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DMS Operations Memo 25-17

To: Income Maintenance Supervisors
Income Maintenance Lead Workers
Income Maintenance Staff

Affected Programs:
- ☐ BadgerCare Plus
- ☐ Caretaker Supplement
- ☐ FoodShare
- ☐ FoodShare Employment and Training
- ☒ Medicaid
- ☐ SeniorCare

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Maintaining Coverage During Redeterminations of Eligibility for Additional Programs and Pending Disability Determinations

CROSS-REFERENCE

- Operations Memo 25-07, Maintaining Coverage During Redeterminations of Health Care Eligibility

EFFECTIVE DATE

November 1, 2025

PURPOSE

This memo announces changes to ensure existing coverage is maintained for:

- Katie Beckett Medicaid (KBM), Wisconsin Well Woman Medicaid (WWWMA), and Senior Care members while their eligibility is being redetermined at renewal or following a change in circumstances.
- Members moving from BadgerCare Plus (or other non-disability-based Medicaid category) to a disability-based Medicaid category while disability is being determined, provided they are otherwise eligible for disability-based Medicaid.

BACKGROUND

Katie Beckett Medicaid (KBM) is a full-benefit Medicaid program for children under 19 with disabilities who have complex health care needs and live at home. KBM is administered by Bureau of Children's Services (BCS) and Bureau of Clinical Policy and Pharmacy (BCPP) staff.

Wisconsin Well Woman Medicaid (WWWMA) is a full-benefit Medicaid program for people under age 65 who have been diagnosed with and need treatment for breast or cervical cancer or certain precancerous conditions of the breast or cervix. WWWMA is administered by Enrollment Management Central Application Processing Operation (EMCAPO) staff.

SeniorCare is a limited-benefit Medicaid program that helps adults 65 or older pay for prescription drugs and vaccines. SeniorCare is also administered by EMCAPO staff.

REDETERMINATIONS AT RENEWAL

Federal rules require states to maintain coverage while completing regularly scheduled renewals as long as the renewal is received before the end of the month the renewal is due. Prior to the changes announced in this memo, coverage was only maintained for KBM, WWWMA, and SeniorCare members if their renewal was received by the due date on their renewal letter, which is the adverse action date of the month the renewal was due.

REDETERMINATIONS DUE TO A CHANGE

When a member experiences a change in circumstances and no longer meets the eligibility requirements of their current health care category, federal rules require states to maintain the member's existing coverage until it is determined if they qualify for a different health care category. One exception to this general requirement is SeniorCare, because changes other than death, incarceration, or moving out of state do not impact a member's SeniorCare eligibility during their certification period. Prior to the changes announced in this memo, coverage was not maintained for people losing KBM or WWWMA while their eligibility for a different form of Medicaid was determined.

REDETERMINATIONS WITH PENDING DISABILITY

Federal rules require existing coverage to be maintained when a member is moving from BadgerCare Plus (or other Medicaid category that does not require a disability determination) to a disability-based category of Medicaid while their disability application is being processed, provided they are otherwise eligible for the disability-based category of Medicaid. Prior to the changes announced in this memo, a member's benefits were not maintained pending disability determination. Instead, Medicaid benefits were opened retroactively after a disability determination was approved.

POLICY

MAINTAINING KBM, WWWMA, AND SENIORCARE COVERAGE DURING REGULARLY SCHEDULED RENEWALS

Effective November 1, 2025, the following renewal policy will be implemented for KBM, WWWMA, and SeniorCare members.

The member's existing health care coverage must be maintained while their renewal is being processed. This requirement applies to all renewals 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: Anne and Horace are a married couple enrolled in SeniorCare. January is their renewal month. They do not submit the renewal by adverse action in January. On January 17, a notice is sent to inform them that their SeniorCare coverage will end January 31. 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 letter that they are enrolled in SeniorCare effective February 1 and will remain enrolled while their renewal is being processed. On February 9, the renewal is processed and Anne and Horace remain eligible for SeniorCare. A new 12-month certification period is established beginning on March 1.

For SeniorCare only, when an individual is already enrolled in SeniorCare and adds their spouse at renewal, the newly added spouse's enrollment begin date will align with the existing spouse's SeniorCare enrollment begin date. When the currently enrolled spouse's SeniorCare coverage must be maintained and is reinstated for the following month because the renewal is still being processed, the newly added spouse's SeniorCare start date will align with the existing spouse's begin date once the renewal has been processed.

Example 2: Curtis and Marie are married. Curtis's SeniorCare renewal month is February. Although Marie is not enrolled in SeniorCare, she is included in Curtis's SeniorCare group. Curtis does not submit his renewal by the adverse action date. On February 14, he is sent a notice stating that his SeniorCare coverage will end on February 28 because he did not complete his renewal.

On February 28, Curtis submits his renewal during regular business hours and indicates that Marie now wants to enroll in SeniorCare. Curtis's SeniorCare coverage is reinstated for March, and he receives a letter confirming his enrollment effective March 1. He will remain enrolled while his renewal is being processed. However, because Marie was not previously enrolled in SeniorCare, she will not be enrolled starting March 1.

On March 10, the renewal is processed. Curtis and Marie's SeniorCare 12-month certification period will begin on April 1.

MAINTAINING KBM COVERAGE WHILE CONSIDERING MEDICAID OR BADGERCARE PLUS ELIGIBILITY

Effective November 1, 2025, when a KBM member no longer qualifies for KBM for a reason other than turning 19, eligibility for other categories of health care must be considered before coverage under KBM ends. Since BCS staff do not determine eligibility for other forms of full-benefit Medicaid, the IM agency must make this determination. A health care request must be made by the member to IM for Medicaid or BadgerCare Plus for the individual losing KBM coverage, unless there is already an open health care assistance group on the case. Depending on the circumstances of the case, additional information may be needed to determine if the member qualifies for another form of Medicaid or BadgerCare Plus.

