WISCONSIN DEPARTMENT of HEALTH SERVICES

HEALTH MANAGEMENT ORGANIZATION COVID-19 UNWINDING Q&AS

Last Updated: April 17, 2023

TIMELINE

1. When will the federal requirement to maintain continuous coverage for Medicaid programs end?

For people who were part of a Medicaid program prior to March 31, 2023, their coverage will be maintained until they complete their next renewal with the state. Renewal due dates have been scheduled across a 12-month period between June 30, 2023, and May 31, 2024. Letters were sent in March 2023 to notify members of their scheduled renewal due date. Note: if a member renews early, they could lose coverage earlier than their scheduled date.

For individuals who apply after March 31, 2023, regular program eligibility rules and requirements to report changes are in effect immediately.

2. When will participants receive information from the Wisconsin Department of Health Services (DHS) regarding the actions they need to take?

DHS mailed letters in March 2023 to inform members of their scheduled renewal due date. Next, DHS will send a renewal packet 45 days before a member's scheduled due date. Getting this packet tells a member that it is time to renew.

For more information on communications to members from DHS, please see the Return to Routine Health Care Operations Planned Unwinding Member Communications timeline (P-03338).

RENEWALS AND ELIGIBILITY

3. When do members need to complete their Medicaid renewals?

DHS mailed letters in March 2023 to inform members of their scheduled renewal due date. DHS will also send a 45-day renewal packet. Getting this packet tells a member that it is time to renew. Note: if a member renews early, they could lose coverage earlier than their scheduled date.

Renewal due dates have been scheduled across a 12-month period between June 30, 2023, and the last in May 31, 2024.

4. Can HMOs text current members with renewal reminders?

HMOs should follow the guidance written in the Communication Outreach and Marketing Guide. DHS will communicate specific renewal dates directly to members. HMOs should *not* text specific renewal dates to members.

5. When will members who are determined to be no longer eligible for BadgerCare Plus or Medicaid be disenrolled from the HMO?

All members will stay enrolled until their first BadgerCare Plus or Medicaid renewal after April 1, 2023, is completed. If they are found to be ineligible at the time of their renewal, the member will be disenrolled

from the HMO effective the first day of the month after the month they lose eligibility. For example, if the member's renewal is due by September 30, 2023, and they are no longer found eligible, their eligibility will end on September 30, 2023 and their HMO disenrollment is effective on October 1, 2023. HMOs will receive a monthly report telling them who among their members have been disenrolled throughout the Unwinding period.

6. Can HMOs temporarily attain access to MyACCESS to assist members with address updates?

No. MyACCESS contains HIPAA-protected member information and cannot be shared with HMOs.

7. What is the difference between routine renewals and administrative renewals?

Most members will need to complete a renewal, which requires the member to confirm and/or update information with DHS. They may also need to provide verification of their information. This is considered our routine.

In a limited number of cases, DHS is able to determine member eligibility based on information available through data exchanges. This is referred to as an administrative renewal. In such cases, members will receive notice that they have been renewed, with a summary of the information that was used and asked to contact DHS if any corrections are necessary.

8. Will members need to pay BadgerCare Plus or Medicaid premiums once continuous enrollment ends?

Members will not be asked to pay BadgerCare Plus or Medicaid premiums until January 2024 at the earliest. More information is forthcoming for members and partners regarding communication of this change.

TELEHEALTH AND SERVICES

9. Will members continue to be able to utilize telehealth?

For many services, yes. For specific information about telehealth, please visit the ForwardHealth telehealth resources page and the ForwardHealth max fee schedule page.

10. Will SSI Care Management Services delivery flexibilities continue?

No, all SSI care management services must be provided as described in the DHS-HMO contract.

DATA AND REPORTING

11. What reports will HMOs receive from DHS?

DHS will share multiple reports with the HMOs to assist with raising awareness regarding the end of continuous coverage and member renewals.

12. What are the categories of reasons that a member's enrollment may end following their Medicaid renewal that DHS is required to report to CMS?

