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 23-04**

Release Date: 12/18/2023

Effective Date: 12/18/2023

EFFECTIVE DATE		The following policy additions or changes are **effective 12/18/2023** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.2	**Continuous Coverage for Qualifying Children**	New section. Effective 01/01/2024.
2.5.1.1	**Signatures From Representatives**	Clarified the types of legal guardians and POA who can act on behalf of the applicant.
3.1.5.1	**Administrative Renewals Introduction**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023.
3.1.5.2	**Administrative Renewal Selection Criteria**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023.
3.1.5.3	**Administrative Renewal Process**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023
3.1.5.3.1	**Successful Administrative Renewals**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023.
3.1.5.3.2	**Unsuccessful Administrative Renewals**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023.
3.1.5.3.3	**Change Reporting After Administrative Renewal**	Added policy about administrative renewals being conducted at an individual level instead of case level. Effective 06/30/2023. Removed obsolete information on overpayments.
5.9.2	**Presumptive Disability Determined by the IM Agency**	Added a note about an “urgent need” situation in which workers must certify presumptive disability even if the applicant does not have one of the listed impairments.
5.9.2.1	**Definition of Urgent Need**	Updated definition of "urgent need" and changed list numbering style to match presumptive disability form.
5.9.2.2	**Impairments**	Changed list numbering style to match presumptive disability form.
11.1	**Premium or Cost Share**	Update related to continuous coverage for children. Effective 01/01/2024.
13.4	**Suspension End Date**	Clarified that people can report an upcoming release date and don’t have to wait until after they are released from jail or prison.
13.8.1	**Children Whose Parent/Caretaker is an Inmate**	Updated the grace period information due to continuous coverage for children. Effective 01/01/2024.
15.3.35	**Temporary COLA**	Changed section title and clarified that the COLA disregard also

	Disregard for Social Security Recipients	applies to MAPP premiums.
15.4.2	**Sick Benefits**	Update regarding cash from an insurance policy that pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred.
17.2.3.2	**Transfers of Exempt Income or Assets**	Removed COVID stimulus payments as an example of "temporarily" exempt assets per section 16.7.33.
18.4.6.1	**Asset Transfer Period**	Updates related to automation of asset transfer notice in October 2022.
18.8	**Spousal Impoverishment Notices**	Updates related to automation of income allocation and asset transfer notices in October 2022.
20.8.3	**Negative Actions**	Updates related to continuous coverage for children. Effective 01/01/2024.
22.1.4.1	**Notice of Intent to File a Lien**	Updates to reflect that the notice of intent to file a lien is available as a manual notice in CWW as of June 2022.
22.1.7	**Notify Members**	Minor editorial changes and updates to reflect that it is the applicant's responsibility to read the notice of liability on the application.
22.1.8	**Disclosure Form**	Removed and updated numbering of subsequent sections.
22.1.8	**Estate Recovery Program Contacts**	Updated contact information.
22.1.11	**Other Programs**	Added a note that benefits paid under the Community Options Program may be recoverable even though the program no longer exists.
22.5.1	**Authorized Representatives**	Clarified the types of legal guardians who can act on behalf of the applicant or member.
22.5.4	**Legal Guardians and Conservators**	Clarified the types of legal guardians who can act on behalf of the applicant or member.
22.5.5	**Power of Attorney**	Clarified the types of POA who can act on behalf of the applicant or member.
26.3.2	**Disability**	Updates related to continuous coverage for children. Effective 01/01/2024.
26.3.3.3	**Employment Ending**	Updates related to continuous coverage for children. Effective 01/01/2024.
26.3.5.3	**Health and Employment Counseling Participation Changes**	Updates related to continuous coverage for children. Effective 01/01/2024.
26.5.1	**Calculation**	Updates to clarify that, at renewal, the IM agency only needs to check if total deposits into an Independence Account over the previous certification period exceeded 50% of the member's total gross earnings over the same period.
26.5.1.1	**Independence Account Penalty**	Updates related to continuous coverage for children. Effective 01/01/2024.
26.5.2	**Initial Premium**	Clarification that a MAPP member may owe a premium for some but not all initial months, and if the initial premium is not paid, they can only be certified for months when there was no premium.
27.1.2.3	**Children and Young Adults in IMD**	Updates related to continuous coverage for children. Effective 01/01/2024.
27.1.4	**Minors in a Medical Institution**	Updates related to continuous coverage for children. Effective 01/01/2024.
28.1	**Adult Home and Community-Based Waivers Long-Term Care Introduction**	Updates related to continuous coverage for children. Effective 01/01/2024.
34.1.2	**Determination of**	Updates related to continuous coverage for children. Effective

	Emergency Services Eligibility	01/01/2024.
34.1.3	**Certification of Emergency Services Eligibility**	Updates related to continuous coverage for children. Effective 01/01/2024.
36.2.2.1	**Temporary Enrollment (TE) / Presumptive Eligibility (PE) Available Only to Women Enrolling through WWWP**	Clarified existing rule that temporary enrollment is only available once in 12-month period.
36.2.4.1	**Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services**	Updated outdated age restriction for FPOS.
36.5.1	**Member Loses Eligibility**	Updates related to continuous coverage for children. Effective 01/01/2024.
36.6	**WWWMA Renewals**	Updated outdated age restriction for FPOS.
37.1.2	**Eligibility Requirements**	Updates related to continuous coverage for children. Effective 01/01/2024.
39.11.1	**SeniorCare Income Limits Introduction**	Corrected Level 3 income threshold for a couple. Effective 02/01/2023.

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1.2 Continuous Coverage for Qualifying Children

On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law. This legislation requires that children in certain Medicaid programs and the Children's Health Insurance Program (CHIP) are provided with 12 months of continuous health care coverage, with some limited exceptions, effective January 1, 2024. Continuous coverage means that the child will not lose coverage during that time, even if the family's situation changes.

1.2.1 Continuous Coverage Period

Effective January 1, 2024, most children under age 19 enrolled in BadgerCare Plus and Medicaid programs will have 12 months of continuous coverage, starting with the date of their health care application, new certification period at renewal, or when the child otherwise becomes eligible under a qualifying group. This also applies when a new child under 19 is added to a case that already has a child with 12 months of continuous coverage.

Example 1	James applies for health care for his 13-year-old son Henry on January 17, 2024, with a three month backdate, and Henry is determined eligible as of October 1, 2023. Henry will have continuous coverage from January 1 through December 31, 2024. Even if the household has a change in circumstances during the certification period, Henry will remain eligible through December 31, 2024.

Note	Backdated months do not count toward the 12-month continuous coverage period. To qualify for a 12-month continuous coverage period, a child must be eligible for the application month and/or a following month. If a child is only eligible in a backdated month, they do not qualify for a 12-month continuous coverage period.

Children who are already members of an applicable health care program on January 1, 2024, will have a continuous coverage period that extends to their next renewal date.

Example 2	Jill is 10 years old. She was enrolled in Medicaid in May 2023. She is still enrolled as of January 1, 2024, so she will have continuous coverage from January 1, 2024, to her renewal date of April 30, 2024. Even if the household reports a change and she goes above the program income limit, she will remain eligible through April 30, 2024.

At renewal, a child must meet the program's eligibility requirements in order to get a new 12-month period of continuous coverage.

Example 3	Gino is 16 and has been enrolled in Medicaid since May 2020. Gino's renewal is due in March 2024. Because Gino is enrolled as of January 1, 2024, he also has continuous coverage until his renewal in March 2024. At renewal, Gino no longer meets program rules, so his health care benefits end March 31, 2024. He does not qualify for a new 12-month continuous coverage period.

