 and purchased $3,000 in jewelry. Mr. Hollenback does not wear the jewelry. The IM workers must determine whether the jewelry is excluded from resources as a personal effect or is a countable resource in the form of other personal property. Mr. Hollenback's statements establish that the jewelry has no family significance and that he purchased the jewelry for its value as a means to spend down the $10,000. The IM workers correctly determines that the jewelry is not an excludable personal effect because an item purchased for its value cannot be a personal effect. The IM worker correctly determines the jewelry as a countable asset.

16.7.9 Vehicles (Automobiles)

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

16.7.9.2 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 is owned by an eligible individual or couple

        - It can't 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 (see ~~Section 15.6.3.1 Business Assets)~~Section 16.9 Property Essential to Self-Support)
    - Plan to achieve self-support (see ~~SECTION 15.7.2.2 PLAN TO ACHIEVE SELF-SUPPORT~~Section 15.7.2.2 Plan to Achieve Self-Support)
    - Vehicles that are homes (see Section 16.8.1.7 Vehicles that are Homes)
- 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 from someone other than the member, 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~~.~~ and are not more than the beneficiary's qualified disability expenses. "Qualified disability expenses" means any expenses related to the eligible person's blindness or disability that are incurred for the benefit of an eligible person who is the designated beneficiary. This includes the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses consistent with the purposes of the ABLE program. Unless the 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.

16.9 ~~Non-Home~~ Property ~~Exclusions~~Essential to Self-Support

~~Non-home property is any countable asset other than a homestead. 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.~~

16.9.1 Introduction to Property Essential to Self-Support

Certain assets deemed to be essential to an individual's means of self-support are excluded. These assets fall into three main categories:

- Property used in an established trade or business, which is excluded regardless of its value or rate of return~~.~~ if the business is currently operating for the self-support of the individual or their spouse, or there is a reasonable expectation it will resume operating within the next 12 months (see SECTION 15.6.3.1 BUSINESS ASSETS)
- Nonbusiness property used to produce goods or services essential to self-support, which is excluded up to $6,000
- Nonbusiness income-producing property, which is excluded up to $6,000 if it produces at least a six percent rate of return

16.9.2 Business Property Excluded Regardless of Value Rate of Return

This category includes:

- 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~~, if the individual is actively involved in the business operation on a day-to-day basis~~.~~
- Government-issued permits (such as commercial fishing permits)
- Personal property used by an individual as an employee for work or required by an employer for work

Note:	Rental property is not considered 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 to produce passive income, they are not considered to be the owner of a trade or business.

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:~~

When determining if a trade or business exists in an LLC or other questionable situations, the agency should consider:

- Does the IRS regard this as a trade or business?
- Does the individual have documents to support the claim of trade or business such as licenses, permits, registration, etc.?
- Is the individual a member of a business or trade association?

16.9.3 Nonbusiness Property ~~excluded~~Excluded up to $6,000~~, regardless~~ Regardless of ~~rate~~Rate of ~~return.~~ 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~~
Nonbusiness 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~~is exempt.

16.9.4 Nonbusiness Income-Producing Property ~~excluded~~Excluded up to $6,000 if it ~~is nonbusiness property that produces a net annual~~Produces at Least Six Percent Rate of Return

Nonbusiness income ~~(either cash or in-kind income) of at least 6 percent.~~

~~Nonbusiness income~~ producing property is ~~land~~real property or other non-liquid property ~~which~~that 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:

- Structures producing rental income
- 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.

~~-~~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

IM agencies evaluate information provided about a transfer to determine if it is a divestment. If a divestment occurs, the agency determines if it is allowed or if it requires a penalty period. Note: Divestment rules do not apply to the applicants or members listed in 17.1.2 Excluded Applicants and Members.

The evaluation of a transfer for divestment includes:

- ~~17.2.1 EXEMPTION OR DISREGARDED STATUS OF INCOME AND ASSETS~~
- ~~17.2.2 DATE OF TRANSFER~~
- ~~17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT~~
- ~~17.2.4 DETERMINING FAIR MARKET VALUE~~
- ~~17.2.5 VERIFICATION~~
- ~~17.2.6 ALLOWED DIVESTMENTS~~
- ~~17.2.7 DIVESTMENTS THAT ARE NOT ALLOWED THAT RESULT IN A PENALTY PERIOD~~

~~17.2.1 Exemption or Disregarded Status of Income and Assets~~

~~Transfers of exempt income and assets do not count as divestments. For the purposes of divestment, exempt and disregarded have the same meaning. This chapter uses the word exempt.~~
~~Income and assets are either exempt or nonexempt following the policies in Chapter 15 Income and Chapter 16 Assets.~~

- ~~Transfers of **exempt** income and assets are **not** divestment with the exception of homestead property 17.2.7.1 TRANSFER FOR LESS THAN FAIR MARKET VALUE (see 17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT).~~
- ~~Transfers of **nonexempt** income and assets **are evaluated** for divestment rule applicability.~~

- 17.2.1 Exemption or Disregarded Status of Income and Assets
- 17.2.2 Date of Transfer
- 17.2.3 Transfers that are Not Divestment
- 17.2.4 Determining Fair Market Value
- 17.2.5 Verification
- 17.2.6 Allowed Divestments
- 17.2.7 Divestments that are Not Allowed that Result in a Penalty Period

17.2.2 Date of Transfer

Any transfer of nonexempt income or nonexempt assets that occurs during the look back period (see ~~17.2.2.1 THE LOOK BACK PERIOD~~17.2.2.1 The Look Back Period) or while a person is eligible for long-term care services must be evaluated for divestment.

The exact date of each transfer is needed to evaluate the transfer for divestment rule applicability. For real property, such as homestead property, the date of transfer is the date the Quit Claim Deed was signed and notarized or authenticated by an attorney. The date the county Register of Deeds recorded the transfer is not the date of transfer.

17.2.2.1 The Look Back Period

Per federal law, transfers of nonexempt income or assets that occur during the 60 months (five years) prior to the month of application must be evaluated for divestment. This 60-month period is the "look back period."

17.2.2.1.1 Beginning of the Look Back Period

The first month (month one) of the look back period is the more recent of either:

- The month before the institutional Medicaid application month.
- The month before the Community Waivers program application month.

The application month is the first month all of these conditions are true:

Program	Conditions
Institutional Medicaid	• The applicant is institutionalized. • The applicant has applied for health care.
Community Waivers Programs	• The applicant is determined to be functionally eligible. • The applicant has requested one of the Community Waivers programs. • The applicant is otherwise eligible for enrollment in Family Care, Family Care Partnership, PACE, or IRIS.

Example 1:	Kaylee was institutionalized on March 2. She submitted a signed application for Medicaid to the agency on May 5. Her look back period begins with April as month one.

Example 2:	Judas had options counseling with the ADRC and submitted a signed Medicaid application and request for Family Care on June 19. He was found functionally eligible on May 5 and was otherwise eligible for enrollment in FC through Waiver Medicaid. His look back period begins with May as month one.

17.2.2.1.2 Transfers Prior to the Look Back Period

Transfers that occur before the 60-month (five-year) look back period are not subject to divestment rules. This includes the irrevocable assignment of an asset or purchase of an annuity that has not been changed (see 17.2.3 ~~TRANSFERS THAT ARE NOT DIVESTMENT~~Transfers that are Not Divestment).

17.2.2.1.3 Transfers ~~during~~During the Look Back Period

An applicant or member may be ineligible for long-term care services if the applicant or member, their spouse, or anyone acting on their behalf divests the applicant's or member's income or assets during the look back period. The period of long-term care ineligibility is based on the value of the divestment. Applicants must report any divestment that occurred during the look back period when they apply.

17.2.2.1.4 Transfers ~~during~~During the Look Back Period ~~that are~~That Are Reported Late

Divestments that occurred during the look back period and are reported or discovered after eligibility was established must be evaluated. A divestment reported after eligibility was established doesn't result in an overpayment but may result in a penalty period. See 17.3 ~~PENALTY PERIOD~~Penalty Period.

Example 3:	Trisha is 70, institutionalized, and applies for institutional Medicaid. She reports no divestment on her application. Several years later, Trisha reports that she gave her granddaughter $10,000 four years prior to her initial institutional Medicaid application. This divestment happened during her look back period, which is now seven years ago. Because this divestment

	occurred during the look back period and was required to be reported in her application, the divestment must now be evaluated.

17.2.2.1.5 Transfers Made by the Community Spouse Who Later Applies for Medicaid

If a community spouse applies for Long Term Care services, any divestment that occurred during their own look back period must be evaluated. This includes allowed divestments made by the community spouse that were previously evaluated for the institutionalized person. See also 17.3.8 ~~BOTH SPOUSES INSTITUTIONALIZED~~Both Spouses Institutionalized.

Example 4:	Brent is an institutionalized person. Eight years after Brent was found eligible for Long Term Care services, Brent's community spouse, Sven, applied for Long Term Care services. Sven reported a gift of $15,000 to his niece six months before he applied for Long Term Care services. Because this divestment occurred over 60 months (five years) after Brent was found eligible, the divestment was allowed and didn't impact Brent's eligibility. See 17.2.6.6 ~~DIVESTMENT BY THE COMMUNITY SPOUSE AFTER FIVE YEARS~~Divestment by the Community Spouse After Five Years. This divestment must still be evaluated for Sven's Long Term Care eligibility because it occurred during Sven's look back period.

17.2.3 Transfers That Are Not Divestments

Once a transfer is determined not to be a divestment, it has no impact on eligibility.

17.2.3.1 Transfers for Fair Market Value

A transfer for fair market value (FMV) is not a divestment. ~~See 17.2.4 DETERMINING FAIR MARKET VALUE.~~See 17.2.4 Determining Fair Market Value. This includes:

- Receiving equal value in return for an asset.
- Converting an asset from one form to another of equal value.

Example 5:	Tally purchases a sailboat for $12,000. He verifies the value of the sailboat to be $12,500. Because this purchase was converting a cash asset into another asset (the sailboat), purchasing and keeping the sailboat isn't a divestment. Tally's assets now count the $12,500 sailboat instead of the $12,000 in cash used to purchase the boat.

Example 6:	Sterling transferred ownership of his RV to his parents. In payment, his parents signed over to Sterling the deed to their cottage. The FMV of the RV was the same as the FMV of the cottage. This transfer is not a divestment because Sterling received FMV for his transfer, and the cottage will be evaluated as a countable asset.

17.2.3.2 Transfers of Exempt Income or Assets

Income or assets determined to be exempt (except homestead property per 17.2.7.1 ~~TRANSFER FOR LESS THAN FAIR MARKET VALUE~~Transfer for Less Than Fair Market Value) are not subject to divestment rules.

Example 7:	Hattie is eligible for Medicaid and receiving long-term care services. She owns one car. Hattie transfers ownership of the car to her sister. Hattie buys another car, and now once again owns one car. She gives this car to her father. Because one car is an exempt asset, these transfers are not subject to divestment rules.

