Unwinding the Public Health Emergency: Strategies for Advocates to Protect Medicaid Beneficiaries

NATIONAL CENTER ON LAW & ELDER RIGHTS

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Key Lessons

1. Several Medicaid and Medicare flexibilities will end once the Public Health Emergency (PHE) expires. The PHE declaration expires after 90 days or must be renewed by the Secretary of Health and Human Services (HHS). The PHE is still ongoing and HHS will provide at least 60 days' notice prior to end of PHE.

2. At the end of the PHE, states must undergo an "unwinding" process and begin initiating re-determinations for Medicaid beneficiaries. CMS has provided states an extra two months to complete re-determinations for a total 14-month unwinding period after the PHE ends.

3. Millions of beneficiaries will likely lose Medicaid once continuous coverage protections expire. Older adults and people with disabilities may also lose many expanded Home- and Community- Based Services (HCBS) benefits.

4. Advocates and stakeholders can work with state Medicaid officials to prevent significant gaps in coverage and delays in services.

Medicaid and Medicare Flexibilities Ending with the Expiration of the PHE

The President and Secretary of Health and Human Services declared a Public Health Emergency (PHE) in early 2020 in response to the COVID-19 pandemic.[1] This declaration gave states the authority to waive or modify certain requirements under Medicare and Medicaid.[2] The Secretary has extended the PHE every 90 days since Jan 31, 2020, and will provide at least 60 days' notice prior to the expiration of the PHE. States have 12 months from the end of the PHE to process re-determinations for eligibility. Centers for Medicare & Medicaid Services (CMS) provided guidance clarifying that states can initiate redeterminations before the 12-month unwinding period, and will be given an additional two months to complete re-determinations.[3]

States were able to provide flexibilities under the Section 1135 emergency waiver and 1915(c) Appendix K.[4] States could also submit a Section 1115 demonstration waiver or a State Plan Amendment (SPA) to provide pandemic-related flexibilities.[5] Some of these flexibilities include allowing family caregivers and legally responsible persons to receive Medicaid payments; expanded telehealth and remote services; changes to level of care evaluations; and increased provider payments.[6]

Several Medicare flexibilities will also terminate at the end of the PHE, including the waiver of three-day hospitalization prior to nursing home admission, no cost-sharing for at-home COVID tests; coverage for out-of-network facilities under Medicaid Advantage; and part D coverage of 90-day prescriptions.[7] Although expanded telehealth visits, including audio-only visits, are available to Medicare beneficiaries under the Section 1135 emergency waiver, those services will not terminate at the end of the PHE. The Consolidated Appropriations Act of 2022 extended telehealth services under the Section 1135 waiver to 151 days after the PHE ends.[8]

Expiration of Continuous Coverage Protections and Redetermination

The expiration of continuous coverage protections and redetermination processes will result in millions of disenrollments. The Families First Coronavirus Relief Act (FFCRA) provided states with additional funding for Medicaid provided they meet certain Maintenance of Effort (MOE) requirements, including continuous coverage for beneficiaries.[9] Under this provision, states must treat any beneficiary enrolled in Medicaid as of March 18, 2020, as eligible until the end of the PHE, even if they are no longer financially eligible.[10] In December 2020, CMS issued an Interim Final Rule (IFR) that restricted continuous coverage protections by allowing states to keep their additional funding while limiting or terminating coverage for enrolled beneficiaries.[11] However, in March 2021, the American Rescue Plan Act (ARPA) was passed, which extended the FFCRA's continuous coverage provisions as a requirement for states to receive additional funding for Medicaid HCBS.[12]

Some projections suggest as many as 5.3 million Medicaid beneficiaries could lose coverage once continuous coverage ends at the end of the PHE.[13] While many of these individuals may not meet financial eligibility requirements for Medicaid due to increased income or assets, several beneficiaries who are eligible may lose Medicaid due to confusing redetermination process.

