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

To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 23-03**

Release Date: 08/14/2023

Effective Date: 08/14/2023

EFFECTIVE DATE		The following policy additions or changes are **effective 08/14/2023** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.1	**Application Introduction**	Clarified when the Notice of Assignment and Child Support Cooperation & Good Cause notice must be sent.
2.2	**Application Methods**	Added fax to the list.
2.5.1	**Valid Signature Introduction**	Clarified policy and when two signatures are needed when there is an RFA and application.
2.8.1	**Begin Dates Introduction**	Removed outdated information about inmates
3.1.6	**Late Renewals**	Updated text to align with BadgerCare Plus Handbook.
3.1.6.1	**Verification Requirements for Late Renewals**	Updated text to align with BadgerCare Plus Handbook.
3.1.6.2	**Gaps in Coverage**	Updated text to align with BadgerCare Plus Handbook.
7.3.3.1	**Qualifying Immigrants**	Added reference to new section.
7.3.3.6	**Cuban & Haitian Entrants**	New section.
8.1.3	**Referral to Child Support Agencies**	Removed case processing instructions.
8.3.2	**Notice**	Clarified when the Notice of Assignment and Child Support Cooperation & Good Cause notice must be sent.
8.3.3	**Good Cause Claim**	Clarified when the Notice of Assignment and Child Support Cooperation & Good Cause notice must be sent.
9.1.2	**Third Party Liability**	Updated text to align with BadgerCare Plus Handbook.
9.1.5	**Assignment Process**	New section.
15.7.1	**Maintaining Home or Apartment**	Clarified that the home maintenance allowance is only for Institutional Medicaid.
16.8.1.3	**Real Property**	Updated link.
19.1.4	**Access by Someone Else**	Clarified what a person or organization with a Release of Information can do on a case.
20.1.4	**General Rules**	Removed "recovered" to align with policy.
21.6.1.1	**Voluntary HMO Enrollment**	Removed reference to BadgerCare Plus.
32.1.1	**Medicare Savings Programs Introduction**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.

32.1.3	**Medicare Savings Program Benefits**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.
32.2.1	**Introduction**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.
32.2.2	**Entitled to Medicare**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.
32.3.1	**Introduction**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.
32.4.1	**Introduction**	Updated with new policy for Medicare Part B-ID benefit. Effective 1/1/2023.
39.4.4	**Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share**	Updated Spousal Impoverishment Allowances table with new Federal Poverty Level Adjustments.

Contents

2.1 Applications Introduction

Anyone has the right to apply for Medicaid. However, people younger than 18 years old must have a parent, caretaker relative, or legal guardian apply for Medicaid on their behalf unless they are living independently. In situations where a legal guardian, parent, or caretaker is absent, an adult acting responsibly may apply on behalf of a person who is younger than 18 years old.

The applicant may be assisted by any person they choose in completing an application.
Anyone who expresses interest in applying should be encouraged to file an application as soon as possible (see Section 2.2 Application Methods).

The income maintenance (IM) agency must provide the following documents at application or a new request for health care on an existing case:

- Notice of Assignment ~~()~~: Child Support, Family Support, Maintenance, and Medical Support (DCF-F-DWSP 2477) must be provided to all applicants.
- Child Support Cooperation & Good Cause ~~Notice~~notice (DCF-P-5600~~)~~)- must be provided to applicants with children applying for ~~Medicaid or~~ health care who have an absent parent. The IM agency must also provide this notice to the member in situations where a parent leaves the home resulting in a child on the case now having an absent parent.

Exception: The IM agency does not need to provide these documents to applicants who apply via ACCESS since this information is included in the ACCESS application.

The IM agency must also provide these documents to anyone who~~that~~ requests ~~either of these~~them.

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.

Example 1	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.~~application must be denied.

2.2 Application Methods

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

- ACCESS: access.wisconsin.gov
- Mail-in or fax using the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet (F-10101)
- Telephone interview
- Face-to-face interview
- Use of the paper or online application available through the Federally-Facilitated Marketplace (FFM)
- Telephone application with the ~~Marketplace~~FFM

2.5 Valid Signature

2.5.1 Valid Signature Introduction

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

- The paper application form
- The signature page of the Application Summary (by telephone, electronically, or 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~~Federally Facilitated Marketplace (FFM)

Note	When an applicant calls to complete a Request for Assistance (RFA) but does not complete a full application on the same day, a telephonic signature must be collected for the RFA. Another telephonic signature will be required when the full application is completed. However, if the RFA and full application are completed on the same day, a telephonic signature only has to be collected once, and it is valid for both the RFA and the application.