1.2.2 Populations

Children under age 19 in the following programs are eligible for 12 months of continuous coverage:

- BadgerCare Plus
- Supplemental Security Income (SSI) Medicaid
- SSI-Related Medicaid

- Special Status Medicaid
- Institutional Medicaid
- Home and Community Based Waiver (HCBW) Medicaid
- Family Planning Only Services (FPOS)
- Medicaid Purchase Plan (MAPP)
- Foster Care Medicaid
- Wisconsin Well Woman Medicaid
- Emergency Services Medicaid
- Tuberculosis-Related Medicaid
- Katie Beckett Medicaid
- Medicare Savings Programs

Continuous coverage does not apply to children:
- Enrolled under presumptive eligibility.
- Required to meet a deductible in order to enroll in BadgerCare Plus or Medicaid.

1.2.3 Termination of Coverage
Qualifying children under 19 will only lose health care coverage during their 12-month period for the following reasons:
- The child turns 19.
- The child is no longer a resident of Wisconsin.
- The child passes away.
- The child's citizenship or immigration status is not verified within the reasonable opportunity period.
- The child was eligible as a pregnant minor, turns 19, and their postpartum period ends.
- There is a voluntary request for disenrollment from BadgerCare Plus or Medicaid.

Example 4	Carlos is 17 and enrolls in Medicaid on February 1, 2024. On May 12, the household reports moving to Florida. Carlos' Medicaid ends May 31, 2024.

Example 5	Carolina applies for Medicaid for her son Javier. Javier is eligible, but verification of his citizenship is still needed. Javier is enrolled in Medicaid as of February 1, 2024, and is given a reasonable opportunity period to verify his citizenship. Javier's citizenship is not verified by the due date of May 10, 2024, so his Medicaid ends May 31, 2024.

1.2.4 Incarceration
If a child becomes incarcerated and their eligibility is suspended, their continuous coverage will run in the background. If they are released from incarceration within the 12-month period, they will qualify for continuous coverage for the rest of the 12-month period.

If a child's only parent or caretaker becomes incarcerated, the child will keep their health care for the rest of the 12-month period. If the child becomes eligible on another case or if they are enrolled in Foster Care Medicaid, they will get a new 12-month period of continuous coverage (see BadgerCare Plus Handbook, SECTION 1.2.8 FOSTER CARE MEDICAID).

1.2.5 Emergency Services
An immigrant child enrolled in Emergency Services qualifies for a 12-month period of continuous coverage. Their enrollment is not limited to the period their provider indicates they require treatment of an emergency medical condition.

1.2.6 Institutionalized Children

If a child enrolled in Institutional Medicaid is discharged from a medical institution or institution for mental diseases (IMD), and they are not eligible for another category of health care, they will keep their Institutional Medicaid for the rest of the 12-month period.

1.2.7 HCBW Medicaid

If a child enrolled in HCBW Medicaid is disenrolled from their waiver services or managed care organization (for example, due to loss of functional eligibility or non-payment of cost share), and they are not eligible for another category of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of the 12-month continuous coverage period.

Example 6	Chen is enrolled in CLTS as of January 1, 2024. His renewal date is September 30, 2024. In April 2024, the county waiver agency reports that Chen is no longer functionally eligible for CLTS. Chen does not qualify for BadgerCare Plus or Medicaid, so he remains enrolled in HCBW Medicaid through September 30, 2024.

Note	If someone voluntarily disenrolls from HCBW services, it will be treated as a voluntary disenrollment from HCBW Medicaid and continuous coverage under HCBW Medicaid will end.

1.2.8 SSI Medicaid

If a child getting SSI Medicaid loses their SSI cash benefits or 1619(b) eligibility, they will keep their SSI Medicaid for the rest of the 12-month continuous coverage period. Their 12-month period is based on the month their most recent enrollment in SSI Medicaid began, since SSI Medicaid does not have applications or renewals.

Example 7	Jill is enrolled in SSI Medicaid as of February 1, 2024. Her 12-month continuous coverage period is February 1, 2024, to January 31, 2025. Jill no longer qualifies for SSI cash benefits in September 2024. She will keep her SSI Medicaid through January 31, 2025.

Example 8	Abdul has been enrolled in SSI Medicaid since May 1, 2021. In July 2024, Abdul loses his SSI cash benefits. He will keep his SSI Medicaid through April 30, 2025.

Example 9	Leo was enrolled in SSI Medicaid since January 1, 2021. In August 2024, Leo loses his SSI cash benefits. He will keep his SSI Medicaid through December 31, 2024. In May 2025, Leo starts getting SSI cash benefits again and he is re-enrolled in SSI Medicaid. He gets a new 12-month continuous coverage period from May 1, 2025, to April 30, 2026.

1.2.9 WWWMA

If a child enrolled in WWWMA no longer requires treatment or gets health insurance that covers their treatment, they will keep their WWWMA for the rest of the 12-month continuous coverage period.

1.2.10 Transitions Between CHIP and Medicaid

During the 12-month continuous coverage period, a child may not move from a Medicaid-funded category of health care to a CHIP-funded category of BadgerCare Plus (see BadgerCare Plus Handbook SECTION 51.1 BADGERCARE PLUS CATEGORIES). However, a child may move from a CHIP-funded category of BadgerCare Plus to a full-benefit Medicaid program. One exception to this is that a child may not move from a CHIP-funded category of BadgerCare Plus into an earned income or spousal support extension.

2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures From Representatives

The following people can sign the application with their own name on behalf of the applicant:

1. **Guardian**
   When an application is submitted with a signature of someone claiming to be the applicant's guardian, the IM agency must obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on their behalf.

   When someone has been designated as one of the following, only the guardian, not the applicant, may sign the application or appoint an authorized representative:
   - Guardian of the estate
   - Guardian of the person and the estate
   - ~~Guardian in general~~
   - Guardian of the person and the court document appointing the legal guardian of the person specifically grants the guardian the authority to enroll their ward in BadgerCare Plus, Medicaid, and public assistance programs.

   If the applicant only has a ~~legal~~ ~~**guardian of the person**~~**guardian of the person**, and the applicant's guardian does not have the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs, the guardian can sign the application since they are acting responsibly for an incompetent or incapacitated person. ~~However, a legal~~A guardian of the person who does not have the authority to enroll the person in Medicaid or public assistance programs 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.

   The conservator is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has a conservator, the applicant can still sign the application on their own behalf.
3. **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). 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.

The authorized representative is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has an authorized representative, the applicant can still sign the application on their own behalf.

4. **Durable Power of Attorney for Finances (Wis. Stat. ch. 244)**
   A durable power of attorney for finances 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. Only ~~a~~an activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for the purpose of providing a valid signature on the application. A power of attorney for health care is not considered the power of attorney for the purpose of providing a valid signature on the application.

   When a submitted application is signed by someone claiming to be the applicant's activated durable power of attorney for finances, 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 of attorney for finances.
   - Review the document for a reference that indicates the durable power of attorney for finances authority continues notwithstanding any subsequent disability or incapacity of the applicant.

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

   The Durable Power of Attorney for Finances form will specify what authority is granted. The appointment of a durable power of attorney for finances does not prevent an individual from filing their own application, nor does it prevent the individual from granting authority to someone else to apply for public assistance on their behalf.
5. **Someone acting responsibly for an incompetent or incapacitated person**

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

6. **A superintendent of a state mental health institute or center for the developmentally disabled**
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.
8. **The superintendent of a county psychiatric institution**
   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.

3.1 Renewals

3.1.5 Administrative Renewals

3.1.5.1 Administrative Renewals Introduction

Based on federal requirements, health care eligibility must be redetermined once every 12 months based on information available to an agency. Agencies cannot require information from health care members during an annual renewal unless the information cannot be obtained through an electronic data exchange or the information from the electronic data exchange is not reasonably compatible with the information on file. The process of using electronic data exchanges for renewals is referred to as an administrative renewal.

If information from electronic data exchanges validated information about the member's income as currently recorded in~~-~~ CARES, additional information about income cannot be requested from the member at renewal. This includes member-reported information about earned income ~~information~~ that is found to be reasonably compatible with ~~member-reported information,~~ earned income information obtained from the State Wage Information Collection Agency (SWICA) and Federal Data Services Hub (FDSH) data exchanges, as well as any information about unearned income verified through~~-~~ the Social Security Administration (SSA) or~~-~~ Unemployment Insurance Benefits (UIB) data exchanges. Unless reported otherwise, it is assumed during the administrative renewal process that household composition has not changed.

