

Medicaid Handbook Coversheet

Change Summary for Medicaid Eligibility Handbook Release 25-04

Release Date: 12/10/2025

This coversheet contains a summary of the changes included in this release and the redline edit changes that were made in the handbook.

Policy Changes

TOPIC	SUMMARY	SECTIONS	SOURCE
MAPP Premium Project	<p>Project introduces changes in how applicants pay an initial MAPP premium and how MAPP members pay ongoing premiums.</p> <p>MAPP members that do not pay their monthly premium will lose MAPP eligibility at the end of the month following the month the premium had been due.</p>	<ul style="list-style-type: none"> • 26.5 MAPP Premiums 	<ul style="list-style-type: none"> • OM 25-16
Medicaid Redetermination Compliance Project	<p>When a member no longer meets the eligibility requirements of their current health care category at a renewal or due to a change in their circumstances, the IM agency must determine whether the member qualifies for a different health care category. The member's existing coverage must be maintained while eligibility for all other health care programs is being determined. This</p>	<ul style="list-style-type: none"> • 2.9 Denials and Terminations • 3 Eligibility Renewals and Redeterminations • 20.7 When to Verify • 20.8 Actions • 23.1 Notices • 26.7 MAPP Changes • 27.10 ILTC Liability Effective Dates • 28.6 HCBWLTC Eligibility Groups and Cost Sharing • 29 Katie Beckett • 32 Medicare Savings Program • 33.15 SeniorCare • 36 Wisconsin Well Woman Medicaid 	<ul style="list-style-type: none"> • OM 25-07 • OM 25-17

	includes transitions to a disability Medicaid type, when disability needs to be determined.		
Katie Beckett Disability	New subsections addressing KBM members that are no longer eligible for Katie Beckett Medicaid Katie Beckett and how their disability status is transitioned while eligibility for other health care programs is being determined.	<ul style="list-style-type: none"> • 5.2.1 Definition of Disability • 5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs • 28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy 	<ul style="list-style-type: none"> • OM 25-19
HMO Enrollment	Wisconsin updated its managed care authority for BadgerCare Plus and SSI HMOs to reflect that sickle cell gene therapy recipients are excluded from managed care. This change is effective 1/1/26.	<ul style="list-style-type: none"> • 21.6.5 Enrollment Exceptions 	<ul style="list-style-type: none"> • Wisconsin is one of the states participating in the CGT Access Model project via WI SPA 25-0012 which was approved by CMS on 7/21/2025.

Clarifications and Corrections

TOPIC	SUMMARY	SECTIONS
Renewals, Changes, and Related Verification	Alignment of text with BadgerCare Plus Handbook. Reorganization of the section numbering to align with BadgerCare Plus Handbook.	<ul style="list-style-type: none"> • 3 Eligibility Renewals and Redeterminations • 20.7 When to Verify • 20.8 Actions • 23.1 Notices
Disability Redeterminations	Removing outdated processing language. Process was automated as a part of Disability Redetermination Project in October 2023.	<ul style="list-style-type: none"> • 5.7.1 Redetermination Introduction

Immigration	Clarification following reports that the U.S. Department of Health and Human Services has shared Medicaid beneficiary information with the Department of Homeland Security. IM agencies and Tribal agencies cannot share member information for immigration enforcement purposes.	<ul style="list-style-type: none"> • 7.3.5 Immigration and Customs Enforcement (ICE) Reporting
Gifts	Clarification of the value allowed to be disregarded as a gift.	<ul style="list-style-type: none"> • 15.4.6 Gifts • 16.7.21 Gifts
Deductible and Remedial expenses	<ul style="list-style-type: none"> • Moved portion of info out from 24.7 into 15.7.3. • Removed remaining information from when the Deductibles moved into CWW from Mainframe. • Edited out references to years in examples. • Clarification on deductible prepayments to match PH 19.3.2. 	<ul style="list-style-type: none"> • 15.7.3 Medical/Remedial Expenses • 24.7 Meeting the Deductible
Reasonable Compatibility and Unearned Income from Equifax	<p>Updating to specify this policy is for earned income, due to recently discovering that Equifax/Federal Data Services Hub (FDSH) also provides unearned income data.</p> <p>Removing processing text that is already in Process Help.</p> <p>Aligning this section with the corresponding section in the BadgerCare Plus Handbook.</p>	<ul style="list-style-type: none"> • 20.3.8.1.4 Use of Equifax for Verification of Income
Allowable Divestments	Clarification that receiving HCBW services with a nursing home level of care is considered an institutional status for certain allowable divestments.	<ul style="list-style-type: none"> • 17.2.5 Institutionalized Person • 17.2.6.8 Transfer of Homestead Property
Dual enrollment in MAPP and SSI 1619(b) Medicaid	Policy clarification.	<ul style="list-style-type: none"> • 26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction
Katie Beckett address	New address for KBM office.	<ul style="list-style-type: none"> • 29 Katie Beckett
SeniorCare Enrollment Fees	Clarification to align with 20-day verification policy requirement.	<ul style="list-style-type: none"> • 33.3.2 Enrollment Fee

Contents

- 2.9 Denials and Terminations 8
 - 2.9.1 Termination..... 8
- 3.1 Renewals 9
 - 3.1.1 Timely Renewals 9
 - 3.1.2 Late Renewals 10
 - 3.1.3 Late Verifications for Renewals 11
 - 3.1.4 Gaps in Coverage 12
 - 3.1.5 Program Changes at Renewal 12
- 3.2 Administrative Renewals 14
 - 3.2.1 Administrative Renewals Introduction 14
 - 3.2.2 Administrative Renewal Selection Criteria 14
 - 3.2.3 Administrative Renewal Process..... 14
 - 3.2.3.1 Successful Administrative Renewals 14
 - 3.2.3.2 Unsuccessful Administrative Renewals..... 14
 - 3.2.3.3 Change Reporting After Administrative Renewal 14
- 3.3 Redeterminations for Changes 15
 - 3.3.1 Changes in Circumstance 15
 - 3.3.1.1 Time-Limited Benefits 16
 - 3.3.1.2 Children in Continuous Coverage Periods 17
 - 3.3.1.3 Other Health Care Programs 17
 - 3.3.2 Member Transition to Disability 17
 - 3.3.3 Program Changes 18
- 3.4 Renewal Requirements 20
 - 3.4.1 Choice of Renewal..... 20
 - 3.4.2 Signature at Renewal 20
 - 3.4.3 Renewal Notices..... 20
- 5.2 Determination of Disability 23
 - 5.2.1 Definition of Disability..... 23
 - 5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs 23
- 5.7 Redetermination 26
 - 5.7.1 Redetermination Introduction 26
- 7.3 Immigrants 28
 - 7.3.5 Immigration and Customs Enforcement (ICE) Reporting 28
- 15.4 Unearned Income 29

15.4.6 Gifts	29
15.7 Income Deductions	30
15.7.3 Medical/Remedial Expenses	30
16.7 Liquid Assets	32
16.7.21 Gifts	32
17.2 Evaluation of Transfers for Divestment	33
17.2.5 Institutionalized Person	33
17.2.6 Allowed Divestments	33
17.2.6.8 Transfer of Homestead Property	33
20.3 Mandatory Verification Items.....	34
20.3.8 Income	34
20.3.8.1 Reasonable Compatibility for Income for Health Care	34
20.7 When to Verify.....	35
20.7.1 Application and Renewal	35
20.7.1.1 Application	35
20.7.1.2 Eligibility Renewals.....	35
20.7.2 Changes.....	37
20.8 Actions	38
20.8.1 Positive Actions.....	38
20.8.2 Delay	38
20.8.3 Negative Actions	38
21.6 HMO Enrollment	40
21.6.5 Enrollment Exceptions	40
23.1 Notices	43
23.1.1 Notice Requirements	43
24.7 Meeting the Deductible	44
24.7.1 Countable Costs	44
24.7.1.1 Countable Expenses	46
24.7.2 Noncountable Costs.....	49
24.7.3 Prepaying a Deductible	49
24.7.3.1 Payment of Entire Deductible Amount.....	50
24.7.3.2 Combination of Payment and Incurred Expenses.....	50
24.7.3.3 Combination of Payment and Outstanding Expenses	50
24.7.3.4 Calculation Errors.....	51
24.7.3.5 Insufficient Funds.....	51

26.3 Nonfinancial Requirements	52
26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction.....	52
26.5 MAPP Premiums	53
26.5.1 Calculation	53
26.5.2 Initial Premium.....	54
26.5.3 Ongoing Premiums.....	55
26.5.4 Payment Information	56
26.5.4.1 Payment Methods.....	56
26.5.4.2 Advance Payments.....	57
26.5.4.3 Excess Payments	57
26.5.5 Late Payment of Premium	57
26.5.6 Non-Payment of Premium	59
26.5.6.1 Partial Payments	61
26.5.7 Temporary MAPP Premium Waivers due to Hardship	61
26.6 Opting Out.....	64
26.7 MAPP Changes	65
26.7.1 MAPP Changes Introduction	65
26.7.2 Premium Changes	65
27.10 ILTC Liability Effective Dates	66
28.1 Adult Home and Community-Based Waivers Long-Term Care Introduction.....	67
28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy	68
28.6 HCBWLTC Eligibility Groups and Cost Sharing	69
28.6.3 Cost Share Amount	69
29.1 Katie Beckett Medicaid	70
29.2 Katie Beckett Medicaid Renewals.....	71
29.2.1 Ineligible for KBM after Renewal	71
29.3 Katie Beckett Medicaid Changes in Circumstance.....	72
29.4 Katie Beckett Medicaid Members Turning Age 19	73
32.7 Medicare Beneficiaries Begin Dates	74
32.7.1 QMB Begin Dates	74
32.8 Medicare Beneficiaries Backdating.....	75
32.8.1 QMB Backdating	75
32.8.2 SLMB, SLMB+, QDWI Backdating	75
32.10 Medicare Savings Programs Renewals	76
32.10.1 QMB Renewals.....	76

32.10.2 QMB Changes in Circumstance.....	77
32.10.3 SLMB, SLMB+, QDWI Renewals	77
32.10.4 SLMB, SLMB+, QDWI Changes in Circumstance	78
32.10.5 Program Choice.....	78
33.3 SeniorCare Nonfinancial Requirements.....	79
33.3.2 Enrollment Fee.....	79
33.15 SeniorCare Annual Eligibility Renewal	80
33.15.1 Maintaining SeniorCare Coverage During Regularly Scheduled Renewals.....	80
36.5 WWWMA Changes.....	81
36.5.1 Maintaining WWWMA Coverage While Considering other Medicaid Eligibility	81
36.6 WWWMA Renewals.....	83
36.6.1 Maintaining WWWMA Coverage During Regularly Scheduled Renewals	83

2.9 Denials and Terminations

2.9.1 Termination

During the calendar month after a member's enrollment has been terminated for a reason other than not completing a renewal, Medicaid can be reopened without requiring a new application or a new signature. The certification period for the health care assistance group (AG) prior to termination will be reinstated. The person may need to provide verification if required to complete the eligibility determination.

If more than a calendar month has passed since a member's enrollment ~~was terminated~~ended, the applicant must file a new application or make a new request (if another health care AG is open on the case) to reopen their Medicaid.

Example 1	<p>Leroy is enrolled in MAPP with a renewal date of December 31. On September 3, he reports to his IM agency that he received a raise at work, which requires verification to be provided. <u>MAPP coverage for Leroy is maintained while eligibility is pending.</u> Leroy does not submit the required verification by the due date <u>of September 23</u>, so his eligibility for MAPP ended<u>ends as of September 30.</u> On October <u>31</u>. On <u>November 7</u>, Leroy contacts his IM agency to request that his health care be re-opened, and he provides the required verification of his income. <u>on November 20</u>. Since this is within the calendar month after his MAPP was terminated<u>ended</u>, Leroy does not need to submit a new application or new signature. Leroy remains eligible for<u>is re-enrolled in</u> MAPP and his MAPP certification period is reinstated with a renewal date<u>as of December 31</u><u>November 1</u>.</p>
-----------	--

Example 2	<p>Linda is enrolled in BadgerCare Plus and her husband Leo is enrolled in MAPP with a renewal date of January 31. On September 2, she reports to her IM agency that Leo received a gift from his aunt, which increased his assets to \$16,000. Leo's <u>MAPP ends September 30 because his assets are over the MAPP program asset limit, so his MAPP ends as</u> and he is not eligible for <u>any other form of September 30-Medicaid.</u></p> <p>On December 10, Linda contacts her IM agency to request that Leo's health care<u>MAPP</u> be reopened, as he purchased a vehicle (which is their only vehicle) and is no longer over the MAPP asset limit. It has been more than a calendar month since his MAPP was terminated<u>ended</u>, but because Linda is open for BadgerCare Plus, they do not need to submit a new application or new signature. <u>Asset verification is received on December 15, and</u> Leo's eligibility for MAPP is reinstated and his MAPP certification period is reinstated with a renewal date of January 31<u>starting December 1</u>.</p>
-----------	---

If ~~a case closed at renewal~~health care coverage ended due to failure to ~~complete~~submit the renewal, ~~including providing~~timely or provide required verification for ~~that~~the renewal, the ~~person's case~~person can ~~be reopened for Medicaid without filing a new application if they provide the~~submit the renewal and any necessary ~~information~~verification within three months of the renewal month to have eligibility redetermined from the eligibility end date without completing a new application (see [Section 3.1.2 Late Renewals](#)).

3.1 Renewals

3.1.1 Renewals Introduction

A renewal is the process during which all eligibility factors subject to change are reexamined and eligibility is redetermined. ~~The group's continued eligibility depends on its timely completion of a renewal and receipt of required verification.~~ Each renewal results in a determination to continue or ~~discontinue eligibility.~~ For members who submit their renewal timely (see SECTION 3.1.1 TIMELY RENEWALS), existing health care coverage must be maintained until the renewal is completed.

The first required ~~eligibility~~ renewal for a Medicaid ~~case~~ is 12 months from the most recent certification month, except for cases ~~open~~ with a deductible. ~~A renewal is not scheduled for a case that did not meet its deductible unless someone in the case was open for Medicaid.~~ For cases that ~~did meet~~ met the deductible, the renewal date is six months from the start of the deductible period. A renewal is not scheduled for an unmet deductible unless another health care program is due for renewal.

An early renewal can only be completed at the member's request.

A child within their continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN) may be adversely impacted by an early renewal (for example, they could be ineligible, or have a new or higher premium). However, the child will not lose coverage or be charged a new or higher premium during their current continuous coverage period. Other household members may be renewed early and may qualify for new 12-month certification periods.

3.1.1 Timely Renewals

Health care renewals received by the last business day of the renewal month are considered timely. When a renewal is received timely, the member's existing health care coverage must be maintained until the renewal is fully processed by the agency. This includes situations where the member no longer meets the requirements of their current health care category and the agency needs to request additional information to determine if the member is eligible for a different form of health care.

