FAQ: SSI Managed Care

**HMO/ Managed Care Questions**

**What is an HMO?**
HMO stands for Health Maintenance Organization, a type of health insurance plan that limits its members to only seeing providers in its network.

**What is the SSI Medicaid Managed Care program?**
The state of Wisconsin's Medicaid program contracts with a group of HMOs to provide health care services for those who receive "Medicaid for SSI" or "SSI-related Medicaid" because of a disability determined by the Social Security Administration or the Disability Determination Bureau. The state pays a set dollar amount to the HMO for each member each month. Out of this money, the HMO pays the health care claims of its members. In regular Medicaid, your doctor bills the state. In Managed Care Medicaid, your doctor bills your HMO.

**Why is it called "SSI" Managed Care, when I am on Social Security Disability (SSDI) and not SSI?**
The "SSI" refers to the type of Medicaid you receive. Everyone who receives an SSI payment gets "Medicaid for SSI", while some people on Social Security Disability may be eligible for "SSI-related Medicaid" if their income and assets are low enough. There are other types of Medicaid such as "BadgerCare Plus" for children and families- people in BadgerCare Plus also have to enroll in HMOs, but they do not always have the same set of HMOs to choose from as those on SSI-related Medicaid.

**Who are the SSI HMOs?**
CompCare, Group Health Co-op Eau Claire, 1-Care, Managed Health Services, Network Health Plan, Molina, Group Health Co-op South Central, Care Wisconsin and United HealthCare. Which HMOs are available to you will depend on which county you live in.

**What are networks?**
Each HMO has contracts with various providers: medical, mental health and dental providers, home health and personal care agencies, durable and disposable medical equipment suppliers. This group of providers makes up the HMO's network. As a member of an HMO, you must see providers that are in the HMO's network.

**What are the benefits of enrolling in an HMO?**
As an HMO member, you do not have to pay co-pays on doctor/office visits, lab work, treatments or services, though you will still pay co-pays on prescriptions. Your HMO will do a health needs assessment when you are first enrolled, to help them determine what services, medical or social, you may need. You will have access to a care manager who can help you navigate through medical services, find new providers or connect you to other resources.

**What is covered and not covered by the HMO?**
Except for some "carved-out" services, the HMOs must cover everything regular Medicaid covers. Carved-out means that Wisconsin Medicaid pays for certain services instead of the HMO. Carved-out services include prescriptions, dental (in most counties), and case management services, such as CSP, TCM and CCS.
**How do I connect with my HMO?**

When you are enrolled, you will receive a member handbook that will have a list of phone numbers for your use: customer service, dental (if available) mental health, vision, and the member advocate. You will also get a provider directory.

**What if my doctor isn't in an HMO network?**

HMOs guarantee "continuity of care" for the first two months after enrollment. This means the HMO will pay your current doctor for services in the first two months you are enrolled in the HMO, even if your doctor is not in the HMO's network. This gives you time to find a new doctor, choose a different HMO or ask to be opted out of the managed care program.

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**Enrollment Questions**

**Who must enroll in an HMO?**

There is a mandatory two month trial enrollment period for two groups: people who are 19 years or older and receive Medicaid as a result of being on SSI, and people who are 19 years or older, on SSDI and are receiving Medicaid, but are not yet on Medicare.

**Is enrollment voluntary for anyone?**

People on Medicaid through MAPP and people on Medicaid and Medicare (dual enrollees) are not required to enroll; they can ignore the enrollment packet and will not have an HMO chosen for them. If they wish, they can try enrollment in an HMO and they can opt-out at any time.

**Who cannot enroll in an HMO?**

People who are living in a nursing home (but not including rehab stays of less than 90 days) or are participating in a home and community-based waiver program, such as Family Care, IRIS, Pace or Partnership, are not allowed to enroll in an HMO. This group should not receive an enrollment packet.

**Can anyone be exempt from enrolling in an HMO?**

Depending on the individual situation; people diagnosed with AIDS, in a methadone treatment program, or with significantly complicated care requirements may be found exempt from HMO enrollment. The decision is made by the Enrollment Services Center.

**Can enrollment in an HMO be postponed?**

If a person is in the middle of a course of treatment or pregnant, enrollment may be delayed until the baby is born or the treatment is completed. This decision is also made by the Enrollment Services Center.