3.1.5.2 Administrative Renewal Selection Criteria ~~and Exclusions~~

To be considered for an administrative renewal, a ~~case~~member must be due for renewal in the following month and have eligibility in one or more qualifying BadgerCare Plus, Family Planning Only Services (FPOS~~,~~), or~~-~~ Elderly, Blind, or Disabled (EBD) Medicaid assistance groups (AGs) open, including ~~health care assistance groups~~ members open with a suspended status.

A member's health care eligibility can be administratively renewed if all of the information necessary to determine the member's eligibility is on file and their income and assets can be verified through a data exchange (for example, income with a SWICE match or Equifax match through FDSH, Social Security income, Unemployment income).

Some members in a household may have their eligibility administratively renewed while other members in the household must complete a regular renewal to continue their eligibility.
~~The following Medicaid subprograms can be administratively renewed:~~

- ~~SSI-related Medicaid~~
- ~~MAPP without premiums (income up to and including 100 percent of the FPL)~~
- ~~MSP~~
- ~~Group A Community Waivers with eligibility based on SSI~~

~~The following Medicaid subprograms cannot be administratively renewed:~~

- ~~SSI-related Medically Needy Medicaid with met or unmet deductibles~~
- ~~MAPP with premiums (income over 100 percent of the FPL)~~
- ~~Institutional Medicaid~~
- ~~Group B and B+ Community Waivers~~

- ~~Group A Community Waivers with eligibility based on 1619(b), BadgerCare Plus, EBD Medicaid, or Adoption Assistance~~
- ~~SSI-related Medicaid, MAPP, and MSP can be administratively renewed if all members on the case have:~~
- ~~Only income that can be verified through a data exchange (for example, income with a SWICA match or Equifax match through the FDSH), or only Social Security or Unemployment income~~
- ~~Countable assets at or below 50% of the asset limit~~

~~SSI-related Medicaid, MAPP, and MSP cannot be administratively renewed if any members on the case have or are:~~

- ~~Income or deductions that cannot be verified through a data exchange (for example, self-employment, in-kind income, child support/maintenance, or IRWEs)~~
- ~~An unverified or missing SSN~~
- ~~An unresolved Prisoner, UIB, or SOLQ-I discrepancy~~
- ~~An expired immigration status~~
- ~~An expired disability diary date~~

~~MAPP benefits with a work requirement waiver or Health and Employment Counseling enrollment~~

- ~~A presumptive disability~~
- ~~Persons turning 19 or 65 years old~~

~~**Note:** Members who receive SSI and SSI MA but are open in CARES for Group A Community Waivers and/or QMB will go through administrative renewal unless the case is in review mode. The criteria listed above do not apply to and will not exclude these types of cases from the Admin Renewal process.~~

~~Medicaid also cannot be administratively renewed if anyone on the case is receiving BadgerCare Plus or Family Planning Only Services benefits and is excluded from administrative renewal for a reason listed in .~~

~~Health care will not be successfully administratively renewed if any of the following occur during the administrative renewal process:~~

- ~~A new Error Prone Profile (EPP) is generated~~
- ~~A new discrepancy if found through a data exchange~~
- ~~A new or increased premium is required~~
- ~~Health care or FPOS benefits would pend or terminate for any person on the case~~
- ~~Related unprocessed items are found, such as applications, change reports, renewals, or FoodShare Six Month Report forms~~

3.1.5.3 Administrative Renewal Process

The administrative renewal process begins in the 11th month of a member’s certification period. CARES determines who qualifies for an administrative renewal, verifies and updates information based on data exchanges, tests employment income and SWICA and FDSH results for

reasonable compatibility, and runs through batch eligibility (see Process Help, Section 4.7 Administrative Renewals~~. See .~~).

3.1.5.3.1 Successful Administrative Renewals

~~Cases that~~ Members who have a successful administrative renewal will have health care eligibility redetermined and will be certified for a new 12- month certification period~~. The member~~ and will receive a notice of decision.

If all members in the household can be administratively renewed, they will be sent a letter notifying them that their eligibility has been renewed, along with a case summary (except for cases open only for Group A Community Waivers and/or QMB based on SSI eligibility). The member(s) must review the information on the case summary and report if any of the information is incorrect within 30 days of the mailing date. The member~~-~~(s) can make the changes on the summary and mail or fax it to their agency, or they can report their changes through ACCESS or by phone. If all of the information on the case summary is correct, the member~~ does~~ (s) will not need to take any other action~~. Members who have their health care administratively renewed will be sent a Notice of Decision~~.

If any members of the household cannot be administratively renewed, the household will be sent a renewal letter and a pre-printed renewal form. If the household does not complete this renewal process, then only the members who were administratively renewed will continue to be eligible in the next 12-month certification period.

If a successfully administratively renewed case is open only for Group A Community Waivers and/or QMB based on SSI eligibility, the member will be sent a different administrative renewal letter that does not include a case summary. Because these members are categorically eligible based on their SSI eligibility, the letter informs them that their benefits have been renewed because they continue to receive SSI. These members will not need to review a case summary and do not need to take any other action.

3.1.5.3.2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the ~~case~~member will be excluded from the administrative renewal process, and ~~the member~~they will be sent a 45-day renewal letter and a Pre-Printed Renewal Form (PPRF). The member will have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS.

3.1.5.3.3 Change Reporting After Administrative Renewal

~~Cases that~~Members who have a successful administrative renewal remain subject to ~~their applicable~~ change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the information provided in the attached case summary~~ and informs him or her of the potential consequences for not reporting those changes. If a member does not correct information that is wrong and gets benefits that he or she should not get, the member would be liable for any resulting overpayments. ~~. In addition, ~~administrative renewal cases~~members who are administratively renewed will~~-~~ receive a Notice of Decision that identifies program-specific change reporting requirements~~, as well as the potential consequences for not reporting changes timely. ~~. Changes reported for a ~~case that~~ member who has undergone an administrative renewal should be processed under existing policy.

Changes reported as part of a renewal for another program should also be applied to health care.

5.9 Presumptive Disability

5.9.2 Presumptive Disability Determined by the IM Agency

When an applicant or member has an urgent need for medical services attested to in writing by a medical professional~~,~~ and is likely to be found disabled by DDB because of an apparent impairment, the applicant or member may be certified as presumptively disabled by the IM agency. When the IM agency is making the presumptive disability decision, they should do so as quickly as possible. However, the normal 30-day application processing period applies (see~~).~~ Section 2.7 Application Processing Period).

In determining that the applicant is presumptively disabled, the IM agency will need a medical professional to attest in writing that:

1. The person has an urgent need for medical services (see Section 5.9.2.1 Definition of Urgent Need).
2. The person has one of a certain set of impairments (see Section 5.9.2.2 Impairments).

Note	If the attending physician attests under "Urgent Need for Medical Services" that the applicant has one or more medically determinable physical or mental impairments that cause severe functional limitations and/or inability to work, and that have lasted or can be expected to last for at least 12 months or are expected to result in death, and the applicant is otherwise eligible for Medicaid, the IM worker must certify presumptive disability even if the applicant does not have one of the specific listed impairments (see SECTION 5.9.2.1 Definition of Urgent Need).

For purposes of presumptive disability determinations, a "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an urgent need and the presence of one of the impairments. A medical professional may be a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker. Some urgent need criteria ~~and impairment categories~~ specifically require a physician to make the attestation, which is noted where applicable.

If someone has an impairment but not an urgent need, the normal disability application process must be followed (see~~).~~ SECTION 5.3 DISABILITY APPLICATION).