<p>Note Example 1</p>	<p>For manually certified Medicaid cases, send a manual renewal notice 45 days prior to the end of the renewal month. <u>Marta is enrolled in MAPP. July is the last month of her certification period. On July 18, a notice is sent to inform Marta that her coverage will end July 31 because she did not yet complete her renewal. Marta's renewal is submitted on July 31 during business hours. Marta's MAPP coverage is reinstated for the month of August, and she is sent a notice that she is enrolled in MAPP effective August 1 and will remain enrolled while the agency processes her renewal. On August 19, the renewal process is completed, and Marta is no longer eligible for any category of health care. Marta receives a notice that her MAPP coverage will end September 30, in accordance with notice requirements.</u></p>
-----------------------	---

For QMB renewals, benefits reopen from the first of the month following when coverage ends if the eligibility redetermination is fully completed during the renewal month or the month following the renewal month. See Section 32.10.1 QMB RENEWALS Agency Option
~~The agency may renew any case at any other time when the agency can justify the need. Examples include:~~

- ~~1. Loss of contact, or~~

2. Member request

Note Example 2	<p>Shortening certification periods in an attempt to balance agency workload is not permissible. Diana is open for SSI-Related Medicaid and QMB which is due for renewal in February. She submits her renewal on February 20. Because her renewal is timely, her benefits are maintained for March. On February 22, the worker processes the renewal and requests needed verification with a due date of March 14. On March 14, verifications are received for the renewal and eligibility is determined. Diana is enrolled in a new certification period starting April 1. There is no gap in her MS or QMB enrollment.</p>
----------------------	---

For Katie Beckett Medicaid renewals, see [Section 29.2 Katie Beckett Medicaid Renewals](#).

3.1.2 Late Renewals

Health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. There is no requirement for prior health care benefits to be maintained for a late renewal. The three-month period that allows for late renewals and renewal-related verifications starts the month after enrollment ended. It does not restart when a late renewal or when late verification has been submitted.

Exceptions: Late renewal policies do not apply to SeniorCare.

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

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons.

Late renewals and renewal-related verifications must be accepted for up to three calendar months after the renewal month. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

A late submission of an online or paper renewal form or a late renewal request by phone or in person is a valid request for health care. If verification is required to complete the renewal, the member has 20 days to provide it, even if this extends renewal processing into the fourth month after benefits closed.

Example 1	<p>Jenny's renewal is due in January. No renewal is received by January adverse action, so a notice is sent to Jenny explaining her coverage will end effective January 31. Her renewal is later received on March 10, and Jenny requested backdated coverage for February. Jenny's income verification is due on March 30. She provides verification of February and March income by the due date and meets all other eligibility criteria for Medicaid. Her new certification period starts on February 1.</p>
--------------	--

Example 2	<p>Joni's renewal is due in January. Joni did not submit a renewal by January adverse action, so a notice is sent to Joni explaining her coverage will end effective January 31. She submits a renewal on April 25, with a backdate request to February. The renewal is processed the same day, and she is asked to provide verification of her income by May 15.</p>
--------------	---

	<p>If Joni provides verification of her February, March and April income on or before May 15 and meets all other eligibility criteria for Medicaid, she will be enrolled in a new certification period starting on February 1. Her next renewal will be due January 31 of the following year.</p> <p>If Joni submits verification after the May 15 due date, a new application is required. She can request up to three months of backdated coverage when she reapplies.</p>
--	--

For QMB renewals benefits reopen from the first of the month following when current coverage ends, whether the renewal is completed timely in the renewal month or completed late in the month following the renewal month. See [Section 32.10.1 QMB Renewals](#)~~If an early renewal is completed for a child within their continuous coverage period, and that child would be adversely impacted by the early renewal (for example, they would be ineligible, or would have a new or higher premium), then the child will remain in their current continuous coverage period. However, other household members can be renewed and may qualify for new 12-month certification periods.~~

3.1.1.1.

<p>Example 3</p>	<p>Shelly has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on March 20. On March 30, the worker processes the renewal and verifications which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid and QMB with a new certification period starting March 1. There is no gap in her QMB eligibility because benefits are confirmed in the month following the renewal month.</p>
----------------------	---

<p>Example 4</p>	<p>Cindy has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on April 20, requesting a backdate for March. On April 22, the renewal and verifications for March and April are processed, which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid with a new certification period starting March 1, and QMB with a new certification period starting May 1. There is a gap in her QMB eligibility because the redetermination was not confirmed during the renewal month or the month following the renewal month.</p>
----------------------	--

3.1.3 Late Verifications for Renewals

If a health care renewal is received timely but verifications are not provided with the renewal submission, the health care program open during the renewal month is maintained while awaiting verifications. If verification is not received by the verification due date, the requirement to maintain benefits ends and health care coverage ends.

If a health care renewal is received late, health care is not maintained while eligibility is being redetermined. Regardless of whether a renewal was received timely or late, if verifications are submitted anytime in the three months following the renewal month health care can reopen without a new application.

During the three months following the renewal due month, any verification that was previously provided as part of the renewal process, including AVS results, remains acceptable unless a subsequent change was reported. Only the missing verifications must be provided.

If a member has a gap in coverage, and is requesting backdated coverage, verification is required for all requested months. The member will have 20 days to provide the verification.

Example 5	<u>Sunny's Medicaid renewal is due in January. She completes her renewal timely on January 5, and income verification is requested with a due date of January 25. Medicaid coverage is maintained for February. Sunny does not submit the requested verification by January 25, and her Medicaid eligibility ends February 28. On April 27, she submits paystubs for March 10 and March 24, and requests a backdate to March. Verification of her current income for April is requested, with a due date of May 17. On May 17, April income verification is provided. Sunny meets the eligibility criteria for Medicaid and her new certification period begins on March 1.</u>
-----------	---

3.1.4 Gaps in Coverage

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

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

Note	<u>QMB coverage is not retroactive. For QMB see Section 32.10.1 for QMB begin dates following a renewal.</u>
------	--

Example 6	<u>Marge's SLMB+ renewal is due in January. No renewal is received by January adverse action. A notice of SLMB+ coverage ending January 31 is sent to Marge. She calls the agency to complete a late renewal on April 15 and requests a backdate to February. Verification is requested for February, March and April. The due date is May 5. If she provides verifications for each month on or before May 5 (and she meets all other eligibility criteria) her eligibility and certification period restart as of February 1.</u>
-----------	---

3.1.5 Program Changes at Renewal

If health care coverage was maintained during a renewal and the member's enrollment changes to a new health care program or has a reduction in their premium, liability, or cost-share, their eligibility may need to be redetermined for the month(s) that coverage was maintained.

After a renewal is processed, if a member's enrollment changes from a limited-benefit to a full benefit health care program, the eligibility in the new program may need to be redetermined for the months that coverage was maintained and any month in which the member may be eligible for the new health care program.

After a renewal is processed, if the member becomes eligible for SLMB, SLMB+, or QDWI, their eligibility will be redetermined in the new MSP program retroactively back to the date their prior benefits were maintained. Normally, an individual cannot qualify for SLMB+ if they are enrolled in full-benefit Medicaid, but in this circumstance the overlap is allowed.

<p>Example 7</p>	<p>Tom is enrolled in MAPP and receives Medicare. The only Medicare Savings Program he qualifies for financially is SLMB+, but he is not enrolled because he has full-benefit Medicaid. His health care renewal is due in February. He submits a renewal on February 3. Verification is requested with a due date of February 23. Because his renewal was received timely, his MAPP coverage is maintained for March. Verification is received on February 19 along with a report that Tom is no longer meeting the MAPP work requirement. MAPP enrollment ends as of March 31 and Tom's eligibility for SLMB+ begins on March 1.</p>
----------------------	---

<p>Example 8</p>	<p>Matt's Institutional Medicaid is due for renewal in February. He submits a renewal on February 3. Income verification is requested with a due date of February 23. Because his renewal was received timely his Institutional Medicaid coverage and his patient liability from February are maintained for March. Verification is received on February 19 verifying an income reduction. Although Institutional Medicaid coverage was maintained through March, the income reduction was reported in February and verified timely, so his patient liability is reduced retroactively for February and March.</p>
----------------------	--

Eligibility must be retroactively determined in situations where health care coverage was maintained for one household member and, after the redetermination of eligibility, another household member that was previously not eligible for health care is newly eligible. Eligibility is determined back to the date the change was reported.

<p>Example 9</p>	<p>John and his wife Julieta both applied for health care. Julieta was denied for being over assets for MAPP, but John opened for MAPP. John is due for renewal in February. On February 3 the renewal is submitted. Verification is requested with a due date of February 23. John's MAPP coverage is maintained for March. Verification is received on February 19. A joint asset decrease makes both John and Julieta eligible for MAPP with a new certification period starting April.1. However, because the asset reduction was reported and verified in February, Julieta's eligibility for MAPP is determined retroactively for February and March.</p>
----------------------	---

3.2 Administrative Renewals

3.2.1 Administrative Renewals Introduction

3.2.2 Administrative Renewal Selection Criteria

3.2.3 Administrative Renewal Process

3.2.3.1 Successful Administrative Renewals

3.2.3.2 Unsuccessful Administrative Renewals

3.2.3.3 Change Reporting After Administrative Renewal

3.3 Redeterminations for Changes

When a member no longer meets the eligibility requirements of their current health care program due to a change, their existing coverage must be maintained while eligibility for all other health care programs is being determined.

Example 1	Anders is enrolled in SSI-Related Medicaid and QMB. On July 13, he reports an income increase, bringing his countable income to 115% FPL, which is over the income limit for both SSI-Related Medicaid and QMB. While the income verification is requested and his eligibility for other benefits is being determined, Anders's existing benefits are maintained. On July 22, Anders is determined eligible for an unmet Medicaid deductible and SLMB. Anders' SSI-Related Medicaid and QMB end August 31, and the Medicaid deductible and SLMB begin September 1.
-----------	--

Example 2	Ella is enrolled in MAPP. Outside of CWW, she is also enrolled in IRIS. On November 2, she reports that she received an inheritance that puts her over the \$15,000 asset limit for MAPP. Because she is enrolled in IRIS, eligibility must be determined for other health care, including Waiver Medicaid. Ella is married and spousal impoverishment policies apply to the Waiver Medicaid determination. Verification is requested for the additional financial information (and spousal signature) needed to determine if Ella is eligible for Waiver Medicaid under spousal impoverishment rules. Ella's MAPP coverage is maintained for December while eligibility for Waiver Medicaid is determined. On November 23, Ella is determined eligible for Waiver Medicaid. Ella's MAPP coverage ends December 31, and Waiver Medicaid begins January 1.
-----------	---

3.3.1 Changes in Circumstance

Health care eligibility must be promptly redetermined between regular renewals whenever information is received about a change in a member's circumstances that may affect their eligibility. Requests for information or verification must be limited to information related to the change. ~~During redeterminations of eligibility due to a change in circumstances, the member must remain enrolled in their prior health care assistance group without disruption until~~ enough information is available to determine all health care eligibility. ~~following the change, new certification periods may begin.~~

When an individual ~~opens for~~ is enrolled in a new health care certification period on a case, new 12-month certification periods will be established for ~~other~~ all eligible health care members in the household, with some exceptions.

New certification periods will be established for existing eligible members when an individual ~~opens~~ is enrolled in health care following a change in circumstances, person-add, new program request, or renewal. For example, new certification periods can be established when a person joins the household and ~~opens for~~ is enrolled in health care, changes health care categories, or a previously ineligible person becomes eligible due to a change (for example, a reduction in income puts them under the program limit).

New certification periods will not be established for an existing member when:

- A newly added person is found ineligible.
- A new assistance group is pending.
- The member is open for time-limited benefits.

- The member is a child who is in their 12-month continuous coverage period and the change would result in a negative action or would move the child from Medicaid to CHIP.
- The existing member is ineligible based on the change in circumstances.

<p>Example 13</p>	<p>Margaret and Phillip are enrolled in BadgerCare Plus as childless adults with a certification period of January 1, 2025, through December 31, 2025. On July 2, 2025, 11-year-old William joins the household and requests health care. William does not have continuous coverage from another case. William is enrolled in BadgerCare Plus with continuous coverage from July 1, 2025, through July 31, 2026. <u>of the following year</u>. Margaret and Phillip are now eligible for BadgerCare Plus as parents <u>caretakers</u> and will also start a new certification period from August 1, 2025, through July 31, 2026 <u>of the following year</u>.</p>
-----------------------	---

<p>Example 24</p>	<p>Santhosh <u>Diego</u> and Reema <u>Sofia</u> are enrolled in BadgerCare Plus and their 4-year-old daughter Kashvi <u>Gabriella</u> is enrolled in Medicaid from February 1, 2025, through January 31, 2026. On August 8, 2025, Santhosh's 11 <u>Diego's 12</u>-year-old daughter Amara <u>Isabella</u> joins the household and requests health care. Amara <u>Isabella</u> has had BadgerCare Plus on another case since January. Her BadgerCare Plus is closed <u>enrollment ends</u> on the other case, <u>and</u> she is determined eligible on Santhosh's <u>Diego's</u> case. <u>Isabella is enrolled in BadgerCare Plus</u> with a new continuous coverage period, and is enrolled in BadgerCare Plus from September 1, 2025, through August 31, 2026. Santhosh, Reema, <u>Diego</u> and Amara <u>Sofia</u>, remain eligible for BadgerCare Plus and start a new certification period from September 1, 2025, through August 31, 2026. Kashvi. <u>Gabriella</u> remains eligible in Medicaid and starts a new certification period from September 1, 2025, through August 31, 2026.</p>
-----------------------	---

<p>Example 35</p>	<p>Bill and Carrie are enrolled in BadgerCare Plus as parents and their 12-year-old daughter Kiley is disabled and enrolled in SSI-Related Medicaid. Their certification period is January 1, 2025, through December 31, 2025. Kiley is determined to no longer be disabled on June 5, 2025. There was no other change. Kiley transitions from SSI-Related Medicaid to BadgerCare Plus with a new certification period of July 1, 2025, through June 30, 2026. A new 12-month certification period is established for Bill and Carrie from July 1, 2025, through June 30, 2026.</p>
-----------------------	--

<p>Example 46</p>	<p>Edith is enrolled in SSI-Related Medicaid from January 1, 2025, through December 31, 2025. In July, Edith gets married and requests health care for her husband, Chester. Chester is eligible and enrolled in SSI-Related Medicaid. Edith continues to be eligible. Because someone is newly opening for a health care certification period, a new 12-month certification period is established for Edith and Chester.</p>
-----------------------	---

<p>Example 57</p>	<p>Davis <u>Dimitri</u> is enrolled in SSI-Related Medicaid from July 1, 2024, through June 30, 2025. In October, Davis <u>Dimitri</u> gets married and requests health care for his wife, Polly. <u>Polly Polina</u>. <u>Polina is not neither</u> a US citizen or <u>nor</u> a qualifying immigrant and is found ineligible. Davis' <u>Dimitri's</u> SSI-Related Medicaid certification period does not change.</p>
-----------------------	--

Time 3.3.1.1 Time-Limited Benefits

New certification periods will not be established for members enrolled in time-limited health care benefits, including:

- Pregnant and postpartum individuals enrolled in BadgerCare Plus,

- Continuously Eligible Newborns,
- People in a four or twelve-month BadgerCare Plus Extension, and
- People who need to meet or have met a deductible to enroll in BadgerCare Plus or Medicaid.