Assets can be permanently or temporarily exempt (~~16.7 LIQUID ASSETS).~~16.7 Liquid Assets). The transfer of temporarily exempt assets is not subject to divestment rules during the time they are exempt. This includes, but is not limited to, giving away funds from:

- Retroactive Social Security payments during the nine months after the payment was received.
- Patient liability or cost share refunds during the nine months after the refund was received.
- Federal Economic Impact payments made during the Coronavirus Pandemic during the 12 months after the payment was received.

Example 8:	On February 15, Sri received a cost share refund of $5,000. This refund is exempt in February and remains exempt for nine months (March through November). Sri gives away the entire $5,000 to her mother and reports that gift to the IM agency. • If Sri gave the $5,000 to her mother between February 15 and November 30, the gift is not a divestment because it was exempt during that time. • If Sri gave the $5,000 to her mother December 1 or later, the gift is a divestment and must be evaluated.

17.2.3.3 Prenuptial Agreements

The act of signing a prenuptial agreement is not a divestment.

17.2.3.4 Payments to a Relative ~~while~~While the Institutionalized Person Received Room and Board

An institutionalized person paying a relative for room and board is not a divestment if the payments do not exceed fair market value, the institutionalized person is actually receiving room and board, and the institutionalized person provides a written lease that existed during the time they received room and board from the relative.

17.2.3.5 Ownership Returned ~~before~~Before Application

Returning the ownership or full value of a divested asset during the look back period is not divestment. This is because both the transfer and the return occurred before the request for Long Term Care services.

Example 9:	Dan transfers ownership of his lake house (not homestead property) to his daughter, Cile, as a gift. Two years later, Dan and his daughter realize that this transfer affects his future eligibility for Medicaid, so Cile signs the lake house back over to Dan. Later that year, Dan applies for Long Term Care services. No divestment penalty period is imposed for the transfer of his lake house to his daughter because ownership was returned to him prior to his application.

~~17.2.4 Determining Fair Market Value~~

~~Fair market value FMV is an estimate of the price an asset has when sold on the open market. The FMV is based on the time an asset is transferred and not when the transfer is reported to or evaluated by the IM agency.~~

~~The FMV of real property can be established by:~~

- ~~**Assessment**~~
  ~~Property tax assessments or appraisals may document a property's FMV if both the IM agency and applicant or member agree that it accurately represents the FMV.~~
- ~~**Statements from Realtors**~~
  ~~Statements from one or more realtors giving the FMV.~~
- ~~**Comparative Market Analysis**~~
  ~~Prepared by a realtor, a Comparative Market Analysis estimates the FMV of the applicant or member's property by evaluating the recent sale prices of comparable properties. If the IM agency requests this document, the agency must pay for it.~~

~~The applicant or member has the right to file a fair hearing if they disagree with the FMV of the property determined by the IM agency.~~

~~Example 10:~~	~~Paul applied for institutional Medicaid this month and reported transferring ownership of his house to a friend three years ago. Today, the house is worth $70,000, but three years ago, the value of the house was $54,000. The FMV is $54,000 for divestment purposes as that is the value Paul could have received if he had sold it three years ago.~~

~~17.2.5 Verification~~

~~Verification of a divestment can be provided by the applicant, member, spouse, or someone acting on their behalf. Statements from physicians, insurance agents, insurance documents, and/or bank records that confirm the person's statements should be considered. Self-attestation is not sufficient verification. Verification to show that the divestment was allowed must include both:~~

- ~~Proof of the specific purpose and reason for the transfer.~~
- ~~Information establishing that the resource was transferred for a purpose other than to qualify for Medicaid.~~

17.2.6 Allowed Divestments

A divestment must be checked against all types of allowed divestments described in this section before checking it against those that are disallowable as described in 17.2.7 ~~DIVESTMENTS THAT ARE NOT ALLOWED AND RESULT IN A PENALTY PERIOD~~Divestments that are Not Allowed and Result in a Penalty Period.

There is no penalty period for allowed divestments.

This section does not include a comprehensive list of all allowed divestments. The member or applicant's intent must be evaluated to determine whether it is an allowed divestment.
Prior to determining whether a transfer is an allowed divestment or not, the transfer must be evaluated as a divestment based on the following:

- ~~17.2.1 EXEMPTION OR DISREGARDED STATUS OF INCOME AND ASSETS~~
- ~~17.2.2 DATE OF TRANSFER~~
- ~~17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT~~
- ~~17.2.4 DETERMINING FAIR MARKET VALUE~~
- ~~17.2.5 VERIFICATION~~

- 17.2.1 Exemption or Disregarded Status of Income and Assets
- 17.2.2 Date of Transfer
- 17.2.3 Transfers that are Not Divestment
- 17.2.4 Determining Fair Market Value
- 17.2.5 Verification

17.2.6.1 Sufficient ~~resources~~Resources for ~~five years~~Five Years of ~~long-term care~~Long-Term Care

A transfer by an applicant or member who has sufficient financial resources or Long Term Care insurance for at least a five-year period at the time of the transfer is an allowed divestment and doesn't result in a penalty period.

For the average monthly nursing home cost of care in effect at the time of a divestment, see ~~39.4.3 INSTITUTIONAL COST OF CARE VALUES.~~39.4.3 Institutional Cost of Care Values. This cost per month

multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual at the time of the divestment.

Example 11:	Lucius had a money market account that could pay for more than five years of Long Term Care services. At that time, Lucius gave a graduation present to his granddaughter worth $25,000. Two years later, Lucius suffers a traumatic brain injury and is institutionalized. Because the cost of specialized nursing home care is significantly greater than a regular nursing home, Lucius must apply for institutional Medicaid after only two years. Because Lucius had enough money to pay for five years of care at a regular nursing home at the time he gave the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period.

Example 12:	Pierce had an investment portfolio with assets that could pay for more than five years of Long Term Care services. At that time, Pierce paid for his granddaughter to take a trip to Europe. Later, his investments plummeted in value due to the stock market, and he quickly spent his remaining assets on his care. Pierce then applied for Medicaid to continue receiving his necessary Long Term Care services. Because Pierce had assets to pay for his long-term care for five years when he made the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period even though gift was in Pierce's look back period.

17.2.6.2 Life ~~expectancy~~Expectancy of ~~less than five years~~Less Than Five Years

A divestment is allowed and doesn't result in a penalty period if both:

- The institutionalized person's life expectancy was less than five years at the time of the transfer.
- The institutionalized person's resources, insurance, or both were sufficient to pay for their ~~Long Term Care~~long-term care services for their remaining life expectancy.

For the average monthly nursing home cost of care in effect at the time of the divestment, see ~~39.4.3 INSTITUTIONAL COST OF CARE VALUES.~~39.4.6 Institutional Cost of Care Values. This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual at the time of the divestment.

17.2.6.9 Intent ~~to~~To Sell for Fair Market Value (FMV)

The disposal of an asset by an institutionalized person who can prove they intended to receive FMV, is an allowed divestment and doesn't result in a penalty period.

Example 17:	Gary sells a boat and agrees to two payments that total the FMV of the boat. He cashes a check for the first payment, but the second payment is a bad check. Gary shows proof of the bad check and that he has been unable to recover the boat or the second payment. When Gary applies for Medicaid, this is an allowed divestment and doesn't result in a penalty period.

17.2.6.10 Undue Hardship Request ~~is~~Is Granted

Any divestment associated with an undue hardship waiver request that is approved by the IM agency per ~~22.4 UNDUE HARDSHIP~~22.4 Undue Hardship, is an allowed divestment and doesn't result in a penalty period.

17.3 Penalty Period

17.3.1 Penalty Period Introduction

If an unallowable divestment occurs, the institutionalized person is ineligible for Medicaid coverage of long-term care services for a time period known as the penalty period.

The length of the penalty period is based on the value of the divestment. Once the penalty period starts, it runs uninterrupted until it expires, even if the person is no longer in a long-term care facility or "otherwise eligible" for long-term care Medicaid. If an undue hardship waiver is requested and granted, then the penalty period will be waived per 22.4 ~~UNDUE HARDSHIP~~Undue Hardship.

Penalty periods only impact someone's eligibility for LTC services and do not affect an applicant or member's eligibility for Medicaid card services (21.4.1.1 Medicaid Card Services) when they are residing in a medical institution. An individual ineligible for Community Waivers programs due to a divestment may still be eligible for other types of Medicaid that do not cover long-term care services.

17.3.2 Calculating the Penalty Period

The divestment penalty period is calculated in days ~~using~~by dividing the ~~average daily nursing home private pay rate. For divestments that occurred during or after the lookback period, the penalty period is calculated using~~ divested amount by the average daily nursing home private pay rate in effect at the time of the application (see Section 39.4.6 Institutional Cost of Care Values). This rate is updated annually on January 1.

~~For~~

Example 3:	Jeff moved to a nursing home and applied for Medicaid on March 1, 2022. One month earlier, Jeff transferred $18,500 in cash to his son, and it is determined to be a divestment that is not allowed resulting in a penalty period. 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 ($307.40) equals 60.18 days, Jeff will have a divestment penalty period of 60 days.

For divestments that occur after long term care eligibility is established or 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)~~Section 17.3.6 Divestments During a Penalty Period).

~~The rate effective January 1, 2022, is $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 3/1/22. 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 ($307.40) equals 60.18 days, Jeff will have a divestment penalty period of 60 days.~~

18.6 Spousal Impoverishment Income Allocation

18.6.1 Spousal Impoverishment Income Allocation Introduction

After an institutionalized person is found eligible, ~~he or she~~they may allocate some of ~~his or her~~their income to the community spouse and any dependent family members ~~living with the community spouse. Income that is allocated for the community spouse must actually be given to the community spouse each month in order for it to be allowed as a post-eligibility income deduction for the institutionalized spouse. However, income that is allocated for a dependent family does not have to be actually given to the dependent family member.~~

~~Dependent family members include:~~

~~Dependent minor children (natural, adopted, step) of either parent~~ who live with the community spouse.

Dependent family members are defined as follows:

- Children ~~(natural, adopted, step), 18 years old or older~~under the age of 18, of either parent
- Children of any age, of either parent, who are claimed as tax dependents ~~for tax purposes~~ under the Internal Revenue Code (IRC ~~and who live with the community spouse.~~)
- Siblings of either the institutionalized person or the community spouse who are claimed as tax dependents ~~and who live with~~under the ~~community spouse.~~IRC
- Parents of either the institutionalized person or the community spouse who are claimed as tax dependents ~~and who live with~~under the ~~community spouse.~~IRC

~~An institutionalized person must decide how much income to allocate. He or she may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or he or she may choose to allocate a lesser amount.~~

~~Since he or she may have medical costs that are not covered by Medicaid, he or she may wish to keep some income and not allocate it all.~~

Income that is allocated to the community spouse must be given (or made available) to the community spouse each month for it to be allowed as a post-eligibility income deduction for the institutionalized person. Income that is allocated to a dependent family member does not have to be given to the dependent family member.