5.9.2.1 Definition of Urgent Need

To be considered to have an urgent need, a person must be in one of the following situations due to a physical or mental health condition:

A. The attending physician (defined as a doctor who has completed residency and is responsible for providing care for the patient in a hospital or clinic) attests that applicant has one or more medically determinable physical or mental impairments that cause severe functional limitations and/or inability to work, and that have lasted or can be expected to last for at least 12 months or are expected to result in death.

Note	If Box A in Section I – Urgent Need for Medical Services is checked on the Medicaid Presumptive Disability form (F-10130) and the form is signed by an attending physician, the worker must certify the presumptive disability if the applicant meets all other Medicaid program rules, even if the applicant does not have any of the specific impairments listed in SECTION 5.9.2.2 IMPAIRMENTS.

~~A.~~B. The applicant is a patient in a hospital or other medical institution.

~~A. The applicant is seriously impaired, and the attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months.~~

~~B.~~C. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment. For example, someone with schizophrenia who will need to be hospitalized if they do not take prescribed medication has an urgent need if such medication is not available without Medicaid coverage.

~~C.~~D. The applicant needs long-term care, and the nursing home will not admit the applicant until Medicaid benefits are in effect.

~~D.~~E. The applicant is unable to return home from a nursing home unless in-home service or equipment is available, and this cannot be obtained without Medicaid benefits.

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM agency can certify the person as presumptively disabled if they have one of the following impairments, as attested to in writing by a medical professional.

A. Amputation of a leg at the hip
B. Total deafness
C. Total blindness
D. Bed confinement or immobility without a wheelchair, walker, or crutches due to a longstanding condition, excluding recent accident and recent surgery
E. Stroke (cerebral vascular accident) more than three months in the past and marked difficulty in walking or using a hand or arm
F. Cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (for example, the use of braces), speaking, or coordination of the hands or arms
G. Down syndrome
H. Intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) (this category only pertains to persons who are at least four years old)
I. A child has not attained their first birthday and had a birth weight under 1200 grams (2 pounds, 10 ounces)
J. A child has not attained their first birthday and had a gestational age (GA) at birth and corresponding birth weight within one of the ranges below:
   1. GA of 37-40 weeks and birth weight under 2000 grams (4 pounds, 6 ounces)
   2. GA of 36 weeks and birth weight of 1875 grams (4 pounds, 2 ounces) or less
   3. GA of 35 weeks and birth weight of 1700 grams (3 pounds, 12 ounces) or less
   4. GA of 34 weeks and birth weight of 1500 grams (3 pounds, 5 ounces) or less
   5. GA of 33 weeks and birth weight of 1325 grams (2 pounds, 15 ounces) or less
   6. GA of 32 weeks and birth weight of 1250 grams (2 pounds, 12 ounces) or less
K. A physician confirms that the person has a terminal illness with a life expectancy of six months or less; or a physician or hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian) confirms that the person is receiving hospice services because of a terminal illness
L. Spinal cord injury producing an inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks
M. End stage renal disease (ESRD) requiring chronic dialysis
N. Symptomatic human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS)

O. Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig’s disease

11.1 Premium or Cost Share

Nonpayment of a~~ ~~ MAPP~~ ~~ premium will result in nonfinancial ineligibility~~. See ~~ for an adult age 19 or older (see Section 26.5 MAPP Premiums~~more information.~~).

Nonpayment of a Home and Community-Based Waivers cost share will result in nonfinancial ineligibility~~. See for more information.~~ for an adult age 19 or older (see Section 28.1 HCBWLTC Eligibility Groups and Cost Sharing).

Members under age 19 cannot lose their health care during their 12-month continuous coverage period for failure to pay a premium or cost share (see Section 1.2 Continuous Coverage for Qualifying Children).

13.4 Suspension End Date

A member's suspension is lifted, and full-benefit Medicaid coverage starts on the first of the month in which the member is released, if the member continues to meet the eligibility criteria for Medicaid. A new application is not needed to lift the suspension and start full-benefit Medicaid.

Members can report their expected release date to their IM agency prior to their release. If the expected release date is known, the IM agency will redetermine Medicaid eligibility prior to the release to lift the suspension and start full-benefit Medicaid, if eligible, on the first of the month in which the member is released.

Example 1	Dolores is incarcerated and enrolled in suspended Medicaid. On August 25, she reports to her IM agency that her expected release date is September 20. The IM agency redetermines her eligibility. Her suspension will be lifted, and full-benefit Medicaid will be opened on September 1.

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

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

Example 2	Risha is incarcerated and enrolled in suspended Medicaid. Her current certification period started January 1. She was released on April 3, but she does not inform the IM agency that she has been released. She continues to be enrolled in suspended Medicaid. On July 5, she reports to the IM agency that she was released from jail on April 3. The IM agency lifts her suspension and reinstates full-benefit Medicaid starting April 1.

The member's health care certification renewal date will not change.

Example 3	Cameron is incarcerated and enrolled in suspended Medicaid. His renewal date is June 30, 2021. Cameron is released on December 15, 2020. Cameron opens for full-benefit Medicaid starting December 1, 2020. His renewal date remains June 30, 2021.

13.8 Special Rules

13.8.1 Children Whose Parent/Caretaker is an Inmate

If the only parent(s~~/~~) or caretaker(s) in the household are incarcerated, any children on the case open for Medicaid will remain eligible ~~for a three~~the remainder of their 12-month ~~grace~~ continuous coverage period. Eligibility for the children will end ~~after~~at the ~~three~~end of the 12-month ~~grace~~ period~~-~~ unless they open for health care on another case.

Example 1	Faye and her 10-year-old daughter, Chantelle, are both enrolled in health care as of January 1, 2024. Faye is enrolled in medically needy Medicaid and Chantelle is enrolled in BadgerCare Plus. On March 9, 2021, Faye is incarcerated. Faye's suspended Medicaid starts April 1, 2021. Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for the ~~three~~remainder of her 12-month ~~grace~~continuous coverage period.~~-~~ Chantelle's BadgerCare Plus will end ~~June 30, 2021~~December 31, 2024. Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.

15.3 Exempt/Disregarded Income

15.3.35 Temporary COLA Disregard for Social Security Recipients

The annual Cost of Living Adjustment (COLA) increase to Social Security benefits is disregarded in certain months for the following programs and categories, which have income limits that are tied to the ~~FPL:~~Federal Poverty Level (FPL):

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

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

Example 11	In December, Ed's Social Security payment was $875 per month. It increased to $900 in January. The current COLA disregard amount is calculated by subtracting Ed's previous Social Security payment amount from his current payment amount. Ed's current COLA disregard amount is $25, which is disregarded from January 1 until February 28. The disregard ends when the new FPL amounts go into effect on March 1.

15.4 Unearned Income

15.4.2 Sick Benefits

Sick benefits are payments, such as income continuation, received from insurance. Cash from any insurance policy that pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is unearned income. Examples of these types of insurance policies are per diem hospitalization or disability insurance, or cancer or dismemberment policies.

Do not count the following:

- Reimbursement for medical or social services
- Payments restricted to the future purchase of a medical or social service
- ~~Any flat-rate benefits, such as per diem hospitalization or disability insurance, cancer insurance policies, or dismemberment policies~~

17.2 Evaluation of Transfers for Divestment

17.2.3 Transfers That Are Not Divestments

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 ~~().~~(see Section 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.

18.4 Spousal Impoverishment Assets

18.4.6 Asset Transfer

18.4.6.1 Asset Transfer Period

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

Example 3~~:~~	Robert was first institutionalized September 2013. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2013. The couple's total combined assets were $42,000, $32,000 of which were owned solely by Robert. Robert had until the next scheduled review (August 2014) to get his total assets under the $2,000 Medicaid asset limit. ~~CARES does not generate sufficient notice regarding the transfer of assets by the next scheduled renewal. See for information on manual notices that must be sent to the couple.~~ By August 2014, Robert had only transferred $23,000 to Lucinda. Robert still had $9,000 in assets. Robert became ineligible September 2014 and will remain ineligible as long as his assets are over $2,000.