<p>Example <u>68</u></p>	<p>Matthew and his child Lee are enrolled in BadgerCare Plus from January 1, 2025, through December 31, 2025. Lilly, Lee’s mother, is enrolled in BadgerCare Plus as a pregnant individual with a renewal date of September 30, 2025. In May, their other child Silas joins the household. Lilly remains pregnant. Silas’s information is verified and there is no other change. Silas is enrolled in BadgerCare Plus from May 1, 2025, through May 31, 2026. A new 12-month certification period is established for Matthew and Lee from June 1, 2025, through May 31, 2026. Lilly’s certification period does not change.</p>
------------------------------	---

However, a new time-limited health care benefit will result in other members getting a new 12-month certification period.

<p>Example <u>79</u></p>	<p>Deepak, Fatima, and their son Ravi are enrolled in BadgerCare Plus from July 1, 2025, through June 30, 2026. In August 2025, Fatima’s pregnancy is reported, and she moves from BadgerCare Plus as a parent to BadgerCare Plus as a pregnant individual through May 31, 2026. There are no other changes, and Deepak and Ravi remain eligible. A new 12-month certification period is established for Deepak and Ravi from September 1, 2025, through August 31, 2026.</p>
------------------------------	---

3.3.1.2 Children in Continuous Coverage Periods

If a child would be negatively impacted or move to a CHIP category of health care because of a change, person-add, or new program request during their 12-month continuous coverage period, the child will not get a new 12-month certification period. They will remain in their current period. However, other eligible household members can get new 12-month certification periods. Households may also have different health care renewal dates. See BadgerCare Plus Handbook, [Section 1.2.10 Certification Period Changes for Children in Continuous Coverage Periods](#) for examples.

3.3.1.3 Other Health Care Programs

If an individual opens for a new certification period for Wisconsin Well Woman Medicaid, Katie Beckett Medicaid, the SeniorCare Prescription Drug Program, or benefits outside of the CARES eligibility system, new 12-month certification periods will not be established for existing members on the case.

For more information regarding changes in circumstances for Katie Beckett members, see [Section 29.3 Katie Beckett Medicaid Changes in Circumstances](#).

3.3.2 Member Transition to Disability

When a member enrolled in BadgerCare Plus or other health care program not based on disability no longer meets the requirements of their current health care category due to a change in circumstances, the IM agency must determine if they qualify for Medicaid based on disability if any of the following are true:

- The member has been determined disabled.
- The member indicates they want to apply for a disability determination.
- The member is enrolled in an adult long-term care program (Family Care, Family Care Partnership, PACE, or IRIS).

Prior coverage is maintained while the Medicaid Disability Application Form, [F-10112 \(MADA\)](#), Authorization to Disclose Information to Disability Determination Bureau, [F-14014](#)

3.1.2 Choice of Renewal

The member has the choice of the following methods for any Medicaid renewal:

- ~~Face-to-face Interview~~
- ~~Telephone Interview~~
- ~~Mail in: Mail in renewals can be submitted using the paper application () or the Pre-Printed Renewal Form (PPRF) generated through CWW. Cases requesting to complete a Mail-in renewal must be sent the PPRF if the case includes a blind or disabled child~~
- ~~ACCESS ()~~

3.1.3 Renewal Processing

~~A Medicaid eligibility renewal letter and a Pre-Printed Renewal Form (PPRF) are generated on the first Friday of the 11th month of the certification period. The notice states that "some or all of your benefits will end" if a renewal is not completed by the end of the following month. Do not process a renewal until after adverse action in the month prior to the month of renewal.~~

(ADDD), and any other necessary information (including an Asset Assessment, if appropriate) are requested. If the member is otherwise eligible for EBD Medicaid types after the MADA, ADDD, and all necessary information is collected, the prior coverage continues to be maintained while the Disability Determination Bureau (DDB) makes the determination of disability.

Example 110	<p>CARES sends out the renewal letter on July 7 for a renewal due in August, do not process the renewal prior to July 18. Hoai is enrolled in BadgerCare Plus and IRIS. On March 20, he reports an income increase from his part-time job that puts him over the limit for BadgerCare Plus. He does not have a disability determination and is not married. Because he is enrolled in a long-term care program, BadgerCare Plus must be maintained until it is determined if Hoai is eligible for Medicaid based on disability.</p> <p><u>On March 21, a request for asset information and the MADA and ADDD are sent to Hoai.</u></p> <p><u>Hoai provides the requested asset information and disability application forms by the due date, and he meets the eligibility criteria for Medicaid Purchase Plan (MAPP) if determined disabled by the DDB. On April 10, Hoai's disability application is sent to the DDB. Hoai's BadgerCare Plus coverage (and IRIS enrollment) will be maintained until the DDB makes a decision, as long as he remains otherwise eligible for MAPP or another form of full-benefit Medicaid based on disability. A notice is sent informing Hoai that he is now subject to EBD reporting rules, and his existing coverage will be maintained while the DDB is making their decision.</u></p> <p><u>On July 10, the DDB returns a decision that Hoai's disability application is approved for Medicaid. His BadgerCare Plus ends on July 31 and he is enrolled in MAPP effective August 1. He remains enrolled in IRIS.</u></p>
----------------	--

3.3.3 Program Changes

If health care coverage was maintained during a redetermination of eligibility and the member's enrollment changes to a new health care program or has a reduction in premium, liability, or cost-share for a current health care program, their eligibility may need to be redetermined for the month(s) that coverage was maintained.

After redetermination, if a member's enrollment changes from a limited-benefit to a full-benefit health care program, their eligibility in the new program may need to be redetermined for the months that coverage was maintained and in any month in which the member may be eligible for the new health care program.

After redetermination, if a member becomes eligible for SLMB, SLMB+, or QDWI, eligibility will be determined in the new MSP program retroactively back to the date their prior benefits were maintained. Normally, an individual cannot qualify for SLMB+ if they are enrolled in full-benefit Medicaid, but in this circumstance the overlap is allowed.

Example 11	<u>Tim applied for health care on October 2. He was denied for SSI-Related Medicaid due to being over the asset limit and he opened for SLMB. On February 3, he reports a reduction in assets. Verification is requested with a due date of February 23. His SLMB coverage is maintained for March. Verification is received on February 19. His asset decrease makes him eligible for SSI-Related Medicaid with a new certification period starting April 1. However, because the asset reduction was reported in February and verified timely, his eligibility for SSI-Related Medicaid must also be tested retroactively for February and March.</u>
---------------	---

Eligibility must be retroactively determined in situations where health care coverage was maintained for one household member, and, after the redetermination of eligibility, another household member that was previously not eligible for health care is newly eligible. Eligibility is determined back to the date the change was reported.

Example 12	<u>Jim and his wife, Bonnie, both applied for health care on October 2. Bonnie was denied for being over assets for MAPP, but Jim opened for MAPP. On February 3, Jim and Bonnie report a reduction in joint assets. Verification is requested with a due date of February 23. Jim's MAPP coverage is maintained for March. Verification is received on February 19. The asset decrease makes both Jim and Bonnie eligible for MAPP on April 1. However, because the asset reduction was reported in February and verified timely, eligibility for Bonnie's MAPP must also be tested retroactively for February and March.</u>
---------------	--

3.4 Renewal Requirements

3.4.1 Choice of Renewal

The member may complete a Medicaid renewal using any of the following methods:

- Face-to-face
- Telephone
- Mail-in (paper application or Pre-Printed Renewal Form (PPRF))

ACCESS (<https://access.wis.gov>) Do not require a new authorized representative form at renewal if the person signing the renewal is the authorized representative on file.

~~If the renewal is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES at adverse action in the renewal month.~~

- 3.1.4)

3.4.2 Signature at Renewal

The member must include a valid signature at the time of renewal. This includes either signing telephonically, electronically or providing a handwritten signature on one of the following:

- The paper application form or Pre-Printed Renewal Form (PPRF)
- The signature page of the Application Summary
- The ACCESS or FFM application form with an electronic signature

~~The~~ With the exception of renewals completed through the administrative renewal process, the signature requirements for renewals are the same as those for applications (see Section 2.5 Valid Signature). ~~The signature requirements do not apply to people whose renewal is completed through the administrative renewal process.~~

A new authorized representative form is not required at renewal if the person signing the renewal is the authorized representative on file.

~~**3.1.5 Administrative Renewals**~~

~~**4.3.1.5.1 Administrative Renewals Introduction**~~

~~**3.4.33.1.5.2 Administrative Renewal Selection Criteria**~~ Notices

~~**3.1.5.3 Administrative Renewal Process**~~

~~**3.1.5.3.1 Successful Administrative Renewals**~~

~~**3.1.5.3.2 Unsuccessful Administrative Renewals**~~

~~**3.1.5.3.3 Change Reporting After Administrative Renewal**~~

3.1.6 Late Renewals

~~Most~~A Medicaid eligibility renewal letter and a Pre-Printed Renewal Form (PPRF) are generated on the second Saturday of the 11th month of the certification period. If a renewal has not been received by adverse action of the renewal month, a notice is sent informing the member that their benefits are ending at the end of the month.

If a renewal is in progress at adverse action, or if a renewal is received after adverse action but by the last business day of the renewal month, a letter is sent indicating that health care ~~renewals received within three months of the renewal month can~~coverage will be maintained until the renewal process is completed.

See [Process Help 4.3 Renewal Notices](#)~~processed as a late renewal instead of requiring a new application. This policy applies for the following~~renewal notices for manually certified health care programs:

- ~~• BadgerCare Plus~~
- ~~• FPOS~~
- ~~• SSI-Related Medicaid~~
- ~~• HCBW~~
- ~~• Institutional Medicaid~~
- ~~• MAPP~~
- ~~• Medicare Savings Programs (QMB, SLMB, SLMB+, QDWI)~~
- ~~• Wisconsin Well Woman Medicaid (WWWMA)~~
- ~~• Katie Beckett Medicaid~~

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

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

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

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

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

3.1.6.1 Verification Requirements for Late Renewals

~~If the health care renewal was completed timely but the requested verifications were not provided as part of the renewal, the health care program can reopen without a new application if these verifications~~

are submitted within three months of the renewal month. The submission of the renewal related verifications is considered a request for health care. Only the missing verifications must be provided. However, the verifications must include information for any month(s) of the eligibility determination. For example, if verification was submitted for a past month, the agency must request current verification, allowing the member 20 days to submit the verification.

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

3.1.6.2 Gaps in Coverage

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

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

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

5.2 Determination of Disability

5.2.1 Definition of Disability

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

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

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

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

5.2.3 [Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs](#)

[Katie Beckett Medicaid \(KBM\) is a full-benefit Medicaid program for children with disabilities who have complex health care needs and live at home \(see Chapter 29.1 Katie Beckett Medicaid\). KBM workers determine eligibility for KBM. Eligibility for KBM requires a disability determination that is completed by the Bureau of Clinical Policy and Pharmacy \(BCPP\) rather than the Disability Determination Bureau \(DDB\). BCPP uses the same criteria as the Social Security Administration \(SSA\) and the DDB. When a member loses eligibility for KBM for any reason other than a medical cessation of disability, the member's KBM disability determination meets the disability requirement for all categories of EBD Medicaid as long as the member submits requested information timely. The member's submission of information is timely if a health care application is submitted to IM within three months of when their KBM coverage ended. When an application is received, if the former KBM member otherwise meets all financial and non-financial requirements, they will be enrolled in an EBD Medicaid program first and then asked to submit the Medicaid-Disability Application, F-10112 \(MADA\), and an Authorization to Disclose Information to Disability Determination Bureau \(DDB\), F-14014 \(ADDD\). As long as all required information is provided timely and they are otherwise eligible, the former KBM member will continue to be considered to meet the disability requirement for all Medicaid programs until there is a decision on their DDB disability application. The member's eligibility will be redetermined once there is a final decision on their DDB disability application.](#)

[If the health care application is submitted more than three months after KBM coverage ends, or if the required MADA and ADDD forms and all requested information and verification are not submitted](#)

timely, the KBM disability determination will no longer satisfy the disability requirement for other Medicaid programs. The member will need a DDB disability determination to enroll or maintain their enrollment in an EBD Medicaid program or they may qualify for a health care program that does not require a disability determination, such as BadgerCare Plus.