2.8 Begin Dates

2.8.1 Begin Dates Introduction

Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. ~~Those~~For these exceptions, begin dates are the date a valid application is submitted, all program requirements are met, and:

1. Deductible – The date the deductible was met.
~~1. Inmates – The date the member is no longer an inmate of a Public Institution.~~
2. Person Adds – The date the person moved into the household.
3. Recent Moves – The date the member moved to Wisconsin.
   Exception: The begin date for an SSI recipient who moves to Wisconsin is the 1st of the month of the move.
~~2.~~ Home and Community-Based Waivers – The program start date provided by the ~~care manager.~~
4. ~~Family~~Managed Care ~~and PACE~~Organization (MCO), IRIS Consultant Agency (ICA), or ~~Partnership – The date the individual is enrolled in the MCO.~~County Waiver Agency (CWA).
5. Institutionalized – ~~His or her~~The date the person entered ~~entry into~~ the nursing home or hospital.
6. QMB – The first of the month following the eligibility confirmation.
7. SeniorCare – The first of the month following the month in which all program requirements have been met.

3.1 Renewals

3.1.6 Late Renewals

~~Late~~Most health care renewals ~~are only permitted for members whose eligibility ended because~~received within three months of ~~lack of~~the renewal ~~and not for any other reasons~~ month can be processed as a late renewal instead of requiring a new application. This policy applies for the following ~~EBD~~ health care programs:

- BadgerCare Plus
- FPOS
- ~~EBD~~ SSI-Related Medicaid
- HCBW~~s~~
- Institutional Medicaid
- MAPP
- Medicare Savings Programs~~SP~~ (QMB, ~~/~~SLMB, ~~/~~SLMB+, ~~/~~QDWI)~~.~~

This policy applies to members receiving health care benefits based on a met deductible but not to members with an unmet deductible.

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons. Late renewals and renewal-related ~~renewal~~ verifications ~~should~~must be accepted for up to three calendar months after the renewal ~~date~~month. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

~~Consider~~Agencies must consider late submissions of an online or paper renewal form or a late renewal request by phone or in person ~~as~~ to be a valid request for health care. The new health care certification date should be set based on receipt date of the signed renewal. If verification is required to complete the renewal, the member ~~will have~~ has 20 days to provide it.

Example 1	Jenny's renewal is due on January 31. She submits an online renewal via ACCESS on March 10. If the renewal is processed on the same day and verification is requested, the verification would be due on March 30. If she provides verification on or before this due date and meets all other eligibility criteria for Medicaid, her eligibility and certification period would start on March 1. Her next renewal would be due February 28 of the following year.

Note	The late renewal three-month period starts after the month the renewal was due. It does not restart when a late renewal has been submitted. If Jenny submits her renewal on March 15 but does not provide verification until May 20, she will need to reapply since she submitted her verification after the three-month period that started with her January renewal date and ended April 30.

3.1.6.1 Verification Requirements for Late Renewals

If the health care renewal was completed timely but the requested verifications were not provided as part of the renewal, the health care program can ~~be reopened~~ reopen without a new application if these verifications are submitted within three months of the renewal month. ~~The~~The submission of the renewal-related verifications is considered a request for health care. Only the missing verifications must be provided. However, the verifications must include information for ~~the current~~any month(s) of the eligibility~~. If~~ determination. For example, if verification was submitted for a past month, the agency

must request current verification~~. The~~, allowing the member ~~will have~~ 20 days to ~~provide it~~submit the verification.

~~If a gap in coverage occurs because of a late renewal, the member may request coverage of the past month in which the gap occurred. The member must provide all necessary information and verification for those months and must pay any required premiums to be covered for those months. For EBD Medicaid renewals, the member must provide the missing verification and verify assets for the current month if there was a gap in coverage.~~

~~Note:~~Example 2	~~QMB coverage is not retroactive. Members cannot request backdated eligibility for this program.~~Jenny's renewal is due on January 31. She completes her renewal on January 5, and a Verification Checklist is generated requesting income verification for the previous 30 days. Jenny does not submit the requested verification, and her Medicaid eligibility is terminated as of January 31. On April 27, she submits paystubs for April 10 and April 24. If she meets the eligibility criteria for Medicaid, her certification period will start on April 1, and her next renewal will be due March 31 of the following year. If she had submitted the verification of her income for January, a new Verification Checklist should be generated asking for verification of her current income for April. If she is requesting a backdate, verification must be requested for all backdated months.