18.8 Spousal Impoverishment Notices

After the institutionalized person ~~has been~~is determined eligible for Institutional Medicaid ~~eligible~~or HCBW Medicaid, the ~~worker must send the~~ following ~~manual~~ notices are sent to both spouses:

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

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

20.8 Actions

20.8.3 Negative Actions

Deny or reduce benefits when all of the following are true:

- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- The requested verification is needed to determine current eligibility. ~~Do not deny current~~Current eligibility ~~because~~cannot be denied for lack of verification of a ~~member does not verify some~~ past circumstance that does not ~~affecting~~affect current eligibility.
- The member is not a child in a continuous coverage period (see Section 1.2 Continuous Coverage for Qualifying Children).

Note~~:~~	Do not deny or terminate eligibility for failure to verify expenses. The disallowance of unverified expenses is the only penalty to be imposed.

22.1 Estate Recovery

22.1.4 Liens

22.1.4.1 Notice of Intent to File a Lien

~~Complete a~~A Notice of Intent to File a Lien (F-13038~~ paper form)~~) must be sent when a Medicaid member meets all the following criteria~~. They~~:

1. ~~Live~~They live in a nursing home or inpatient hospital and are required to contribute to the cost of care. (Individuals eligible under a~~-~~ MAGI~~-~~ group are not required to contribute to the cost of care and are not subject to liens on their homes.)
2. ~~Have~~ They own a home~~ (see)~~..
3. ~~Are~~They are not expected to return to live at that home.
   Base this decision on the person's medical condition. Their physician's statement that ~~he or she~~they can reasonably be expected to return home is sufficient support for the person's claim that ~~he or she~~they will return.

   The physician's statement should include a description of the diagnosis and prognosis for the member. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

   When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the member, family, guardian, power of attorney, or physician that the person will return home, consult with the ERP's Estate Recovery Specialist. Do~~-~~ not~~-~~ file a Notice of Intent to File a Lien until ERP staff has checked with DHS medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.
4. None of ~~these~~ the following relatives of the member reside in ~~that~~ the home~~.~~:
   a. Spouse~~.~~
   b. Child who is~~:~~ any of the following:
      i. Under age 21~~, or~~
      ii. Blind~~, or~~
      iii. Disabled~~.~~
   c. Sibling, if the two following conditions apply to the sibling:
      i. ~~Has~~They have an equity interest in the home~~; and~~.
      ii. ~~Lived~~They have lived in the home continuously beginning at least 12 months before the member's nursing home or hospital admission.

~~When you have~~ A copy of the completed Notice of Intent to File a Lien must be stored in the member's case file and sent to the following:

- The member or their authorized representative
- The Estate Recovery Program (ERP) office

See Process Help, Section 11.10.3.1 How to Send the Notice of Intent to File a Lien

ERP staff delays further action until the period given to the member to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

22.1.7 Notify Members

A copy of the Wisconsin Medicaid Estate Recovery Program Handbook (P-13032) must be provided to every Medicaid member who is 54 1/2 years old or older or institutionalized at application, except ~~members~~people who are only applying for ~~or a member of~~ are enrolled in one of the ~~Medicare Savings Programs.~~MSPs. CARES will send this documentation automatically. ~~Have each~~The applicant or member or ~~his or her~~their representative should read the notice of liability on the application form ("Estate Recovery"). ~~He or she~~ The member acknowledges understanding of this notice when signing the application.

~~22.1.8 Disclosure Form~~

~~The Estate Recovery Program (ERP) must be provided with asset information whenever a Medicaid member:~~

1. ~~Enters or resides in a nursing home, **or**~~
2. ~~Enters or resides in an inpatient hospital and is required to pay a Medicaid cost of care liability, **or**~~
3. ~~Becomes 55 years old.~~

~~This information must be provided even if he or she has zero assets. CARES will send this information automatically.~~

22.1.8~~9~~ Estate Recovery Program Contacts

The ERP address is:

Estate Recovery Program Section
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer members to Member Services at 1-800-362-3002. ~~Direct case-specific questions about:~~

1. ~~Estate recovery disclosure forms and liens to the Estate Recovery Specialist, 608-264-6755.~~
2. ~~For small estates of $50,000 or less, provide the phone number of the "Affidavit Help Line," 608-264-6756, to heirs of deceased members who have questions about ERP. The Help Line provides recorded messages that answer the most frequently asked questions regarding small sum estates. It also provides the caller with an opportunity to either leave a message or talk to ERP staff.~~
3. ~~Tribal inquiries should be re-directed to the ERP Section Chief, 608-261-7831.~~

22.1.~~10~~9 Voluntary Recovery (Not Estate Recovery Program)

22.1.~~11~~10 Incentive Payments

22.1.~~12~~11 Other Programs

ERP also recovers for Community Options Program (COP),~~ ~~ Wisconsin Chronic Disease Program (WCDP~~,~~), and non-Medicaid Family Care.

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

Note	The Community Options Program no longer exists as of June 30, 2018. However, ERP could recover from those who received benefits under this program prior to June 30, 2018.

22.5 Legal Guardians, Conservators, Power of Attorney, and Other 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)

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. A guardian of the person can appoint the authorized representative only if the court document appointing the legal guardian of the person includes language granting the guardian the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs.

If the applicant or member only has a ~~legal~~ guardian of the person who does not have the authority to enroll the person in Medicaid or public assistance programs, 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 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 two witness 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~~ their 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~~Medicaid 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.

22.5.4 Legal Guardians and Conservators

Persons or interested parties may petition a court to appoint a guardian or conservator. There are a variety of reasons that an appointment may be sought including but not limited to:

- Inability to manage finances
- Inability to manage personal health
- Inability to function safely without supervision
- Parent or guardian of minor is now deceased

Some of these appointments might be an emergency or temporary reason, or for the purposes of succession after the death of the previous guardian or conservator.

A judge grants the guardian or conservator powers based on the circumstances of the person. A ~~legal~~ guardian of the person and the estate~~,~~ ~~legal~~or a guardian of the estate~~, or legal guardian in general~~ is considered to be the applicant or member's ~~legal~~ guardian for Medicaid purposes. A guardian of the person is the applicant's or member's legal guardian for Medicaid purposes only if the court document appointing the legal guardian of the person includes language granting them the authority to enroll the person in Medicaid or public assistance programs.
If a person or entity is one of these ~~legal~~ guardian types or the conservator, the applicant or member does not need to separately appoint them as the authorized representative. The legal guardian or conservator appointment grants them the powers that an authorized representative would have on the Medicaid case.

~~A person or entity with~~If the court document appointing the guardian ~~type legal guardian~~ of the person ~~is~~does not ~~considered~~grant the authority to ~~be~~enroll the applicant or ~~member's legal guardian for~~member in Medicaid ~~purposes. The~~public assistance programs, 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 their behalf.
Depending on their court appointed powers, a guardian or conservator can apply for and act in the same capacity as an authorized representative for the household. It is possible the court appointed powers will give the guardian or conservator sole authority to manage the person's eligibility.

The ~~legal~~ guardian or conservator should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The ~~legal~~ guardian or conservator can take any action on the application or case on behalf of the applicant or member unless the guardianship or conservatorship court order limits their powers.

Applicant and member notices and other communications from the agency will be sent to the legal guardian or conservator.

See Section 20.3.7 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See Section 2.5 Valid Signature for information on valid application signatures by ~~legal~~ guardians or conservators.

22.5.5 Power of Attorney

A person may appoint a power of attorney. A power of attorney may act within the scope of authority granted in the power of attorney appointment.

A durable power of attorney for finances 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. Only ~~a~~an activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for Medicaid purposes.

If a person has ~~a~~an activated durable power of attorney for finances, the applicant or member does not need to separately appoint them as an authorized representative. The durable power of attorney for finances appointment grants them the powers that an authorized representative would have on the Medicaid case.