There are two categories of terminations:

- Procedural terminations are related to a preventable issue with renewal submission, including failure to initiate a Medicaid renewal or submission of incomplete information. HMOs should contact members who fail to complete their Medicaid renewal by their deadline to encourage them to reapply for backdated coverage.
- Eligibility terminations occur when a member completes their Medicaid renewal application but is found ineligible because they don't meet program rules. HMOs should contact members ineligible for Medicaid renewal with health insurance resources.

COMMUNICATION

13. When and how often should HMOs contact members regarding their Medicaid renewals?

HMOs should refer to the HMO Communication Guide for this information. The Return to Routine Health Care Operations Planned Unwinding Member Communications timeline (P-03338) may be an additional helpful reference.

14. Will providers be notified of their patients' upcoming Medicaid renewal dates?

DHS will not be notifying providers of information related to their patients' renewal dates if those patients are members who are part of an HMO. Providers *can* check member eligibility in the ForwardHealth system. DHS *will* be sharing renewal due date information for fee-for-service members with their providers to be used on a voluntary basis.

15. Can HMOs contact former members with information related to renewal and reapplying for coverage?

Yes, HMOs may contact former members with messaging related to renewals. Also, if a member is going to lose coverage due to a procedural termination, HMOs may contact members within 90 days of their coverage ending to encourage them to reapply for backdated coverage. Refer to the HMO Communication Guide for more guidance.

16. Can HMOs market Qualified Health Plans to members at risk of Medicaid disenrollment?

Yes, but all marketing materials distributed in conjunction with Medicaid renewal efforts must be approved by DHS. Marketing Qualified Health Plans to members will only be allowed according to the timeline set by DHS. If an HMO chooses to market Qualified Health Plans to *any* members at risk of Medicaid disenrollment, they must do so to *all* of their eligible members at risk of disenrollment.

17. What guidance has been updated regarding communication to members in response to the end of continuous enrollment requirement?

The Communication Guide has been updated to the following language:

4.12.5 Text Message Notifications

4.12.5 Health Plans must follow the standard DHS approval process for written communications to members prior to circulation of materials, including text messages. DHS approval indicates only that the content of the message is acceptable to DHS. Health Plans will need to work with their own legal counsel to confirm they have consent to text members and ensure that all materials are HIPAA and Telephone Consumer Protection Act (TCPA), if applicable, compliant.

Section 4.13: Contact with Former Members Who Have Recently Lost Medicaid Eligibility for Limited Purpose of Providing Enrollment and Renewal Information.

4.13.1 For CY 2022 and 2023 only, Health Plans may contact former members who have recently lost eligibility due to lack of renewal or late verification, for the limited purpose of providing former members with information about re-establishing Medicaid eligibility.

4.13.2 Health Plans may only contact former plan members if the former plan members are within their 90-day period to complete a renewal. The Department will provide Health Plans with lists of former members who have lost eligibility and the timeframe in which the member must complete the renewal process.

4.13.3 Health Plans must follow the standard DHS approval process for communications to members prior to circulation of materials to former members.

4.13.4 Health Plans may provide former members with information about enrollment, including renewals, in BadgerCare Plus and Medicaid programs. Health Plans may direct former members to do the following as applicable:

4.13.4.1 Apply online at the ACCESS website: www.access.wisconsin.gov

4.13.4.2 Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf;

4.13.4.3 Call ForwardHealth Member Services at 1-800-362-3002;

4.13.4.4 Call or go to their county IM agency or tribal agency to complete an application; www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

4.13.4.5 For Medicaid SSI information please direct members or potential members to:

4.13.4.5.1 The Department Link - https://www.dhs.wisconsin.gov/ddb/apply.htm

4.13.4.5.2 Social Security Administration Resources – How to apply for Medicaid SSI:

4.13.4.5.2.1 https://www.ssa.gov/disabilityssi/

4.13.4.5.2.2 https://www.ssa.gov/ssi/text-apply-ussi.htm

4.13.5 Health Plans are prohibited from completing the renewal process on behalf of a former member.

4.13.5.1 Health Plans may provide a member with assistance in completing the ACCESS website renewal process.

4.13.5.2 With the former member's permission, Health Plans may contact an IM agency on a former member's behalf in order to obtain contact information or arrange for an initial appointment between IM staff and the former member.