~~Note:~~	~~Income allocated to the community spouse is countable income for him or her and must be added to the community spouse's case.~~
~~Example 1~~Note:	~~Caroline has monthly income of $400. She transfers $310 to her community spouse, keeping only her personal needs allowance (see SECTION 39.4.2 ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES) and $45 to pay as her monthly patient liability. She incurs $80 in noncovered medical expenses each month. Those expenses will be charged first to her patient liability, but she must pay the remaining $35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.~~Income allocated to the community spouse is countable income for the community spouse if they apply for health care.

~~**18.6.2 Community Spouse Income Allocation**~~

~~To determine how much of the~~ The institutionalized ~~spouse's~~ person must decide how much income to allocate~~:The~~ to their community spouse~~-~~. They may allocate an amount that brings the community spouse's income up to the maximum ~~income~~ allocation ~~is one of the following:~~ (see Section 18.6.2 Community Spouse Income Allocation) or they may choose to allocate a lesser amount.

~~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 $3,435.00.~~

~~"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:~~

Since the institutionalized person may have medical costs that are not covered by Medicaid, they may need to keep some income rather than allocating the maximum allowable amount.

Example 1:	Finella is in a nursing home and open for Institutional Medicaid. Her husband Teddy lives in the community. Finella's monthly income is $500. She incurs $80 in noncovered medical expenses each month. She decides to give $375 to Teddy, keeping only her $45 personal needs allowance (see Section 39.4.3 LTC Post-Eligibility Allowances) and $80 to pay for her medical expenses (see Section 27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services). These post-eligibility income deductions and allowances reduce her nursing home patient liability amount to $0.

18.6.2 Community Spouse Income Allocation

The maximum amount of income that the institutionalized spouse can allocate to their community spouse is determined as follows:

1. Find the Community Spouse Lower Income Allocation Limit. This amount is updated annually and can be found in SECTION 39.4.4 LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE.
2. Determine the excess shelter allowance, calculated as the community spouse's shelter expenses that are in excess of the Shelter Base Amount. The Shelter Base Amount is updated annually and can be found in Section 39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share.

Note:	Do not grant the excess shelter allowance for HCBW cases where the institutionalized person lives together with the community spouse.

Allowable shelter expenses include:

- Rent
- Mortgage principal and interest
- Taxes (including special assessments) and homeowner's or renter's insurance for the principal place of residence. ~~This includes renters insurance.~~
- Any required maintenance fee if the community spouse lives in a condominium or cooperative.
- The standard utility allowance established under FoodShare~~:~~. See the FoodShare Wisconsin Policy Handbook, Section 8.1.3 Deductions for the current standard utility allowance amounts.

If the community spouse pays:	Add:
Heat and utilities	HSUA (Heating Standard Utility Allowance*)
Utilities only	LUA (Limited Utility Allowance*)
Telephone only	PUA (Phone Utility Allowance*)

~~If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee.~~
~~* See the FoodShare Wisconsin Handbook Section 8.1.3 Deductions for the current standard utility allowance amounts.~~

- ~~For HCBW cases, follow these rules to determine when to add~~
  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.

3. Determine the lesser of:
   - The sum of the Community Spouse Lower Income Allocation Limit (Step 1) and the excess shelter ~~cost to the community spouse income allocation:~~ allowance (Step 2), if applicable.
   - ~~If the waiver person's~~The Community Spouse Income Allocation Maximum. This amount is updated annually and can be found in Section 39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share.
4. Subtract the community spouse's monthly gross income from the amount determined in Step 3. Use the EBD rules for countable income, but do not give earned income, unearned income, or work-related deductions.
   ~~i.~~ The result is the maximum amount of income that the institutionalized person can give to their community spouse ~~lives with him or her, do not add the excess shelter cost to the income allocation.~~
   i. ~~If the waiver person's community spouse does~~. They may give an amount less than this, but not ~~live with him or her, add the excess shelter cost to the income allocation.A larger amount~~ more unless 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.

~~1. The maximum allocated amount is the difference between the allowable community spouse income allocation and the community spouse's monthly gross income. Use the EBD income rules, but do not give earned income, unearned income, and work-related deductions.~~
~~The institutionalized spouse may choose to allocate less than the maximum amount.~~

18.6.3 Dependent Family Member Income Allowance

The institutionalized person can allocate ~~up to $725.84 per month to each~~ a certain amount of their income to dependent family ~~member~~ members (as defined in Section 18.6.1 Spousal Impoverishment Income Allocation Introduction) who ~~lives~~ live with the community spouse.
~~The allocated amount is the difference between $725.84 and the actual monthly income of the~~Each dependent family ~~member.~~member's income allowance is calculated as follows:

1. Subtract the dependent family member's actual income from the Dependent Family Member Income Allowance Standard. This amount is updated annually and can be found in SECTION 39.4.4 LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE. Use the EBD rules for countable income, but do not give earned income, unearned income, or work-related deductions.
~~1.~~2. Divide the result by three.

20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

~~Verify the~~The following ~~mandatory~~ items must be verified for Medicaid:

- SSN
- Citizenship and Identity (see Section 7.2 Documenting Citizenship and Identity)
- Immigrant status
- Disability and incapacitation

~~1. Income~~~~SSN (see SECTION 20.3.2 SOCIAL SECURITY NUMBER).~~

~~2. Alien Status (see SECTION 7.3 IMMIGRANTS).~~

~~3. Disability and Incapacitation (see SECTION 5.2 DETERMINATION OF DISABILITY).~~

- ~~Assets for the Elderly, Blind, and Disabled (see Section 16.1 Assets Introduction).~~
- Divestment, for ~~EBD~~Medicaid long-term care ~~(see Section 17.1 Divestment Introduction).~~programs
- Medical expenses, for deductibles only ~~(see Section 24.7 Meeting the Deductible).~~
- Medical/remedial expenses for noncovered services for an institutionalized person (see ~~SECTION 27.7.7.2 DISALLOWED EXPENSES).~~Section 27.7.7.2 Disallowed Expenses)

~~4. Documentation for Power of Attorney and Guardianship (see SECTION 20.3.7 POWER OF ATTORNEY AND GUARDIANSHIP).~~

- Documentation for power of attorney and guardianship
- Migrant ~~workers~~worker's eligibility in another state (see Section 31.2 Simplified Application), if applicable~~.~~
- ~~Physician~~For the home maintenance allowance income deduction (see Section 15.7.1 Maintaining Home or Apartment), physician certification (verbally or in writing) that ~~the person~~ an applicant or member who resides in a medical institution is likely to return to ~~the~~their home ~~or apartment~~ within six months
- Temporary hardship for ~~institutionalized persons maintaining a home or property (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT) and is entitled to a home maintenance allowance.~~MAPP premium waiver

~~5. Income.~~

~~6. Citizenship and Identity (see Section 7.2 Documenting Citizenship and Identity).~~

- ~~Accept~~Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see Section 13.8.3 Huber Law)

Unless determined questionable, self-declaration is acceptable for all other items~~, unless you document them as questionable~~.

20.3.8 Income

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

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

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

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

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

Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.
Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance. In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

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

20.3.8.1 Reasonable Compatibility for Income for Health Care

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

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see ~~SECTION 15.5.18 PRISON OR JAIL JOB~~Section 15.5.18 Prison or Jail Job), or information from the data source is not "reasonably compatible" with what the applicant has reported. Information from ~~the~~a data source ~~is "reasonably compatible" if it results in the same~~that supports an eligibility ~~outcome as member reported~~determination based on the attested information~~:~~ provided by an applicant or member is considered "reasonably compatible."

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

- If both the electronic data source and the member-reported information put the individual's total countable income below a given income threshold, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
- If the electronic data source puts the individual's total countable income above a given income threshold, but the member-reported information puts the individual's total countable income below that same threshold, an additional test that uses a 20% threshold occurs.
    - If the individual's total countable income using information from the electronic data source is less than or equal to 120% of the individual's total countable income using the member-reported information, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
    - If the individual's total countable income using information from the electronic data source is more than 120% of the individual's total countable income using the member-reported information, the two data sources are not reasonably compatible and further verification is required as a condition of eligibility.
- If the member reports income that is above a given threshold, the member-reported income information ~~will be~~ is used to deny or terminate health care benefits, regardless of what the outcome would be using information from the electronic data source. In this scenario, verification is not required.

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

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

Self-employment and in-kind job income ~~will continue to be~~ are verified as outlined in Section 15.6.6 Verification and ~~15.5.1~~Section 15.5.1 Income In-Kind and Process Help Sections 16.2 and 16.6.

20.3.8.1.2 Reasonable Compatibility Thresholds

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

- EBD Categorically Needy SSI-Related MA and Medically Needy MA thresholds are based on the income limits shown in ~~SECTION~~Section 39.4.1 Elderly, Blind, or Disabled Assets and Income.
- MAPP and MSP thresholds are based on the income limits shown in Section 39.5 FPL Table.
- MAPP Premium thresholds are based on 100% FPL for a group of one as shown in Section 39.5 FPL Table. and described in the table below.

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

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

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

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	And total gross income using the monthly earnings reported by SWICA or Equifax is:	Is it reasonably compatible?
~~Below~~Equal to or below the MAPP premium threshold (100 ~~percent~~% of the FPL)	~~Below~~Equal to or below the MAPP premium threshold (100 ~~percent~~% of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
~~Below~~Equal to or below the MAPP premium threshold (100 ~~percent~~% of the FPL)	~~At or above~~Above the MAPP premium threshold (100 ~~percent~~% of the FPL)	~~No.~~The 20% threshold test occurs. • If the total gross income using the monthly earnings reported by SWICA or Equifax is equal to or less than 120% of the total gross income using the monthly earnings amount reported by the member, the amounts are reasonably compatible. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed. • If the total gross income using the monthly earnings reported by SWICA or Equifax is greater than 120 % of the total gross income using the monthly earnings amount reported by the member, the amounts are not reasonably compatible. Further verification must be requested.
~~At or above~~Above the MAPP premium threshold (100 ~~percent~~% of the FPL)	~~At or above~~Above the MAPP premium threshold (100 ~~percent~~% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
~~At or above~~Above the MAPP premium threshold (100 ~~percent~~% of the FPL)	~~Below~~Equal to or below the MAPP premium threshold (100 ~~percent~~% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

Example 4	Leonard is applying for EBD Medicaid. He is not married and has no children. The SSI-Related Medically Needy monthly income limit is $1,132.50. Leonard reports monthly earned income of $1,000; this is his only income, and it is below the income limit. The State Wage Information Collection Agency (SWICA) reports that Leonard's monthly earned income is $1,150. This income amount is above the income limit. Therefore, the reasonable compatibility test using the 20% threshold will be applied. The 20% threshold amount is the amount that is 20% greater than the total income that includes the earned income reported by the applicant or member. In this example, the 20% threshold amount is $1,200. The total income that includes the earned income reported by SWICA ($1,150) is less than the 20% threshold amount ($1,200). Therefore, the amounts are determined to be reasonably compatible. Leonard does not need to verify the earned income.