The durable power of attorney for finances should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the

person being represented. The durable power of attorney for finances can take any action on the application or case on behalf of the applicant or member unless the power of attorney appointment limits their powers.

See Section 20.3.7 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See Section 2.5 Valid Signature for information on valid application signatures by a power of attorney.

26.3 Nonfinancial Requirements

26.3.2 Disability

Disability is a non-financial eligibility requirement for MAPP, even for members who are age 65 and older. DDB must certify disability (see~~).~~ Section 5.10 Medicaid Purchase Plan Disability).
There is no requirement that a member be a current or former SSI or SSDI beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If an applicant or member does not have a disability determination from DDB, complete the disability application process outlined in Section 5.3 Disability Application Process even if the applicant or member is age 65 or older (unless the applicant or member fits the policy on converting from SSDI to SSRE). The rest of the MAPP application must be completed at this time, and MAPP eligibility can only be pending for the disability determination before the MADA will be sent to DDB through the automated process (see Process Help Section 9.4 Automated Medicaid Disability Determination).

Applicants and Members Converting from SSDI to SSRE
An applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because ~~he or she~~they began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. The member is not required to provide verification of the disability unless the worker is not able to use data exchanges or other information from ~~SSA~~the Social Security Administration (SSA) to confirm that the individual received disability payments immediately prior to receiving SSRE.

Redeterminations
Follow the rules in Section 5.7 Redetermination on when to review disability determination.

Members Who Have Lost Their SSDI Due to Exceeding Substantial Gainful Activity
A current MAPP member who loses SSDI because ~~he or she exceeds~~ they exceed the Substantial Gainful Activity level remains MAPP-eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with adverse action notice for the reason "not MAPP disabled."

Note	An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are determined no longer disabled (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

26.3.3 Work Requirement

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. Eligibility cannot be terminated until one full calendar month has passed since employment ended.

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

Note	An 18-year-old MAPP member who does not qualify for any other full-benefit health care

	category cannot lose MAPP during their continuous coverage period even if they are determined no longer meeting the work requirement (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

26.3.5 Health and Employment Counseling Program

26.3.5.3 Health and Employment Counseling Participation Changes

Whenever a member notifies the IM agency that ~~he or she has~~they have stopped participating in the HEC program and ~~is~~ are not meeting the work requirement in another way, MAPP eligibility will be terminated with an adverse action notice.

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

Note	An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are no longer meeting the work requirement (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

26.5 MAPP Premiums

26.5.1 Calculation

Medicaid Purchase Plan (MAPP) premiums are calculated using only the member's income. A premium is calculated if the member's monthly Premium Gross Income exceeds 100% of the ~~FPL (see)~~ Federal Poverty Level (FPL) (see Section 39.5 Federal Poverty Level Table) for a group of one.

Tribal members are not exempt from paying MAPP premiums (unlike BadgerCare Plus premiums). Federal statutes for MAPP supersede other parts of the law that exempt tribal members from premiums and copayments for services.

Eighteen-year-old MAPP members are not required to pay a premium.

To calculate monthly premium amount:

1. Determine the member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income.
2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:
    a. The member's own verified monthly impairment-related work expenses (any amount)
    b. The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    c. The current cost-of-living adjustment (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~~3% (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 Section 26.5.1.1 Independence Account Penalty~~the Medicaid Eligibility Handbook, Section 26.5.1.1 Independence Account Penalty).~~).

The result is the member's monthly premium amount.

Note~~:~~	503, Disabled Adult Child (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 181% 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 − $1,215 (100% of the FPL) -------------- $535 Premium Net Income X 0.03 (3%) -------------- $16.05 +$25 Base Premium Amount -------------- $41.05 (round down to nearest whole dollar) Susan's monthly MAPP premium is $41.

26.5.1.1 Independence Account Penalty

If the ~~member~~member's total deposits ~~income (earned or unearned) in an amount that exceeds~~ into an Independent Account exceed 50 ~~percent~~ % of the member's gross earnings ~~into an Independence Account~~, the member will be penalized using the following formula. At renewal or re-application for MAPP, look back 12 months and:

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

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

26.5.2 Initial Premium

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

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

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

It is possible that an applicant owes a premium for some but not all initial months at application. For example, they request backdated coverage, and their income was under 100% FPL during the backdated months, but their income is over 100% FPL in the application month, so no

premium is required for the backdated months, but a premium is owed for application month. The premium for the application month (or the next month if the application is being processed after the application month) must be paid before the individual can enroll in MAPP. If the premium is not paid, eligibility can be granted for any months a premium was not required but will be denied for months a premium was not paid.

Example 7	Bernice applied for MAPP on March 10 and requested backdated eligibility for January and February. She had no income in January. She started a job in February, and her income went over 100% FPL starting in March. On March 15, the worker determined that she met eligibility requirements effective January 1. Due to Bernice's income, she is not charged a premium for January or February but owes a premium beginning in March. Bernice must pay the March premium before her eligibility can be confirmed. If Bernice does not pay March's premium by the due date, she will only qualify for eligibility for the months of January and February.

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

27.1 Institutions

27.1.2 Institutions for Mental Disease

27.1.2.3 Minors Children and Young Adults in IMD

When a child or young adult applies for Medicaid while in an IMD or after being discharged from an IMD, the IM agency must determine eligibility for Institutional Medicaid for the inpatient IMD days, regardless of the length of stay.

Young adults aged 19-20 must be enrolled in Institutional Medicaid for the inpatient IMD days only, if eligible.

Children aged 18 or younger are subject to continuous coverage requirements (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN). This means that the child, if eligible, may be enrolled in Institutional Medicaid for the inpatient IMD days plus an additional period of time for a total of 12 full months of Institutional Medicaid eligibility, even when they are no longer in the IMD. However, the child's enrollment should be changed to BadgerCare Plus or another form of Medicaid not based on institutionalization, if they are eligible.

When a minor applies for Medicaid after being discharged from the IMD, certify the individual as a member, if eligible, for the inpatient IMD days onlySECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN. Certify for the remainder of the month if he or she would be eligible after being tested for Family Medicaid with his or her parents and siblings.

Example 1	Jax is 15 years old and was in an IMD from March 10 through March 18, 2024. On April 1, 2024, Jax applies for Medicaid and is determined eligible for Institutional Medicaid. Jax is enrolled effective March 10. Jax is not eligible for BadgerCare Plus or any other form of full-benefit Medicaid. Jax's Medicaid coverage through Institutional Medicaid ends on March 31, 2025.

27.1.4 Minors in a Medical Institution

Minor children who reside (or are likely to reside) in a hospital or other medical institution for 30 or more days can be eligible for Institutional Medicaid if they are determined disabled or presumptively disabled (see SECTION 5.2 DETERMINATION OF DISABILITY and SECTION 5.9 PRESUMPTIVE DISABILITY and).).

For Institutional Medicaid, a blind or disabled minor is a one-person fiscal test group. Only the child's income is counted. No parental income is deemed to the institutionalized minor.

Hospitalized children under the age of 19 who have not been determined disabled or presumptively disabled must be tested for BadgerCare Plus with their families.

See Process Help, Section 11.2.4 Health Care Applications for Institutionalized Children for processing instructions.

Minors in a medical institution qualify for 12 months of continuous coverage. If they are discharged from a medical institution during their continuous coverage period and they do not qualify for any other form of full-benefit health care after they have been discharged, they remain eligible for Institutional Medicaid for the rest of their continuous coverage period.

28.1 Adult Home and Community-Based Waivers Long-Term Care Introduction

Medicaid-eligible adults who meet the LOC requirements can receive their LTC services through enrollment in an MCO or through the fee-for-service program IRIS.

Managed LTC programs include:

- Family Care
- Family Care Partnership
- PACE

Medicaid Eligibility
Community waivers enable elderly, blind, or disabled people to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for services and supports permitting a person to remain in a community setting that normally are not covered by Medicaid. These programs include Family Care, Family Care Partnership, PACE, and IRIS.

