Medicaid Redeterminations: Resource to Support Providers

Frequently asked questions

Overview

Starting on April 1, 2023, Medicaid consumers across the country found themselves needing to take steps to continue their coverage through Medicaid or the Children's Health Insurance Program (CHIP). This is because states have resumed Medicaid and CHIP eligibility reviews following Congressional action at the end of 2022.

This means some people with Medicaid or CHIP, including dually eligible and/or individuals living with disabilities could be disenrolled from those programs if they do not take the necessary steps to verify Medicaid eligibility. This will not be an easy task. That's because states may not have had any contact with many Medicaid enrollees for 2–3 years. So many addresses or contact information may be out of date.

Providers can help by reminding consumers who have Medicaid to:

- **Update** their contact information with the state ensuring their mailing address, phone number, email and other contact information is correct
- **Check** their mail and email for information from the state about coverage and renewal requirements
- **Complete** their renewal application promptly and return it to their state to help avoid a gap in coverage

Individuals who do not complete their state's Medicaid eligibility verification by the appropriate deadline may be disenrolled from the program. In some states, people living with disabilities may automatically qualify for Medicaid and may not need to take additional steps during redetermination process. In other states, individuals with disabilities will be required to participate in the redeterminations process to maintain Medicaid eligibility. In **every state,** individuals with disabilities who don't receive SSI may qualify for Medicaid because they meet other eligibility thresholds for individuals living with disabilities in their respective states.

To qualify for Medicaid long-term services and supports, an individual must meet both the financial eligibility criteria as explained above as well as functional – or level of care – criteria. States use an assessment to determine whether individuals meet this additional criteria. During the national public health emergency (NPHE), all Medicaid eligibility determinations and level of care assessments were paused; however, some states continued conducting them without terminating members. In addition to restarting financial eligibility processes, all states will resume functional eligibility assessments.

Key points

- Medicaid redeterminations were paused during the COVID-19 national public health emergency (NPHE) but are now resuming
- Each state will handle redeterminations differently
- Some beneficiaries may be automatically renewed by their state Medicaid agency
- Some beneficiaries may need to provide documentation to verify their Medicaid eligibility
- If a beneficiary does not submit requested documentation, their coverage may be terminated
- If someone is deemed ineligible for Medicaid, their coverage will not be terminated immediately
- State plans are required to send beneficiaries notice and give them time to respond and provide documentation to verify their Medicaid eligibility
- Beneficiaries who are found ineligible may be able to buy a health plan through the Health Insurance Marketplace

Frequently asked questions

Starting April 1, 2023, states have up to 12 months to recertify the eligibility of Medicaid recipients. This means the consumers you provide long-term services and supports to may need to renew their coverage and/or undergo a functional needs assessment. If they do not, they could lose their eligibility or face a reduction in services in their authorized service plan. As a result, providers could potentially lose a significant number of consumers or end up providing uncompensated care if patients lose Medicaid coverage. Providers can help by reminding their consumers who have Medicaid to submit needed redetermination documentation and educate them about the Medicaid redetermination process. Below you'll find answers to frequently asked questions to help inform consumers about their upcoming redeterminations and information about PHE waivers and flexibilities for providers.

For Beneficiaries:

Q: What Are Medicaid Redeterminations?

A: Medicaid redeterminations, also called renewal or recertification, is the process through which Medicaid agencies redetermine enrollees' eligibility for Medicaid. The Medicaid redetermination process ensures that a person is still eligible to receive Medicaid benefits.

Q: Why Have Medicaid Redeterminations Been Paused?

A: Medicaid redeterminations have been paused during the COVID-19 public health emergency (PHE). This is due to requirements put in place by Congress and the additional federal Medicaid funding that states received during the PHE. In exchange for enhanced funding, states have had to maintain continuous enrollment in Medicaid, meaning an individual could not have their Medicaid coverage terminated (exceptions include moving out of state and beneficiary request to terminate coverage).

Q: What Are Level Of Care Evaluations?

A: Under federal regulations, states are required to do a reevaluation, at least annually, for individuals receiving long-terms services and supports. This reevaluation determines whether the scope, amount and duration of authorized services are still appropriate and whether the participant continues to meet the nursing home level of care. This requirement can usually be met through the annual functional reassessment of needs, which directly impacts the patients' service plan. Due to the PHE, states did not terminate eligibility for people who no longer met the level of care. Additionally, some states allowed dates for level of care determinations to be extended during the PHE, but these changes are ending as states implement their redetermination processes.