3.1.6.2 Gaps in Coverage

If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. Backdated coverage under the late renewal policy is available to all health care members who meet program rules (see Section 2.8.2 Backdated Eligibility).

If a member requests coverage for past months during a late renewal, they must provide all necessary information and verification for those months (including verification of income and assets for all months requested) and must pay any required premiums to be covered for those months.

Note:	QMB coverage is not retroactive. Members cannot receive backdated eligibility for this program.

7.3 Immigrants

7.3.3 Immigrants Eligible for Medicaid

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants.

1. A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. An immigrant admitted under this refugee status may be eligible for Medicaid even if ~~his or her~~their immigration status later changes.
2. An asylee admitted under INA Section 208. Similar to a refugee, ~~this~~ an asylee is a person who seeks asylum and is already present in the U.S. when they request permission to stay. An immigrant admitted under this asylee status may be eligible for Medicaid even if ~~his or her~~their immigration status later changes.
3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997. An immigrant admitted under this status may be eligible for Medicaid even if ~~his or her~~their immigration status later changes.
4. A Cuban/Haitian entrant. An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if ~~his or her~~their immigration status later changes. Haitians paroled into the U.S. through the Haitian Family Reunification Parole Program are considered Cuban-Haitian entrants (see Section 7.3.3.6 Cuban & Haitian Entrants~~.~~).
5. An American Indian born in Canada who is at least 50 ~~percent~~% American Indian by blood or an American Indian born outside the U.S. who is a member of a federally recognized Indian tribe.
6. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386) (see Section 7.3.11 Victims of Trafficking~~.~~).
7. ~~Lawfully~~An immigrant lawfully admitted for permanent residence under the INA 8 USC 1101 et seq.*
8. ~~Paroled~~An immigrant paroled into the U.S. under INA Section 212(d)(5).*
9. ~~Granted~~An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)]*
10. An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
11. An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
12. An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
13. Citizens of the Compacts of Free Association (COFA~~. (See~~) countries (see Section 7.1.3 Compacts of Free Association).

*If these immigrants lawfully entered the U.S. on or after August 22, 1996, they must also meet one of the following criteria:

- Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces (see Section 7.3.10 Military Service)

- Be lawfully residing in Wisconsin and the spouse , unmarried dependent child, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces
- Be a certain Amerasian immigrant defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, with Class of Admission codes: AM1, AM2, AM3, AM6, AM7 or AM8.
- Have resided in the U.S. for at least five years since his or her date of entry (see Section 7.3.6 Continuous Presence).

7.3.3.6 Cuban & Haitian Entrants

The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Cuban-Haitian entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA). CHE are qualified immigrants with no waiting period.

The following individuals meet the definition of Cuban-Haitian Entrant:

- An individual granted parole as a Cuban-Haitian Entrant (Status Pending) or any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or
- A national of Cuba or Haiti who is not subject to a final, non-appealable and legally enforceable removal order, and:
    - Was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act; or
    - Is in removal proceedings under the Immigration and Nationality Act; or
    - Has an application for asylum pending with USCIS.

8.1 Medical Support

8.1.3 Referral to Child Support Agencies

The income maintenance (IM) agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services. ~~At confirmation, CARES automatically sends a referral to the CSA for all Medicaid~~

For health care applications, new health care requests on existing cases, and person ~~adds~~add requests that include ~~minors, unless~~minor children who have an absent parent, a referral is systematically sent to the CSA at the ~~referral field on~~ time health care eligibility is confirmed, with the ~~Absent Parent Page is answered "No." The information on the Absent Parent page must be filled out accurately to the best~~exception of the ~~worker's ability, given that detailed~~situations listed in Section 8.2.2 Exemptions from Cooperation. Detailed questions about absent parents (such as, name, Social Security number, date of birth, or contact information) cannot be asked during the application process for health care-only applications. The referral will still be sent to the CSA, even if the absent parent's name is unknown (see Process Help, Section 65.1 Enter Absent Parent Information~~.~~).

Note:	A Referral to Child Support form (DCF-F-DWSP 3080) only needs to be completed when the Absent Parent page cannot be completed in CWW.