Example 4	<p>Carmen is 2 years old and enrolled in KBM through the end of May of this year. In February, Carmen is hospitalized and remains hospitalized in April. Despite her hospitalization for over 30 days, Carmen remains in KBM because she is still within her 12 months of continuous coverage. In late April, Carmen's parents complete a KBM renewal. Due to her hospitalization, she is no longer eligible for KBM after her continuous coverage ends. She receives a letter informing her that her KBM enrollment will end on May 31. The letter states that if she submits a health care application to the IM agency within 30 days of the letter's date, her KBM coverage will be extended until it is determined whether she is eligible for another Medicaid program. On May 5, Carmen's parents submit a health care application to the IM agency. On May 10, the IM agency processes Carmen's application and determines that she is eligible for Institutional Medicaid, and she is enrolled as of June 1. Carmen is sent a letter requesting that she submit the MADA and ADDD forms within 20 days. On May 20, Carmen's parents submit the completed MADA and ADDD forms. Carmen's Katie Beckett disability determination meets the EBD Medicaid disability requirement while she waits for a decision on her DDB application. Carmen's disability application is later approved by the DDB, and her Institutional Medicaid continues with a May renewal date.</p>
--------------	---

Example 5	<p>Tim is 15 years old and enrolled in KBM through the end of September. In July, it is determined that he no longer requires an institutional level of care, but he remains enrolled in KBM because he is still within his 12 months of continuous coverage. In August, Tim's parents complete a KBM renewal. Because he does not meet the institutional level of care requirement, he is no longer eligible for KBM after his continuous coverage period ends. Tim receives a letter informing him that his KBM enrollment will end on September 30. The letter states that if he submits a health care application to the IM agency within 30 days of the letter's date, his KBM coverage will be extended until it is determined whether he is eligible for another Medicaid program. In mid-September, Tim receives a notice informing him that his KBM enrollment will end on September 30. Tim's KBM enrollment ends on September 30 because he did not submit his health care application by the 30-day deadline, so his KBM coverage is not extended. On December 10, Tim's parents submit a health care application to the IM agency requesting a two-month backdate. On December 15, the application is processed, and Tim is determined non-financially and financially eligible for SSI-Related Medicaid. Tim is enrolled in SSI-Related Medicaid with a retroactive start date of October 1. On December 15, Tim is sent a letter requesting that the MADA and ADDD forms be completed and returned within 20 days. Tim's parents submit the MADA and ADDD forms on December 30. Because Tim's application was received within three months of the KBM end date and he submitted the MADA and ADDD forms timely, the KBM disability determination meets the disability criteria for all EBD Medicaid programs while he waits for a decision on his DDB application. Tim's disability application is later approved by the DDB, and his Medicaid continues with a September renewal date.</p>
--------------	--

Example	Sam is enrolled in KBM. Sam turns 19 on August 20. Six months prior to her birthday, Sam
---------	--

6	<p>receives a letter informing her that her enrollment in KBM will end August 31 due to turning 19. On August 1, Sam submits a health care application, MADA, and ADDD to the IM agency. At adverse action in August, Sam receives a notice informing her that her KBM enrollment will end as of August 31. On August 20, Sam's application is processed, and she is determined non-financially and financially eligible for Medicaid Purchase Plan (MAPP). Sam's KBM disability determination meets the disability requirement for MAPP while she waits for a decision on her DDB application. Sam is enrolled in MAPP beginning September 1. Her disability application is later approved by the DDB, and her Medicaid continues with an August renewal date.</p>
---	---

<p>Example 7</p>	<p>Daniel is 5 years old and enrolled in KBM through the end of June. In January, it is determined that he no longer requires an institutional level of care, but he remains enrolled in KBM because he is still within his 12 months of continuous coverage. In May, Daniel's parents complete a KBM renewal. Because he does not meet the institutional level of care requirement, he is no longer eligible for KBM after his continuous coverage period ends. Daniel receives a letter informing him that his KBM enrollment will end on June 30. The letter states that if he submits a health care application to the IM agency within 30 days of the letter's date, his KBM coverage will be extended until it is determined whether he is eligible for another Medicaid program. On June 2, Daniel's parents submit a health care application to the IM agency. On June 10, Daniel is determined eligible for SSI-Related Medicaid. Daniel is enrolled in SSI-Related Medicaid with a start date of July 1. Daniel is sent a letter requesting that the MADA and ADDD forms be completed and returned within 20 days. On June 25, Daniel's parents submit his MADA and ADDD forms. Daniel's disability application is denied by the DDB on September 1. Since Daniel no longer meets the disability requirement for EBD Medicaid programs, he is no longer eligible for SSI-Related Medicaid. If he is ineligible for any other Medicaid program, he will remain in SSI-Related Medicaid until the end of his continuous eligibility period on June 30.</p>
----------------------	--

5.7 Redetermination

5.7.1 Redetermination Introduction

Review a [DDB](#) 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~~ When a disability redetermination is required, the following ~~paper forms~~ information is required and is sent electronically to DDB at:

~~Disability Determination Bureau~~

~~P.O. Box 7886~~

~~Madison, WI 53707-7886~~

- ~~A signed and completed~~ Medicaid Disability Redetermination Report ([F-10114](#)).
- ~~A signed and completed~~ [Authorization to Disclose Information to Disability Determination Bureau \(DDB\) form, F-14014](#) ~~Signed Confidential Information Release forms.~~
- ~~The~~
- ~~From the existing Electronic Case File (ECF), 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~~ [an approval response](#), which includes the SSA-832, ~~to form which is stored in the ECF for~~ the IM agency to ~~be kept until the next redetermination is made~~ [review](#).

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 [temporarily](#) 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~~ [an approval response will be sent electronically at that time and](#) a revised SSA-832 will be ~~sent to the IM agency at that time~~ [stored in ECF](#).

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~~ documentation to ECF 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~~ indicator to the ~~front of the folder~~ document 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 health care 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 who receives <u>Medicaid benefits</u> 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.
-------	--

Upon receipt of the notification ~~(of Medicaid Disability Cessation)~~ from DDB, the IM agency must then redetermine whether or not the member qualifies for ~~some any other~~ category of ~~Medicaid other than that~~ health care not related to disability. If the member is not eligible for any other ~~Medicaid health care~~ category, the IM agency ~~would then take~~ takes the necessary action to discontinue the member's Medicaid eligibility in the normal manner, issuing all required notices. The member ~~would then have~~ has 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

7.3.5 Immigration and Customs Enforcement (ICE) Reporting

Medicaid member information cannot be ~~used~~ shared by Income Maintenance or Tribal Agencies for immigration enforcement purposes. Do not refer an immigrant to ~~ICE~~ U.S. Immigration and Customs Enforcement. The Wisconsin Department of Health Services is required to share information with the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

15.4 Unearned Income

15.4.6 Gifts

A gift is something a person receives that is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is unearned income only in the month of receipt. Count the gift as an asset in the months following the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total \$~~30~~50 or less for each AG member for each calendar quarter.

Funds received through a crowdfunding account, such as GoFundMe and Kickstarter, would be considered a gift and counted as unearned income in the month of receipt and as an available asset in subsequent months as long as the funds are still in the person's possession (i.e., the person did not spend it in the month of receipt).

Funds that are not accessible for a person to withdraw are an unavailable asset. Disbursements would be unearned income in the month withdrawn and an available asset in subsequent months if the funds are still in the person's possession.

15.7 Income Deductions

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- HCBW programs
- Patient liability calculations for residents of a medical institution
- Cost share and MAPP premium calculations
- [Meeting a Medicaid deductible \(see Section 24.7 Meeting the Deductible\)](#)
- MAPP eligibility calculation if expenses are over \$500 monthly (see Section 26.4.2.1 Deduction for Medical and Remedial Expenses over \$500 for more information on this MAPP-specific deduction)

Medical Expenses

Medical expenses are anticipated, incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

- Deductibles and copayments for Medicaid, Medicare, and private health insurances
- Health insurance premiums.
- Bills for medical services that are not covered by Wisconsin Medicaid
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

Medicaid overpayments, unpaid patient liabilities, and unpaid cost shares are not medical expenses. They cannot be deducted from income to lower a current or future patient liability or cost share or used to meet a deductible.

Remedial expenses

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

1. Case management
2. Day care
3. Housing modifications for accessibility
4. Respite care
5. Supportive home care

• ~~Transportation~~

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- a) Assistance with activities of daily living
- b) Attendant care

- c) Supervision
 - d) Reporting changes in the participant's condition
 - e) Assistance with medication and medical procedures which are normally self-administered
 - f) The extension of therapy services, ambulation and exercise
 - g) Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well-being and care at home
6. Transportation to obtain medical care. This includes but is not limited to taxi, rideshare services, bus fares, or a person's own vehicle, if approved.

~~6.7. Services recognized under Wis. Stat. § 46.27~~

~~• Community Options Program expenses that are included in the person's service plan
Remedial expenses do not include housing or room and board services.~~

8. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.
- a) In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

16.7 Liquid Assets

16.7.21 Gifts

A gift is something a person receives that is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is income in the month of receipt. It is an asset in the months after the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total \$~~30~~60 or less, for each assistance group member, for each calendar quarter.

17.2 Evaluation of Transfers for Divestment

17.2.5 ~~Reserved~~ Institutionalized Person

When determining whether a divestment is allowable or not, an institutionalized person is defined as someone who participates in a Home and Community-Based Waivers program or who resides in a medical institution. See details in Section 17.1 Divestment Defined.

17.2.6 Allowed Divestments

17.2.6.8 Transfer of Homestead Property

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

- The institutionalized person's spouse.
- The institutionalized person's child if at least one of the following criteria is met:
 - The child is under the age of 21.
 - The child is blind or permanently and totally disabled.
 - The child resided in the institutionalized person's home for at least two years immediately before the institutionalized person either moved to a medical institution, ~~and~~ or began receiving HCBW services with a nursing-home level-of-care. The child provided care that allowed the institutionalized person to ~~reside~~ remain residing at home ~~rather than in the institution~~ for the entire two years immediately before the ~~institutionalized~~ person ~~moved~~ met institutional status (by moving to a medical institution, or receiving HCBW services with a nursing-home level-of-care). The child's provision of care must be verified by a notarized statement from the institutionalized person's physician or someone else who has personal knowledge of the circumstances. A notarized statement from the child is not sufficient. ~~The homestead transfer does not have to take place after the provision of care in order to be an allowed divestment.~~
- The institutionalized person's sibling if both of the following criteria are met:
 - The sibling resided in the institutionalized person's home for at least one year immediately before the institutionalized person either moved to a medical institution or began receiving HCBW services with a nursing-home level-of-care.
 - The sibling has a verified equity or ownership interest in the home. The equity or ownership interest must be verified by documentation such as a copy of the deed ~~or~~ land contract. ~~The sibling's name on the document is not sole proof, so, or~~ other documentation such as canceled checks ~~and~~ or receipts ~~may be needed.~~

20.3 Mandatory Verification Items

20.3.8 Income

20.3.8.1 Reasonable Compatibility for Income for Health Care

20.3.8.1.4 Use of Equifax Data for Verification of Income

~~Agencies may not consider~~ If Equifax data ~~to be the final “verified” income amount unless~~ is available for a given employment, and the Equifax ~~data amount~~ is the same as ~~what the member amount~~ reported. ~~Agencies may not deny or terminate health care benefits based on~~ by the applicant or member, the earned income ~~data received from Equifax without giving~~ must be considered verified. Earned income that is verified is not subject to a reasonable compatibility test. If the amount reported by the applicant or member ~~an opportunity to verify their reported~~ is not the same as the Equifax amount, the earned income ~~amount~~ is not considered verified. The reasonable compatibility test is completed for earned income that has not otherwise been verified.

If the ~~amount reported by the applicant or member~~ reports that he or she is unable to obtain the ~~requested~~ is not reasonably compatible, the applicant or member is required to provide verification, ~~the worker should~~ of earned income. IM agencies must assist the applicant or member in obtaining verification if they request help or tell their agency that they are having difficulty obtaining it (see Section 20.1.4) ~~General Rules~~.

If the applicant/~~member~~ 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.

Health care benefits cannot be denied or terminated based on earned income data received from Equifax without giving the applicant or member an opportunity to verify their reported earned income amount.

Note	The same policies for use of Equifax data apply policy applies when a member is reporting a change in earned income. If the Equifax data can be used for verification if it amount is the same as what the amount reported by 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 , the earned income must be considered verified.
------	---

Example 5	<p><u>Anya applies for health care for herself. She is 65 years old but does not yet receive Social Security income. The only income she reports is earned income. The monthly earned income amount she reports is different than the monthly earned income amount returned by Equifax, so earned income is not considered verified and the reasonable compatibility test occurs. The earned income amount reported by Anya is not reasonably compatible, so she must provide verification of her earned income. Anya verifies that her earned income is less than 100% of the federal poverty level, so she is determined financially eligible for SSI-Related Medicaid.</u></p> <p><u>If the monthly earned income amount reported by Anya and the monthly earned income amount returned by Equifax had been the same, the earned income would have been considered verified, and the reasonable compatibility test would not have occurred. Eligibility</u></p>
--------------	--

	would have been determined using the amount reported by Anya, and no verification would be requested.
--	---

20.7 When to Verify

Proof of certain information is required to determine eligibility for Medicaid. Mandatory (see [Section 20.3 Mandatory Verification Items](#)~~Verify mandatory and questionable items~~) and questionable (see [Section 20.4 Questionable Items](#)) items must be verified at application, renewal, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. ~~Do not reverify one~~ One-time only verification items do not need to be re-verified. For changes in circumstance and timely renewals, current benefits are maintained until a redetermination of benefits is completed.

Verification means to establish the accuracy of verbal or written statements made by, or about an individual's circumstances. Case files or case comments must include documentation for any information required to be verified to determine eligibility or benefit levels.

Exception: Veterans benefits, including allowances for Aid and Attendance, Housebound, and Unusual Medical Expenses usually increase only once a year, in January. If an IM agency verifies the January veterans benefit increase, it does not have to re-verify the veteran benefit income at the time of the next scheduled eligibility renewal, which occurs later in that same year. If another change in the veterans benefit does occur between January and the next scheduled eligibility renewal, that income change will have to be verified. This exception is being adopted to reduce the verification workload for both the IM agency and Veterans Administration staff, who routinely pursue and provide veterans benefit income verification every January.

20.7.1 Application and Renewal

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days. ~~Applicants must be given at least 20 days to provide any necessary verification.~~ from the filing date (see [SECTION 2.6 FILING DATE](#) and [SECTION 2.7 APPLICATION PROCESSING PERIOD](#)).

Eligibility ~~must not~~ cannot be denied for failure to provide the required verification until the later of:

1. The 20th day after ~~the request for~~ requesting verification ~~is sent.~~
1. ~~The 30th day after the application is received by the agency~~ filing date.
2. ~~If you request~~ requesting verification ~~more than 20 days prior to the 30th day you must still allow the applicant 30 days from the application filing date to provide the required verification.~~

The applicant will be advised of the specific verification required and given a minimum of 20 calendar days to provide any necessary verification.

20.7.1.2 Eligibility Renewals

Eligibility must not be denied for failure to provide the required verification until the 20th day after requesting verification. ~~or the end of the renewal month, whichever is later~~ Renewal verifications are accepted late if they are received anytime within the three months following the renewal month. The three-month period begins the month after eligibility ends. If verifications are required to complete a timely or late renewal, the member will have 20 days to provide it.

Example	Fred's eligibility renewal is due in April. He submits a paper renewal form on April 8. The
----------------	--

1:	worker requests verification of his income on April 9. Because his renewal was returned by adverse action and verification requested, his health care is extended by one month. If the verification is not submitted by May adverse action, his eligibility will end on May 31.
----	---

Example 2:	Shannon's renewal was due in June. At adverse action in June, a notice was sent to Shannon to let her know her Medicaid eligibility would end June 30 because she did not complete her renewal. Shannon called the agency on June 30 and completed her renewal. Verification of income is requested with a July 20 due date. Shannon did not submit the required verification by July 20, so her eligibility beginning July 1 was denied. If Shannon submits the requested verification by September 30, it must be treated as a late renewal (see Section 3.1.6.1 Verification Requirements for Late Renewals)
------------	--

20.7.1.3 Late Renewals

IM agencies must accept and process health care renewals and renewal-related verifications up to three calendar months after the renewal due date. Late renewals are only permitted for members whose eligibility has ended because of lack of renewal and not for other reasons. Members whose health care benefits are closed for more than three months because of lack of renewal must reapply.

This policy applies to the following programs:

- BadgerCare Plus (BC+)
- Family Planning Only Services (FPOS)
- SSI-related Medicaid
- Home and Community-Based Waivers (HCBW)
- Institutional Medicaid
- MAPP
- MSP (QMB/SLMB/SLMB+/QDWI)

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

Late submission of an online or paper renewal form, or a late renewal request by phone or in person, is a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verifications are required during the completion of a late renewal, the member will have 20 days to provide it.