**How does enrollment happen?**

Newly eligible members will receive an enrollment packet that explains managed care and lists the HMOs available to them. Members are responsible for contacting the Enrollment Services Center through Automated Health Services (800-291-2002) to choose an HMO or request an exemption or postponement. If they do not do so within 4 weeks of getting the enrollment packet, an HMO will be chosen for them. This 'auto- enrollment' applies only to people in the mandatory groups.

**How do I choose an HMO?**

The Enrollment Services Center can tell you which HMO network each of your providers belongs to. Choose the HMO that includes your most important providers in their network.
Can I change to a different HMO?
During the first 4 month of enrollment, a person can contact the Enrollment Services Center and ask to be changed to a different HMO. Generally, people cannot change HMOs during the "lock-in" period.

What is Lock-In?
From the 5th month to the 12th month of enrollment, a person cannot change to a different HMO, unless there is an extraordinary situation. After 12 months of enrollment, a person can change their HMO or opt-out of managed care.

What is an opt-out?
If managed care doesn't work for a person, they can request an opt-out, and be returned to regular Medicaid. But they still must be enrolled for the two month trial enrollment. The continuity of care guarantee applies to these two months. They must request opt-out before the end of the 4th month of enrollment or they will be locked in for the next 8 months.

SSI Managed Care External Advocacy Project Questions

Who is Disability Rights Wisconsin (DRW)?
DRW is the State of Wisconsin's protection and advocacy agency, serving people with any type of disability. DRW focuses on abuse and neglect, deinstitutionalization, long term care, special education, discrimination and patients' rights.

What is the SSI Managed Care External Advocacy Project?
DRW has a contract with the state of Wisconsin to provide education and advocacy to Medicaid recipients enrolled in the SSI Managed Care program. Each HMO is required by contract to have an "internal" advocate to support members. As the "external" advocates, we are an additional resource for members and work closely with the HMO's "internal" advocates.

How do people find out about the SSI MC EAP?
Our brochure is included in every enrollment packet. We do an annual postcard outreach to every HMO member. Our contact information is provided on the service denial, reduction or termination notices sent to members by the HMOs.

Can SSI MC EAP help with enrollment?
We can explain managed care and the enrollment process. We cannot recommend a particular HMO. Only the Enrollment Services Center can do the actual enrollment.

What if I don't think managed care is going to work for me?
We can discuss your situation to see if you may be eligible for an exemption or delay of enrollment and help you make your request to the Enrollment Services Center. We can assist you in requesting an opt-out after the trial enrollment and we can work with the HMO to ensure that the continuity of care guarantee works for you.

What if I am having problems with my HMO?
The SSI MC EAP can help you communicate with your HMO. We can explain who to talk to at the HMO to find a new provider. We can explain the prior authorization process. We can assist you in working out a solution to the problem or filing a complaint about the HMO to the state, if necessary.
What if I am having a problem with my provider?
Depending on what the problem is, we can help you communicate with the provider or complain to the HMO. We can refer you to the Wisconsin Division of Quality Assurance (DQA) for serious issues. We can help you connect with the HMO to find a new provider. We cannot make a provider see or treat you.

What if I am denied a service or treatment, or my service or treatment is terminated or reduced?
We will evaluate the denial, termination or reduction to determine if it is proper under Medicaid regulations. If it is not, we will assist you in appealing the action to the HMO, the State or to the Division of Hearings and Appeals.

What if I am billed for a Medicaid covered service?
Medicaid recipients cannot be billed for any Medicaid covered service received from a Medicaid certified provider unless they sign a form stating they will be responsible for a specific service on a specific date. If you get a bill, we will contact the provider to determine why you were billed, who is responsible for the bill and try to get the account balance zeroed out.

What if I can't get a prescription filled?
We will contact the pharmacy to determine what the problem is: requesting a re-fill too early, need the re-fill Ok’d by doctor, need new prior authorization from doctor. Then we will take steps to solve the problem.

What if I am having problems getting Medicaid-covered transportation services?
We will look at your specific situation and work with the Medicaid transportation broker, MTM, Inc., to attempt to resolve the problem. We can assist you in filing a complaint.

What if I lose my Medicaid eligibility?
We will look into why you lost your Medicaid and advise/assist you with what needs to be done (complete new application, complete review, submit verifications) to regain Medicaid, so you can re-enroll in your HMO.

This document & information provided courtesy of Disability Rights Wisconsin (DRW). Please visit http://www.disabilityrightswi.org/ for more information.