BadgerCare Plus Note: While IM agencies are to continue referring the following individuals who are receiving BadgerCare Plus, the CSA's will be determining on their own which cases will be provided Child Support Services. Not all BadgerCare Plus members will qualify for free Child Support services and be required to cooperate with CSA's.

The following individuals (including minors) for whom Medicaid is requested or being received, must be referred to the local CSA unless an exception is noted:

1. A pregnant member who is unmarried or married and not living with their husband. However, pregnant members are not required to cooperate with the CSA during the pregnancy and for an additional 60 days after the last day of the pregnancy and through the end of the month in which the 60th day occurs. The member's eligibility for Medicaid will continue during this period, regardless of the member's cooperation.
2. A child receiving SSI only if the parent or caretaker relative requests child support services for the child. Do not sanction this parent or caretaker relative if they do not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when both parents are in the same home.
   Exception: Do not refer parents to the CSA when both parents are in the home and the father is on the child's birth certificate or the father's paternity has been legally established in another state by a court order or by a Voluntary Paternity Acknowledgement Form filed with a state agency.
4. Biological or adoptive parent(s) not living in the household.
   Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because they are in the military.
5. Married biological parents in the home, but:
   a. Child was born prior to their marriage, and

b. Paternity was not established by court action, or the birth was not legitimized after their marriage.

Do not refer people residing in domestic abuse shelters to the CSA. Once a person moves out of a domestic abuse shelter, complete the Absent Parent page in CWW so that the referral is sent to the CSA.

8.3 Claiming Good Cause

8.3.2 Notice

~~An applicant or member must receive a Good Cause Notice~~At application or a new request for health care on an existing case, the income maintenance (IM) agency must provide a Child Support Cooperation & Good Cause notice (DCF-P-5600) whenever a child with an absent parent is part of the ~~Medicaid~~ health care application or case. The Child Support Cooperation & Good Cause notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support from the absent parent.

Exception: The agency does not need to provide this notice to applicants who apply via ACCESS since this information is included in the ACCESS application.

The agency must also provide this notice to the member in situations where a parent leaves the home, resulting in a child on the case now having an absent parent.

Applicants and members are not required to sign the Child Support Cooperation & Good Cause ~~Notice~~notice in order to be eligible for ~~Medicaid~~health care programs.

8.3.3 Good Cause Claim

The Good Cause Claim form (DCF-F-DWSP2019) must be provided to any ~~Medicaid parent~~health care applicant or ~~caretaker~~ member who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the Good Cause Claim form in order to initiate the claim. The income maintenance (IM) agency must send a copy of the submitted Good Cause Claim form to the parent or caretaker upon request.

The ~~original copy is filed in the case record, a copy is given to the parent or caretaker and a copy is attached to the referral document when a good cause claim is made at application.~~
~~A copy of good cause claims~~ child support agency (CSA) must be ~~sent to the Child Support Agency (CSA)~~ informed within two business days ~~of signing~~ that a good cause claim has been filled. When the CSA is informed of a good cause claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of the final determination.

9.1 Third Party Liability

9.1.2 Third Party Liability Cooperation

All Medicaid members must assign to the ~~state~~State of Wisconsin their rights to payments for medical services from third-~~-~~party payers. A member complies with this requirement by signing the application form. The assignment includes all unpaid medical support and all ongoing medical support obligations for as long as Medicaid is received. In addition, Medicaid members must cooperate in identifying and providing information to assist the ~~state~~State in pursuing third parties who may be liable to pay for care and services, unless the individual establishes good cause for not cooperating. If a member fails to cooperate with TPL requirements, ~~he or she~~they could be sanctioned.

9.1.5 Assignment Process

At application or a new request for health care on an existing case, the IM agency must give a Notice of Assignment: Child Support, Family Support, Maintenance, and Medical Support (DCF-F-DWSP2477, available in English and Spanish) to each applicant. Applicants and members are not required to sign this form in order to be eligible for health care programs.

Exception: The agency does not need to provide the Notice of Assignment to health care applicants who apply via ACCESS since this information is included in the ACCESS application

15.7 Income Deductions

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution (see Section 27.1.1 Institutions Introduction) has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from their income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the 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' 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~~the person 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.

Note	The home maintenance allowance may only be given for Institutional Medicaid. It does not apply to HCBW Medicaid.

16.8 Real Property

16.8.1 Home/Homestead Property

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (see Section 17.2.7.233~~.1~~ Homestead Property).

