

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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Madison WI 53703

To: Medicaid Eligibility Handbook Users

From: Bureau of Eligibility and Enrollment Policy

Re: **Medicaid Eligibility Handbook Release 25-03**

Release Date: 08/13/2025

Effective Date: 08/13/2025

EFFECTIVE DATE	The following policy additions or changes are effective 08/13/2025 unless otherwise noted. Underlined text denotes new text. Text with a strike through it denotes deleted text.
POLICY UPDATES	
1.2.3 Termination of Coverage	Added new subsection 1.2.3.1 about how continuous coverage periods are affected when a child’s eligibility is redetermined because of incorrect information or agency error.
1.2.10 Transitions between CHIP and Medicaid	Added clarification and example.
2.1 Applications Introduction	Fixed broken link.
3.1.5.3.1 Successful Administrative Renewals	Updated to reflect that, since administrative renewals are now done at the individual level, if at least once member in the household can be administratively renewed, they will receive the administrative renewal notice.
7.3.8.2 Refugee Medical Assistance	Change in eligibility period for Refugee Medical Assistance.
13.2 Covered Services	Clarification that the restriction on covered services for incarcerated people begins and ends based on the incarceration begin date and release date. This is separate from the suspension begin and end dates.
13.3 Suspension Start Date	Clarification that the restriction on covered services for incarcerated people begins and ends based on the incarceration begin date and release date. This is separate from the suspension begin and end dates.
13.4 Suspension End Date	Clarification that the restriction on covered services for incarcerated people begins and ends based on the incarceration begin date and release date. This is separate from the suspension begin and end dates.
15.3.36 Guaranteed Income Payments	Added new guaranteed income program to the list, the Madison Forward Fund 2.0.
15.4.4 Retirement Benefits	Reorganized content and moved to new section 16.11 Retirement Funds.

15.6.6	Verification	Clarification that there are other sources of sufficient verification of self-employment income in addition to tax forms and SEIRF's, such as bookkeeping records.
16.7.4	Annuities	Reorganized content and moved to new section 16.12 Annuities.
16.7.34	Guaranteed Income Payments	Added a new guaranteed income program to the list, the Madison Forward Fund 2.0.
16.11	Retirement Funds	New section.
16.12	Annuities	New section.
20.1.4	General Rules	Clarification that applicants and members must not be subject to different verification requirements solely based on certain categories.
20.3.8	Income	Updated the reasonable compatibility policy to reflect that Equifax provides some types of unearned income date.
26.3.4	Work Requirement Exemption	Clarification that premiums must be paid during work requirement exemption periods unless a premium waiver has been granted.
26.5.8	Temporary MAPP Premium Waivers due to Hardship.	Clarification of qualifying hardships for temporary premium waivers.
26.3.5.4	Health and Employment Counseling Program	Clarifications related to when a HEC period may begin.
32.8	Medicare Beneficiaries Backdating	Clarifications related to MSP backdating at renewal.
33.16.1	SeniorCare Benefits Introduction	Clarification that SeniorCare covers certain vaccines.
34.1	Emergency Services	Updated non-qualifying alien to non-qualifying immigrant.
36.3.2	Disqualifying Insurance Coverage	Clarification that people who are only eligible for an unmet deductible are not considered to be "enrolled" in Medicaid or BadgerCare Plus.
39.4.4	LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share	Updates to FPL-based spousal impoverishment figures effective 7/1/2025

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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.

1.2.3 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.
- The child’s eligibility was based on incorrect information or agency error.
- 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.
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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.
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1.2.3.1 When Eligibility was Based on Incorrect Information or Agency Error

Children whose eligibility determination at application or renewal was made based on incorrect information or agency error will have their eligibility redetermined when the error is discovered. When eligibility is redetermined, depending on the circumstances of the case, the following may happen:

- The child’s existing coverage ~~may~~ will end if they are not eligible for any category of health care based on the corrected information (see Example 6).
- A new 12-month continuous coverage period will be established if the child remains eligible for their existing or a different category of health care coverage (see Example 7).
- If the child no longer meets eligibility rules due to a change in circumstances unrelated to the corrected information (and the change causing ineligibility is not one of the reasons that a continuous coverage period may end), the child will remain enrolled until the end of their existing continuous coverage period, but will move to the benefit category that aligns with the corrected information for the remainder of that period, and may have a new or increased premium (see Example 8).

Example 6	<u>Maggie is 12 years old and enrolls in SSI-Related Medicaid on February 1. Maggie’s continuous coverage period is set from February 1 through January 31 of the following year. On March 10, it is discovered that Maggie’s eligibility determination was based on incorrect income information. When eligibility is redetermined with the corrected information, it is determined that Maggie would only be eligible by meeting a deductible. Maggie’s SSI-Related Medicaid coverage ends effective April 1.</u>
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Example 7	Henry is 3 years old and enrolls in SSI-Related Medicaid on January 1. Henry's continuous coverage period is set from January 1 through December 31. On March 12, it is discovered that Henry's eligibility determination was made based on incorrect income information. Henry's eligibility is redetermined based on accurate income information, and he is now eligible for BadgerCare Plus. Henry receives a new 12-month certification period with continuous coverage starting April 1 through March 31 of the following year.
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Example 8	Ethan is 10 years old and enrolls in BadgerCare Plus on July 10. His continuous coverage period is set from July 1 through June 30 of the following year. At the time of enrollment Ethan had no other health insurance coverage. Ethan obtained health insurance through his father's employer in December, which is not a reason a child's continuous coverage period can end. On January 1, it is discovered that Ethan's eligibility determination was based on incorrect income information. Ethan's eligibility is redetermined based on accurate income information and he is still under the income limit for BadgerCare Plus. Ethan is not eligible for a new 12-month certification period because at his family's income level, he would be ineligible due to health insurance crowd-out rules. However, his BadgerCare Plus will continue and he will be charged a monthly premium for the remainder of his existing continuous coverage period.
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1.2.10 Transitions Between CHIP and Medicaid

BadgerCare Plus is funded by both Medicaid (Title 19) and CHIP (Title 21) (see SECTION 51.1 BADGERCARE PLUS CATEGORIES).

During ~~the~~ a child's 12-month continuous coverage period, ~~a child~~ they may not move from a Medicaid-funded ~~category of~~ health care ~~category~~ to a CHIP-funded category ~~of BadgerCare Plus (see BadgerCare Plus Handbook unless their eligibility determination was based on incorrect information or agency error (see SECTION 51.1 BADGERCARE PLUS CATEGORIES)-~~ Section 1.2.3.1 When eligibility was based on incorrect information or agency error).

However, ~~a child~~ they may move from a CHIP-funded category ~~of BadgerCare Plus~~ to a full-benefit Medicaid ~~program. One-funded category, with one exception to this is that:~~ a child may not move from a CHIP-funded ~~category of~~ BadgerCare Plus ~~category~~ into ~~an~~ a BadgerCare Plus earned income or spousal support extension. When a child moves from a CHIP-funded category to a Medicaid-funded category, they will begin a new 12-month certification period with continuous coverage.

Example 13	Max is 10 years old and enrolls in a CHIP-funded category of BadgerCare Plus on January 1. Max's continuous coverage period is set from January 1 through December 31. On March 14, Max enrolls in the Children's Long-Term Support program (CLTS) with HCBW Medicaid as his basis of eligibility. The change results in Max being moved from a CHIP-funded category of BadgerCare Plus to HCBW Medicaid. Max receives a new 12-month certification period with continuous coverage from April 1 through March 31 of the following year.
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2.1 Applications Introduction

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

The applicant may be assisted by any person they choose in completing an application.

Anyone who expresses interest in applying should be encouraged to file an application as soon as possible (see Section 2.2 Application Methods).

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

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

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

The IM agency must also provide these documents to anyone who requests them.

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

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

3.1.5 Administrative Renewals

3.1.5.3 Administrative Renewal Process

3.1.5.3.1 Successful Administrative Renewals

Members who have a successful administrative renewal will have health care eligibility redetermined and will be certified for a new 12- month certification period and will receive a Notice of Decision.

If ~~all~~any members in the household can be administratively renewed, ~~they~~the household 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(s) will not need to take any other action. If any members of the household cannot be administratively renewed, the household will be sent an eligibility renewal letter and a Pre-Printed Renewal Form_(PPRF). 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.

5.7 Redetermination

5.7.1 Redetermination Introduction

Review a disability determination when any of the following are true:

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form and the person is not currently receiving SSDI or SSI Disability Benefits.
2. The person is younger than 65 years old and no longer receives OASDI (Social Security) disability benefits. This does not include members who have converted from OASDI benefits to Social Security Retirement benefits (see Section 5.10.2 Medicaid Members Who Convert from Social Security Disability to Social Security Retirement).
3. The medical circumstances have significantly improved (see [Section 5.7.2 Members Exceeding the Substantial Gainful Activity Level](#)).
4. The person has returned to work.

Complete and/or forward the following paper forms to DDB at Disability Determination Bureau

P.O. Box 7886

Madison, WI 53707-7886

- Medicaid Disability Redetermination Report ([F-10114](#)).
- Signed Confidential Information Release forms.
- The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-832).

- Item 9 (SSA-832) indicates the decision of (A) continuing or (B) ceased.
- Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If the member's disability is found to continue, the DDB will send the paper folder, which includes the SSA-832, to the IM agency to be kept until the next redetermination is made.

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid benefits will continue until a hearing is held and a decision is made. DDB will retain the SSA-832 in these cases.

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a paper folder with a revised SSA-832 will be sent to the IM agency at that time.

If the member appeals the proposed cessation and DDB is unable to reverse this decision, the file will be forwarded directly to the DHA for a hearing. DHA will notify the IM agency of its final decision.

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send the paper folder that contains the original SSA-832 to the IM agency following the expiration of the 45-day appeal period. DDB will add a Medicaid Disability Cessation Case note to the front of the folder to highlight these cases. See [Section 5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text](#) for an example.

Once the IM agency receives final notice of a cessation, then they must follow existing procedures to notify the member of the termination of Medicaid benefits (unless the member qualifies for Medicaid on some other basis). The member will be given another 45 days to appeal that decision.

Note:	The process described above provides the Medicaid member with two opportunities to file an appeal regarding whether or not he or she continues to be disabled. This is the result of federal laws that require the DDB to notify a disabled member of Medicaid or Social Security benefits that he or she no longer meets the disability criteria necessary to continue receiving those benefits. These notice requirements for DDB also include an opportunity for the member to appeal the DDB decision within 45 days. Medicaid benefits must be continued during this potential 45-day appeal period, whether or not the client actually files an appeal. DDB cannot notify the IM agency that the client is no longer disabled until this 45-day appeal period has expired, and the client did not file an appeal within that time frame. Once this initial 45-day appeal period expires, with no appeal request from the client, DDB will then notify the IM agency that the Medicaid member is no longer disabled.
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Upon receipt of the notification (Medicaid Disability Cessation) from DDB, the IM agency must then redetermine whether or not the member qualifies for some category of Medicaid other than that related to disability. If the member is not eligible for any other Medicaid category, the IM agency would then take the necessary action to discontinue the member's Medicaid eligibility in the normal manner, issuing all required notices. The member would then have another opportunity to appeal the termination of his or her Medicaid eligibility. The fact that this second potential fair hearing essentially involves the same issue (disability) that was the subject of the first appeal is irrelevant. As stated earlier, this process is required by federal law.

7.3 Immigrants

7.3.8 Refugee Assistance Programs

7.3.8.2 Refugee Medical Assistance

If ~~an individual does~~ refugees, asylees, and certain other immigrants apply for BadgerCare Plus or Wisconsin Medicaid and ~~do~~ not meet the ~~other~~ eligibility requirements ~~for Medicaid~~, they may ~~apply~~ be eligible for Refugee Medical Assistance (RMA), ~~which is not funded by~~. However, unlike BadgerCare Plus and Wisconsin Medicaid, ~~Refugee Medical Assistance is considered a separate time-limited benefit from Medicaid but~~ and people must apply within a certain timeframe of receiving their refugee, asylee or other eligible immigration status.

RMA provides the same level of benefits. ~~Refugee Medical Assistance is available only in the first 12 months after a special immigrant's date of entry. If it is not applied for in that 12-month period, it cannot be applied for later~~ as BadgerCare Plus but is funded separately.

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

More information about this program is in ~~Wisconsin Works (W-2)~~ the [Bureau of Refugee Programs Policy Manual](#), [Section 18.3 Refugee Medical Assistance](#). [Section 6 Refugee Medical Assistance](#).

Note

The federal Medicaid eligibility for all other refugees admitted under Registration Status Code 04 remains the same.

13.2 Covered Services

Individuals who are inmates of a public institution may be eligible for suspended SSI-related Medicaid or Wisconsin Well Woman Medicaid if they otherwise meet eligibility requirements. See Chapter 24 SSI Related Medicaid and Deductibles or Chapter 36 Wisconsin Well Woman Medicaid for information about these programs.

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

~~During the suspension~~ When a member is incarcerated in a public institution, Medicaid will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

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

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

See Section 13.8.5 Services for Youth for information on coverage for certain pre-release and post-release services for youth.

13.3 Suspension Start Date

13.3.1 Applicants

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

Example 1	Mark is incarcerated on January 17, 2021 . He applies for health care on April 20, 2021 , and is found eligible for suspended SSI-related Medicaid. Mark's suspension start date is April 1, 2021 .
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If the applicant was incarcerated after the first of the application month, the suspension will start the first of the month following the application month.

Example 2	Jane is incarcerated on April 15, 2021 . She applies for health care on April 20, 2021 , and is found eligible. She is certified for full-benefit SSI-related Medicaid from April 1, 2021 , until April 30, 2021 . Jane's suspended SSI-related Medicaid starts on May 1, 2021 . <u>However, the restriction on covered services will be effective April 15 (the date Jane became incarcerated).</u>
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13.3.2 Backdated Eligibility

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

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

Example 3	Sophia is incarcerated on December 4, 2020. Her husband applies for health care for their household on May 21, 2021, and requests three months of backdated benefits. They are found eligible for SSI-related Medicaid. Sophia is open for suspended SSI-related Medicaid starting February 1, 2021. Her husband is open for full-benefit SSI-related Medicaid starting February 1, 2021.
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Example 4	Brady is incarcerated on February 9, 2021. He applies for health care on April 20, 2021, and requests three months of backdated benefits. He is found eligible for SSI-related Medicaid, and opens for full-benefit SSI-related Medicaid from January 1, 2021, until February 28, 2021. He is open for suspended SSI-related Medicaid starting March 1, 2021.
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13.3.3 Existing Members

Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported. This policy applies even when the incarceration is reported untimely. See Section 12.1 Change Reporting Introduction.

Example 53	Olivia is open for full-benefit SSI-related Medicaid. On December 23, 2020 , Olivia reports she is incarcerated as of December 20, 2020 . Olivia's SSI-related Medicaid is suspended starting January 1, 2021 . <u>However, the restriction on covered services will be effective December 20 (the date Olivia became incarcerated).</u>
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13.3.4 Deductibles

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

Example <u>64</u>	Jordan has a Medicaid deductible period from April 1, 2021 , until September 30, 2021 . He meets his deductible on May 10, 2021 , and becomes eligible for full-benefit Medicaid. He is incarcerated on June 19, 2021 . His suspension starts July 1, 2021 , and his certification period goes to September 30, 2021 . <u>However, the restriction on covered services will be effective June 19 (the date Jordan became incarcerated).</u>
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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.

The suspension period will have an end date at the end of a month, but the restriction on covered services will end when the person is no longer incarcerated. That means that the restriction on covered services may end on a date after the suspension end date displayed in the system. See Section 13.2 Covered Services.

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. <u>effective September 1. The restriction on covered services will be lifted on September 20 (the date Dolores is released)</u>
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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.

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 <u>is lifted effective April 1. The restriction on covered services will be lifted on April 3 (the date Risha was released)</u>
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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, of the following year. Cameron is released on December 15, 2020. Cameron opens for full-benefit Medicaid starting. <u>The suspension is lifted effective December 1, 2020.</u> <u>The restriction on covered services will be lifted on December 15 (the date Cameron is released).</u> His renewal date remains June 30, 2021 <u>of the following year.</u>
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15.3 Exempt/Disregarded Income

15.3.36 Guaranteed Income Payments

A guaranteed income payment is excluded for all categories of Medicaid if both of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.

Guaranteed income payments that are excluded include, but are not limited to, payments from the Madison Forward Fund, [the Madison Forward Fund 2.0](#), and The Bridge Project in Milwaukee.

See [Section 16.7.34 Guaranteed Income Payments](#) for information about asset treatment of guaranteed income payments.

15.4 Unearned Income

15.4.4 Retirement Benefits

~~Retirement benefits include work-related plans for providing income when employment ends. Examples of retirement benefits include:~~

- ~~• Pension disability or retirement plans administered by an employer or union~~
- ~~• Accounts owned by the individual, such as IRAs~~
- ~~• Plans for self-employed individuals, sometimes referred to as Keogh plans~~

~~Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.~~

~~Any periodic payments from individually owned accounts (e.g., IRA) should not be counted as income in the month of receipt. They are considered the same as withdrawals from an applicant's savings account. Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.~~

Example 1	Mike withdraws \$2,000 he has in an IRA and deposits it into a savings account. Continue to treat the \$2,000 as a countable asset. This is just a conversion from one form of an asset to another.
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~~See Section 16.11 Retirement Funds~~

15.6 Self-Employment Income

15.6.6 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see [Section 20.3.8 Income](#) ~~Section 20.3.8 Income~~).

Completed IRS tax forms (see [Section 15.6.2.2 By IRS Tax Forms](#)) are sufficient verification of farm and self-employment income. ~~A completed and signed SEIRF (or SEIRFs) is also~~ if tax forms are not available or cannot be used because of a significant change in circumstances, other documents, such as a completed and signed Self-Employment Income Report form(s) (SEIRF) or bookkeeping records, are sufficient verification.

If a Program Add request is made on a case with self-employment income, use the existing ~~SEIRF~~ previously verified information, instead of re-verifying it, if all of the following are true:

- A recent determination was made.
- SEIRFs or bookkeeping records were used.

- No significant change has been reported by the individual.
- The business has not filed taxes in the meantime.

Note:	It is not necessary to collect copies of supportive verification, such as receipts from sales and purchases. However, verification can be requested when the information given is in question (see Section 20.4.1 Questionable Items Introduction). If requesting verification, workers must document the reason for the request in case comments.
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16.7 Liquid Assets

16.7.4 ~~Annuities~~ Reserved

16.7.20 Reserved

16.7.34 Guaranteed Income Payments

A guaranteed income payment that is retained in the month after the month of receipt is excluded as an asset indefinitely if all of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.
- The payment is separately identifiable (See section 16.3 Separate and Mixed Assets).

Guaranteed income payments that can be excluded include, but are not limited to, payments from the Madison Forward Fund, the Madison Forward Fund 2.0, and the Bridge Project in Milwaukee. See Section 15.3.36 Guaranteed Income Payments for information about income treatment of guaranteed income payments.

416.11 Retirement Funds

16.11.1 Types of Retirement Funds

Retirement funds include employer-sponsored retirement plans and individually owned retirement plans.

Employer-Sponsored Retirement Plans

Employer-sponsored retirement plans include:

- 401(k) or SIMPLE 401(k).
- 403(b) Plans: For employees of public schools and certain tax-exempt organizations.
- 457(b) Plans: Deferred compensation plans available to state and local government employees.
- Thrift Savings Plans (TSPs): Similar to a 401(k) plan but only available to federal employees and military members.
- Qualified Pension Plans: Employer-sponsored pension (such as Wisconsin Retirement System's Employee Trust Fund (ETF)).
- Profit-Sharing Plans: Employer-contributed plans.

Individually Owned Retirement Plans

Individually owned retirement plans include:

- Keogh plans: For self-employed individuals.
- Individual retirement arrangements (IRAs): Types include traditional, Roth, SEP, and SIMPLE IRAs.

An IRA can be in the form of an individual retirement account or an individual retirement annuity. An individual retirement account can hold a variety of asset types, including stocks, bonds, mutual funds,

annuities, CDs, and other assets. An individual retirement annuity (also called “IRA annuity”) invests only in fixed or variable annuities and provides a guaranteed income stream at retirement. IRA annuities can be in accumulation or pay out status, but most often IRA annuities are annuitized at the time they are established.

IRAs cannot be jointly owned. IRAs are not transferable and have exclusive benefits for the individual who funded the IRA (or that individual’s beneficiary after they die). In limited situations, a spouse can fund an IRA for their partner, but in that situation only the partner has access to the assets.

Other Funds Set Aside for Retirement

Funds that are intended for retirement but not held in an employer-sponsored or individually owned retirement plan are not considered retirement funds for purposes of Medicaid eligibility. They are evaluated based on the type of account in which the funds are held. For example, if funds being saved for retirement are held in a regular savings account, the funds are evaluated as a savings account.

16.11.2 Retirement Funds as Assets

Employer-sponsored and individually owned retirement plans must be evaluated for availability as assets.

Retirement Funds of a Medicaid Applicant or Member

In general, individually owned retirement plans (IRAs and Keoghs) are counted as available assets. The available amount is calculated as the principal, less any penalties for withdrawal. Tax withholdings are not deducted from the available asset value. Exception: IRA annuities that are currently paying out are treated as annuities rather than retirement funds when evaluating their availability as assets (see SECTION 16.12 ANNUITIES).

<u>Note</u>	<u>For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply to IRA annuities regardless of whether the annuity is evaluated as a retirement fund or as an annuity (see SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS).</u>
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Employer-sponsored retirement plans are not counted as available assets if any of the following are true:

- The individual is currently receiving periodic payments from the plan.
- The individual is still employed and would have to quit their job to obtain the funds.
- The individual does not have access to the account’s principal.

If none of the above are true and the individual has the ability to cash out their employer-sponsored retirement plan, the cash value of the plan (after any penalties but before any tax withholding) is counted as an available asset.

Retirement Funds of an Ineligible Spouse

In general, both employer-sponsored and individually owned retirement plans of an ineligible spouse (defined as a Medicaid applicant or member’s spouse who is not requesting full-benefit health care) are disregarded as assets.

However, IRA annuities owned by an ineligible spouse are only considered exempt retirement funds if the annuitant is the person who funded the IRA. Otherwise, the ineligible spouse’s IRA annuity must be evaluated as an annuity rather than a retirement fund when determining whether it must be counted as an asset (see SECTION 16.12 ANNUITIES).

<u>Note</u>	<u>For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply regardless of whether the ineligible spouse’s IRA annuity is evaluated as a retirement fund or as an annuity (see</u>
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SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS

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Conversion of Retirement Funds

Retirement funds that are cashed out or rolled over are treated as a conversion from one asset type to another.

<u>Example 1</u>	<u>Carol has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and rolls the funds into a newly created IRA. Once the IRA is established, the funds are assessed for asset and income availability as an individually owned retirement plan.</u>
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<u>Example 2</u>	<u>Jane has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and deposits the funds into her checking account. The funds are assessed for asset availability as part of her checking account as soon as they are deposited into the account and are no longer treated as retirement funds.</u>
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16.11.3 Retirement Funds as Income

Employer-Sponsored Retirement Plans

Regular, periodic payments from an employer-sponsored retirement plan are counted as unearned income in the month received.

<u>Example 1</u>	<u>Mike receives \$500 per month from his 401(k) retirement fund and deposits the funds into his checking account. The \$500 per month is counted as unearned income.</u>
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Individually Owned Retirement Plans

Withdrawals and distributions from individually owned retirement funds (IRAs and Keoghs) are not counted as income. These transactions are considered a conversion from one asset type to another, similar to a withdrawal or transfer from a bank account. Exception: IRA annuities that are currently paying out are treated as annuities rather than retirement funds when evaluating their availability as income (see SECTION 16.12 ANNUITIES).

<u>Example 2</u>	<u>Mike regularly withdraws \$500 per month from his IRA and deposits the funds into his checking account. The \$500 per month is not income. It is an asset in his checking account.</u>
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16.12 Annuities

16.12.1 Annuity Introduction and Definitions

An annuity is a purchase contract where the purchaser (person funding the annuity) pays a lump sum or makes periodic payments to a bank or insurance company (annuity issuer) in return for an expectation of future payments.

The annuitant is the person entitled to the payments. ~~These~~ An annuity may include a beneficiary clause under which, if the annuitant dies, the contracting entity converts any funds remaining in the annuity into a lump sum or periodic payments which are paid to a designated remainder beneficiary. Depending on the settlement option of an annuity, payments may continue for a fixed period or for as long as the annuitant or another designated beneficiary lives, creating an ongoing income stream. ~~The annuity may or may not include a remainder beneficiary clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum or periodic payments that are paid to a designated beneficiary from the previously deposited funds.~~

~~It is most common for~~ When an annuity to have cash surrender value during the accumulation phase is established, payments may be immediate or deferred. Deferred annuities are established with a funding timeframe, called an accumulation phase. The accumulation phase ~~This is the~~ a period when the investor makes deposits are made into the annuity to build up its cash value. Some annuities (such as immediate ~~Immediate~~ annuities) don't have an accumulation phase because they are annuitized at the time of purchase.

~~The pay~~ Typically, annuities only have cash surrender value during the accumulation phase. The pay-out phase ~~phase~~ (annuitization) begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

~~If the annuity's cash value is available for withdrawal (minus any penalty), the annuity can be surrendered.~~ Revocable vs Irrevocable Annuities

If the terms of the annuity contract allow the fund to be surrendered, it is considered revocable. If the terms of the annuity contract do not allow the annuity fund to be surrendered, it is considered irrevocable.

16.7.4.12.2 Treatment of Annuities as Assets or Income

~~When an annuity is in the payout phase, payments are only counted as unearned income if the annuity itself is considered an unavailable asset. Annuities that~~ Asset Treatment of Annuities

Annuities that can be surrendered (revocable annuities) are considered available, countable assets include the following:

- ~~• Annuities that can be surrendered (see SECTION 16.7.4.3 CASH VALUE OF ANNUITIES THAT CAN BE SURRENDERED).~~
- ~~• Annuities purchased on or after March 1, 2004, that cannot be surrendered, but can be sold on the secondary market (see SECTION 16.7.4.4 AVAILABILITY OF ANNUITIES THAT CANNOT BE SURRENDERED (IRREVOCABLE ANNUITIES)).~~

16.7.4.3 Cash Value of Annuities That Can Be Surrendered

~~To determine the cash,~~ The countable asset value of an annuity that can be surrendered (for example, an annuity in the accumulation phase), use the following formula ~~is determined as follows:~~

- Total deposits made to the annuity

- Plus any earnings on the deposits not previously paid out
- Minus any earlier withdrawals and any surrender costs charged for the withdrawal. Income tax withheld or tax penalties for early withdrawal ~~should~~are not ~~be~~ deducted from the ~~cash~~ surrender value.

16.7.4.4 Availability of Annuities That Cannot Be Surrendered (Irrevocable Annuities)

~~An that cannot be surrendered (irrevocable annuity may or may not be annuities) are considered an available, countable asset, depending on when it was purchased and whether it can be sold on the secondary market.~~

~~If an irrevocable annuity was purchased prior to March 1, 2004, it unavailable assets. For long-term care cases, irrevocable annuities must be evaluated for divestment (see SECTION 17.2.6.14 IRREVOCABLE ANNUITIES). An irrevocable annuity is considered an unavailable asset on the date the settlement option iswas made final. (typically the annuitization date).~~

~~If an irrevocable annuity was purchased on or after March 1, 2004, it is only considered unavailable~~Income Treatment of Annuities

Annuity payments are counted as unearned income if the ~~owner cannot sell the annuity on the secondary market.~~

~~Even if the annuity contract states that it is “non-assignable” or “non-transferrable,” it may still be possible to sell the rights to the income stream. In general, retirement and pension annuities cannot be sold on the secondary market.~~

~~To verify the availability of an irrevocable annuity purchased on or after March 1, 2004, the agency must check the annuity contract to see if the annuity (or the right to receive the income stream from the annuity) can be sold:~~

- ~~If it can be sold, it is considered an available asset unless the applicant or member demonstrates that they have made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.~~

~~If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity or the right to the payments, that amount is considered an available asset. The annuity is considered is an unavailable asset if the company provides documentation that it places no value on the annuity. Unavailable annuities must be evaluated for possible divestment (see SECTION 17.2.6.14 IRREVOCABLE ANNUITIES).~~

~~Example 1
Cynthia is 83 years old and applying for Medicaid. She purchased an immediate annuity for \$110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. The contract states that it is irrevocable and non-assignable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia’s annuity contract at \$82,000. Cynthia’s annuity is therefore considered to be an available asset with a value of \$82,000, which is the amount used to determine Cynthia’s Medicaid eligibility. The payments from the annuity are not counted as income.~~

Example 2	Sam is 66 years old and applying for Medicaid. He purchased an immediate annuity for \$110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. The contract states that it is irrevocable and non-transferable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written
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~~statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility. The payments from the annuity are counted as income. Because the annuity is unavailable and was purchased during the look back period, it must be evaluated for possible divestment.~~

Annuity payments are not counted as unearned income if the annuity is an available asset.

16.7.4.512.3 Long-Term Care Annuity Disclosure Requirement for Long-Term Care and Remainder Beneficiary Designation Requirements

~~People applying for or receiving Medicaid long-term care services are required at application and renewal to disclose information about any annuities that meet both of the following criteria:~~

- ~~• The institutionalized person or their community spouse has an interest in the annuity.~~
- ~~• The annuity was purchased or substantively changed on or after January 1, 2009.~~

For long-term care cases, annuities purchased or substantively changed after January 1, 2009, are subject to annuity disclosure (see SECTION 16.12.3.1 ANNUITY DISCLOSURE) and remainder beneficiary designation (see SECTION 16.12.3.2 REMAINDER BENEFICIARY DESIGNATION) requirements.

Annuities purchased prior to January 1, 2009, that have not been substantively changed since that date are not subject to LTC annuity disclosure or remainder beneficiary assignment requirements, but these annuities must still be reported and evaluated for their availability as income or assets.

The following actions are considered substantive changes:

- Additions of principal
- Elective withdrawals
- Requests to change the distribution of the annuity
- Elections to annuitize the contract
- A change in ownership
- Any other non-routine action not listed below

The following actions ~~do not subject an annuity that was purchased prior to January 1, 2009, to the disclosure requirement~~are not considered substantive changes:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances.
- Changes that occur based on terms of the annuities that existed prior to January 1, 2009, and which do not require a decision, election, or action to take effect.
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A-separate 16.12.3.1 Annuity Disclosure

For annuities purchased or substantively changed after January 1, 2009, an annuity disclosure form (Annuity Information - Disclosure, ~~F-10192~~ F-10192) must be completed for each annuity owned by the ~~institutionalized person~~ LTC applicant/member or their community spouse. ~~This form must also be sent to SSI recipients who are applying for a community-based long-term care program (including Family Care, Family Care Partnership, and PACE). A copy of the completed form and any documents verifying the status of the annuity must be stored in the case file.~~

If the long-term care applicant or member, their spouse, or representative refuses to disclose the required information related to the annuity, the LTC applicant or member is /member or their community spouse does not complete the annuity disclosure form, they are ineligible for Medicaid coverage of long-term ~~care services~~ care services for failure to ~~cooperate in providing~~ provide requested information.

16.7.4.6~~12.3.2~~ **Remainder Beneficiary Designation Requirement for Long-Term Care**

For annuities purchased or substantively changed after January 1, 2009, the annuity contract must name the State of Wisconsin Estate Recovery program as the remainder beneficiary in the first position, or in second position if a community spouse or minor or disabled child is named in the first position, unless it is verified that the annuity has no death benefit.

To fulfill this requirement, the annuity owner must complete and submit the Medicaid Annuity Beneficiary Designation form (F-10191) to the IM agency. The form must be completed when the annuity is disclosed even if the State of Wisconsin Estate Recovery program is already named as the appropriate remainder beneficiary on the annuity contract.

If the completed F-10191 is received by the due date, the eligibility determination must be completed and the completed F-10191 along with the Medicaid Issuer of Annuity - Notice of Obligation form (F-10190) must be sent to both the annuity issuer and the Wisconsin Medicaid Estate Recovery program. If the LTC applicant/member or spouse fails to cooperate with naming the state as remainder beneficiary when required, a divestment penalty period will be imposed. The divested amount is the full purchase price of the annuity.

~~When an individual is requesting or receiving Medicaid long-term care services, they must complete an annuity designation form (Medicaid Annuity Beneficiary Designation form, F-10191) for all annuities that meet the criteria in SECTION 16.7.4.5 ANNUITY DISCLOSURE REQUIREMENT FOR LONG-TERM CARE.~~

~~After receiving the completed annuity designation form, the IM agency must then complete the notice of obligation form (Medicaid Issuer of Annuity – Notice of Obligation, F-10190) and send the completed form (along with the corresponding completed annuity designation form) to the annuity issuer, instructing them to make the Wisconsin Department of Health Services Estate Recovery Program a remainder beneficiary. The issuer must be allowed up to 30 days to confirm the designation has been made.~~

~~The Wisconsin Department of Health Services Estate Recovery Program must be the primary remainder beneficiary unless a community spouse, disabled child, or minor child is listed as the primary remainder beneficiary. If a community spouse, disabled child, or minor child is the primary beneficiary, the Wisconsin Department of Health Services Estate Recovery Program must be the secondary remainder beneficiary.~~

~~When the issuer responds and indicates that the state has been designated the remainder beneficiary or that there is no death benefit available under this annuity, the annuity must be treated as meeting the designation requirement.~~

~~If the issuer does not respond within 30 days of the date when the Notice of Obligation form was sent, the IM agency must contact the issuer by phone and request that they respond within 10 days. If the issuer does not respond within 40 days after the Notice of Obligation form was sent, the agency should contact the CARES Problem Resolution Center for further guidance.~~

~~If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, the agency should contact the CARES Problem Resolution Center for further guidance.~~

16.12.3.3 Notice of Obligation to Annuity Issuer

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the ~~Notice of Obligation form.~~ Medicaid Issuer of Annuity - Notice of Obligation form (F-10190). When the IM agency receives a completed F-10190, or any other subsequent annuity

information from the annuity issuer, it must be sent to the Estate Recovery program.

~~Copies of the completed forms must be saved in the case file.~~

~~A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process~~

~~The divested amount is the full purchase price of the annuity.~~

16.7.20 Retirement Benefits

~~Retirement benefits include work-related plans for providing income when employment ends (e.g., pension disability or retirement plans administered by an employer or union).~~

~~Other examples of retirement funds include accounts owned by the individual, such as IRAs and plans for self-employed individuals, sometimes referred to as Keogh plans.~~

- ~~• Employment related pension plans should be treated as follows:
 - ~~• If an applicant or member has the ability to cash in a work-related benefit, the net amount of the benefit (after any penalties but before any tax withholding) available to the applicant or member should be treated as an available asset. Some retirement benefit plans allow employees to cash in their benefits as a lump-sum payment when they leave their job instead of waiting until they reach retirement age to get the pension. However, do not count retirement funds as an available asset if the applicant or member has to quit a job to get at the retirement funds or if the applicant or member is receiving periodic payments from the retirement benefit plan.~~
 - ~~• If the applicant or member does not have access to the account's principal in his or her retirement benefit plan, the principal should be treated as an unavailable asset.~~
 - ~~• Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.~~~~
- ~~• Individually-owned retirement funds, such as IRAs, Keogh plans, etc., that are owned by the applicant or member should be counted as available non-exempt assets (minus any early withdrawal penalty) for the Medicaid applicant or member. The applicant or member always has access to the principal in these accounts, subject to an early withdrawal penalty.~~

~~Any periodic payments from these accounts should not be counted as income in the months of receipt. These payments are considered assets. They are considered the same as withdrawals from an applicant's saving account. Only interest earned on the funds in a retirement fund is to be counted as income (see Section 15.4.9.1 Elderly, Blind, or Disabled Interest and Dividend Income).~~

- ~~• Disregard work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs, of an ineligible spouse in an EBD case. This policy includes the disregard of retirement funds held by the community spouse in spousal impoverishment cases.~~

~~Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.~~

Example 11	Mike withdraws \$2,000 from his IRA and deposits it in a savings account. Continue to treat the \$2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.
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16.7.34 Guaranteed Income Payments

~~A guaranteed income payment that is retained in the month after the month of receipt is excluded as an asset indefinitely if all of the following apply:~~

- ~~• The payment itself is privately funded.~~
- ~~• The payment is administered by a non-profit organization.~~
- ~~• The payment is separately identifiable (See section 16.3 Separate and Mixed Assets).~~

~~Guaranteed income payments that can be excluded include, but are not limited to, payments from the Madison Forward Fund and the Bridge Project in Milwaukee.~~

~~See Section 15.3.36 Guaranteed Income Payments for information about income treatment of guaranteed income payments.~~

20.1 Verification

20.1.4 General Rules

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

Example <u>1</u>	Marie reports on her application that she is a U.S. citizen. She also reports that the primary language spoken in her home is a language other than English, and it is her preferred language. Marie's U.S. citizenship was found questionable because she has a preferred language that is not English. A request was sent to Marie to specifically submit her birth certificate in order to verify her U.S. citizenship. This action is not allowed. Verification of U.S. citizenship must first be attempted through data exchange or other documentation as explained in Section 7.2 Verifying U.S. Citizenship.
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6. The applicant or member can't be required to sign a release form (either blanket or specialized) when the member provides required verification.
7. Verification of information that is not used to determine eligibility can't be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.

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

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

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

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

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

20.3 Mandatory Verification Items

20.3.8 Income

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

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e., check stubs, award letters, etc.). The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

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

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

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

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

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

This section addresses reasonable compatibility for income. Reasonable compatibility for assets can be found in [Section 20.3.5.2 Reasonable Compatibility for Assets](#)[Section 20.3.5.2 Reasonable Compatibility for Assets](#).

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see Section 15.5.18 Prison or Jail Job), or information from the data source is not "reasonably compatible" with what the applicant has reported. Information from a data source that supports an

eligibility determination based on the attested information provided by an applicant or member is considered “reasonably compatible.”

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

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

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

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

Self-employment and in-kind job income are verified as outlined in [Section 15.6.6 Verification](#) and Section 15.5.1 Income In-Kind and [Process Help Sections 16.2](#) and [16.6](#).

20.3.8.1.1 Programs for Which Reasonable Compatibility Will Apply

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

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

20.3.8.1.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each AG for which earned income is reported, has not already been verified, and for which SWICA and/or Equifax data is available. Because different AGs are subject to different income and premium thresholds, the thresholds described below will be used by population as the first step in determining whether reported information is reasonably compatible.

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

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

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

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

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	And total gross income using the monthly earnings reported by SWICA or Equifax is:	Is it reasonably compatible?
Equal to or below the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
Equal to or below the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	The 20% threshold test occurs. <ul style="list-style-type: none"> • If the total gross income using the monthly earnings reported by SWICA or Equifax is equal to or less than 120% of the total gross income using the monthly earnings amount reported by the member, the amounts are reasonably compatible. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed. • If the total gross income using the monthly earnings reported by SWICA or Equifax is greater than 120 % of the total gross income using the monthly earnings amount reported by the member, the amounts are not reasonably compatible. Further verification must be requested.
Above the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

Above the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
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Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

Example 4	<p>Leonard is applying for EBD Medicaid. He is not married and has no children. The SSI-Related Medically Needy monthly income limit is \$1,304.17. Leonard reports monthly earned income of \$1,200; this is his only income, and it is below the income limit. The State Wage Information Collection Agency (SWICA) reports that Leonard’s monthly earned income is \$1,400. This income amount is above the income limit. Therefore, the reasonable compatibility test using the 20% threshold will be applied.</p> <p>The 20% threshold amount is the amount that is 20% greater than the total income that includes the earned income reported by the applicant or member. In this example, the 20% threshold amount is \$1,440. The total income that includes the earned income reported by SWICA (\$1,400) is less than the 20% threshold amount (\$1,440). Therefore, the amounts are determined to be reasonably compatible. Leonard does not need to verify the earned income.</p>
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20.3.8.1.3 Reasonable Compatibility Test

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

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

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

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

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

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

20.3.8.1.4 Use of Equifax Data for Verification of Income

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

If the member reports that he or she is unable to obtain the requested verification, the worker should assist the member in obtaining verification (see [Section 20.1.4](#), [Section 20.1.4](#)). If the applicant and/or worker have made reasonable efforts to obtain verification and are not able to do so, then the agency

should determine the income amount based on “best available” information, and then document how this amount was determined.

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

26.3.4 Work Requirement Exemption

If serious mental or physical illness or hospitalization that causes the member to be temporarily unable to work or participate in the HEC program, the work requirement can be suspended for up to six months. The IM agency may grant up to two non-consecutive work requirement exemptions (up to six months each) within any three-year period. The member must contact the IM agency to request the exemption using the Medicaid Purchase Plan (MAPP) Work Requirement Exemption ([F-10127](#)) form.

The agency may grant a work requirement exemption if the MAPP member:

- Has been enrolled in MAPP for at least six months and has paid any applicable premiums prior to the request of an exemption.
- Is expected to be able to return to work within the next six months.
- Provides a doctor’s statement as proof of the mental or physical health-related hardship making them unable to work or participate in the Health and Employment Counseling program.
- Has not already been granted two exemptions in the past three years.

The MAPP member must continue to pay all applicable premiums during the work requirement exemption period or have an approved temporary premium waiver.

DHS may also grant a temporary waiver of the work requirement for good cause.

Example 1	A MAPP member who has already been granted two work requirement exemptions by the IM agency within the last three years has a car accident and will be unable to work for three months. The agency cannot grant a third exemption but can refer the request to DHS for consideration.
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If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

In the last month of an exemption, the agency must send a notice to the member indicating the date the work requirement exemption will end and any steps the member must take to continue MAPP eligibility.

26.3.5 Health and Employment Counseling Program

Health and Employment Counseling (HEC) is a pre-employment program for MAPP members who are not employed but are looking for work. HEC participation is one way to meet the MAPP work requirement. Individuals enrolled in or applying for MAPP who are interested in HEC can call 866-278-6440 to learn more about the program.

HEC participation can occur for up to nine months with one three-month extension, for a total of 12 months.

- Members can re-enroll in HEC to meet the eligibility criteria for MAPP. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

26.3.5.1 Health and Employment Counseling Processing

MAPP applicants or members interested in enrolling in HEC are required to complete and submit a HEC Application (F-00004). Applications may be printed from the Department of Health Services' website at: <https://www.dhs.wisconsin.gov/employment-skills/hec-faq.htm>. Applicants can also contact their local agency to request a HEC application be mailed to them. The applicant can complete the application on their own, with the assistance of the HEC coordinator or an advocate. IM workers are not expected to assist with completing or submitting the form for the applicant.

Once submitted, the HEC coordinator will make a final approval or disapproval decision within 10 business days. If the HEC application is approved, the HEC coordinator will send the member an approval letter and notify the IM agency. The HEC period ~~will~~ can begin as of the first of the month ~~the~~:

- The approved application was submitted ~~if the~~
- The application was approved
- After a member's existing work activity ends
- An applicant's MAPP begins

The application is not approved, the member will be informed that they have not been approved and can contact the HEC coordinator with any questions. The right to file a fair hearing will be provided on their notice of decision for MAPP eligibility.

Note	Qualifying for HEC is contingent on the member having an approved disability determination. A HEC application for an individual with a pending disability determination will be processed after a disability decision has been made by DDB. If approved, retroactive HEC participation will <u>can</u> begin the first of the month the approved HEC application was submitted.
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26.3.5.2 Health and Employment Counseling Extension

If the HEC period is ending prior to the member meeting their employment plan goals, the member can apply to extend their HEC period by three months.

A HEC Extension Request form (F-00004A) will be sent to the member two months before their 9-month HEC period will end. To avoid any gaps in coverage, the participant should apply for an extension before the end of the seventh month of their HEC period. To be approved for an extension, the participant must request an extension before the last day of their HEC period. The HEC coordinator will make an approval or denial decision within 10 business days. ~~The and the~~ member will be mailed a decision letter.

26.5 MAPP Premiums

26.5.8 Temporary MAPP Premium Waivers due to Hardship

MAPP applicants and members who experience a temporary hardship that makes them unable to pay their premium can apply for a temporary premium waiver. There is no limit to how many temporary premium waivers may be requested, but the temporary premium waiver cannot exceed 12 months in duration for the same hardship reason. Applicants and members may request the premium waiver for a backdated period of up to three months, but the premium waiver cannot exceed 12 months. If a temporary premium waiver is approved for months where a premium has already been paid, those premiums must be refunded.

To request a temporary premium waiver, MAPP applicants and members will use the Request for a Temporary Waiver of Your Medicaid Purchase Plan Premium Because of a Difficult Situation (F-02603) form. The applicant or member must describe the short-term hardship and state when it began (up to three months in the past) and its expected duration.

~~Note that temporary premium waiver periods can begin no earlier than August 1, 2020.~~

A qualifying temporary hardship is an unexpected, unusual expense or situation related to the member's health or ability to work, such as an injury or illness, or reduction of hours worked.

A temporary hardship may include, but is not limited to, the following:

~~The, when the~~ applicant or member ~~has~~:

- ~~Has~~ an unusual expense related to ~~his or her~~their health or ability to work. An unusual expense is an expense that is necessary for the ability of the individual to work or take care of ~~his or her~~their health that is not a regular, recurring, or planned expense. The expense cannot be anything that was used to establish eligibility or the premium amount for the individual, as these should be regular and recurring.
- ~~The applicant or member has~~Has experienced a decrease in work hours.
- ~~The applicant or member has~~Has lost a job but remains non-financially eligible due to a medical exemption or participation in a HEC plan.
- ~~The applicant or member is~~is the survivor of a crime, such as someone who has ~~experience~~experienced domestic violence or sexual assault, battery, theft, and other crimes. As a result, the member has incurred extra expenses or is unable to access ~~his or her~~their funds due to the crime.
- ~~The applicant or member is experiencing~~is experiencing temporary transportation issues, causing a decrease in the hours ~~he or she~~they can work.
- ~~The applicant or member i~~s experiencing temporary child care issues, causing a decrease in the number of hours ~~he or she~~they can work.

~~The~~Situations that do not qualify for a temporary premium waiver include, but are not limited to:

- Expenses that are not related to an applicant or ~~member has experienced a sudden~~member's health or ability to work.
- Inflation or other regular increase in ~~household~~price, such as groceries or gasoline.
- Regular, recurring expenses ~~such as that can be budgeted for, like rent, vehicle insurance, or utilities, gas, etc~~that are not the result of an unexpected or unplanned change.

IM workers will be required to review temporary premium waiver requests and approve or deny them within 30 calendar days after receipt of the request.

In determining whether there is hardship, the IM worker may only consider circumstances that are documented. Hardship must be verified (see Section 20.1 Verification~~Section 20.1 Verification~~). Proof includes, but is not limited to, the following:

- Agency form
- Employer statement/paystub/taxes/Employer Verification of Earnings form (EVF-E)
- Collateral contact
- A statement from a health care or mental health provider, such as a medical doctor, psychiatrist, social worker, AODA professional, or psychologist, that identifies there is an issue and time period in which the individual cannot work.
- A receipt for the unusual health or work related expense.

Verification must be received by the due date (or the extended due date if additional time is requested) in order to process an application for a temporary waiver of premium. If verification is not received by the due date or extended due date, the request must be denied. This denial does not prevent the applicant or member from submitting another request for the same time period and being approved once verification has been received, as long as the request does not include a backdate of longer than three months prior to the month the request is received.

Example 7:	On November 1, John requested a temporary waiver of premium starting August 1, but he did not provide the requested verification, so the request was denied. On December 1, John submits a new request for a temporary waiver of premium with the appropriate verification. The earliest that the waiver could be approved is September 1.
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If the request for temporary waiver of premium is denied, the waiver applicant will be notified. The waiver applicant has the right to appeal the decision through a written request to the Division of Appeals (DHA). The waiver applicant has 45 calendar days from the date of the notice issuance to file the appeal.

If the request is approved, the premium waiver period will begin on one of the following:

- The first day of the month in which the temporary premium waiver request was received.
- The first day of the month after the month in which the temporary premium waiver request was received.
- The first day of the month one, two, or three months prior to the month in which the temporary premium waiver request was received, if the applicant or member stated on the request form that the temporary hardship began in the past.

When processing temporary premium waiver requests received before October 2020, IM

Note: workers should remember that the premium waiver period can begin no earlier than August 1, 2020, even if the hardship began before August 1.

Example 8:	Susie requests a temporary waiver of premium on March 31. If approved, the premium waiver period could start as early as December 1 and as late as April 1, depending on the request and the verification.
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The member's premium will be waived for the duration approved by the agency (up to 12 months). Temporary premium waivers that have been granted for a shorter duration than 12 months can be extended at the member's request for up to the full 12-month limit for a given hardship reason.

Example 9:	Mae is a MAPP member who uses a car to get to work. Her vehicle requires an expensive fix by a mechanic. She requests a three month temporary premium waiver to help her redirect the funds toward the repairs on the car. The request is approved. When the repairs are completed, they were twice what she was quoted. She requests a three month extension of her temporary premium waiver in order to redirect those funds to the remaining repair bill. That request is approved.
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Example 10:	Stan is a MAPP member. He is experiencing health concerns that impact his ability to work the number of hours he typically works. While the IM worker has adjusted his premium due to the decrease in income, his doctor tells him it could be nine months before he will be back to normal work hours. He requests a temporary premium waiver and is approved. At month eight of his premium waiver, Stan's doctors inform him that they cannot approve an increase in his hours for another six months. Stan requests an extension to his temporary premium waiver. Because he has an approved nine month waiver and the maximum time a waiver can be granted for the same hardship reason is 12 months, the IM worker can only approve an additional three months to extend the waiver.
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32.8 Medicare Beneficiaries Backdating

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for QMB do not correctly begin on the first of the following month. This can occur if:

- The eligibility process was not completed within 30 days.
- Certification of eligibility was not completed.
- A fair hearing decision has ordered backdated QMB benefits.

See [Process Help Section 61.2.2](#) for instructions for QMB backdating.

[For QMB renewals, see MEH Section 32.7.1.2 QMB Renewals for information for QMB begin dates following a renewal.](#)

32.8.2 SLMB, SLMB+, QDWI Backdating

Benefits can be backdated for up to three months prior to the month of application, or within three months of a late renewal (see MEH Section 3.1.6 Late Renewals). Use the backdating guidelines in Section 2.8.2 Backdated Eligibility.

A person cannot receive backdated SLMB, SLMB+, or QDWI benefits for months in which he or she would have been income-eligible for QMB.

Example:	Henry applied for MSP on June 15. He also requested a three-month backdate. His income for June was under the QMB income limit (100% of the FPL). He was determined eligible for QMB for ongoing months. His backdated eligibility was denied because his income in each of the backdated months of March, April, and May was under the QMB income limit (100% of the FPL). Since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB or SLMB+ benefits.
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33.16 SeniorCare Benefits

33.16.1 SeniorCare Benefits Introduction

For all of the participation levels, SeniorCare allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.
5. Certain vaccines. For a list of covered vaccines, ~~please access this Wisconsin Department of Health Services webpage~~ SeniorCare Vaccines.

Most prescriptions are limited to a 34-day supply of medication. There are a few classes of medications that are allowed to be filled as a three-month supply. Members should work with their pharmacist and prescriber to determine whether it is clinically appropriate to dispense a three-month supply. The co-payment amount is not affected by the number of days in the supply.

Note: Some drugs require prior approval from the SeniorCare program, called prior authorization.

Note:	The member should contact his or her provider to verify that SeniorCare covers a specific drug.
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SeniorCare does not cover the following:

1. Prescription drugs administered in a physician's office.
2. Prescription drugs that are experimental or are for a cosmetic; and not a medical, purpose.
3. Over-the-counter drugs such as vitamins and aspirin, even with a prescription.
4. Prescription drugs for which authorization has been denied.
5. Prescription drugs from manufacturers who have not signed the appropriate rebate agreement:
 1. Prescription drugs for members in levels 1 and 2a are limited to drugs from manufacturers who have signed a federal rebate agreement.
 2. Prescription drugs for members in levels 2b and 3 are limited to drugs from manufacturers who have signed a SeniorCare rebate agreement with the state of Wisconsin.
6. Drugs that have not been dispensed from a pharmacy.

Note:	Immunizations and vaccines (for example, flu shots, pneumonia vaccines, etc.) are not covered under the SeniorCare program.
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If a member chooses to purchase a prescription that is not covered under SeniorCare, they are responsible for the cost at the pharmacy's retail price and it will not count towards their spenddown and/or deductible.

SeniorCare provides medication therapy management (MTM) services. The MTM services are provided by the pharmacist to answer the member's questions about the drugs they get. The goal of MTM services is to help the member understand more about the drugs they take, make sure they are taking their drugs properly, and make sure they are only taking drugs they need.

34.1 Emergency Services

34.1.1 Emergency Services Eligibility Introduction

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 for Medicaid because of their immigration status is eligible for Emergency Services Medicaid coverage if they:

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

See BadgerCare Plus Handbook, [SECTION 39.1 EMERGENCY SERVICES INTRODUCTION](#) 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~~immigrants.

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 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.
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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 immigrant meets all other eligibility requirements during the dates of service and to certify if they are eligible for Emergency Services.

If a non-qualifying alien immigrant provides a Certification of Emergency for Non-U.S. Citizens form (F-01162) at the time of application, determine 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 immigrant does not have the form at the time of application, ask them for the dates that 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. They must meet the eligibility requirements for their type of Medicaid, such as being elderly, blind, or disabled,* and provide required verifications. The IM agency must provide a manual positive or negative notice regarding the applicant's eligibility. Positive notices must provide the dates of eligibility for Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

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

Note	Emergency Services has the same policies on referrals to child support agencies (CSA) and cooperation as Medicaid (see Chapter 8 Medical Support).
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34.1.2.1 Medicaid Deductible

Individuals may become eligible for Emergency Services by meeting the Medicaid deductible. If, on the date they apply, they are otherwise eligible except for excess income, normal deductible policies (see Section 24.2 Medicaid Deductible Introduction) are applicable.

36.3 WWWMA Nonfinancial Requirements

36.3.2 Disqualifying Insurance Coverage

A person is ineligible for WWWWMA if they are currently ~~covered by~~ enrolled in any of the following:

- Group health plans that cover treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Full benefit health insurance that covers treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Medicare Part A
- Medicare Part B
- BadgerCare Plus without a premium or any other category of full benefit Medicaid that covers their treatment for breast or cervical cancer or precancerous condition of the breast or cervix

Note	An unmet deductible is not full benefit Medicaid. <u>A person who must meet a deductible to be enrolled in BadgerCare Plus or Medicaid but has not yet met the deductible is not considered to be enrolled in BadgerCare Plus or Medicaid. This person may be eligible for WWWWMA if they meet all other eligibility requirements.</u>
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- Veteran's benefits/TRICARE that cover treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Federal employee health plans
- Peace Corps health plans
- Other full-benefit private or public health care plans that provide cancer treatment as determined by their health care team

Except for BadgerCare Plus or Medicaid, a person is ineligible for WWWWMA if they are enrolled in any of these health care plans and have not yet met a deductible for the plan.

Health insurance coverage information is collected at application and renewal. Health insurance coverage information available to Wisconsin Medicaid from third party liability sources may also be used to identify if a person has current coverage.

39.4 Elderly, Blind, or Disabled Assets and Income Tables

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

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	\$3, 406.66 <u>525.00</u>	7/1/ 2024 <u>2025</u>	Yes
Shelter Base Amount	\$1, 022.00 <u>057.50</u>	7/1/ 2024 <u>2025</u>	Yes
Community Spouse Income Allocation Maximum	\$3,948.00	1/1/2025	Yes
Dependent Family Member Income Allowance Maximum	\$ 851.67 <u>881.25</u>	7/1/ 2024 <u>2025</u>	Yes
Dependent Family Member Income Allowance Standard	\$2, 555 <u>643.75</u>	7/1/ 2024 <u>2025</u>	Yes
Community Spouse Asset Share (CSAS) Maximum	\$157,920	1/1/2025	Yes