20.3.8.1.3 Reasonable Compatibility Test

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

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

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

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

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

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

~~In this situation,~~See SECTION 22.2.1.2.4 ELIGIBILITY AND PREMIUM DETERMINATIONS BASED ON REASONABLE COMPATIBILITY for information about when members ~~are not liable for overpayments because the initial determination was~~ with eligibility or premium determinations based on income that was reasonably compatible ~~with a data exchange.~~

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

20.3.10 Huber Law Exemption

Applicants and members who are incarcerated but allowed to leave jail under the Huber Law can become or remain eligible for full-benefit Medicaid if the reason for the release is to return home to care for their minor children (see SECTION 13.8.3 HUBER LAW for the Huber Law exemption criteria). To qualify for the Huber Law exemption, verification that the applicant or member is returning home to care for minor children is required.

Acceptable verification sources include:

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

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

21.6 HMO Enrollment

~~21.6.1~~In Wisconsin, health maintenance organization (HMO) refers to managed care organizations that contract with health care providers and facilities to provide services for BadgerCare Plus and the Medicaid for Elderly, Blind or Disabled programs.

The HMO Enrollment ~~Introduction~~

~~Most~~Specialist is an organization under contract with DHS to provide unbiased HMO enrollment counseling to BadgerCare Plus and SSI Medicaid members ~~who are eligible for BadgerCare Plus, MAPP, or SSI-related Medicaid and reside in a Medicaid HMO service area must enroll in an HMO.~~

~~Members may choose their own HMO or work with the HMO enrollment specialist to choose the best one for their needs. They may choose at any time during the~~ and outreach about enrollment ~~process. All eligible~~choice options. The HMO Enrollment Specialist also assists members ~~of the member's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.~~

~~This is the enrollment process:~~

1. ~~Members residing~~ in making an HMO ~~service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.~~
2. ~~If the member does not choose an HMO within two weeks of receiving the enrollment packet, he or she receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in an HMO.~~
3. ~~If the member has not chosen an HMO after four weeks and lives in an area covered by two or more HMOs, he or she will be assigned an HMO. A letter explaining the assignment will be sent to him or her. He or she will receive another enrollment form and have an opportunity to change the assigned HMO.~~

~~He or she will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO~~selection and ~~cannot change for nine months. If your member has~~ responds to questions about ~~HMO enrollment, he or she should contact the enrollment specialist at 1-800-291-2002~~enrollment.

~~21.6.2 Exemptions~~

~~A member may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns.~~

~~If the member believes he or she has a valid reason for exemption, he or she should call the HMO enrollment specialist at 1-800-291-2002. The number is also in the enrollment materials they receive.~~

~~21.6.3 Change of Circumstances~~

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

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

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

Note:	~~The policies in this section also apply to members whose Medicaid was suspended due to incarceration but have regained full Medicaid eligibility upon release from jail or prison.~~This section only addresses enrollment in an SSI HMO and does not cover enrollment in a BadgerCare Plus HMO or Long-Term Care Managed Care Organization (LTC MCO).

21.6.~~4 Disenrollment~~1 SSI HMO Enrollment

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

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

~~Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process.~~SSI Medicaid and SSI-Related Medicaid are mandatory HMO enrollment programs, meaning most members are required to enroll in an HMO. Individuals who are eligible for suspended benefits or enrolled in a long-term care managed care organization (MCO) cannot enroll in an HMO. Certain individuals may enroll in an HMO on a voluntary basis (see SECTION 21.6.1.1 VOLUNTARY HMO ENROLLMENT) or qualify for an exemption from HMO enrollment (see SECTION 21.6.5 EXEMPTIONS).

HMO enrollment always begins ~~again. If no HMO covers~~the 1st of a month. The month in which enrollment begins depends on the time of the month when eligibility was established or when the member's ~~new area, he or she remains~~enrollment status changed:

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

Until a member's HMO enrollment has started, the member will receive their services on a fee-for-service basis, which means they can receive covered services from any Medicaid-certified provider.
If the member's enrollment status changes during the month (for example, going from being exempt from HMO enrollment to no longer being exempt), the member will be enrolled in an HMO effective the 1st of the following month.

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

The list of medical status codes under which a member is eligible for SSI HMO enrollment can be found on the ForwardHealth Enrollment information page. This list does not differentiate between voluntary or mandatory HMO enrollment. It is only a compilation of all medical status codes that could be enrolled in an HMO.

21.6.51.1 Voluntary HMO ~~Ombudsmen~~Enrollment

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

- The member is residing in a service area where there is only one HMO available.
- The member reports they are a Native American, American Indian, an Alaskan Native, or a member of a federally recognized tribe or has verified their tribal member status for eligibility purposes.
- The member is eligible for both BadgerCare Plus/Medicaid and Medicare, often referred to as a dual eligible.
- The member is eligible for benefits under MAPP. MAPP is a voluntary enrollment program.

21.6.2 HMO Selection and Assignment

Members can choose an HMO after they are found eligible for SSI Medicaid, SSI-Related Medicaid, or MAPP. Individuals who are applying for benefits online through ACCESS can indicate an HMO preference when they submit their application. Indicating a preference does not guarantee the individual will be enrolled in the HMO they selected when they submitted the application, but the preference will be taken into account when assigning the member to an HMO after they become eligible for benefits. If the member did not indicate a preference when they submitted their application, an HMO will be assigned for the individual based on any previous enrollment in an SSI HMO or based on a round-robin HMO assignment.

Enrollment in an SSI HMO is on an individual basis, meaning household members could be in different HMOs from other members of the household or their spouse. If the member was previously enrolled in an SSI HMO in the last 12 months, the member will be assigned to their previous HMO.

For members who are required to enroll in an HMO, if the member never indicated a preference to begin with, they will be assigned to an HMO and will receive an HMO enrollment packet in the mail. The enrollment packet includes a cover letter with information on their assigned HMO and start date, an SSI HMO Program Guide (P-12770) with a list of available HMOs and their service areas, an enrollment form, and instructions on how to choose or change an HMO.

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

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

- Log in to their ACCESS account and navigate to the “Manage My HMO” tab.
- Complete and return the HMO Enrollment Choice form by mail.
- Call the HMO Enrollment Specialist by phone at 1-800-291-2002.

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

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823
Phone: 1-800-760-0001 (Monday through Friday from 8 a.m. to 4:30 p.m.)

The SSI Managed Care External Consumer Advocate also provides advocacy services for SSI Medicaid HMO members with a disability. Members can contact the SSI Managed Care External Consumer Advocate at 800-928-8778 from 8:30 a.m. to 5 p.m., Monday through Friday.

21.6.3 Open Enrollment and Lock-in Periods

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

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

Example 1	Lorena applies and is found eligible for SSI-Related Medicaid on September 15 with a certification period of September 1 through August 31. She is assigned to HMO A with an enrollment start date of November 1. Her open enrollment period is from November 1 through January 31. Her lock-in period is from February 1 through November 30.

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

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

Voluntary members will be subject to the open enrollment and lock-in period if they choose to enroll in an HMO. During the open enrollment period, a voluntary member may choose to disenroll from the HMO without cause and choose fee-for-service (FFS).

21.6.4 HMO Disenrollment

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

21.6.4.1 Automatic Disenrollment

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

Reason for Disenrollment	Disenrollment Date
Loss of Medicaid eligibility	End of the month in which the loss/termination occurred, even if that is prior to when the loss of

	benefits is effective
Date of Death entered	Date of Death
Moving outside of the HMO's service area	End of the month in which the move was reported
Incarceration or Institutionalization	End of the month in which the incarceration or institutionalization was reported
Enrollment in a Waiver program or Long-Term Care MCO	End of the month prior to the month waiver program or LTC MCO enrollment starts
Becoming eligible for Medicare	Depending on when notification of Medicare eligibility was received and the Medicare eligibility start date, if the notification is received: • Prior to the Medicare eligibility begin date, the disenrollment date is the end of the month in which notification was received. • After the Medicare eligibility begin date, the disenrollment date is the end of the month prior to the month of notification.

21.6.4.2 Voluntary Disenrollment

The member may voluntarily disenroll from the HMO for any reason as long as they are no longer in their lock-in period.

If the member is still in the lock-in period, the member, the member's family, or the legal guardian must request a voluntary disenrollment based on a qualifying reason.

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

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

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

If the SSI HMO fails to complete a required assessment and care plan during the first 90 days of enrollment and is able to demonstrate a good faith process to complete the assessment, the open enrollment period will be extended an additional 30 days.

21.6.4.3 Involuntary Disenrollment

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

The HMO must submit a disenrollment request to the Department and include evidence attesting to the reason. The HMO must direct all members for whom an involuntary disenrollment request has been made to the HMO Enrollment Specialist for assistance and/or for choice counseling.

Involuntary disenrollments may include but are not limited to:

- Just Cause – A situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with medically necessary services for reasons beyond the HMO's control. An HMO cannot request just- cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished capacity, or uncooperative disruptive behavior resulting from the member's special needs (except when their continued enrollment in the HMO seriously impairs the HMO's ability to furnish services to the member or other members).
- The member is residing in a nursing home for longer than 90 days – The member, the nursing home, or the HMO may contact the HMO enrollment specialist to disenroll the member from the HMO so nursing home services can be billed fee-for-service. Once the member is no longer residing in the nursing home, the member may be eligible for HMO enrollment.