Example 3:	Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day and verification is requested, the verification will be due on March 25, 2015. If she provides verification on or before this due date and meets all other eligibility criteria, her eligibility and certification period will start on March 1, 2015. Her next renewal will be due February 28, 2016. The three-month period starts from the month the renewal was due. It does not restart when a late renewal has been submitted.
------------	---

Example 4:	Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day, and verification is requested, the verification will be due on March 25, 2015. If Jenny does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date. If a member has a gap in coverage because of his or her late renewal, he or she
------------	--

may request coverage of the past months in which the gap occurred and must provide all necessary information and verifications of income and assets for the current month and the gap months and must pay any required premiums to be covered for those months.
Because QMB coverage is not retroactive, the ability to request coverage for past months does not apply for this program.

Example 5: Jenny's renewal is due on January 31, 2015. She completes her renewal on January 20, 2015, and a VCL is generated requesting income verification for the 30 days prior to January 20. Jenny does not submit the requested verification, and her BadgerCare Plus eligibility is terminated as of January 31, 2015. On April 27, 2015, she submits her paystubs for April 10 and April 24. If she meets the eligibility criteria for BadgerCare Plus, her certification period will start on April 1, 2015, and her next renewal will be due March 31, 2016. If she had submitted the verification of her income for January, a new VCL should be generated asking for verification of her current income for April.

20.7.2 Changes

When a member reports a change ~~is reported~~ that requires verification, the current health care benefits are maintained while the change is being processed, including while verification is requested. The member must be notified in writing of the specific verification required and allowed a minimum of 20 days to provide it.

20.8 Actions

20.8.1 Positive Actions

~~Begin~~ Benefits will begin or continue ~~benefits~~ when:

- The member has submitted a timely renewal which remains in progress over adverse action of the renewal month.
- The member submitted a timely renewal after adverse action but by the last business day of the renewal month.
- The member has a change in circumstance and verification is requested to determine eligibility for other forms of health care.
- The member provides requested verification within the specified time limits and is otherwise eligible.
- Requested verification is mandatory, but the member does not have the power to produce the verification and he or she is otherwise eligible. In this situation, the agency must also make an effort to obtain the verification (see Section 20.1.4 General Rules).

20.8.2 Delay

~~Notify the member~~ Applicants must be notified of a processing delay when:

- Verification is needed.
- ~~He or she~~ The applicant has the power to produce the verification.
- The minimum time period allowed for producing the verification has not passed.
- ~~CARES provides a~~ Additional time is needed to produce the verification checklist.

A notice is sent to notify the member of applicant indicating the reason for the delay, the specific verification required, and the date the verification is due.

If eligibility is maintained following a timely renewal with pending verification, a notice is generated to explain health care benefits are being maintained during the redetermination.

20.8.3 Negative Actions

~~Deny~~ Benefits will be denied or ~~reduce benefits~~ reduced when all of the following are true:

- The member has been tested for all categories of health care and is determined ineligible.
- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- The requested verification is needed to determine current eligibility. Current eligibility cannot be denied for lack of verification of a past circumstance that does not affect current eligibility.
- The member is not a child in a continuous coverage period (see Section 1.2 Continuous Coverage for Qualifying Children).

Note	<p>Do not deny <u>Eligibility cannot be denied or terminate eligibility</u> terminated for failure to verify information that the member is not responsible to obtain (see Section 20.1.4 General Rules regarding agency use of data exchanges and verification of information that is not used to determine eligibility).</p> <p><u>Eligibility cannot be denied or terminated for failure to verify medical expenses.</u> The disallowance of unverified expenses <u>and deductions</u> is the only penalty to be imposed.</p> <p><u>Eligibility cannot be denied or terminated for failure to verify tribal member status (see Section</u></p>
------	--

	20.3.11 Tribal Membership, Descent, or Eligible to Receive Indian Health Services
--	---

|

21.6 HMO Enrollment

21.6.5 Enrollment Exceptions

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

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

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

Types of Enrollment Exemptions

Exemption	Description
Admission or Enrollment in the Birth to 3 Program (BadgerCare Plus only)	The head of the household or the county Birth to 3 Program may request an exemption on behalf of the child when the child is enrolled in the Birth to 3 Program. Birth to 3 Program providers are encouraged to work with the member’s HMO before requesting the enrollment exemption. This exemption can be backdated up to two months from the month the request is received.
Commercial Insurance or Commercial HMO Enrollment	The member is enrolled in a commercial insurance plan or commercial HMO that limits them to a restricted private network and does not align with the SSI HMO provider network.
Continuity of Care	A one- to two- month continuity of care exemption may be granted when a member is newly enrolled or about to be enrolled in an HMO and has an upcoming appointment (within the next two months) with a provider with whom they have a previously established relationship, and that provider is not part of the HMO’s network. If the member has more complex medical needs and requires an exemption longer than two months, the HMO Enrollment Specialist will refer the member to the State Nurse Consultant. In addition, a longer continuity of care exemption

	can be granted for a pregnant individual who wants to see a nurse midwife/practitioner of their choosing who is not part of the HMO's provider network. For a pregnant individual, the exemption can be applied at any time starting from the month of request through two months after the estimated due date.
Distance	This exemption may be granted for a one- to -two-month period when a member has moved out of an HMO's service area while their eligibility has not yet been updated to reflect the change in address AND the member needs immediate care in the area that is not covered by their current HMO.
HIPP Determination in progress or enrollment in the HIPP program	This exemption may be granted if the member is pending an eligibility determination for the HIPP program or is enrolled in the HIPP program, and the employer-sponsored insurance plan limits the member to a restricted provider network that does not align with the HMO's provider network.
Long Term Complex Care	The state Nursing Consultant may apply this exemption for up to 12 months for individuals who have complex needs and may need specialized care outside of a member's HMO network.
Low Birth Weight	The state Nurse Consultant may apply this exemption to newborns with a low birth weight (birth weight less than 2,500 grams or 5 lbs. 8 oz.).
Native American, American Indian, Alaskan Native or member of a federally recognized Tribe	If the member attests they are a Native American, American Indian, Alaskan Native, or a member of a federally recognized tribe, they are not required to enroll in an HMO. The member can choose to remove this exemption at any time to enroll into an HMO.
Care4Kids Extension	This exemption applies to children in BadgerCare Plus who are still receiving services under the Care4Kids 12-month extension after being discharged from out-of-home care. Care4Kids is a specialized managed care program for children in out-of-home care in Kenosha, Ozaukee, Milwaukee, Racine, Washington, and Waukesha counties.
Transplants	The member had a stem cell or bone marrow transplant. The or the member <u>is receiving sickle cell disease gene therapy.</u> <u>Members undergoing stem cell or bone marrow transplants</u> will be permanently exempted from HMO enrollment effective the first of the month in

which the surgery is performed.

Members undergoing sickle cell disease gene therapy will be permanently exempted from HMO enrollment effective the first of the month in which successful apheresis is performed.

Transplant exemption requests may be made by the HMO or the member and are directed to the state Nurse Consultant.

23.1 Notices

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

23.1.1 Notice Requirements

Applicants and members must be provided with written notice of:

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

24.7 Meeting the Deductible

The fiscal test group meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group has not yet met the deductible within the deductible period, it may choose to start a new deductible period that begins with a later month in the current deductible period with a new application (see Section 24.3 Deductible Period).

Example 1	Stanley's deductible period is from January through June. In April Stanley incurs a large medical expense that would meet his deductible. Stanley requests to start his deductible April 1st. His new deductible period is April through September. Stanley will have to submit a new application.
-----------	--

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in Section 24.7.1 Countable Costs below.

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant or member's FTG.

Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example 2	Sally's spouse died of leukemia in April 2014 . In September 2014 , Sally requests that a medical bill incurred for her spouse be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.
-----------	--

2. Meet the Definition of Medical or Remedial expense as defined in [Section 15.7.3 Medical/Remedial Expenses](#) and [Section 24.7.1.1 Countable Expenses](#) ~~(see)~~.
3. Meet one of the following four conditions
 - a) Still be owed to the medical service provider sometime during the current deductible period.

Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a Medicaid deductible.

- i. The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
- ii. If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
- iii. Many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 3	<p>From May- through July 2013 Helen resided in an Institute <u>Institution</u> for Mental Disease <u>Diseases</u> (IMD) and incurred a \$14,000 bill. -As of October-2014, Helen has not paid this bill. In October Helen's social worker, Ruth, applies <u>assists Helen in applying</u> for Medicaid -on Helen's behalf.</p> <p>Ruth tried to help Helen meet her deductible by collecting Helen's medical -bills. The "bill" for Helen's IMD stay listed \$14,000 in - "Deferred Charges". Ruth questioned what deferred meant. -The account's <u>accounts</u> receivable person at the IMD indicated that charges for low-income people are often "deferred." - "Deferred," she explained, means that the member would never <u>not</u> be billed for the charges, but if he or she happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.</p> <p>Helen can use this "deferred" charge toward her deductible.</p>
--------------	--

Example 4	<p>Lestat applies for Medicaid in July, 2014. <u>An</u> A Medicaid deductible of \$700 is calculated for him. In 2013 <u>In the year prior to applying for Medicaid</u> he had a blood transfusion. The bill for the transfusion was \$800. He never paid it and still owes it to the service provider. He <u>Lestat</u> can use the unpaid bill to meet his Medicaid deductible, but <u>he</u> must provide documentation to show that the charges are currently owed. The remaining \$100 can be applied to the next deductible period, as long as it is still owed.</p>
--------------	---

- b) Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 5	<p>Frank and Estelle apply for Medicaid on March 1, 2014, requesting that their deductible period begin January 1, 2014. Their deductible for the period January 1 -through June 30th <u>30</u> is \$340. In April, they had a ten-year-old medical bill of \$300 written off. They can count the \$300 toward the January -through June 2014 deductible because it was written off during the deductible period.</p>
--------------	---

- c) Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 6	<p>Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. -He has a bill that was written off in the prior period. -He can apply this bill to his current deductible.</p>
--------------	---

Example 7	<p>Malcolm is in his second deductible period which began March 1, 2014. <u>He</u> did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. -He has a medical bill that he paid in</p>
--------------	---

	February 2013 , <u>of the year prior</u> . He may not apply this toward his current deductible.
--	--

Example 8	Norah is in her second deductible period which began in September 2014. In June 2014 In June, Norah met her first deductible period and was certified for Medicaid through August. After certification, and before the first deductible period ended in August, Norah paid for medical services that were not Medicaid covered services. <u>Norah is in her second deductible period which began in September</u> . Norah can apply these paid bills to the second deductible period that began in September 2014 .
-----------	---

- d) Paid or written off ~~some times~~sometime during the three months prior to the date of application. -This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 9	Sierra and Skyler apply for Medicaid on August 10, 2014 , requesting that their deductible period begin on August 1, 2014 . Their deductible for the period from August through January is \$1500. -On May 10th <u>10</u> the couple had paid off a \$2000 outstanding medical bill. -They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. -The remaining \$500 cannot be applied to future deductible periods.
-----------	--

Example 10	Anna applied for Medicaid on July 25, 2020 , with no request for any backdated months. Her deductible period is from July 2020 through December 2020 . She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May, and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.
------------	---

Example 11	Anna <u>Anna</u> - Annie <u>Annie</u> applied for Medicaid on July 25, 2020 , requesting a one month backdate. Her deductible period is from June 2020 through November 2020 . She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.
------------	---

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in [24.7.1 Countable Costs](#):

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

Some examples of medical expenses are deductibles and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program. [See Section 15.7.3 Medical/Remedial Expenses](#).

Note	ForwardHealth interChange (iC) data may be used to calculate Medicaid co-payments from the previous deductible period.
------	--

2. Remedial expenses.- Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition ([see Section 15.7.3 Medical/Remedial Expenses](#). ~~Some examples of remedial expenses include:-~~).

- ~~1. Case management~~
- ~~2. Day care~~
- ~~3. Housing modifications for accessibility~~
- ~~4. Respite care~~
- ~~5. Supportive home care~~

~~Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:~~

- ~~a) Assistance with activities of daily living~~
- ~~b) Attendant care~~
- ~~c) Supervision~~
- ~~d) Reporting changes in the participant's condition~~
- ~~e) Assistance with medication and medical procedures which are normally self-administered~~
- ~~f) The extension of therapy services, ambulation and exercise~~
- ~~g) Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well being and care at home~~

- ~~6. Transportation to obtain medical care. This includes but is not limited to taxi, rideshare services, bus fares, or a person's own vehicle at a cost of \$0.24/mile. A transportation log is sufficient verification. The log should provide the time and date of the appointment, name and address of the provider, time departed, time returned, and miles driven.~~
- ~~7. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.~~
- ~~8. Remedial expenses do not include housing or room and board expenses.~~
- ~~9. CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.~~
- ~~10. In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's~~

~~breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.~~

3. Ambulance service and other medical transportation (21.4.2 Transportation).
4. Medical insurance premiums paid by a member of the fiscal test group ~~or FFU.~~ These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. This includes all Medicare premiums paid by the member. [See 24.7.1. # 3 regarding premiums paid for the three months prior to the deductible.](#) Do not allow accidental insurance policy premiums as a countable cost.

Note	Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period. This includes all Medicare premiums owed by the member during the deductible period.
------	--

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible.
6. Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).
7. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.
8. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.
9. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in [24.7.1. # 3](#).
Examples include:
 - a) General Assistance
 - b) Community Options Program [\(COP\)](#)
 - c) AIDS Drug Assistance Program (ADAP)

Example 12	Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.
------------	--

Example 13	Sally received a medical service in January which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.
------------	---

10. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in [24.7.1 # 3](#)

Example	On January 1, Michael received a medical service which will be paid by Indian Health
---------	--

14	Services. -When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.
----	--

Example 15	Charlie received a medical service in January which was paid by Indian Health Services in the same month. -In February Charlie applies for Medicaid requesting a backdate to January. -Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.
------------	--

11. SeniorCare Enrollment Fees

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

Example 16	Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.
------------	---

3. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in [24.7.1 Countable Costs](#).

Example 17	An applicant incurs a \$300 medical bill. She applies the \$300 toward her deductible even though he or she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. -Three years later she applies for Medicaid again and a deductible is calculated for her.-She now pays the \$300 bill. But she She cannot use it to meet her current deductible because she already used it to meet the prior deductible.
------------	--

24.7.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment prior to the begin date of the corresponding deductible period.

Prepayments are submitted to the local agency.

If the member is **55 or older**, ~~forward~~ prepayment checks or money orders should be made payable to: "The Department of Health Services."