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 12-month continuous coverage period for children, if applicable (see Medicaid Eligibility Handbook Section 1.2 Continuous Coverage for Qualifying Children).

At their renewal, at the end of the continuous coverage period, if the member still does not meet KBM requirements, they will be notified that they no longer qualify for KBM, and additional information is needed to determine if they are eligible for a different form of Medicaid. The notice explains how to apply for Medicaid or BadgerCare Plus 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 application is received by the due date, KBM coverage will continue until the Medicaid or BadgerCare Plus request is processed. If an application is not received by the due date, KBM coverage will end with timely notice. KBM coverage will not be maintained for applications received after the due date.

Example 3: 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, Tina's renewal is processed. Tina is still living in a medical institution, and therefore no longer qualifies for KBM. A letter is sent to the household informing them that Tina no longer qualifies for KBM, but if she applies for Medicaid or BadgerCare Plus and the application is received by September 2, her current coverage will continue until the application is processed. Tina's father applies for BadgerCare Plus for Tina by phone on August 10. Tina's healthcare application is pending for verifications that are due by September 9th. Tina's KBM coverage will continue for the month of September and until the BadgerCare Plus eligibility determination is completed.

Note: Members who are losing KBM due to turning 19 are also notified they must apply for Medicaid or BadgerCare Plus with their local agency if they want to keep getting Medicaid, but their KBM coverage will not be maintained during the application processing period. If they apply and are eligible, they can be enrolled in BadgerCare Plus or another form of Medicaid with no gap in coverage, but their KBM coverage will not be extended beyond the month when they turn 19.

Example 4: Freya is enrolled in KBM. She will be turning 19 on July 20. On June 18, she is sent a notice of decision that her KBM will end on July 31. On September 10, Freya submits a health care application with a backdate request. On September 18, she is determined eligible for BadgerCare Plus. She is enrolled in BadgerCare Plus as of August 1.

Example 5: Dale is enrolled in KBM. When he turned 18, he enrolled in IRIS (Include, Respect, I Self-Direct), with KBM as his Medicaid source. Dale will be turning 19 on May 3. On April 20, he is sent a notice that his KBM will end on May 31. Dale applies for BadgerCare Plus on April 28. On May 28, he is determined eligible for BadgerCare Plus. He is enrolled in BadgerCare Plus as of June 1 and remains enrolled in IRIS.

MAINTAINING WWWMA COVERAGE WHILE CONSIDERING MEDICAID OR BADGERCARE PLUS ELIGIBILITY

Effective November 1, 2025, when a WWWMA member no longer meets program requirements due to a change in circumstances, eligibility for other categories of health care must be considered before coverage under WWWMA 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 WWWMA member experiences a change in circumstances and no longer meets program requirements, they will be sent a notice that they no longer qualify for WWWMA, and additional information is required to determine if they qualify for a different form of Medicaid.

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

The notice explains how to apply for Medicaid or BadgerCare Plus 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 WWWMA 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 for Medicaid or BadgerCare Plus. If an application is received by the due date, WWWMA coverage will continue until the application is processed. If the application is not received by the due date, WWWMA coverage will end with timely notice. WWWMA coverage will not be maintained for applications received after the due date

Example 6: Samira is enrolled in WWWMA. She will be turning 65 on April 22. On March 22, she is sent a notice informing her that she will no longer be eligible for WWWMA after she turns 65, but if she applies for Medicaid 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 application is processed and Samira is determined eligible for Specified Low-Income Medicare Beneficiary Plus (SLMB+). She is enrolled in SLMB+ as of May 1. Her WWWMA ends on June 1, in accordance with timely notice requirements.

MAINTAINING COVERAGE DURING TRANSITION TO DISABILITY BASED MEDICAID ELIGIBILITY

Effective November 1, 2025, when a member enrolled in BadgerCare Plus (or other health care category not based on disability) no longer meets the requirements of their current health care category due to a change in circumstances, the member's coverage must be maintained while determining 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).

There are two periods when existing coverage must be maintained:

- While the Medicaid Disability Application Form (MADA), Authorization to Disclose Information to Disability Determination Bureau (ADDD), and asset information is requested: once processed, if the individual is not eligible based on assets, the coverage will end with timely notice.
- While waiting for a disability determination: if they are otherwise eligible for a category of Medicaid after the MADA/ADDD and asset information is received, the existing coverage must be maintained while their disability determination is being made. If they are found to not be disabled, the coverage will end with timely notice.

Example 7: Hoai is enrolled in BadgerCare Plus and IRIS. On March 20, he reports an income increase from his part-time job that puts his income over the program 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, his enrollment in BadgerCare Plus will be maintained until it is determined if Hoai is eligible for Medicaid based on disability.

On March 21, a request for asset verification, the MADA, and ADDD are sent to Hoai.

Hoai provides the requested asset information and disability application forms by the due date, and it is determined that he would be eligible for MAPP if determined disabled by the Disability Determination Bureau (DDB). On April 10, Hoai's disability application is sent to DDB. Hoai's BadgerCare Plus coverage (and IRIS enrollment) will be maintained until 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 to Hoai informing him that he is now subject to reporting rules for disability-based Medicaid, and his existing coverage will be maintained while DDB is making their decision.

On July 10, 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, and he remains enrolled in IRIS.

CONTACTS

DHS CARES Problem Resolution Team

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