21.6.5 Enrollment Exceptions

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

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

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

Types of Enrollment Exemptions

Exemption	Description
Admission or Enrollment in the Birth to 3 Program (BadgerCare Plus only)	The head of the household or the county Birth to 3 Program may request an exemption on behalf of the child when the child is enrolled in the Birth to 3 Program. Birth to 3 Program providers are encouraged to work with the member's HMO before requesting the enrollment exemption. This exemption can be backdated up to two months from the month the request is received.
Commercial Insurance or Commercial HMO Enrollment	The member is enrolled in a commercial insurance plan or commercial HMO that limits them to a

	restricted private network and does not align with the SSI HMO provider network.
Continuity of Care	A one- to two- month continuity of care exemption may be granted when a member is newly enrolled or about to be enrolled in an HMO and has an upcoming appointment (within the next two months) with a provider with whom they have a previously established relationship, and that provider is not part of the HMO's network. If the member has more complex medical needs and requires an exemption longer than two months, the HMO Enrollment Specialist will refer the member to the State Nurse Consultant. In addition, a longer continuity of care exemption can be granted for a pregnant individual who wants to see a nurse midwife/practitioner of their choosing who is not part of the HMO's provider network. For a pregnant individual, the exemption can be applied at any time starting from the month of request through two months after the estimated due date.
Distance	This exemption may be granted for a one- to -two- month period when a member has moved out of an HMO's service area while their eligibility has not yet been updated to reflect the change in address AND the member needs immediate care in the area that is not covered by their current HMO.
HIPP Determination in progress or enrollment in the HIPP program	This exemption may be granted if the member is pending an eligibility determination for the HIPP program or is enrolled in the HIPP program, and the employer-sponsored insurance plan limits the member to a restricted provider network that does not align with the HMO's provider network.
Long Term Complex Care	The state Nursing Consultant may apply this exemption for up to 12 months for individuals who have complex needs and may need specialized care outside of a member's HMO network.
Low Birth Weight	The state Nurse Consultant may apply this exemption to newborns with a low birth weight (birth weight less than 2,500 grams or 5 lbs. 8 oz.).
Native American, American Indian, Alaskan Native or member of a federally recognized Tribe	If the member attests they are a Native American, American Indian, Alaskan Native, or a member of a federally recognized tribe, they are not required to enroll in an HMO. The member can choose to remove this exemption at any time to enroll into an HMO.
Care4Kids Extension	This exemption applies to children in BadgerCare

Transplants	Plus who are still receiving services under the Care4Kids 12-month extension after being discharged from out-of-home care. Care4Kids is a specialized managed care program for children in out-of-home care in Kenosha, Ozaukee, Milwaukee, Racine, Washington, and Waukesha counties. The member had a transplant that is considered experimental, such as liver, heart, lung, heart-lung, pancreas, pancreas-kidney, stem cell, or bone marrow transplant. The member will be permanently exempted from HMO enrollment effective the first of the month in which the surgery is performed. Transplant exemption requests may be made by the HMO and directed to the state Nurse Consultant.

22.2 Overpayments

22.2.1 Overpayments Introduction

22.2.1.1 Recoverable Overpayments

22.2.1.1.1 Date of Discovery and Look ~~back~~Back Period

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

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

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and ~~received services under~~ then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee-for-service claims that were incurred more than two months after the ~~move occurred~~member moved out of state.

Example 1:	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 look back 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.

22.2.1.1.2 Overpayment Claims Minimum Threshold

The minimum threshold for each claim is $500 for recoverable health care overpayments. If the overpaid amount is less than $500, no claim will be established unless it meets one of 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~~,~~ and enrolled in another state's Medicaid program, and ~~received services under~~then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee-for-service claims that were incurred more than two months after the ~~move occurred~~member moved out of state.

Example 2:	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 look back 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.

  See SECTION 22.2.1.2.4 ELIGIBILITY AND PREMIUM DETERMINATIONS BASED ON REASONABLE COMPATIBILITY for information about when members with eligibility or premium determinations based on income that was reasonably compatible can be subject to overpayments after failing to report required changes in financial information.

Example 3:	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 look back 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 of the amount of claims and any HMO capitation payments the state paid for each month, whichever is less.

22.2.1.2.4 Eligibility and Premium Determinations Based on Reasonable Compatibility

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

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

Example 8:	Cameron is a disabled adult with an income limit of $1,132.50 for SSI-Related Medicaid. He applies for Medicaid in January and reports that his earnings are $1,100 per month. The monthly earned income amount reported by Equifax is $1,200 per month. Because Cameron's reported income is below the income threshold and the Equifax-reported income is above the income threshold, the 20% threshold test is applied. The income reported by Equifax ($1,200) is less than the 20% threshold amount (120% of $1,100, or $1,320), so his reported information is reasonably compatible, and he does not need to verify his earned income. In April Cameron applies for FoodShare. Cameron must provide verification of his earned income when applying for FoodShare. His verified earned income is $1,300, and it is discovered that he failed to report in February that his income increased to $1,300. This amount is over the SSI-Related Medicaid income limit of $1,132.50, so Cameron is no longer eligible for SSI-Related Medicaid. However, this amount is not more than 20% greater than the income amount of $1,100 that was used to determine that he was eligible for SSI-Related Medicaid in January. Therefore, he cannot be subject to an overpayment. The amount that is 20% greater than $1,100 is $1,320. If Cameron's income had increased to an amount greater than $1,320 and he failed to report the increase, he could have been subject to an overpayment.

22.3 Interagency Case Transfer

A case transfer occurs when the primary person~~,~~ who is currently receiving benefits ~~from a county or tribal Income Maintenance agency for a particular month, applies for aid from another Income Maintenance agency for the same or next month. The primary person must be a member of a currently open BadgerCare Plus, Child Care, EBD Medicaid, FoodShare, or W2 Assistance Group or one that has~~(or whose benefits have been closed for less than ~~a~~one calendar month~~.~~) reports that they have moved to a different county or tribal area. The only exception to this is protective placements (see Section 2.3.2 Intercounty Placements).

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

The agency to which the member reports the move must collect information about the changes, ~~for example,~~including the new residential address. ~~-~~If the agency does not have sufficient information about the changed circumstances, it must request information from the member~~,~~ according to the verification policy in Chapter 20 Verification.

~~CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.~~

~~The renewal date will remain the same after case transfer.~~

~~Do not require a review or new application for case transfers, except in the following programs:~~

- ~~Community Wavers (28.1 Adult Home and Community Based Waivers Long Term Care Introduction)~~
- ~~Family Care (29.1 FAMILY CARE LONG TERM CARE (FCLTC) INTRODUCTION)~~
- ~~Deductible Met (24.11 Deductibles and Inter Agency Transfers)~~

~~See Process Help Section 6.1 Interagency Case / RFA Transfer in for information on how to process case transfers.~~

22.4 Undue Hardship

22.4.1 Application of Policy

Undue hardship may apply only when eligibility for long-term care services is denied or terminated for any of the following situations:

- A community spouse has refused to sign the application or provide required information (see ~~SECTION~~Section 2.5.3 ~~SPOUSAL IMPOVERISHMENT MEDICAID SIGNATURES~~Spousal Impoverishment Medicaid Signatures)
- The applicant's or member's home has equity interest of more than $750,000 (see Section 16.8.1.4 Home Equity Over $750,000.00)
- A divestment penalty period has been imposed (see Section 17.2.6.10 Undue Hardship Request is Granted)
- A spousal impoverishment case has excess assets (see Section 18.4.5 Undue Hardship)

Undue hardship occurs if denial or termination of an applicant's or member's eligibility for coverage of long-term care services would deprive the person of any of the following:

- Medical care, which then endangers the person's health or life
- Food
- Clothing
- Shelter
- Other necessities of life

22.5 Representatives

22.5.1 Authorized Representatives

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

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

If an applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal guardian of the person to act on ~~his or her~~their behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

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

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

There can be only one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

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

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An

authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

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

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or (Organization F-10126B) to his or her IM agency.

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

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

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~~ 3 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~~ 4 Notice of Adverse Action

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

23.1.~~3~~4.1 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

23.1.4.2 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.

23.2 Fair Hearings

23.2.1 Fair Hearing Request

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

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

Fax (608) 264-9885

Email: DHAMail@wisconsin.gov

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

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

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

23.2.2 Prior to the Hearing

At least 10 days prior to the hearing, DHA sends a Notice of Scheduled Hearing to the applicant or member, their representative, or both. This allows the applicant or member 10 days to prepare for the hearing. The applicant or member may request less advance notice to expedite scheduling the hearing. The notice states that:

- DHA will dismiss the request if the applicant, member, or any representative fails to appear without good cause.
- The name, address, and phone number of whom to notify if the applicant, member, or representative cannot attend.
- The applicant or member and any representative may examine the case record prior to the hearing.

23.2.3 Continued Benefits

DHA may order a member's Medicaid benefits to continue while a decision on the hearing is pending. The IM agency must comply with DHA's initial order until otherwise notified or the member waives this

continuation of benefits. The IM agency must inform members that they may have to pay back any continued benefits received if they lose the hearing decision and of their right to waive continued benefits.

DHA can reverse its continuance order only when the hearing was not requested prior to the action's effective date. If DHA does not order benefits reinstated and the agency believes that the member is entitled to them, the agency must notify DHA.

Once benefit continuation has begun, the IM agency must maintain those benefits until DHA orders a change or some other change in eligibility occurs.

23.2.4 Time Limits

DHA must conduct the hearing and issue its decision and the IM agency must implement the decision within 90 days of the date DHA receives the hearing request.

When a decision is favorable to the applicant or member, the IM agency must carry out the decision's orders within 10 days of the order or 90 days of the date DHA receives the hearing request, whichever comes first.

When the decision is not favorable to the applicant or member, the decision notice is the final notice for the case, with the exception of overpayment notices. No further timely or adequate notice requirement applies for the issue that was appealed. Medicaid benefits will be discontinued or reduced immediately.

The DHA decision includes a description for the applicant or member of their right to rehearing, judicial review, or both. It is not necessary to request a rehearing before going to circuit court.

23.2.5 Recoupment

If an agency's adverse action is upheld, or the fair hearing is withdrawn or is abandoned, any overpayments caused by benefits having been continued may be subject to recovery based on the overpayment policies in SECTION 22.2.2 OVERPAYMENT CALCULATION.

24.3 Deductible Period

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

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

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

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

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

Example 3:	Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31, but no longer had the $5,000 on June 30. Her deductible period will run from April through September. However, if she meets the deductible in April, she would only be eligible through the end of April and from June 1 to September 30. If she meets the deductible in May, she would only be eligible from June 1 to September 30. Due to excess assets in May, she may not be eligible for any day in that month.

Example 4:	Marion applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September. Marion was incarcerated from April ~~30th~~ 30 through May ~~18th~~18. She meets the deductible with a countable expense from April ~~10th~~10, so she should be certified from April ~~10th~~ 10 through April ~~29th~~29, and May ~~19th~~ 19 through September ~~30th~~30.

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

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

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

~~An individual can establish a~~A new deductible period can be established at any time ~~if they file an~~ before the current deductible has been met. The person must sign and submit a new application in order for ~~Medicaid. This includes situations where someone has already established a~~the new deductible period~~, hasn't yet met the deductible, and wishes~~ to ~~establish a new deductible period~~be established.

Example 7:	Jeff applies for Medicaid ~~on~~in January~~ 1, 2014, and his~~. His monthly excess income is $100.~~00.~~ His Medicaid deductible is $600~~.00~~ and his deductible period is January 1~~, 2004~~ through June 30~~, 2014~~. In April~~ 2014~~, Jeff's monthly excess income decreases to $10~~.00~~ a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have ~~his worker~~the agency recalculate the original $600~~.00~~ deductible which would then become a $330~~.00~~ deductible (three months of $100~~.00~~ excess income and three months of $10~~.00~~ excess income) or, since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April ~~2014~~ through September~~ 30, 2014~~ with a $60~~.00~~ deductible obligation ($10~~.00~~ x 6 = $60~~.00~~). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible~~. (See~~ (see Section 24.6.1 Changes During the Deductible Period~~> Income Changes.)~~).