The following should be included with the payment:

- Documentation that the payment is voluntary
- The member's name, and Medicaid ID number

The IM agency forwards the payment to:

ForwardHealth
Estate Recovery/Casualty Collections
313 Blettner Blvd

Madison WI
53714-2405

~~Prepayment checks or money orders should be made payable to: "The Department of Health Services."~~
~~With the payment, include:~~

- ~~1. Documentation that the payment is voluntary.~~
- ~~2. The member's name and Medicaid ID number.~~

If ~~he or she~~ the member is **under 55**, ~~instruct~~ the member ~~to~~ would make the payment payable to ~~your~~ their IM Agency. ~~Report the~~ The receipt is reported on the Community Aids Reporting System (CARS) ~~labeled~~ as a Medical Refund.

24.7.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 18	Laura's deductible period is from March 1st through August 31st. The total deductible amount is \$1,000. Laura submits payment of \$1,000 on August 15th. Laura's Medicaid eligibility begins on March 1st.
------------	--

~~Enter the first date of the deductible period on AGTM as the date the payment was received.~~

24.7.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses are counted first. ~~Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.~~

Example 19	Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,800. Chad submits a medical bill with a March 8th date of service for \$800. On July 15th, he submits payment of \$1,000. Chad's Medicaid eligibility begins March 8th. Submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update () identifying the provider of service on March 8th and the \$800 member share amount.
------------	---

~~Enter the incurred medical expense first. Perform a PF23 sort. The remaining balance is the amount that can be paid to meet the deductible. Enter the payment date as the same date of the last incurred medical expense, which equals the balance of the deductible, on CARES screen AGTM. Complete and submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update () to the fiscal agent. Enter the deductible met date as the date of the last incurred medical expense. Enter the member share as the amount of the last incurred medical expense.~~

24.7.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 20	Roberta's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,500. She submits an outstanding bill from January 10th for \$500. On August 15th, she submits payment of \$1,000. Roberta's Medicaid eligibility begins March 1st.
------------	--

~~Enter the first date of the deductible period on AGTM as the date the payment was received.~~

24.7.3.4 Calculation Errors

If any portion of the deductible is paid and ~~you find~~ it is determined that the amount was wrong due to agency error, ~~refund~~ the ~~paid~~ amount ~~that was incorrect~~ incorrectly paid shall be refunded and ~~report~~ the refund reported on CARS.

24.7.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, the person is no longer ~~eligible~~ eligible.

26.3 Nonfinancial Requirements

26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction

Members must:

- Meet general Medicaid nonfinancial requirements (see Section 4.1 Who is Nonfinancially Eligible for Medicaid?).
- Be at least 18 years old (there is no maximum age limit).
- Be determined disabled, presumptively disabled, or MAPP-disabled by the DDB, regardless of age (see [Section 5.2 Determination of Disability](#) and Section 5.10 Medicaid Purchase Plan Disability).
- Be meeting or exempt from the work requirement (see [Section 26.3.3 Work Requirement](#) and [Section 26.3.4 Work Requirement Exemption](#)).

Note	<p>People who are receiving Medicaid through SSI's 1619(b) program are nonfinancially eligible for MAPP. People who are SSI-eligible under 1619(b) can be on SSI Medicaid and MAPP at the same time. These people are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals. Because this group is the most likely to move from SSI Medicaid to MAPP, DHS has decided to allow them to be eligible for both at the same time.</p>
------	---

26.5 MAPP Premiums

~~Effective August 1, 2024, MAPP applicants and~~ MAPP members with gross monthly income over 100% of the FPL will be charged a premium.

~~Applicants with a filing date on or after August 1, 2024,~~ MAPP applicants with gross monthly income over 100% of the FPL must pay an initial premium to ~~become eligible for~~ enroll in MAPP.

26.5.1 Calculation

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

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

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

To calculate monthly premium amount:

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

The result is the member's monthly premium amount.

Note	503, Disabled Adult Child (DAC), widow or widower disregards allowed in eligibility determinations cannot be allowed in premium calculations.
------	---

Example 1	Shannon applies for MAPP. Her Premium Gross income <u>Income</u> is under 100% of the FPL. She has no premium.
-----------	---

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

Example 3	<p>Susan is a MAPP member whose Premium Gross income <u>Income</u> is 169% of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is \$1,750. Her monthly MAPP premium will be calculated as shown below:</p> <p>\$2,200 Premium Gross Income – \$300 monthly IRWE deduction – \$150 monthly medical/remedial deduction ----- \$1,750 Countable Net Income – \$1,304.17 (100% of the FPL) ----- \$445.83 Premium Net Income X 0.03 (3%) ----- \$13.37 +\$25 Base Premium Amount ----- \$38.37 (round down to nearest whole dollar) Susan’s monthly MAPP premium is \$38.</p>
--------------	---

26.5.2 Initial Premium

There are no free premium months. Before enrolling in MAPP, the applicant must pay applicable premiums for the initial benefit month and for any requested backdated months for which they are eligible and are charged a premium. Premiums must be paid up to the current month, so if eligibility is not determined until the month after application, the premium for the current month also must be paid before they can be enrolled in MAPP.

Example 5	Eric applies for MAPP on January 29, but his application is not processed until February 11. Eric was determined eligible for MAPP effective January 1 with a monthly premium of \$50. Eric must pay a \$50 premium for January and a \$50 premium for February to open for MAPP.
--------------	---

Example 6	Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. Eric is determined eligible for MAPP effective February 1. Eric does not have to pay February's premium before MAPP opens because it is for a future month. Eric will be enrolled in MAPP and be sent a premium statement to pay February's premium by the due date of February 10.
--------------	--

It is possible that an applicant owes a premium for some but not all initial months at application because ~~premiums were suspended (before August 2024) or their~~ their monthly premium gross income was ~~lower~~ less than 100% FPL for some of the months. For example, if the applicant requests ~~backdated~~ coverage, and their monthly premium gross ~~income~~ income was under 100% FPL during the backdated months, but their monthly premium gross ~~income~~ income is over 100% FPL in the application month, no premium is required for the backdated months, ~~however, and~~ and a premium is owed for the application month. The premium for the application month (or the next month if the application is being processed after the application month) must be paid before the individual can enroll in MAPP. If the premium is not paid, eligibility can be granted for any months a premium was not required ~~but will be denied for months~~ for which a premium was ~~not paid~~ owed.

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

Example 8	Jessie applied for MAPP on August 5, 2024, with a two-month backdate request. She was determined eligible for MAPP effective June 1, 2024, with a monthly premium of \$25. Jessie does not owe a premium for June or July 2024, as MAPP premiums were not in effect. However, Jessie must pay the August premium to open for MAPP benefits for the month of August and ongoing. If Jessie's August premium is not paid, she will be determined ineligible for MAPP for August and ongoing, but she will be eligible for MAPP without a premium from June 1, 2024, to July 31, 2024.
-----------	--

The Medicaid Purchase Plan Premium Information/Payment [form \(F-00332\)](#) is sent to the member with the verification checklist (VCL) notifying them of the premium amount due and where to submit the premium payment (see Process Help, [Section 25.3 MAPP Premium Processing for Applications and Renewals](#)).

An applicant could change or remove their request for backdated [benefits eligibility](#) if they are unable or do not want to pay the premiums.

Example 98	Vang applied for MAPP on October 8, with a two-month backdate request. He was determined eligible for MAPP effective August 1, with a monthly premium of \$39. Vang must pay his monthly premium for August, September, and October to open for MAPP as of August 1. If Vang is unable to pay the premiums for all three benefit months at application, he can gain eligibility as of September 1 by paying the September and October premium, or as of October 1 by paying the October premium only.
------------	---

26.5.3 Ongoing Premiums

[Ongoing premium payments can be paid through any of the methods listed in Section 26.5.4.1 Payment Methods.](#) Premiums are due on the 10th of the benefit month regardless of which payment method is chosen.

[Members enrolled in ACCESS AutoPay or Electronic Funds Transfer \(EFT\) or Wage Withholding are mailed a monthly automatic premium payment reminder letter. This letter is mailed around the 20th of the month before the benefit month. ACCESS AutoPay payments occur on the 3rd calendar day of the benefit month. EFT and Wage Withholding payments occur on the 3rd business day of the benefit month.](#)

[Members not enrolled in ACCESS AutoPay or EFT or Wage Withholding are mailed a premium statement. The fiscal agent sends the premium statement around the 20th of the month before the benefit month.](#)

26.5.4 Payment Information

26.5.34.1 Payment Methods

Initial premium payments required to gain MAPP eligibility ~~must~~ can be paid ~~by:~~

- Online using the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account, or
- By sending a check or money order ~~and are collected by the Income Maintenance (IM) agency to the fiscal agent.~~

This includes initial premiums at application or re-request.

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

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

- ~~Check~~
- ~~Money order~~
- ~~Electronic Funds Transfer (EFT)~~
- ~~Wage withholding~~
- ~~Credit or debit card~~
- ~~Members are able to make~~ Make one-time payments online using ~~a credit or debit card, or EFT from a checking or savings account, through~~ the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account.
- ~~For~~ Make recurring ~~EFT~~ monthly payments online using the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account. This method is called ACCESS AutoPay.
- Make recurring monthly payments via Electronic Funds Transfer (EFT) or Wage Withholding with a savings account or checking account.
- Send a check or money order to the fiscal agent.

To ensure that premium payments are properly posted by the fiscal agent, individuals may no longer pay their initial or ongoing MAPP premiums to their local or tribal IM agency. If an individual brings a premium payment to the agency, the agency must assist them with paying online or mailing their premium payment. In-person premium payments will be processed by the agency only in very limited circumstances, when the following criteria are met:

- The individual is unable to pay their premium online; and
- The individual's benefits will end before the payment, if mailed, will be processed by the fiscal agent (applicable only to ongoing members); and
- The individual has a specific and immediate medical need, where a delay in the beginning of benefits or a temporary closure of benefits will result in not being able to get a prescription, not being able to attend a medical appointment, or loss of long-term care services prior to the premium being processed.

To make recurring monthly payments via EFT, members must submit a ~~complete~~ completed Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form ([F-13023](#)).

To make recurring monthly payments via Wage Withholding, members must submit a completed Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form ([F-13023](#) ~~To have premiums taken out of a paycheck,~~) and the employer must submit the Medicaid Purchase Plan Premium Employer Wage Withholding form ([F-13024](#)) ~~must be submitted by an employer. Members~~

~~must submit payments through one of the other methods until they get confirmation that their recurring EFT or wage withholding request has been processed. Once enrolled in EFT payments, monthly premium statements will no longer be sent.)~~

Members who are awaiting enrollment in EFT or Wage Withholding must pay their monthly premiums using another method until they receive confirmation that their EFT or Wage Withholding enrollment is complete.

Members enrolled in ACCESS AutoPay or EFT or Wage Withholding will be mailed a monthly automatic premium payment reminder letter instead of a monthly premium statement.

26.5.3.2 Advance Payments

Premiums may not be paid in advance.

26.5.4.3.3 Refunds Excess Payments

The fiscal agent issues refunds if the premium was paid and is for a month in which one of the following situations occurs:

1. The individual was ineligible for MAPP.
2. AThe individual made an excess payment and the excess cannot be applied to the next month's premium.
- 2.3. The member requested to close MAPP and already paid the premium for a month in which they will not be open for MAPP.

The member's estate can receive a refund if he or she dies between adverse action and the beginning of the benefit month.

The fiscal agent either issues a refund or applies an excess payment to the next month's premium if a change is reported that results in no premium or a lower premium amount.

If the change is reported within 10 days of when the change occurred, the lower premium amount or \$0 premium amount is effective during the month in which the change occurred. If the change is not reported within 10 days of when the change occurred, the lower premium amount or \$0 premium amount is effective during the month in which it was reported. ~~The fiscal agent will refund any excess premium that was paid.~~ See [Section 26.7 MAPP Changes](#) for information on change reporting.

Note	When determining if a change was reported within 10 days of when the change occurred, the worker should use the <u>member's</u> reported date of change from the member is used. If the worker has information that makes the reported date of change <u>is</u> questionable, the worker can request verification of the date of change <u>may be required.</u>
------	---

~~The individual overpaid and the excess cannot be applied to the next month's~~ **26.5.5 Late Payment of Premium**

1. ~~If a MAPP member does not pay an ongoing monthly premium.~~
2. ~~The by the due date, but the~~ member ~~requested to close MAPP and already paid~~ pays the premium.

~~The member's estate can receive a refund if he or she dies between adverse action and the beginning of premium is processed in~~ the benefit month.

26.5.4 Ongoing Cases

Ongoing premium payments can be paid through any of the methods listed in . Ongoing premium payments paid by check are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the 10th of the benefit or the next month regardless of which payment method is chosen. The fiscal agent sends the premium statement around the 20th of the month before the benefit month. The payment is due on the 10th of the benefit month. EFT occurs on the third business day of the benefit month. Members, the member will remain enrolled in EFT do not get premium statements mailed to them each month.

26.5.5 Late Payments

If a late payment is received and processed after the 10th of the month but before the end of the month, MAPP will be reinstated, and a premium statement will be sent for the following month's premium MAPP.

Example 19	<p>Donald has been open for MAPP since March 2023. In early July 2024, Donald <u>Darren</u> is notified that his gross monthly income is over 100% of the FPL, and he will owe a <u>enrolled in MAPP with an ongoing monthly premium of \$56 starting 25</u>. His premium for August 2024. Donald receives a premium statement in mid-July for his premium <u>is due August 10, 2024</u>. Donald <u>Darren</u> does not pay his <u>the August</u> premium by the due date. <u>On August adverse action, Donald's MAPP eligibility closes for non- but makes a \$25 payment of premium effective September 1, 2024</u>. If Donald pays his premium <u>before on August 31, he can 12 via ACCESS</u>. On August 13, ACCESS shows that his August premium is paid. Darren will <u>remain open for MAPP</u> enrolled in MAPP. In late August, Darren is mailed a premium statement for September.</p>
------------	---

Payments

Example 10	<p>Fatima is enrolled in MAPP with an ongoing monthly premium of \$43. Her premium for February is due February 10. Fatima does not pay the February premium by the due date. She will remain enrolled in MAPP through March. In late February, Fatima is mailed a premium statement for the March premium along with a cover letter that specifies the February premium is late. Fatima submits a \$43 payment via ACCESS on March 5. The payment is applied to the past due February premium, and on March 6, ACCESS shows that her February premium is paid. The March premium remains unpaid. Fatima will remain enrolled in MAPP through April. In late March, Fatima is mailed a premium statement for the April premium along with a cover letter that specifies the March premium is late.</p>
------------	--

If a late payment is received and processed in the month after the premium was due and closure notice has been sent but before eligibility has ended, the member will remain enrolled in MAPP.