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

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

1. His or her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.
2. The institutionalized person expresses his or her intent to return to the home. If he or she is able to form an intent but unable to express it, determine his or her intent through other available evidence. Other evidence includes:
    a. His or her written statements.
    b. His or her oral statements made before incapacitation. Accept reports of these statements made by family members.
    c. Accept reports of his or her intent made by an authorized representative. If there is no evidence he or she disagrees with the statement, accept the authorized representative's statement.

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

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

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

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

19.1 Applicant and Member Access Rights

19.1.4 Access by Someone Else

An applicant or member may authorize ~~someone else~~the income maintenance (IM) agency to ~~act on their behalf in gaining~~grant access to their case record to another person or organization. This authorized entity has the same right of access to the case record as that of the applicant or member or to the extent that the applicant or member indicates on the release of information form, if applicable.

This authorized entity can be an attorney but does not need to be an attorney. ~~The applicant or member must complete a release of information form, such as , if the entity is not an attorney.~~ The applicant or member does not need to complete a release of information form to authorize their attorney to access their case record. The agency can request proof of the ~~attorney's~~attorney's licensure if the ~~person's~~person's statement that they are an attorney is questionable. If the entity is not an attorney, the applicant or member must complete a release of information form, such as F-02340.

Note	A person or entity who is already known on the Medicaid case as a legal guardian, conservator, power of attorney, or authorized representative can access the case record. They do not need additional authorization to access the case record (see Section 22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives).

20.1 Verification

20.1.4 General Rules

1. Over-verification, including requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility, is prohibited. Once the accuracy of a written or verbal statement has been established, additional verification can't be required. For example, once U.S. citizenship is verified, a member or applicant never has to verify it again (see Section 7.2 Verifying U.S. Citizenship ~~Documenting Citizenship and Identity~~).
2. If information has already been verified, the applicant or member does not need to verify it again except in the following situations:
    a. There is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made (see Section 20.6 Front End Verification).
    b. The member reported a change to information that is subject to mandatory verification rules or is questionable.
    c. At renewal, information is subject to mandatory verification rules or is questionable.
3. One particular type of verification can't be exclusively required when various types are adequate and available.
4. Verification need not be presented in person. Verification may be submitted by mail, fax, email, or another electronic device, or through an authorized representative.
5. Special groups or persons can't be targeted based on race, color, national origin, age, disability, sex, religion, or migrant status for special verification requirements.
6. The applicant or member can't be required to sign a release form (either blanket or specialized) when the member provides required verification.
7. Verification of information that is not used to determine eligibility can't be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.

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

IM agencies must assist the applicant or member in obtaining verification if they request help or have difficulty in obtaining it.

The best information available should be used to process the application or change within the time limit when both of the following conditions exist:

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

Applicants meeting the health care program eligibility criteria based on this best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in their attempts to obtain verification. When the verification is received, benefits may need to be adjusted ~~or recovered~~ based on the new information. The agency must explain this to the applicant or member when requesting verification.

21.6 HMO Enrollment

21.6.1 SSI HMO Enrollment

21.6.1.1 Voluntary HMO Enrollment

Voluntary HMO enrollment means a member~~n 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.

32.1 Medicare Beneficiaries Introduction

32.1.1 Medicare Savings Programs Introduction

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

Medicare is divided into four main types of health coverage:

- Hospitalization insurance (Part A), which pays hospital bills and certain skilled nursing facility, home health care, and hospice expenses
- Medical insurance (Part B), which pays doctor bills and certain other charges
- Medicare Advantage (Part C), which allows private health insurance companies to provide Medicare benefits
- Drug insurance (Part D), which pays for prescription drug charges

Medicare beneficiaries who are eligible for Medicare only due to end stage renal disease (ESRD) lose Medicare coverage 36 months after a kidney transplant. Beneficiaries who meet certain criteria, including not having any other health insurance coverage that covers immunosuppressive drugs, are able to qualify for continuous Medicare-covered immunosuppressive drugs through the Medicare Part B Immunosuppressive Drug (Part B-ID) benefit. The Part B-ID benefit covers only immunosuppressive drugs and no other items or services.