~~Individuals~~Members who have been certified for Medicaid after meeting a deductible~~,~~ will have to complete a ~~review~~renewal to establish a new deductible period. ~~CARES does not send a review notice to the member~~No renewal notice~~s~~ is sent regarding the new deductible period if ~~he or she~~the applicant did not meet the deductible for the current period.

26.4 MAPP Financial Requirements

Follow EBD rules in Chapters ~~15.1 INCOME INTRODUCTION~~15.1 Income Introduction and 16.1 Assets Introduction to determine countable assets and income. The following are MAPP financial eligibility requirements.

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~~their spouse's income if residing together.
2. Deduct the $65 and ½ of the earned income disregard from the spouse and member's earnings (see ~~SECTION~~Section 15.7.5 $65 ~~AND ½ EARNED INCOME DEDUCTION~~and ½ Earned Income Deduction).
3. Deduct the member's and spouse's IRWEs (see ~~SECTION 15.7.4 IMPAIRMENT RELATED WORK EXPENSES (IRWE)~~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~~their 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 (see ~~SECTION~~Section 15.7.2 ~~SPECIAL EXEMPT INCOME~~Special Exempt Income).
8. Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (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~~ 1 and the date the FPL is effective in CARES for that year (see ~~SECTION 15.3.35 COLA DISREGARD FOR SOCIAL SECURITY RECIPIENTS~~Section 15.3.35 COLA DISREGARD FOR SOCIAL SECURITY RECIPIENTS).
10. Subtract the historical COLA Disregard Amount (see ~~SECTION 39.6 COLA~~Section 39.6 COLA Disregard ~~for 503 Assistance Groups~~) 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 Disabled Adult Child (DAC~~).~~)).
11. Compare the result to 250% of the FPL (see Section 39.5 FPL Table). Include the member's minor dependent legal children (~~natural~~ biological or adoptive) when determining fiscal test group size. Include the member's dependent 18-year-old ~~child(ren)~~ children in the ~~FTG~~fiscal test group size. Do not include the member's stepchildren ~~in the fiscal test group size~~.

26.5 MAPP Premiums

26.5.1 Calculation

~~Calculate~~MAPP premiums are calculated using only the member's income. ~~Calculate a~~A premium is calculated if the member's monthly Premium Gross Income exceeds 100% 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:
    1. The member's own verified monthly impairment-related work expenses (any amount)
    2. The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    3. 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% 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 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 – $1,132.50 (100% of the FPL)

	---------- $617.50 Premium Net Income X 0.03 (3%) ---------- $18.53 +$25 Base Premium Amount ---------- $43.53 (round down to nearest whole dollar) Susan's monthly MAPP premium is $43.

26.5.3 Payment Information

26.5.3.1 Payment Methods

~~When requested, the fiscal agent will provide members with instructions for choosing the payment method they want. Members can contact Member Services at 1-800-362-3002.~~

~~The payment methods are:~~

~~Direct payment~~Initial premium payments must be paid by check or money order and are collected by the IM agency.

- ~~EFT.~~
- ~~Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in premium wage withholding. If the employer decides not to participate, the participant will have to choose direct pay or EFT.)~~

~~Provide~~For ongoing premium payments, premium statements will be sent monthly. The statement will provide the amount due and how to pay the premium.

Members have several options to pay their ongoing monthly premiums, including:

- Check
- Money order
- Electronic Funds Transfer (EFT)
- Wage withholding
- Credit or debit card

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

For recurring EFT payments, members ~~with the~~must submit a complete Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form (~~F-13023) and~~F-13023). To have premiums taken out of a paycheck, the Medicaid Purchase Plan Premium Employer Wage Withholding form (~~F-13024) to allow the member to choose a payment method other than direct payment. Since it takes some time to set up EFT and wage withholding, the member pays directly until the fiscal agent informs him or her otherwise~~F-13024) must be submitted by an employer. Members must submit payments through one of the other methods until they get confirmation that their recurring EFT or wage withholding request has been processed.

26.5.4 Ongoing Cases

Ongoing premium payments can be paid through any of the methods listed in Section 26.5.3.1 Payment Methods. Ongoing premium payments paid by check are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the 10th of the benefit month

regardless of which payment method is chosen. For members who have chosen "direct pay' as their payment method, the fiscal agent sends the premium coupon on the 20th of the month before the benefit month. The payment must be received by the fiscal agent by the 10th of the benefit month. EFT occurs on the third business day of the benefit month.

26.5.5 Late Payments

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Members must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 4:	If a member owed a premium for September and does not pay it until October, then he or she will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month

If a member pays their premium between adverse action of the benefit month and the last day of the benefit month, ~~he or she~~ they can reopen~~. Run eligibility with dates and confirm~~ without a break in coverage.

Example 5:	Adverse action is September 16. Jim's September premium was due September 10. Jim has not paid his September premium by September 16. He does pay on September 26. The case closed effective September 30. ~~Run with dates to open for~~Jim will be eligible as of October~~. Then run~~ without ~~dates for November eligibility~~a break in service.

26.5.5.3 Anytime in Month After the Benefit Month

If the member pays their premium any time in the month after the benefit month, ~~he or she~~they can reopen. ~~He or she~~They must pay the premium that closed them. If they owe a premium for that following month, ~~he or she~~they must pay that premium before CARES will open MAPP. The member must pay the IM agency directly (not the fiscal agent). ~~The IM worker can check with the fiscal agent to see if a premium has already been collected for that month.~~

When the payment(s) is received, ~~record~~benefits will be reopened back to the ~~payment in CARES and run eligibility for~~first of the benefit month and ~~confirm. Then run eligibility for the following month and confirm~~there will be no gap in coverage.

Example 6:	Adverse action is September 16. Jim has not paid his September premium by September 16. He pays on October 26. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. ~~To reopen~~If Jim pays his ~~case, run eligibility for~~ premium arrears in October ~~and confirm. Finally, run eligibility for November and confirm. (~~, his benefits will reopen as of October. The November premium is not due until November 10 and does not have to be paid in advance~~.)~~.

26.5.6 Non-Payment

If a MAPP member does not pay the monthly premium by adverse action in the benefit month, ~~apply~~ an RRP will be applied (see Section 26.6 Restrictive Re-enrollment Period~~,~~), unless there is good cause (see Section 26.6.2 Good Cause). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, ~~lift the RRP~~the RRP will be lifted, and benefits will be reinstated.

26.5.6.1 Insufficient Funds

~~You~~IM workers will be notified with a 056 Run SFED/SFEX alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. ~~Apply an~~An RRP will be applied, unless there is good cause (anything that is beyond the member's control), and ~~close~~ the ~~case~~member's benefits will end. The RRP begins with the first month after closure~~. Determine if an overpayment exists and process the overpayment~~.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month, ~~end~~ MAPP eligibility ~~for~~will end the next possible month and ~~do not impose~~ an RRP~~. Refer to~~ will not be imposed (see Process Help 25.1.9 Opting Out~~.~~).

A MAPP applicant's decision to opt out does not affect other family members' eligibility for Medicaid or Medicaid-related programs.

27.5 ILTC Financial

27.5.4 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution (27.1 Institutions) residents with no community spouse.
   Use the Medicaid Institution Worksheet (~~WORKSHEET~~Worksheet #4).
2. Medical institution residents who have a community spouse and who became institutionalized before 09-30-89:
   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the Medicaid Institution Worksheet (~~WORKSHEET~~Worksheet #4).
3. Medical institution residents who have a community spouse and who became institutionalized on or after 09-30-89:
   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form and the Spousal Impoverishment Income Allocation Worksheet (~~WORKSHEET~~Worksheet #7).
4. Community waiver applicants with no community spouse:
   Use the ~~F-20919~~F-20919
5. Community waiver applicants with a community spouse:
   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form the ~~MEDICAID WAIVER ELIGIBILITY AND COST SHARING WORKSHEET~~Medicaid Waiver Eligibility and Cost Sharing Worksheet-, and the Spousal Impoverishment Income Allocation Worksheet (~~WORKSHEET~~Worksheet #7).

27.7 Cost of Care Calculation

27.7.6 Personal Needs Allowance

Deduct the personal needs allowance (see ~~SECTION 39.4.2 ELDERLY, BLIND, OR DISABLED DEDUCTIONS AND ALLOWANCES~~Section 39.4.3 LTC Post-Eligibility Allowances) for all institutionalized members in both the eligibility test and the patient liability calculation.

An institutionalized person's personal needs allowance may accumulate to where he or she may lose eligibility due to excess assets. To prevent this, he or she can spend money on personal needs or make a refund to Medicaid (see Section 22.1.10 Voluntary Recovery [Not Estate Recovery Program]).

28.6 HCBWLTC Eligibility Groups and Cost Sharing

28.6.4 Cost Share Amount

28.6.4.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share. ~~Do not give the special housing amount to waiver participants under age 18.~~

The personal maintenance allowance ~~(Line 6 and Page 2 of the worksheet)~~ is calculated as the total of the following, ~~:~~but must not exceed ~~must not be greater than~~ the Community Waivers ~~EBD Maximum~~ Personal Maintenance Allowance Maximum (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES) ~~(If the total of the above is greater than the EBD Maximum Personal Maintenance Allowance in Section 39.4.1, then the EBD Maximum Personal Maintenance Allowance is used.~~

~~:~~

1. Community Waivers Basic Needs Allowance (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES
2. ~~1.~~2. Sixty-five dollars and ½ earned income deduction (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION)~~.~~
3. ~~2.~~3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:
   - Rent.
   - Home or renter's~~'~~ insurance.
   - Mortgage.
   - Property tax (including special assessments).
   - Utilities (heat, water, sewer, electricity).
   - ~~"~~Room amount for members in a CBRF, Residential Care Apartment Complex, or ~~an~~ Adult Family Home. The case manager determines and provides this amount.

   Waiver participants under age 18 do not qualify for the special housing amount deduction.

~~Note~~	~~Waiver participants under age 18 do not qualify for the special housing amount.~~

   ~~If the total of the above is greater than the EBD Maximum Personal Maintenance Allowance in Section 39.4.1, then the EBD Maximum Personal Maintenance Allowance is used.~~

   If ~~both~~ two spouses who are both waiver participants live together (or they have separate rooms in a substitute care facility, but there is only one room and board contract) the ~~are applying and both have income, divide the~~ special housing amount deduction is allocated between them in the way ~~in whatever way~~ that results in the lowest total cost share for the ~~members~~couple.

Example 1	Jennifer and Markus are married and live together. Both are waiver participants.

	Their total housing costs are $1,600. The special housing amount is calculated as $1600 − $350 = $1250. Before deducting the special housing amount, Jennifer has a cost share of $800 and Markus has a cost share of $500. To get the lowest total cost share for the couple, $500 of the special housing amount is allocated to Markus, reducing his cost share to $0. The remaining $750 of the special housing amount is allocated to Jennifer, reducing her cost share to $50.

Example 2	Dan and Allison are married and live together. Both are waiver participants. Their total housing costs are $1,~~7050~~075. The special housing amount is calculated as $1,075 − $350 = $725. Before deducting the special housing amount, Dan has a cost share of $1,200. Allison is eligible for Group A waivers with no cost share. To get the lowest total cost share for the couple, the full $725 special housing amount is allocated to Dan, reducing his cost share to $475.

~~If only one spouse has income and both spouses are applying, allocate the full special housing amount to the spouse with income.~~

~~When one spouse has income and both are applying:~~

- ~~And If they reside together in the same residence, allocate the full special housing amount to the spouse with income.~~
- ~~And If they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.~~
- ~~And If they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.~~

~~When both spouses have income and both are applying:~~

- ~~And If they reside together in the same residence, divide the special housing amount in whatever way results in the lowest total cost share for the members.~~
- ~~And If they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount in whatever way results in the lowest total cost share for the members.~~

~~And~~ If two spouses who are both waiver participants ~~they reside~~ have ~~in~~ separate living arrangements (e.g., they reside in two different substitute care facilities, ~~OR~~ or they reside in the same substitute care facility~~,~~ but each has a private room and ~~his or her~~ a separate ~~own individual~~ room and board contract) ~~then calculate a~~ a separate special housing amount is calculated for each~~,~~ based on their individual ~~"rent"~~ housing costs ~~that are obtained from the care manager~~.

If the total of 1, 2, and 3 above is greater than the Community Waivers Personal Maintenance Allowance Maximum, the maximum amount is used. See SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES for the current Community Waivers Personal Maintenance Allowance Maximum.

~~The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance .~~

28.6.4.2 Family Maintenance Allowance

A family maintenance allowance, an amount to be used for the support of the applicant's family members, should only be deducted from income when calculating cost share in certain cases. The family maintenance allowance may not be used for a deduction when spousal impoverishment policies apply or if the member is a disabled child. For spousal cases, the institutionalized person can allocate income to the community spouse and children in the home, see ~~SECTION~~Section 18.6 ~~SPOUSAL IMPOVERISHMENT INCOME ALLOCATION~~Spousal Impoverishment Income Allocation.

28.6.4.2.2 Family Maintenance Allowance Calculation - EBD-Related

If there are no minor children in the home, and spousal impoverishment policies do not apply, calculate the following:

1. Spouse's gross earned income.
2. -$65 and ½ of total gross earned income (see Section 15.7.5 $65 ~~AND ½ EARNED INCOME DEDUCTION~~and ½ Earned Income Deduction).
3. =_____.
4. +Spouse's total unearned income.
5. =_____ (3)+(4).
6. -$20 disregard .
7. =_____(6)-(5).

~~1. _____Enter the SSI Payment Level Plus the E Supplement for one person (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).~~

8. _____ Enter the Non-Spousal-Impoverishment Family Maintenance Allowance Maximum (see Section 39.4.3 LTC Post-Eligibility Allowances).

If (7) is greater than (8), there is no family maintenance allowance. If (7) is less than (8), the family maintenance allowance is the difference between (7) and (8).

29.1 Katie Beckett

The Katie Beckett Program tests qualified blind and/or disabled minors for Medicaid. It does not deem assets and income from ~~the natural or adoptive~~ parents or legal guardians.

To qualify under the Katie Beckett Program, a blind or disabled minor:

- Must require a level of care provided in a hospital, SNF, or ICF.
- Can appropriately receive this care in ~~his or her~~their home.
- Would be nonfinancially eligible for Medicaid if they were in a hospital, SNF, or ICF.
- Must have income below the Institutions Categorically Needy ~~Income Limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Table).~~income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.

Members enrolled in Katie Beckett Medicaid are only subject to estate recovery when they have resided in a hospital or nursing home for 30 or more continuous days. Only the child's estate (not the parent's or legal guardian's) is subject to estate recovery requirements. See SECTION 22.1 ESTATE RECOVERY for the criteria used to determine whether services are recoverable.

Families may contact the Katie Beckett Program by:

- Calling 888-786-3246.
- Emailing ~~DHSKatieBeckett@dhs.wisconsin.gov~~DHSKatieBeckett@dhs.wisconsin.gov.
- Faxing information to 888-786-3261.
- Writing to the following address:

Katie Beckett Program
Division of Medicaid Services
Bureau of Children's Services
1 West Wilson Street, Room 418
Madison, WI 53707

32.2 QMB

32.2.1 Introduction

To be eligible for QMB the person must:

1. Meet non-financial Medicaid requirements

~~1. Be receiving Medicare Part A~~

2. Be entitled to Medicare Part A (as defined in Section 32.2.2 Entitled to Medicare).

The following Medicaid members are categorically eligible for QMB benefits:

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

Note:	If a member is not eligible for ~~categorically or medically needy~~ SSI ~~-related~~ Medicaid ~~through any of these four groups, he or she is~~or Special Status Medicaid, they are not automatically eligible for QMB benefits.
Example 1:	Kate receives an SSDC payment from Social Security. Due to other unearned income, however, Kate is not eligible for categorically or medically needy SSI-related Medicaid as a DAC. Even though she receives a "DAC" payment, she is not automatically eligible for QMB because she is not eligible for Medicaid through the receipt of SSI Medicaid or ~~through~~ Special Status Medicaid.

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

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A if ~~he or she meets~~ they meet one of the following conditions:

1. ~~He or she does~~ They do not have to pay a premium for Medicare Part A and ~~is~~ are enrolled in Medicare Part A as of the QMB determination.

Example 2:	Mrs. Smith applies for QMB benefits August 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is "entitled" to Part A at the time of the QMB determination.

2. ~~He or she~~They must pay a monthly premium to receive Medicare Part A and ~~fits~~meet one of the following ~~descriptions~~conditions:
    1. ~~He or she is~~They are a Medicaid member and ~~has~~ have been enrolled in Medicare sometime in the past. In this case, the ~~State~~state will attempt to enroll ~~him or her~~them in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 3:	Eleanor's Part A lapsed because she did not work enough quarters for free enrollment, and she could no longer afford the premiums. When she becomes eligible for Medicaid, the state will begin paying her Medicare premiums.

    2. ~~He or she is~~They are a Medicaid member or QMB or SLMB applicant and ~~has~~ have never been enrolled in Medicare Part A. In this case ~~he or she~~, they must apply at the local SSA

office for Part A Medicare eligibility. ~~He or she~~They will receive a receipt which entitles ~~him or her~~them to ~~enrollment~~ enroll in Part A on the condition that ~~he or she is~~they are found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB or SLMB eligibility cannot begin prior to the Part A begin date~~.~~.

Note: For purposes of QMB or SLMB, a person can request conditional enrollment in Medicare Part A at their local SSA office at any time. They do not have to wait for the general enrollment period.

Example 4:	Pearl was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for ~~Part A~~ Medicare Part A. She goes to the SSA office ~~during the January-March enrollment period~~ and is conditionally determined eligible for Part A effective ~~July~~June 1. She applies for QMB at the IM Agency on May 1. She becomes QMB eligible as of ~~July~~June 1.

33.6 SeniorCare Financial Requirements

33.6.5 Interest and Dividends

The SeniorCare applicant must report the estimated gross amount of all interest and dividends that ~~he or she expects~~ they expect to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to, the following:

- Bonds
- CDs
- Checking accounts
- Money market accounts
- Savings accounts
- Stocks
- Capital gains (see ~~SECTION~~Section 33.6.5.1 ~~CAPITAL GAINS~~Capital Gains)
- ~~Trusts (see SECTION 33.6.5.2 TRUSTS)~~
- ~~IRAs (see SECTION 15.4.4 RETIREMENT BENEFITS)~~
- Trusts (see Section 33.6.5.2 Trusts)
- Annuities
- Land contracts (see ~~SECTION~~Section 15.4.7 ~~LAND CONTRACT~~Land Contract)
- ~~Loans (see SECTION 15.4.8 LOANS, PROMISSORY NOTES, AND MORTGAGES)~~
- Loans (see Section 15.4.8 Loans, Promissory Notes, and Mortgages)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note:	Unlike Medicaid, income that is received irregularly and infrequently and is under $20 per month should be reported as budgetable income for SeniorCare applicants.

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, 2022.~~

Category	Limit	Group Size 1	Group Size 2	Effective	Updated Annually?
~~Category~~		~~1~~		~~2~~	
SSI-Related Categorically Needy ~~Limits~~	~~Assets~~Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$924.78	$1,393.05	1/1/2022	Yes
SSI-Related Medically Needy ~~Limits~~	~~Assets~~Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$1,132.50 ~~(effective 2/1/2022)~~	$1,525.83 ~~(effective 2/1/2022)~~	2/1/2022	Yes
~~SSI Payment Level~~					
~~Federal SSI Payment Level~~MAPP	~~Income~~Asset	$~~794~~15,000.00	~~Income~~N/A	~~$~~3/1~~,191.00~~/2000	No
~~SSP~~	~~Income~~	~~$83.78~~	~~Income~~	~~$132.05~~	
	Income	~~$877.78~~Less than 250% FPL (see Section 39.5 FPL Table)	~~Income~~	~~$~~2/1~~,323.05~~/2022	Yes
~~SSI Payment Level + E Supplement~~	~~Income~~	~~$1,020.77 (Home Maintenance Maximum Allowance)~~		~~$1,668.41~~	
~~SSI E Supplement~~	~~Income~~	~~$95.99~~		~~$345.36~~	
~~Community Waivers Special Income Limit~~	~~Income~~	~~$2,523.00~~			
Institutions Categorically Needy ~~Income Limit~~	Income	$2,523.00	N/A	1/1/2022	Yes
Group B Community	Income	$2,523.00	N/A	1/1/2022	Yes

Waivers ~~Substantial Gainful Activity~~ QMB ~~(non-blind individuals)~~	~~Income~~Asset	$~~1,310~~8,400.00	$12,600.00	1/1/2022	Yes
~~Substantial Gainful Activity Limit (blind individuals)~~	~~Income~~	~~$2,190.00~~			
~~Medicaid Savings Programs~~					
	Income	At ~~or below~~or below 100% FPL		2/1/2022	Yes
SLMB	Asset	$8,400.00 (see Section 39.5 FPL Table)	$12,600.00	1/1/2022	Yes
	Income	At least 100% FPL but less than 120% FPL		2/1/2022	Yes
SLMB+	Asset	$8,400.00 (see Section 39.5 FPL Table)	$12,600.00	1/1/2022	Yes
	Income	At least 120% FPL but less than 135% FPL (see Section 39.5 FPL Table)		2/1/2022	Yes
~~QMB, SLMB, SLMB+~~	~~Assets~~	~~$8,400.00~~		~~$12,600.00~~	
~~QDWI~~	~~Income~~	~~At or below 200%~~			
QDWI	~~Assets~~Asset	$4,000.00	$6,000.00	7/1/1990	No
	Income	$2,265.00	$3,051.66	2/1/2022	Yes