Example 11	<p>Ahmed is enrolled in MAPP with an ongoing monthly premium of \$51. His premium for May is due May 10. Ahmed does not pay the May premium by the due date. He will remain enrolled in MAPP through June. In late May, Ahmed is mailed a premium statement for the June premium along with a cover letter that specifies the May premium is late. As of mid-June, Ahmed has not made a payment and is mailed a notice that his MAPP eligibility will end June 30 due to not paying the May premium. Ahmed submits a \$51 payment via ACCESS on June 26, and the payment is applied to the past due May premium. Because Ahmed has now paid the past due May premium, he is eligible for MAPP through the month of July. The June premium remains unpaid, and Ahmed is mailed a premium statement for the July premium</p>
------------	--

along with a cover letter that specifies the June premium is late.

A payment received and processed in the month after eligibility ended is treated as a re-request and will be applied to the current month to allow the member to regain MAPP eligibility, as long as the payment covers the current month's premium in full.

Example 212	<p>Miles has been open for MAPP since June 2024. In early July, Miles Rick is notified that his gross monthly income is over 100% of the FPL, and he will owe a enrolled in MAPP with an ongoing monthly premium of \$60 starting August 2024. He receives a 37. His premium statement in mid-July for his premium December is due August December 10, 2024. Miles does not pay his premium by the due date. On August adverse action, made a payment and is mailed a notice that his MAPP eligibility closes for non-payment is ending January 31. Rick's last day of premium effective September 1, 2024. A MAPP coverage is January 31. Rick mails a check for \$60 is received 37 on September February 3 that the fiscal agent receives on February 5, 2024. This payment should be is treated as a re-request for MAPP. Miles The \$37 payment is applied as the initial premium for February, and Rick re-opens for MAPP effective September 1, 2024, and the \$60 payment is applied to his September premium February 1.</p>
----------------	--

Payments A payment received more than a calendar month after the premium was due and eligibility ended will be refunded, unless the member individual has reapplied or re-requested for MAPP (or, if other health care benefits are open on the case), and the agency pended for the, has re-requested MAPP.

26.5.6 Non-Payment of Premium

Payment of a premium is a condition of eligibility for MAPP. If a MAPP member does not pay an ongoing premium, the member will lose MAPP eligibility for non-payment of a premium at the end of the month following the month in which the unpaid premium was due.

Example 313	<p>Diego has been open for Aarav is enrolled in MAPP since August 2024. Diego's gross monthly income is over 100% of the FPL, and he owes a with an ongoing monthly premium of \$80. Diego did 30. His premium for April is due April 10. Aarav does not pay his September the April premium by the due date. On September adverse action, He will continue to remain enrolled in MAPP. In late April, Aarav is mailed a premium statement for the May premium along with a cover letter that specifies the April premium is late. If Aarav does not pay the April premium, he will be sent a notice in mid-May that his MAPP eligibility closes for non-payment of premium effective October 1, 2024. A check for \$80 is received by the fiscal agent on November 15, 2024, and it is refunded. There are no health care benefits open on Diego's case, so he needs to reapply for MAPP will end May 31.</p>
----------------	--

MAPP members that lose coverage due to non-payment of a premium are not subject to a restrictive re-enrollment period (RRP). A member whose MAPP eligibility closes due to non-payment of a premium can re-request MAPP.

If an individual loses MAPP eligibility for any reason, any past due premiums are no longer owed. An individual does not have to pay any past due premiums to reopen MAPP, but they must pay any premiums owed for the month(s) in which MAPP is being requested.

<p>Example 414</p>	<p>Carol has been open for MAPP since September 2024. Carol's gross monthly income is over 100% of the FPL and she owes a monthly premium of \$55. Carol did not pay her October premium by the due date. On October adverse action, MAPP eligibility closes for non-payment of premium effective November 1, 2024. On December 5, 2024, Carol reapplies for MAPP. The IM consortium pends for her \$55 December premium, which needs to be sent to the IM consortium. However, Carol mails her payment to the fiscal agent instead. The fiscal agent gets the payment on December 12, and sees that Carol has re-applied for MAPP and needs to pay her premium, so they notify IM of the payment via the late payment file. The IM consortium applies the payment and reopens Carol's MAPP effective December 1, 2024. Tatiana is enrolled in MAPP with an ongoing monthly premium of \$41. Tatiana does not pay the October or November premiums, so her MAPP eligibility ends November 30. Tatiana re-requests MAPP on December 5. There is no RRP, and Tatiana does not need to pay the October or November premiums to regain MAPP eligibility. She only needs to pay an initial premium to gain eligibility for December. Tatiana pays the initial premium on December 6 and opens for MAPP as of December 1. Tatiana will receive a premium statement in mid-December for her premium due January 10.</p>
------------------------	--

26.5.6 Non-Payment

Payment of a premium is a condition of eligibility for MAPP. If a premium payment is not made, a notice will be sent at adverse action and MAPP will close for non-payment of a premium at the end of the unpaid premium month. While MAPP members can lose coverage for non-payment of a premium, they are not subject to a restrictive re-enrollment period (RRP). A member whose MAPP eligibility closes due to non-payment of a premium can re-request MAPP. They do not have to pay the unpaid premium in order to reopen MAPP after the closure. However, they must pay any premiums owed for the month(s) in which MAPP reopens.

If a MAPP member does not pay an ongoing premium that is owed and then has an income reduction that results in not being charged a premium before losing MAPP eligibility, the member will remain eligible for MAPP without paying any past due premiums.

<p>Example 115</p>	<p>Tatiana was determined eligible for MAPP in August with a monthly premium of \$41. Tatiana does not pay her October premium, so her MAPP eligibility closes effective November 1. Tatiana re-requests MAPP on November 5. Because there is no RRP and Tatiana is re-requesting MAPP after the unpaid premium month has passed, she does not need to pay the October premium to regain eligibility. She only needs to pay an initial premium to gain eligibility for November. Tatiana pays the initial premium on November 6 and opens for MAPP as of November 1. Tatiana will receive a premium statement in mid-November for her premium due December 10. Wei is enrolled in MAPP with an ongoing monthly premium of \$39. Wei does not pay the March premium by the due date. He remains enrolled in MAPP through April. On April 8, Wei reports a reduction in income that began in April; the reduction in income is verified the same day. Wei's gross monthly income is now under 100% FPL, and he no longer owes a premium for April. Since he no longer owes a premium as of April, Wei will remain eligible for MAPP for May even if he does not pay the past due March premium.</p>
------------------------	---

26.5.6.1 Insufficient Funds

~~IM workers will be notified with a 056 Run SFED/SFEX alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment, and the payment is rejected for insufficient funds. If the premium is not paid by adverse action, the member's MAPP benefits will end.~~

26.5.6.2_26.5.6.1 Partial Payments

Unless a temporary premium waiver is in place, members with gross monthly income over 100% of the FPL must pay their entire MAPP premium ~~by the end of~~ each month to maintain eligibility.

Partial payments made and processed before the last day of the month will be applied to the benefit month. If the remaining balance is not received and processed before the end of the following benefit month, the MAPP member will lose eligibility due to non-payment of premium.

Example 116	Melinda was determined eligible for MAPP in September with a monthly premium of \$51. Melinda pays her premiums in full until November, when she mails a check on November 1 for a partial payment of \$25. On November adverse action, MAPP eligibility closes for non-payment of premium effective December 1. If she does not pay the remaining \$26 before the end of the month, her MAPP eligibility will end November 30. <u>Gisele is enrolled in MAPP with an ongoing monthly premium of \$35. Her premium for July is due July 10. Gisele submits a \$20 payment on July 3. Although Gisele has not paid the full July premium, she will continue to remain enrolled in MAPP through August. In late July, Gisele is mailed a premium statement for the August premium along with a cover letter that specifies the July premium is late. The premium amount due for August is \$35 and the past due premium amount for July is \$15. Gisele does not make a premium payment in August. In mid-August, Gisele will be sent a notice that her MAPP coverage will end August 31.</u>
----------------	--

26.5.7 Opting Out

~~If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month, MAPP eligibility will end the next possible month.~~

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

26.5.826.5.7 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.

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, when the applicant or member:

- Has an unusual expense related to 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 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.
- Has experienced a decrease in work hours.
- Has lost a job but remains non-financially eligible due to a medical exemption or participation in a HEC plan.
- Is the survivor of a crime, such as someone who has 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 their funds due to the crime.
- Is experiencing temporary transportation issues, causing a decrease in the hours they can work.
- Is experiencing temporary child care issues, causing a decrease in the number of hours they can work.

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’s health or ability to work.
- Inflation or other regular increase in price, such as groceries or gasoline.
- Regular, recurring expenses that can be budgeted for, like rent or utilities, 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). 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 <u>717</u>	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.
-----------------------	--

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.

Note	When processing temporary premium waiver requests received before October 2020, IM 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 818	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.
----------------	--

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 919	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.
----------------	--

Example 1020	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.
-----------------	--

26.6 ~~Reserved~~ Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month, MAPP eligibility will end the next possible month.

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

26.7 MAPP Changes

26.7.1 MAPP Changes Introduction

The member must report within ten days all changes to income, household composition, allowable deductions, including medical and remedial expenses that were once out of pocket but are covered once the applicant is a MAPP member, and other non-financial changes, including loss of employment, which affect eligibility. ~~The IM worker should re-determine eligibility as a result of the changes. If it is determined that he or she remains eligible for MAPP and owes a premium, recalculate the premium amount.~~ When a change in circumstance is reported, current health care benefits must be maintained while eligibility is being redetermined.

Example 1:	Nancy does not have health insurance and currently pays \$550 a month for a variety of medical/remedial expenses. She applies for MAPP and is found eligible as of December 1. Once she is eligible, MAPP will cover some of her medical/remedial expenses and reduce her out of pocket medical/remedial expenses down to \$50 a month in December. Because Nancy must wait until the end of December to determine the final decrease in her monthly out of pocket expenses, she must report this decrease no later than January 10th.
------------	--

26.7.2 ~~Reduced Premiums~~ Premium Changes

Following a change, if it is determined a member has a new or ~~No Premiums~~ increased premium, implement the premium change as of the following effective date:

- Eligibility redetermined before adverse action: Effective the first of the following month.
- Eligibility redetermined after adverse action: Effective the first of the month after the following month.

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. ~~If the change results in no premium, the IM agency may have to run Premium decreases must be reviewed, and eligibility with dates in CARES for the month the change occurred or redetermined when applicable, when coverage was maintained following a reported (whichever is later) and any subsequent change or a timely renewal. Once eligibility is able to be redetermined, premium amounts for months with coverage maintained may need to be reduced or refunded. See Section 26.5.4.3 Excess Payments, PH 25.3.4 Change Processing, and PH 25.4.4 Changes in Premiums and Refunds as well as for recurring.~~

27.10 ILTC Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- ~~Before~~ Eligibility redetermined before adverse action: Effective the first of the following month.
- ~~After~~ Eligibility redetermined after adverse action: Effective the first of the month after the following month.

Do not complete [F-10110](#) (formerly DES 3070) for retroactive patient liability or cost share increases since the member must receive timely notice. This includes scenarios in which a member is switching from a patient liability to a cost share or from a cost share to a patient liability.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later.

Liability changes must be reviewed when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, liability amounts for months with coverage maintained may need to be reduced. See [PH 11.11.1.2 Restoration of Benefits for Institutional Medicaid](#).

Note:	If an Administrative Law Judge or court orders a decreased liability or cost share, the agency must follow the court order and apply changes retroactively as stated in the court order.
-------	--

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

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

Managed LTC programs include:

- Family Care
- Family Care Partnership
- PACE

Medicaid Eligibility

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

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

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

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

Managed Long-Term Care of IRIS Enrollment

Enrollment in managed LTC or IRIS is completed by the ADRC. The ADRC will submit the following information to IM workers:

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

- [Declaration Regarding Transfer of Resources Long-Term Care Medicaid Waiver Program and/or Community Options Program, F-20919D](#), if any potential divestment was reported to the ADRC
- [Disenrollment from the managed LTC program or IRIS, if applicable](#)

28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy

To be eligible for EBD Medicaid or LTC Medicaid, a person must be elderly, blind, or disabled.

Adults over age 18 and younger than 65 years old must have a disability determination unless the person is eligible for BadgerCare Plus, WWWMA, Foster Care, or Adoption Assistance. If a person later loses eligibility for that program and must be tested for EBD Medicaid or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care, Family Care Partnership, PACE, or IRIS.

A disability finding made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirements for managed LTC or IRIS until the first of the following:

- An adult disability determination can be completed
- The child disability determination was redetermined and the child was found to no longer be disabled.

Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

[This policy applies to child disability determinations made by the Bureau of Clinical Policy and Pharmacy \(BCPP\) for Katie Beckett members. See Section 5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs.](#)

28.6 HCBWLTC Eligibility Groups and Cost Sharing

28.6.3 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (Section 25.1 Special Status Medicaid Introduction) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, they do not owe a cost share to the new MCO that month.

Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.

Cost Share or Patient Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- **Before** Eligibility redetermined before adverse action: Effective the first of the following month.
- **After** Eligibility redetermined after adverse action: Effective the first of the month after the following month.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease ~~in income~~ occurs or the decrease is reported, whichever is later.

Cost share changes must be reviewed when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, cost share amounts for months with coverage maintained may need to be reduced. See [PH 11.11.1.1 Restoration of Benefits for Waivers \(Refunding Cost Share\)](#)

29.1 Katie Beckett Medicaid

Katie Beckett Medicaid ([KBM](#)) is a special eligibility pathway for children under 19 who have certain health care needs and live at home. Katie Beckett provides Medicaid health care coverage for children who qualify. Katie Beckett Medicaid does not deem assets and income from parents or legal guardians.

To qualify for Katie Beckett Medicaid, a child must:

- Be under age 19.
- Meet the Social Security Administration's definition of "disabled."
- Be a U.S. citizen or qualifying immigrant.
- Be a Wisconsin resident.
- Live at home, in a foster care setting, or in another eligible community-based setting.
- Require the kind of care typically provided by a hospital, SNF, ICF, or long-term care facility.
- Be able to receive safe and appropriate care at home.
- Have income below the Institutions Categorically Needy income limit (see Section 39.4.1 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.
- Not require care at home that would cost more than the care they would receive in a long-term care facility covered by Medicaid.

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

Families may contact Katie Beckett Medicaid Central Office by:

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

~~Katie Beckett~~
~~Division~~ Wisconsin Department of ~~Medicaid~~ Health Services
DMS/Bureau of Children's Services
~~1 West Wilson Street,~~ 201 E. Washington Ave. Room 418C300
Madison, WI ~~53707~~ 53703

29.2 Katie Beckett Medicaid Renewals

KBM certification periods are 12 months, and eligibility is maintained under continuous coverage policies until the end of the KBM certification period.

When a timely KBM renewal is submitted, a member's existing health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but by the last business day of the renewal month. Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal.

If the member's renewal is received after adverse action but by the end of the renewal month, their current coverage will be reinstated and maintained until the renewal is processed. The member will be notified of the reinstatement.