Typically, Medicaid beneficiaries must submit documentation usually on an annual basis showing they remain financially eligible for Medicaid. Older adults and people with disabilities also usually have annual assessments to show they remain functionally eligible for Medicaid services including HCBS. However, due to continuous coverage, enrolled beneficiaries have not had to submit redetermination paperwork for over two years.

With the PHE unwinding, stakeholders anticipate several challenges when redeterminations begin. First is general confusion—thousands of beneficiaries have received Medicaid without ever completing the paperwork, and they may not be familiar with the process.[14] Similarly, workforce shortages resulted in significant turnover across Medicaid offices, leading to several new workers who are unfamiliar with redeterminations.[15] Communication will be challenging since many Medicaid beneficiaries have moved over the last two years, which makes contact for redeterminations difficult, particularly for older adults and people with disabilities who may have language access difficulties or need assistance completing paperwork.

Beneficiaries receiving SSI-Medicaid face additional challenges since Social Security field offices were closed for the most of the pandemic. Older adults and people with disabilities needing assistance face significant delays due to case backlogs and workforce turnover, leading to gaps in coverage and access to crucial services.

Strategies for Advocates to Minimize Disruptions in Services

Advocates should get information out to beneficiaries as soon as possible informing of upcoming changes when the PHE unwinds. Communications should be accessible, accounting for disability and Limited English Proficiency.[16] Partnerships with health plans like Managed Care Organizations (MCOs) and health plans like Medicare Advantage plans that serve dually eligible Medicare and Medicaid enrollees are also crucial for getting information to beneficiaries.[17]

Stakeholders can also work with their state Medicaid agency to limit improper disenrollments by encouraging the state to perform ex parte reviews of financial eligibility using existing data systems or establishing express lane eligibility based on enrollment in other public benefits; develop statewide toolkits and trackers to monitor disenrollments; ensure materials are accessible; de-prioritize older adults and people with disabilities for re-determination; extend continuous coverage of Medicaid for older adults and people with disabilities; make Appendix K emergency flexibilities permanent by incorporating them into 1915(c) HCBS waivers; and providing clarity around the role of MCOs in re-determinations. Finally, advocates and states should assist with transitions for individuals no longer eligible for Medicaid into other programs they may be eligible for like Medicare and Marketplace coverage.

Conclusion

Advocates across the aging and disability network can utilize their existing partnerships and communication skills to assist older adult and disabled beneficiaries experiencing disruptions in Medicaid.

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

1 U.S. Dep't of Health and Human Services Public Health Emergency Declarations, phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

2 42 U.S.C. §247d.

3 Centers for Medicare and Medicaid Services, State Health Official Letter, March 3, 2022 medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

4 Centers for Medicare and Medicaid Services, Coronavirus Waivers and Flexibilities cms.gov/coronavirus-waivers

5 Id.

6 Approved 1915(c) Appendix K waivers available at medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html; See also Justice in Aging Appendix K tracker justiceinaging.org/summary-how-states-are-modifying-hcbs-programs-to-address-covid-19-emergency/

7 Centers for Medicare and Medicaid Services, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

8 Consolidated Appropriations Act of 2022, Pub. L. 117-103 (2022).

9 Families First Coronavirus Response Act, Pub. L. 116-127 (2020).

10 Kaiser Family Foundation, Key Questions About the New Increase in Federal Medicaid Matching Funds for COVID-19, May 4, 2020 at kff.org/medicaid/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/

11 Centers for Medicare and Medicaid Services, State Health Official Letter, December 22, 2020 medicaid.gov/sites/default/files/2020-12/sho20004.pdf

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15 Id.

16 Administration for Community Living, Preparing for Medicaid Changes When the Public Health Emergency Expires, April 5 2022 at acl.gov/sites/default/files/2022-04/PHE%20Medicaid%20Fact%20Sheet%20Final.pdf

17 Centers for Medicare and Medicaid Services, Medicaid and CHIP Continuous Enrollment Unwinding: A Communications Toolkit, medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf