WISCONSIN DEPARTMENT of HEALTH SERVICES

# Family Care, Family Care Partnership, and PACE

# COVID-19 Unwinding Q&As for Managed Care Organizations (MCOs)

Last updated: April 18, 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 members 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). MCOs will receive additional regular COVID Unwinding-specific reports from DHS listing members with upcoming renewal deadlines.

## 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 participant that it is time to renew. Note: if a member or participant 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.

MCOs will receive regular COVID Unwinding-specific reports from DHS listing members with upcoming renewal deadlines.

### 4. When will MAPP premiums and work requirements begin?

For new applicants as of April 1, 2023, MAPP premiums will begin January 1, 2024.

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Members with continuous coverage who complete a renewal before January 1, 2024, will owe premiums beginning January 1, 2024.

Members with continuous coverage who complete a renewal on or after January 1, 2024, will owe premiums beginning the month after their renewal.

Work requirements will be begin on January 1, 2024. For new applicants as of April 1, 2023, they will need to meet the work requirement to be eligible for January 2024.

Participants with continuous coverage with a renewal on or before November 30, 2023 will need to meet the work requirement in order be eligible after January 1, 2024. Participants with continuous coverage with a renewal due on or after December 31, 2023 will need to meet the work requirement at their renewal to be determined eligible for a new 12-month certification period.

**5. What prevents an administrative renewal from occurring? Does it matter what program they are eligible for?**

Whether a participant can be successfully administratively renewed depends on the participant's circumstances at the time of the administrative renewal. There are several exclusions that could prevent the health care benefits from being administratively renewed. Medicaid sub-programs that do not qualify for administrative renewals include:

- SSI-related Medicaid with met or unmet deductibles
- MAPP with income over 100% of the federal poverty level (FPL).
- Institutional Medicaid
- Group B and B+ Community Waivers
- Group A Community Waivers with eligibility based on 1619(b), BadgerCare Plus, EBD Medicaid, or Adoption Assistance

In addition, someone may not be successfully administratively renewed if:

- they have assets over 50% of the asset limit
- they have claimed medical/remedial expenses and/ or impairment-related work expenses (IRWEs).
- someone on their case is moving into a different age group, for example, turning 19 or 65.

**6. When will eligibility end for members whose most recent functional screen was changed to functionally ineligible during continuous coverage?**

The member must be allowed to complete a new functional screen within the month following their Medicaid renewal due date, if the previous screen was not done within 90 days of that time. For example, if the participant's Medicaid renewal is due no later than July 31, 2023, and completed on time, the MCO should complete a new functional screen for the participant before the end of August.

**7. If a participant is deemed not functionally eligible at that time, they will be disenrolled. Will members on SSI Medicaid and not required to complete a renewal lose eligibility if they have not completed their annual long term care functional screen?**

Members who do not need to complete a Medicaid renewal because they have SSI Medicaid must have a valid functional screen starting June 1, 2023. When continuous enrollment ends, SSI Medicaid members who are not required to complete a renewal and do not complete a screen can be disenrolled from Family Care, Family Care Partnership, or PACE starting June 1, 2023.

**8. After the PHE ends, when should a Notice of Action be sent to members stating a change in their level of care?**

When issuing a Notice of Action, follow the DHS-MCO contract requirements in Article III. F. Members must be allowed to have a new functional screen completed before disenrolling them from the program. MCOs can complete functional screens after April 1, 2023 for members with SSI Medicaid who have maintained Medicaid eligibility. For members who must complete a Medicaid renewal, the screen should be completed the month following their renewal.

**9. If a member requests to transfer between programs due to a change in their level of care, who will manage this transfer?**

The member should contact their local Aging and Disability Resource Center (ADRC) for enrollment counseling.

**10. If a member has not been paying their cost share, will they be required to repay unpaid costs?**

Members do not have to repay any unpaid cost share incurred between March 1, 2020, and March 31, 2023.

Starting April 1, 2023, both new and existing members who are subject to cost share will need to start paying it to stay enrolled.

**11. Members who had an outstanding balance prior to the suspension of cost share during COVID-19 are expected to pay their balance. Members who would normally lose eligibility (eg, in waiver Medicaid) for not paying a cost share must be allowed to remain enrolled until they complete their Medicaid renewal. Can a member change their MCO without a valid Long-Term Care Functional Screen?**

Yes. A member can change their MCO without a new Long-Term Care Functional Screen. If the member has not had an opportunity to complete their Medicaid renewal, the new MCO is responsible for completing a functional screen before the member’s Medicaid renewal date.