29.2.1 Ineligible for KBM after Renewal

At renewal, if the member still does not meet KBM requirements due the change in circumstance during their certification period they will be notified that they no longer qualify for KBM, and that additional information is needed to determine if they are eligible for a different form of Medicaid. The notice explains how to apply for health care with the IM agency and informs the member that, if their application is received by the due date (30 days from the date the notice was sent), they will keep their current coverage until the application is processed.

KBM coverage will be maintained for at least 30 days from the date the letter is sent to give the member time to apply. If the IM agency receives an application by the due date, KBM coverage will continue until the IM agency finishes processing the application. See [Section 5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs](#), regarding disability transition when KBM coverage is ending.

If the IM agency does not receive an application by the due date, KBM coverage will end with timely notice. Applications received after the due date will be processed in accordance with normal application policies.

Example 1	<u>Tina is 12 years old and enrolled in KBM. In March, her father reports that Tina is hospitalized and is expected to remain in the hospital for several months. While KBM requires members to be living in a home or community setting (rather than a medical institution), Tina remains enrolled in KBM for the remainder of her 12-month continuous coverage period, which ends in August. On August 3, the KBM worker processes Tina's renewal. Tina is still living in a medical institution, and therefore no longer qualifies for KBM. On August 4, a letter is sent to the household informing them that Tina no longer qualifies for KBM, but if she applies for health care and the application is received by September 3, her current coverage will continue until the application is processed. Tina's father applies by phone on August 10. On August 20, the IM worker determines Tina is eligible for Institutional Medicaid starting on October 1. Her KBM ends on September 30.</u>
--------------	--

29.3 Katie Beckett Medicaid Changes in Circumstance

When a KBM member experiences a change in circumstances and no longer meets program requirements (for example, they become institutionalized or no longer meet medical criteria), they remain enrolled in KBM until the end of their continuous coverage period.

At renewal, if the member still does not meet KBM requirements due the change in circumstance, a process begins to request the member apply for other health care types with IM. See [MEH Section 29.2.1 Ineligible for KBM after Renewal](#).

29.4 Katie Beckett Medicaid Members Turning Age 19

Members are no longer eligible for KBM once they turn 19, and 19-year-olds are ineligible for continuous coverage (see Medicaid Eligibility Handbook Section 1.2 Continuous Coverage for Qualifying Children). Members receive two notices in advance of turning 19 informing them that their KBM enrollment will end when they turn 19 and recommending that they submit a health care application.

If a member submits a health care application within three months of their KBM enrollment ending, provides any requested documentation on time, and meets all non-financial and financial requirements, the member's KBM disability determination will satisfy the disability requirement for all EBD Medicaid programs while the member completes the required DDB disability application and waits for a decision on their DDB disability application. See [Section 5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs](#).

Example <u>1</u>	Sam is enrolled in KBM. Sam turns 19 on August 20. Six months prior to her birthday, Sam receives a letter informing her that her enrollment in KBM will end August 31 due to turning 19. On August 1, Sam submits a health care application, MADA, and ADDD to the IM agency. At adverse action in August, Sam receives a notice informing her that her KBM enrollment will end as of August 31. On August 20, Sam's application is processed, and she is determined non-financially and financially eligible for Medicaid Purchase Plan (MAPP). Sam's KBM disability determination meets the disability requirement for MAPP while she waits for a decision on her DDB application. Sam is enrolled in MAPP beginning September 1. Her disability application is later approved by the DDB, and her Medicaid continues with an August renewal date.
---------------------	---

32.7 Medicare Beneficiaries Begin Dates

32.7.1 QMB Begin Dates

~~32.7.1.1 QMB Begin Date~~

For initial eligibility, QMB benefits begin on the first of the month after the month in which the person is determined to be eligible, and the case is confirmed in CARES.

Example 1	Henry has been in the same nursing home since 2013. He applied for Medicaid on January 23, 2017, and also requested QMB. His application was processed and confirmed for both programs on January 23, 2017, and he was determined eligible for both. His Medicaid begin date is January 1, 2017. His QMB begin date is February 1, 2017.
-----------	--

~~32.7.1.2 QMB Renewals~~

~~For renewals, QMB benefits begin on the first of the month following the renewal due month, regardless if the renewal was confirmed in the renewal due month or the month following the renewal due month.~~

Example 2	Diamond has been receiving Medicaid and QMB for five years. Her Medicaid and QMB was due for renewal in February. Her Medicaid and QMB renewal began February 20. The worker received verification for the renewal on February 28. The IM worker entered verification to complete the QMB renewal certification March 1. Her QMB renewal was confirmed eligible on March 1. QMB eligibility begins March 1 and not April 1. There is no gap in her QMB eligibility.
-----------	--

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 32.10.1 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 3.1.2 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 <u>1</u>	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.
---------------------	---

32.10 Medicare Savings Programs Renewals and Changes

MSP certification periods are 12 months. The first required renewal is 12 months from the most recent certification month.

32.10.1 QMB Renewals

QMB benefits begin on the first of the month following the renewal due month, if the renewal is confirmed during the renewal month or the month following the renewal month.

While a timely QMB renewal is being processed, the benefit is maintained until the redetermination is completed. (See [MEH 3.1.1 Timely Renewals](#)). When a timely renewal is pended, and verification to complete the renewal is also received timely and the member remains eligible for QMB, the new certification period should align with the extended month(s) of eligibility and there should be no gap in coverage.

Example 1	<u>Diamond’s Medicaid and QMB are due for renewal in February. She submits a renewal on February 20. Because a timely renewal is initiated, Medicaid and QMB coverage are maintained through March while the renewal is being processed. Verification of assets is requested and received on March 3 to complete her QMB renewal. Her new certification period begins April 1. There is no gap in her QMB eligibility.</u>
--------------	--

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined before adverse action, closure is effective the first of the following month.
- Eligibility redetermined after adverse action, closure is effective the first of the month after the following month.

Example 2	<u>Susan’s Medicaid and QMB are due for renewal in February. She submits a renewal on February 3. Verification of assets is requested with a due date of February 23. Because her renewal is received timely, health care benefits are maintained for March. Verification is received and processed on February 23, and she is no longer eligible for QMB. QMB coverage ends effective April 1.</u>
--------------	---

For late QMB renewals that have all needed verification processed in the month following the renewal due month, there should be no gap in coverage.

Example 3	<u>Meghan’s Medicaid and QMB are due for renewal in February. She submits a late renewal on March 3. Because her renewal is received late, health care benefits are not maintained. Verification of assets is requested with a due date of March 23. Verification is received on March 19. Her new certification period for Medicaid and QMB begins March 1. There is no gap in her QMB eligibility because the renewal was confirmed in the month following the renewal due month.</u>
--------------	---

For late renewals with needed verification processed in the second or third month following the renewal due month, there will be a gap in QMB coverage.

Example 4	<u>Eve’s Medicaid and QMB are due for renewal in February. She submits a renewal on April 3. Because her renewal is received late, health care benefits are not maintained. Verification of assets is requested with a due date of April 23. Verification of assets for March and April are received on April 19. Her new certification period for Medicaid begins March 1 and QMB begins May 1. There is a gap in her QMB eligibility because the renewal was not confirmed in the renewal due month or the month following the renewal due month.</u>
--------------	---

32.10.2 QMB Changes in Circumstance

While a change in circumstance is being processed, QMB benefits are maintained until the redetermination is completed.

If timely verification is received and all other eligibility requirements are met, there should be no gap in coverage, even if the member changes MSP categories.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined before adverse action, closure is effective the first of the following month.
- Eligibility redetermined after adverse action, closure is effective the first of the month after the following month.

32.10.3 SLMB, SLMB+, QDWI Renewals

While a timely SLMB, SLMB+, or QDWI renewal is being processed, the benefit is maintained until the redetermination is completed. See [MEH 3.1.1 Timely Renewals](#).

If timely verification is received and all other eligibility requirements are met, there should be no gap in coverage, even if the member changes MSP categories.

Example 5	<u>Donald’s MAPP and SLMB are due for renewal in February. He submits a renewal on February 20. Because a timely renewal is initiated, MAPP and SLMB coverage are maintained through March while the renewal is being processed. Verification of assets is requested and received on March 3 to complete his MAPP and SLMB renewal. His new certification period begins April 1. There is no gap in his SLMB eligibility.</u>
--------------	---

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined before adverse action: closure is effective the first of the following month.
- Eligibility redetermined after adverse action: closure is effective the first of the month after the following month.

Example 6	Jay's MAPP and SLMB are due for renewal in February. He submits a renewal on February 3. Because his renewal is received timely, health care benefits are maintained for March. Verification of assets is requested with a due date of February 23. Benefits are maintained for March. Verification is received and processed on February 23, and he is no longer eligible for SLMB. The effective date of the SLMB termination is April 1.
--------------	---

32.10.4 SLMB, SLMB+, QDWI Changes in Circumstance

While a change in circumstance is being processed, SLMB, SLMB+, or QDWI benefits are maintained until the redetermination is completed.

If timely verification is received and all other eligibility requirements are met, there should be no gap in MSP coverage, even if the member changes MSP categories.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined before adverse action, closure is effective the first of the following month.
- Eligibility redetermined after adverse action, closure is effective the first of the month after the following month.

32.10.5 Program Choice

While a renewal or a change in circumstance is being processed, the benefits that were open during the month of the change are maintained into the following month until the redetermination is completed. If a member receives full-benefit Medicaid that is maintained while a renewal or change is being processed, but is determined no longer eligible for full-benefit Medicaid (but is eligible for SLMB+), SLMB+ eligibility must be determined for the months when full-benefit coverage was maintained. See [MEH Section 3.1.5 Program Changes at Renewal](#) and [MEH Section 3.3.3 Program Changes](#) ~~MSP renewals are every 12 months.~~

33.3 SeniorCare Nonfinancial Requirements

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a \$30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a member reapplies for a new benefit period, a new enrollment fee is required.

When a SeniorCare enrollment fee check is returned for non-sufficient funds, the applicant or member is mailed a letter and provided ~~ten~~twenty calendar days to submit a replacement check. If a replacement check is not received, ~~a letter giving another 10 days to replace the fee is sent. If the check is still not replaced,~~ then eligibility is denied or terminated.

33.15 SeniorCare Annual Eligibility Renewal

33.15.1 Maintaining SeniorCare Coverage During Regularly Scheduled Renewals

When a timely renewal is submitted, a SeniorCare member's health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but on or before the last business day of the renewal month.

Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal, in accordance with timely notice requirements.

However, if the member's renewal is received after adverse action but by the end of the renewal month during business hours, their current coverage will be reinstated for the following month and will be maintained until the renewal is processed. The member will be notified of the reinstatement.

Example 1	<u>Anne and Horace are a married couple enrolled in SeniorCare. January is the last month of their certification period, and their renewal is due on January 12. They do not submit the renewal by the due date. On January 17, a notice is sent to inform them that their SeniorCare coverage will end January 31 because they did not complete their renewal. Their renewal is received on January 31 during business hours. Anne and Horace's SeniorCare coverage is reinstated for the month of February, and they are sent a notice that they are enrolled in SeniorCare effective February 1 and will remain enrolled while their renewal is being processed. On February 9, EMCAPO finishes processing the renewal and Anne and Horace remain eligible for SeniorCare. A new 12-month certification period is established beginning on March 1.</u>
--------------	--

36.5 WWWMA Changes

36.5.1 Member Loses Eligibility

Wisconsin Well Woman Medicaid (WWWMA) members are required to report to EM CAPO within 10 days of occurrence changes that would affect their eligibility. This includes:

1. Turning 65 years old.
2. Change in address or phone number, including if the member is incarcerated in or released from jail or prison.
3. No longer needing treatment for breast or cervical cancer.
4. Obtaining health insurance that covers their treatment for breast or cervical cancer.
5. Obtaining Medicare Part A, Part B, or both.

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

36.5.1 Maintaining WWWWMA Coverage While Considering other Medicaid Eligibility

When a WWWWMA member no longer meets program requirements due to a change in circumstances, all other potential health care eligibility must be considered before coverage under WWWWMA ends. Because EMCAPO workers do not determine eligibility for other forms of full-benefit health care, the redetermination must be completed by the IM agency. Depending on the circumstances of the case, additional information may be needed for the agency to determine if the member qualifies for another form of Medicaid or BadgerCare Plus.

When a WWWWMA member experiences a change in circumstances and no longer meets program requirements, they will be sent a notice that they no longer qualify for WWWWMA, and additional information is required to determine if they qualify for a different form of Medicaid.

- For members losing WWWWMA due to turning 65, the notice will be sent to the member on the Saturday after adverse action of the month before they turn 65.
- For members losing WWWWMA for another reason (such as no longer meeting medical criteria), the notice will be sent when the reported change in circumstances is processed by EM CAPO.

The notice explains how to apply for health care with the IM agency and informs the member that, if their application is received by the due date (30 days from the date the notice was sent), they will keep their current coverage until the application is processed.

WWWMA coverage will be maintained for at least 30 days from the date the letter is sent to give the member time to apply. If the IM agency receives an application by the due date, WWWWMA coverage will continue until the IM agency finishes processing the application. If the IM agency does not receive an application by the due date, WWWWMA coverage will end with timely notice. Applications received after the due date will be processed in accordance with normal application policies.

Example	Samira is enrolled in WWWWMA. She will be turning 65 on April 22. On March 22, she is sent a
---------	--

1

notice informing her that she will no longer be eligible for WWWMA after she turns 65, but if she applies for health care and the application is received by April 21, her current WWWMA coverage will continue until the application is processed. Samira's application is received on April 20. The IM worker processes the application and determines Samira is eligible for SLMB+. Her WWWMA ends on June 1, in accordance with timely notice requirements.

36.6 WWWMA Renewals

Renewals are required every 12 months. To renew WWWMA, the member must submit an updated Wisconsin Well Woman Medicaid Application and Renewal ([F-10075](#)) or the Well Woman Renewal Form (WWRF) that is sent to them approximately 45 days before their renewal date. Enrollment in WWWP, FPOS, or BadgerCare Plus is not a requirement when completing a WWWMA renewal.

WWWMA renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. See [Section 3.1.6 2 Late Renewals](#) for more information.

Example 1	Jenny's renewal is due on January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. Jenny submits the verification prior to March 30, and EM CAPO determines she meets the WWWMA eligibility criteria. Her new WWWMA certification period begins on March 1. Her next renewal date is February 28 of the following year.
-----------	--

Example 2	LaVonne's renewal is due to on January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. LaVonne submits the verification on May 20. Since she submitted, after the verification after the three-month period that started with her January 31 renewal due date and ended April 30, she, She will need to reapply for WWWMA.
-----------	---

36.6.1 Maintaining WWWMA Coverage During Regularly Scheduled Renewals

When a timely renewal is submitted, a WWWMA member's health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but on or before the last business day of the renewal month.

Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal, in accordance with timely notice requirements.

If the member's renewal is received after adverse action but by the end of the renewal month during business hours, their current coverage will be reinstated for the following month and will be maintained until the renewal is processed. The member will be notified of the reinstatement.