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

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

- QMB
- SLMB
- SLMB+
- QDWI

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

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

When determining eligibility for MSP, the same rules for determining financial eligibility for Medicaid are used with the exception of using the MSP asset limits in Section 32.6 Medicare Savings Programs Asset Limits and the MSP income limits in Section 39.5 Federal Poverty Level Table. Nonfinancial eligibility is available as follows:

- For QMB (see Section 32.2 Qualified Medicare Beneficiary)
- For SLMB (see Section 32.3 Specified Low-Income Medicare Beneficiary)
- For SLMB+ (see Section 32.4 Specified Low-Income Medicare Beneficiary Plus)

- For QDWI (see Section 32.5 Qualified Disabled and Working Individual)

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

32.1.3 Medicare Savings Programs Benefits

- QMB: Medicaid pays Medicare Part A, B, and B-ID premiums and Medicare deductibles, copayments, and coinsurance.
- SLMB: Medicaid pays Medicare Part B and B-ID premiums.
- SLMB+: Medicaid pays Medicare Part B and B-ID premiums.
- QDWI: Medicaid pays Medicare Part A premiums.

32.2 QMB

32.2.1 Introduction

To be eligible for ~~QMB~~Qualified Medicare Beneficiary (QMB) benefits, the person must:

1. Meet non-financial Medicaid requirements
2. Be entitled to Medicare Part A or Part B-ID (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 Special Status Medicaid as a 503 ~~assistance group DAC~~or Disabled Adult Child (DAC)

Example 1~~:~~	Kate receives ~~SSDI~~Social Security Disabled ~~Adult~~ Child ~~(~~DAC~~)~~ benefits from Social Security. Due to other unearned income, Kate is not eligible for Special Status Medicaid as a DAC. Therefore, she is not categorically eligible for QMB even though she receives a DAC payment.

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A or Part B-ID if they meet one of the following conditions:

1. They do not have to pay a premium for Medicare Part A and are enrolled in Medicare Part A as of the QMB determination.

Example 1~~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. They must pay a monthly premium to receive Medicare Part A and meet one of the following conditions:
   a. They are a Medicaid member and have been enrolled in Medicare sometime in the past. In this case, the state will attempt to enroll them in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 2~~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.

   b. They are a Medicaid member or a QMB or Specified Low-Income Medicare Beneficiary (SLMB) applicant and have never been enrolled in Medicare Part A. In this case, they must apply at the local Social Security Administration (SSA) office for Part A Medicare eligibility. ~~They~~The SSA office will ~~receive a receipt which entitles them~~add comments to ~~enroll in Part A on~~ the ~~condition~~"Remarks" section of the application and provide a screen shot that ~~they are~~can serve as proof of conditional Part A enrollment provided the applicant is found eligible for QMB or SLMB. ~~The receipt from~~ SSA will ~~have a~~ provide the Part A begin date ~~on it~~. QMB or SLMB eligibility cannot begin prior to the Part A begin date. The earliest QMB can begin is the month after the month of application.

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

3. They are enrolled in Medicare Part B Immunosuppressive Drug (Part B-ID).

32.3 SLMB

32.3.1 Introduction

To be eligible for Specified Low-Income Medicare Beneficiary (SLMB) benefits, the person must:

1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A~~.~~ or Part B Immunosuppressive Drug (Part B-ID).

32.4 SLMB+

32.4.1 Introduction

To be eligible for Specified Low-Income Medicare Beneficiary Plus (SLMB~~+,~~+) benefits, the person must:

1. Meet nonfinancial Medicaid requirements.
2. Be receiving Medicare Part A~~.~~ or Part B Immunosuppressive Drug (Part B-ID).
3. Not be enrolled in full-benefit Medicaid (such as SSI Medicaid, Community Waivers, and BadgerCare Plus), Family Planning Only Services, or Tuberculosis Only Related Services. A person with an unmet deductible should be considered ineligible for Medicaid until ~~he or she meets~~ they meet the deductible

39.4 Elderly, Blind, or Disabled Assets and Income Tables

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

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	$3,~~051~~286.66	7/1/~~2022~~2023	Yes
Shelter Base Amount	$~~915.50~~986.00	7/1/~~2022~~2023	Yes
Community Spouse Income Allocation Maximum	$3,715.50	1/1/2023	Yes
Dependent Family Member Income Allowance Maximum	$~~762.92~~821.67	7/1/~~2022~~2023	Yes
Dependent Family Member Income Allowance Standard	$2,~~288.75~~465	7/1/~~2022~~2023	Yes
Community Spouse Asset Share (CSAS) Maximum	$148,620	1/1/2023	Yes