IM workers are responsible for determining Medicaid eligibility as well as cost share amounts, if applicable. ADRC staff and IRIS consultants are responsible for determining the person's eligibility for enrollment in the specific community waiver program.

If a member disenrolls from the managed LTC program for any reason and does not enroll in IRIS or a managed LTC program, ~~his or her~~their Medicaid eligibility must be tested under non-HCBW rules. Eligibility for HCBW would end following adverse action logic once the IM worker has been notified by the ADRC that the member has disenrolled from the managed LTC program or IRIS.

If an 18-year-old is disenrolled from their managed LTC program during their 12-month continuous coverage period, and they are not eligible for another category of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of the 12-month continuous coverage period. However, a voluntary disenrollment will be treated as a voluntary disenrollment from HCBW Medicaid and continuous coverage under HCBW Medicaid will end (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

Managed Long-Term Care of IRIS Enrollment
Enrollment in managed LTC or IRIS is completed by the ADRC. The ADRC will submit the following information to IM workers:

- ADRC Referral to Income Maintenance for Managed Long-Term Care Services, F-02053, which lists the anticipated program start date for HCBW
- Medicaid application, if the ADRC is assisting the applicant with the Medicaid application process or establishing a Medicaid filing date
- Functional Screen Eligibility Results page
- Medical and Remedial Expenses: checklist For Medicaid Long-Term Care Waiver Programs, F-00295, or other communication of the total expenses
- Housing expenses and any other verification items the ADRC has received from the applicant to support the Medicaid application
- Estate Recovery Program (ERP) Disclosure, F-13039, if completed by the ADRC

Declaration Regarding Transfer of Resources Long-Term Care Medicaid Waiver Program and/or Community Options Program, F-20919D, if any potential divestment was reported to the ADRC

- Disenrollment from the managed LTC program or IRIS, if applicable

34.1 Emergency Services

34.1.1 Emergency Services Eligibility Introduction

~~Documented and undocumented non-citizens~~Emergency Services Medicaid is a limited benefit for immigrants who do not qualify for other forms of Medicaid because of their immigration status.

An immigrant who is ineligible ~~under regular~~for Medicaid ~~due to alien~~because of their immigration status ~~can be~~is eligible for Emergency Services~~,~~ Medicaid coverage if ~~he or she meets~~they:

- Have a qualifying emergency medical condition.
- Meet all ~~other~~the eligibility requirements of any Medicaid category under the state plan except ~~having~~
  - U.S. citizenship or qualifying immigrant status.
  - Having or applying for an SSN.

See BadgerCare Plus Handbook, SECTION 39.1 EMERGENCY SERVICES INTRODUCTION ~~Non-citizens may have an SSN and may still qualify for Emergency Services. If a non-citizen would otherwise be eligible for any type of EBD Medicaid, he or she would qualify for~~ for information about Emergency Services~~.~~ for non-qualifying immigrants who are not elderly, blind, or disabled.

An inmate who is a non-qualifying immigrant may be eligible for Emergency Services for the dates they are hospitalized as an inpatient for emergency treatment as long as they meet the rest of the eligibility criteria for Emergency Services.

A person can be eligible for Emergency Services for an emergency that occurred within the three months prior to the application month as long as the person met the eligibility requirements for Emergency Services during the month(s) in which the emergency occurred.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate Medicaid could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying aliens.

The IM agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to the fiscal agent. It determines if a condition is an emergency medical condition covered by Emergency Services.

A U.S. citizen is not eligible for Medicaid Emergency Services even when ~~he or she~~ they cannot produce citizenship and/or identity verification.

Example 1~~:~~	Jill applies for Medicaid, declares U.S. citizenship, and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services Medicaid does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However, the IM worker cannot process Emergency Services Medicaid eligibility for persons declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency~~.~~ for adults or the end of a 12-month period for children under age 19.

Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying alien meets all other eligibility requirements during the dates of service and to certify if ~~he or she is~~ they are eligible for Emergency Services.

If a non-qualifying alien provides a "Certification of Emergency for Non-U.S. Citizens" (F-01162) at the time of application, determine ~~his or her~~ their eligibility for Emergency Services for the dates of the emergency indicated on the form~~.~~ (unless a child under age 19). If a non-qualifying alien does not have the form at the time of application, ask ~~him/her~~ them for the dates that ~~he or she~~ they received emergency services. The F-01162 is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. ~~He or she~~ They must meet the eligibility requirements for ~~his or her~~their type of Medicaid, such as being elderly blind or disabled*, and provide required verifications. ~~He or she is also entitled to all notice rights and must receive~~ The IM agency must provide a manual positive or negative notice regarding ~~his or her~~the applicant's eligibility. Positive ~~Notices~~notices must provide the dates of eligibility for Emergency Services. Negative ~~Notices~~notices must provide the ~~reasons~~reason(s) for the denial or termination.

*If a non-qualifying ~~alien~~immigrant would only qualify for Medicaid if ~~he or she was~~they were disabled, ~~follow~~the normal disability determination procedures (including presumptive disability) are followed before ~~certifying~~ Emergency Services eligibility~~.~~ is certified.

34.1.2.1 Medicaid Deductible

~~Aliens who apply for emergency services~~Individuals may become eligible for Emergency Services by ~~way of~~meeting the Medicaid deductible. If, on the date ~~he or she applies, he or she is~~ they apply, they are otherwise eligible ~~in all respects~~ except for excess income, ~~apply the same~~normal deductible policies ~~() to him or her as any other client~~(see Section 24.2 Medicaid Deductible Introduction) are applicable.

34.1.3 Certification of Emergency Services Eligibility

~~Certification for Emergency Services, complete and submit a Medicaid/BadgerCare Plus Eligibility Certification form () (formerly DES 3070). Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to an organ transplant procedure are not covered by Emergency Services. The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use~~Individuals enrolled in Emergency Services will be eligible until:

- For adults age 19 and older, the last day of the emergency.~~ If that is~~
- For children under age 19, the end of a 12-month period.
- For a child who is turning 19 in the next 12-month period, the last day of the emergency or the last day or the month the child turns 19, whichever is later.

For adults age 19 and older, if the last day of the emergency is not known, ~~use~~they are eligible through the last day of the month in which the emergency is expected to end.~~ Use the AE medical status code.~~

For information on manually processing applications, see Process Help, Section 9.3 Health Care (BC+ and MA) Emergency Services Manual Application Processing~~The Medicaid/BadgerCare Plus Eligibility Certification form may be submitted to the fiscal agent by fax to 608-221-8815 or by mail to:~~

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

A person eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility typically ends when the emergency ends.

36.2 WWWMA Enrollment

36.2.2 Enrollment through the Wisconsin Well Woman Program

36.2.2.1 Temporary Enrollment ~~/~~(TE)/ Presumptive Eligibility (~~TE~~PE) Available Only to Women Enrolling through WWWP

~~Temporary Enrollment (TE) for WWWMA is available for women to assure immediate access to cancer treatment.~~ Temporary Enrollment (TE), also known as Presumptive Eligibility (PE), is a streamlined eligibility determination for temporary enrollment in Wisconsin Well Woman Medicaid (WWWMA). It allows eligible applicants immediate access to cancer treatment for a short period until an application for ongoing coverage is completed and processed. TE is only available to individuals who are enrolling through the Wisconsin Well Woman Program (WWWP). An applicant may only be temporarily enrolled once in a rolling 12-month period.

The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the F-10075. The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.

The WWWP Local Coordinating Agency (LCA) should then fax a copy of the completed F-10075 to the fiscal agent at ~~(~~608~~)~~-221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of CB) and send the member a ForwardHealth card with the temporary enrollment dates activated on the card. ~~(~~If the member had a previous ForwardHealth card, it will be reactivated~~.)~~.

Until the ForwardHealth card arrives or is reactivated, the new WWWMA member may receive services by presenting both of the following completed forms to any Medicaid provider:

1. WWWP Enrollment Form (F-44818~~F-44818~~)
2. WWWMA Determination Form (F-10075~~).~~)

To continue receiving WWWMA, the member or the WWWP LCA must submit an F-10075 to the EM CAPO. If the member does not apply, ~~her~~ their WWWMA benefits will ~~terminate~~end at the end of the month following the month of diagnosis.

The TE period extends from the date of diagnosis on the F-10075 through the following month. A new TE period would only occur if a new cancer diagnosis was established for the same member. and only if it has been at least 12 months since the first day of their last TE period.

Note~~:~~	If the member applies during ~~her~~their TE certification period and the EM CAPO is not able to process ~~her~~their application, within the 30-day processing time frame, the EM CAPO will extend the members' eligibility for an additional 30 days from the last day of ~~her~~their Wisconsin Well Woman Medicaid TE with a medical status of "CB~~".~~." Submit an F-10110 (formerly DES 3070) to extend the Well Woman Medicaid TE for an additional calendar month.

36.2.4 Enrollment for Family Planning Only Services Members

36.2.4.1 Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services

~~A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a Family Planning Only Services (FPOS) member or hertheir representative is a request to enroll in WWWMA and disenroll from FPOS. Women 15 through 44 years of age, Individuals enrolled in FPOS in CARES who meet the criteria above (see Section 36.2.4 Enrollment for Family Planning Only Services Members,), will be eligible for Well Woman Medicaid.~~

A Wisconsin Well Woman Medicaid Determination form (F-10075) submitted by a FPOS member or ~~her~~their representative is a request to enroll in WWWMA and disenroll from FPOS. ~~Women~~Individuals who are enrolled in FPOS in CARES and meet the criteria ~~in the~~ above (see Section 36.2.4 Enrollment for Family Planning Only Services Members) may be eligible for WWWMA.

36.5 WWWMA Changes

36.5.1 Member Loses Eligibility

Wisconsin Well Woman Medicaid (WWWMA~~-~~) members are required to report changes that would affect their eligibility. ~~Reported~~ Any of the following changes ~~that~~would result in ~~the~~ a loss of WWWMA ~~case closing are~~ eligibility:

1. Reaching the age of 65 years~~,~~

~~1. Moving out of state,~~

2. ~~Reporting that she no~~No longer ~~needs~~residing in Wisconsin
~~2.~~3. No longer needing treatment for breast or cervical cancer~~,~~
~~3.~~4. Obtaining health insurance that covers ~~her~~their treatment for breast or cervical cancer~~, or~~
~~4.~~5. Obtaining Medicare Part A, Part B, or both~~.~~

Note	If a child under age 19 enrolled in WWWMA no longer requires treatment or gets health insurance that covers their treatment, they will not be disenrolled during their continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

If a case closes, the EM CAPO will send a manual negative notice to the member if one of these changes is reported, indicating that ~~she is~~ they are no longer eligible for WWWMA. ~~In situations 1, 3, 4, and 5 above, offer her~~Offer them a BadgerCare Plus / Medicaid Application (F-10182~~, ~~) to test eligibility for other programs~~.~~ (unless they are no longer a Wisconsin resident).

36.6 WWWMA ~~Reviews/Recertifications~~Renewals

~~Reviews/recertifications~~ Renewals are required every 12 months ~~after the initial eligibility determination at the member's WWWMA enrollment date.~~. A ~~review~~ renewal for Wisconsin Well Woman Medicaid (WWWMA ~~only~~) consists of ~~receiving~~ submitting an updated Wisconsin Well Woman Medicaid Application and Renewal (F-10075 ~~WWMA Determination form.~~). There is no financial test.

~~Notices~~Reports identifying the WWWMA members needing ~~recertification~~renewals are sent to the EM CAPO monthly. The ~~EM CAPO notifies the~~ member is notified approximately 45 days before ~~a review~~ their renewal is due~~,~~ and ~~indicates~~is informed what ~~materials or information the member needs to return. The EM CAPO includes a blank~~ steps they need to take to renew their WWWMA. A blank F-10075 is included with the renewal notice. In most cases the member will only need to supply ~~the EM CAPO with~~ an updated F-10075.

Note~~:~~	In order to eliminate unnecessary reviews, a best practice is to check interChange to be sure that the member has not become certified for BadgerCare Plus or another type of full benefit Medicaid ~~(MA)~~ (for example, SSI MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare Part(s) A, B or both, prior to notifying the member that a review is due.

The member or ~~her~~ their representative must send ~~or fax~~ the F-10075 ~~.~~ to the EM CAPO via one of the following:

1. Email: DHSEMCAPO@dhs.wisconsin.gov~~,~~
2. Fax: ~~(~~608~~)~~ -267-3381~~, or~~
3. Mail:
   WI DHS - EM CAPO
   1 West Wilson St.
   P.O. Box 309
   Madison, WI 53701-0309

At ~~review~~renewal, the member must provide a newly completed F-10075~~WWWMA Determination form —~~ indicating ~~she is~~they are still in need of treatment for breast or cervical cancer, as ~~certified~~attested by a ~~physician or~~Wisconsin licensed health care provider, including a doctor of medicine (MD), doctor of osteopathic medicine (DO), nurse practitioner~~.~~ (NP), physician assistant (PA), clinical nurse specialist (CNS), or clinical nurse practitioner (CNP).

Members formerly enrolled in WWWP do not need to provide a new F-44818 (formerly DPH 4818) at recertification.

The EM CAPO sends a manual positive notice if all requirements are met.

The EM CAPO will send a manual negative notice at least ~~ten~~10 days prior to the case closing if the member does not provide an updated F-10075 or if the member reports one of the changes listed in Section 36.5 Changes.

37.1 Children's Long-Term Support (CLTS) Waiver Program Introduction

37.1.2 Eligibility Requirements

To be eligible for the CLTS Waiver Program, an individual must meet all of the following:

- Be under 22 years old
- Meet an institutional level of care, as determined by the CLTS Functional Screen
- Meet nonfinancial and financial eligibility criteria for a full-benefit category of Medicaid (see~~)~~ Section 21.2 Full-Benefit Medicaid)
- Reside in a setting allowed by CLTS Waiver policy

A disability determination is not required for the CLTS Waiver Program.

Children in the CLTS Waiver Program qualify for 12 months of continuous Medicaid coverage. If they are disenrolled from CLTS waiver services (for example, because they lose their functional eligibility) during the continuous coverage period and they do not qualify for any other form of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of their continuous coverage period. If they voluntarily disenroll from CLTS, it will be treated as a voluntary disenrollment from Waiver Medicaid.

39.11 SeniorCare Income Limits

39.11.1 SeniorCare Income Limits Introduction

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

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

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

Note	The FPL may be adjusted annually (see Section 39.5 FPL Table for current FPLs). If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	Annual Out-of-Pocket Expense Requirements and Benefits
Level 1 Income at or below 160% of FPL At or below $23,328 per individual or $31,552 per couple annually.*	• No deductible or spenddown. • $5 co-pay for each covered generic prescription drug. • $15 co-pay for each covered brand name prescription drug.
Level 2a Income above 160% and at or below 200% FPL $23,329 to $29,160 per individual and $31,553 to $39,440 per couple annually.*	• $500 deductible per person. • Pay the SeniorCare rate for drugs until the $500 deductible is met. • After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b Income above 200% and at or below 240% of FPL $29,161 to $34,992 per individual and $39,441 to $47,328 per couple annually.	• $850 deductible per person. • Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 Annual income is above 240% of the FPL $34,993 or higher per individual and $47,~~328~~ 329 or higher per couple annually.*	• Pay retail price for drugs equal to the difference between the member's income and $32,616 per individual or $43,944 per couple. This is called "spenddown." • Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs.

	• After spenddown is met, meet an $850 deductible per person. • Pay SeniorCare rate for most covered drugs until the $850 deductible is met. • After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2023 federal poverty guidelines, which typically increase by a small amount each year.