39.4.2 ~~Elderly, Blind, or~~ Disabled ~~Deductions~~Minors Deeming and Allowances

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

~~Description~~Item	Amount	Effective	Updated Annually?
~~Personal Needs Allowance (effective 7/1/01)~~	~~$45.00~~		
~~EBD Maximum Personal Maintenance Allowance~~	~~$2,523.00~~		
~~EBD~~SSI-Related Deeming Amount to an Ineligible	$420.00	1/1/2022	Yes

Minor			
~~Community Waivers Basic Needs Allowance~~	~~$1,021.00~~		
Parental living allowance - 1 Parent **~~2 Parent~~**	$841.00 ~~$1,261.00~~	1/1/2022	Yes
Parental living allowance - 2 Parents	$1,261.00	1/1/2022	Yes

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

39.4.3 LTC Post-Eligibility Allowances

~~Description~~Item	Amount	Effective	Updated Annually?
~~Community spouse Lower Income Allocation Limit~~Institutions Personal Needs Allowance	$~~2,903.34~~45.00	7/1/2001	No
~~Community Spouse Excess Shelter Cost Limit~~Institutions Home Maintenance Allowance Maximum	$~~871.00~~1,020.77	1/1/2022	Yes
~~Community Spouse Maximum Income Allocation (monthly)~~Non-Spousal-Impoverishment Family Maintenance Allowance Maximum	$1,020.77	~~The lesser of $3,435.00 (as of 1/2022) or the Lower Income Allocation Limit plus excess shelter expenses~~1/1/2022	Yes
~~Family Member Income~~Community Waivers Basic Needs Allowance	$~~725.84~~1,021.00	1/1/2022	Yes
Community ~~spouse asset share (CSAS) maximum~~Waivers Personal Maintenance Allowance Maximum	$2,523.00	1/~~$137,400.00 as of~~ 1/2022	Yes

~~39.4.3 Institutional Cost of Care Values~~

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

39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share

Description	Amount	Effective	Updated Annually?
~~Daily Average Private Pay Nursing Home Rate~~Community	$~~307.40~~3,051.66	7/1/2022	Yes

spouse Lower Income Allocation Limit			
~~Monthly Average Private Pay Nursing Home Rate~~Shelter Base Amount	$~~9,350.08~~915.50	7/1/2022	Yes
~~Monthly Rate for State Centers for Persons with Developmental Disabilities~~Community Spouse Income Allocation Maximum	$~~28,028.96~~3,435.00	1/1/2022	Yes
Dependent Family Member Income Allowance Maximum	$762.92	7/1/2022	Yes
Dependent Family Member Income Allowance Standard	$2,288.75	7/1/2022	Yes
Community spouse Asset Share (CSAS) Maximum	$137,400	1/1/2022	Yes

39.4.~~4 Maximum Cost Share Amount for~~5 Family Care, Family Care Partnership, or PACE Group B Plus Cost Share Cap

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

~~Description~~Item	Amount	Effective	Updated Annually?
~~Maximum~~ Cost Share ~~Amount~~Cap for ~~an individual in~~ Group B~~+ for~~ Plus Family Care, Family Care Partnership, or PACE	$~~2,903.45~~3,228.27	1/1/2022	Yes

39.4.6 Institutional Cost of Care Values

Item	Amount	Effective	Updated Annually?
Daily Average Private Pay Nursing Home Rate	$307.40	1/1/2022	Yes
Monthly Average Private Pay Nursing Home Rate	$9,350.08	1/1/2022	Yes
Monthly Rate for State Centers for Persons with Developmental Disabilities	$28,028.96	1/1/2022	Yes

39.4.7 SSI Reference Values

Item	Group Size 1	Group Size 2	Effective	Updated Annually?
Federal SSI Payment Level	$841.00	$1,261.00	1/1/2022	Yes
State Supplementary Payment (SSP)	$83.78	$132.05	1994	No
SSI E Supplement	$95.99	$345.36	1994	No
Substantial Gainful Activity Threshold for Non-Blind Disabled Individuals	$1,350.00	N/A	1/1/2022	Yes
Substantial Gainful	$2,260.00	N/A	1/1/2022	Yes

Activity Threshold
for Blind Individuals

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~~, which is the sum of:
   ~~1.~~ The amount of the ~~following:~~
      1. OASDI check
      2. Any amount ~~that has been withheld~~being deducted from the OASDI check for ~~a~~ Medicare ~~premium~~premiums (do not include Medicare Part B premiums that are paid for by the state)
      3. Any amount being withheld from the OASDI check to ~~repay an earlier~~ recover a previous overpayment
   ~~2. Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.~~
   ~~1.~~2. ~~On~~In the ~~COLA Disregard Amount Table~~table below, find the decimal figure that corresponds to the last month ~~in which~~when the person ~~was eligible for and~~ received ~~a check for both OASDI and~~ an SSI payment.
   ~~3. Find the decimal figure that applies to this month.~~
   ~~2.~~3. Multiply the ~~person's current~~ gross OASDI income by the applicable decimal figure~~.~~ and round to the nearest whole dollar. The result is the historical COLA disregard amount.

~~COLA Disregard Amount~~Month SSI Last Received	Multiply 2022 OASDI by:	Multiply 2021 OASDI by:
~~January to December~~Jan 2021 - Dec 2021	0.055713	-
~~January to December~~Jan 2020 - Dec 2020	0.067831	0.012833
~~January to December~~Jan 2019 - Dec 2019	0.082511	0.028379
~~January to December~~Jan 2018 - Dec 2018	0.107501	0.054843
~~January to December~~Jan 2017 - Dec 2017	0.125001	0.073376
~~January to December~~Jan 2016 - Dec 2016	0.127618	0.076148
~~January to December~~Jan 2015 - Dec 2015	0.127618	0.076148
~~January to December~~Jan 2014 - Dec 2014	0.142201	0.091590
~~January to December~~Jan 2013 - Dec 2013	0.154877	0.105015
~~January to December~~Jan 2012 - Dec 2012	0.169004	0.119976
~~January to December~~Jan 2011 - Dec 2011	0.197881	0.150556

~~January to December~~Jan 2010 - Dec 2010	0.197881	0.150556
~~January to December~~Jan 2009 - Dec 2009	0.197881	0.150556
~~January to December~~Jan 2008 - Dec 2008	0.241853	0.197123
~~January to December~~Jan 2007 - Dec 2007	0.258899	0.215174
~~January to December~~Jan 2006 - Dec 2006	0.282574	0.240245
~~January to December~~Jan 2005 - Dec 2005	0.310830	0.270169
~~January to December~~Jan 2004 - Dec 2004	0.328948	0.289356
~~January to December~~Jan 2003 - Dec 2003	0.342750	0.303973
~~January to December~~Jan 2002 - Dec 2002	0.351825	0.313582
~~January to December~~Jan 2001 - Dec 2001	0.368250	0.330977
~~January to December~~Jan 2000 - Dec 2000	0.389614	0.353601
~~January to December~~Jan 1999 - Dec 1999	0.403920	0.368751
~~January to December~~Jan 1998 - Dec 1998	0.411569	0.376852
~~January to December~~Jan 1997 - Dec 1997	0.423672	0.389669
~~January to December~~Jan 1996 - Dec 1996	0.439915	0.406870
~~January to December~~Jan 1995 - Dec 1995	0.454108	0.421900
~~January to December~~Jan 1994 - Dec 1994	0.468976	0.437646
~~January to December~~Jan 1993 - Dec 1993	0.482433	0.451897
~~January to December~~Jan 1992 - Dec 1992	0.497508	0.467861
~~January to December~~Jan 1991 - Dec 1991	0.515437	0.486848
~~January to December~~Jan 1990 - Dec 1990	0.540263	0.513138
~~January to December~~Jan 1989 - Dec 1989	0.560900	0.534993
~~January to December~~Jan 1988 -	0.577789	0.552878

Dec 1988		
~~January to December~~Jan 1987 - Dec 1987	0.594807	0.570900
~~January to December~~Jan 1986 - Dec 1986	0.600007	0.576407
~~January to December~~Jan 1985 - Dec 1985	0.612034	0.589144
~~January to December~~Jan 1984 - Dec 1984	0.625153	0.603037
~~July~~Jul 1983 ~~to December~~- Dec 1983	0.637829	0.616461
~~July~~Jul 1982 ~~to June~~- Jun 1983	0.662783	0.642888
~~July~~Jul 1981 ~~to June~~- Jun 1982	0.696748	0.678856
~~July~~Jul 1980 ~~to June~~- Jun 1981	0.734687	0.719034
~~July~~Jul 1979 ~~to June~~- Jun 1980	0.758587	0.744344
~~July~~Jul 1978 ~~to June~~- Jun 1979	0.773321	0.759947
~~July~~Apr 1977 ~~to June~~- Jun 1978	0.785950	0.773321
~~July 1976 to June 1977~~	~~0.798825~~	
~~July 1975 to June 1976~~	~~0.813727~~	

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~~financial worksheets.

~~WORKSHEETS~~Worksheet Number	Form Name
~~NUMBER~~	~~NAME~~
~~Wkst 01~~	~~Medicaid Non-Financial (obsolete)~~
~~Wkst 02~~	~~Dependent Care (obsolete)~~
~~Wkst 03~~3	F-01298 Medicaid Deductible Worksheet
~~Wkst 04~~4	F-01297 Medicaid Institution Determination Worksheet
~~Wkst 05~~	~~Medicaid Extensions (obsolete)~~
~~Wkst 06~~6	F-01305 Supplemental Security Income-Related Determination ~~Worksheet~~
~~Wkst 07~~7	F-01306 Spousal Impoverishment Income Allocation Worksheet
~~Wkst 08~~8	F-01307 ~~Medicaid Purchase Plan (~~Medicaid Purchase Plan (MAPP) Eligibility Worksheet (as of 8/1/2020) ~~Medicaid Purchase Plan (MAPP) Eligibility prior to 8/1/2020~~Click here for old version (prior to 8/1/2020)
~~Wkst 09~~9	F-01316 ~~Medicaid Purchase Plan (MAPP) Premium Calculation as of 8/1/2020~~ ~~Medicaid Purchase Plan (MAPP) Premium Calculation prior to 8/1/2020~~Medicaid Purchase Plan (MAPP) Premium Calculation Worksheet (as of 8/1/2020) Click here for old version (prior to 8/1/2020)
~~Wkst 10~~10	F-01317 Medicaid Purchase Plan (MAPP) Impairment Related Work Expenses (IRWE) Worksheet
~~Wkst 11~~11	F-01318 Medicaid Purchase Plan (MAPP) Medicaid~~/~~ and Remedial Expenses (MRE) Worksheet
~~Wkst 12~~	~~Family Care Eligibility – Non-MA Financial Determination (obsolete)~~
~~Wkst 13~~	~~FFU Income (obsolete)~~
~~Wkst 14~~	~~AFDC-Related Determination Worksheet~~