## Disenrollment

**12. When can members who are no longer financially eligible for Medicaid be disenrolled?**

Members who were part of their program prior to March 31, 2023, must be allowed to remain enrolled until their Medicaid renewal is completed unless they qualify for one of the exceptions in the following questions. If their Medicaid renewal determines the member to be financially ineligible, the member will be disenrolled at that time.

**13. Can any members be disenrolled right after the end of the continuous coverage requirement, even if they have not yet completed their Medicaid renewal?**

Yes, some members may be disenrolled from Family Care, Family Care Partnership, or PACE starting June 1, 2023. These participants are individuals who continue to be eligible for SSI Medicaid and *are therefore not required to complete a renewal*. The reasons an MCO could request disenrollment are:

- Health and safety concerns
- Member is nonresponsive or cannot be contacted
- Member is no longer accepting services

Members who would lose Medicaid eligibility cannot be disenrolled until after they have completed a Medicaid renewal.

**14. What process should MCOs follow to request member disenrollment after the end of continuous coverage?**

MCOs should request member disenrollment according to the process indicated in the DHS-MCO contract, Article IV. B.3.

**15. Will MCOs continue to pay providers while eligibility concerns are addressed?**

Yes.

**16. When will a member be disenrolled if they voluntarily moved out of an MCO's service area once the continuous enrollment requirement ends?**

Members who move out of an MCO's service area should be referred to the ADRC in the county they are residing to receive options counseling. MCOs must work with the new MCO or IRIS Consultant Agency to transition the member and establish a new enrollment date.

If the member does not seek counseling from the ADRC, they may be immediately disenrolled if they are eligible for SSI Medicaid and are not required to complete a renewal. However, if the member would lose Medicaid eligibility, they must be allowed to remain enrolled with their MCO until they complete their Medicaid renewal.

**17. When will a member be disenrolled if they voluntarily moved out of state between March 1, 2020 and March 31, 2023?**

Members who move out of state must be immediately disenrolled, even before the end of continuous enrollment.

**18. What steps should a Family Care Partnership MCO take if a member chooses a primary care physician not in the MCO's provider network?**

The MCO should initiate an involuntary disenrollment due to loss of program eligibility if the member receives SSI Medicaid and is *therefore not required to complete a renewal*. If the member would lose Medicaid eligibility, then the member must be allowed to remain enrolled with their MCO until they complete their Medicaid renewal.

**19. What steps should a Family Care Partnership MCO take if the member chooses to disenroll from, or chooses not to enroll in, the MCO's Dual Eligible Special Needs Plan?**

The MCO must notify the member of the potential for disenrollment and refer the member to their local ADRC for options counseling. This notification must occur prior to the MCO requesting disenrollment of the member for failure to enroll in the Partnership Dual Eligible Special Needs Plan per Article IV.B.3.b.iii.b of the DHS-MCO contract.

## Residential Services

**20. Will a grace period be allowed to promote safe discharge planning from a residential facility if a member is deemed functionally and/or financially ineligible?**

MCOs should monitor members who may potentially lose eligibility in their program and should proactively communicate with members and their residential facilities to coordinate transition if needed.

**21. How should MCOs engage with residential providers regarding member eligibility?**

MCOs are responsible for engaging providers to ensure that members in residential settings undergo Medicaid renewals and functional screens, including communicating any issues or updates on a member's Medicaid and functional screen eligibility per Article III.C.3.g. of the DHS-MCO contract.

## Data and Reporting

**22. How will MCOs receive data regarding members who are affected by the end of continuous coverage?**

DHS will share multiple reports with the MCOs to assist  with raising awareness and understanding about the end of continuous coverage and member renewals. For more information, see the Unwinding Return to Routine Operations HMO, MCO, and IRIS Reporting Timeline.

**23. How are screen dates corrected in MMIS?**

An adult long-term care-enrolled member may have:

- An overdue functional screen.
- A functional screen level of care that is not valid for program enrollment.
- A "no level of care" functional screen.

These could cause:

- A retroactive level of care end-date.
- A level of care end-date that is before the date of disenrollment from the program.

The MCO should contact DHS to report the level of care as a discrepancy. The member's level of care will need to be manually updated through the last day of the program enrollment month.