Q: Does The Process Vary By State?

A: Yes, the redetermination process varies based on the state and the Medicaid program in which a person is enrolled. The state has flexibility to determine how they would like to work through their list of enrollees over the course of many months. Please contact your state Medicaid agency for specific questions about your state's redetermination process or check the online portal (if one is available in your state) to see when you/your clients will have eligibility verified.

Q: What Do Beneficiaries Need To Do Today?

A: Medicaid beneficiaries should make sure that their address, phone number, and other contact information is up to date with their state Medicaid agency. In addition, when a beneficiary receives a request or renewal packet from their state Medicaid agency, they should always respond by the timeline noted.

In some states and situations, a Medicaid beneficiary may not have to do anything during the renewal process. The Medicaid agency may be able to process the entire Medicaid renewal electronically without requesting any documentation from the Medicaid recipient. In other states and cases, the Medicaid beneficiaries may have to complete a redetermination form, either via paper, online, or in person. Proof of income or resources may be requested.

Q: What Happens If A Beneficiary Does Not Renew In Time?

A: If a Medicaid beneficiary does not complete the redetermination process in time, Medicaid benefits may be terminated. Under federal law, a termination notice must be given to the beneficiary, and they 90 days to provide the Medicaid agency with all required information. As applicable, Medicaid benefits can be reinstated without the individual going through the application process again if they continue to meet the eligibility criteria.

Medicaid coverage in some states is retroactive. This means any accrued medical bills during the lapse in coverage that are generally covered by Medicaid will be paid. If one does not submit the necessary documentation and complete the redetermination process within the 90-day period, they must reapply for Medicaid benefits and a gap in benefits is very likely to occur. Some states do not offer retroactive coverage during a lapse. For this reason, it is best to act quickly to ensure no gaps occur.

Q: If A Beneficiary Is Found Ineligible, What Options Do They Have?

A: Beneficiaries who are found ineligible for Medicaid can enroll in other insurance affordability programs, like qualified health plans. State Medicaid agencies are required to help transition Medicaid ineligible beneficiaries into other coverage. Individuals can explore their coverage options on healthcare.gov or the state-based health exchange.

Q: Does Pandemic-Related Financial Assistance Impact An Individual's Financial Medicaid Eligibility?

A: For individuals whose Medicaid eligibility is determined using supplemental security income (SSI) methodologies, most pandemic-related disaster assistance, including Recovery Rebates, are permanently disregarded from income and resources. A complete list of the types of assistance that are permanently disregarded from income and resources under SSI's disaster assistance policy can be found in Social Security Administration's (SSA's) emergency memo. For non-Modified Adjusted Gross Income (MAGI) individuals whose eligibility is not based on SSI methodologies (e.g., medically needy parents/caretaker relatives whose eligibility would be determined using aid to families with dependent children (AFDC) or MAGI-like methodologies), retained pandemic-related income may be countable if a resource test is applied. However, such assistance could be disregarded under the authority of section 1902(r)(2) of the Social Security Act.

For Providers:

To address the PHE, federal and state policy makers implemented a variety of temporary Medicare and Medicaid regulatory flexibilities to ensure that sufficient health care items and services were available to meet the needs of the community, especially as individuals were encouraged to stay at home to minimize the risk of disease exposure. These flexibilities aimed to improve the delivery of services in beneficiaries' homes, stabilize provider payments, expand program eligibility and enrollment, and broadly maintain access while minimizing risk during the PHE. On January 30, 2023, the Biden Administration announced its intent to end the COVID-19 national emergency and PHE declarations on May 11, 2023.[1] The flexibilities granted by the emergency authorities expired on May 11, 2023, unless a state requested an earlier end date in their waiver amendment, CMS approved the end date of the flexibility through the six months after the expiration of the PHE, or the flexibility will be continued through your state's formal regulatory waivers. CMS published provider-specific fact sheets on PHE waivers and flexibilities. These fact sheets include information about which waivers and flexibilities have already been terminated, have been made permanent, or ended with the end of the PHE. If your state has not communicated which COVID flexibilities related to provider operations will be impacted with the end of the PHE, please contact your state Medicaid agency.

[1]SAP - H.R. 382 H.J. Res. 7 (whitehouse.gov)

Helpful Links

CMS Fact Sheet on CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency: This CMS Fact Sheet details what individuals can expect at the end of the PHE regarding coverage of COVID-19 vaccines, testing, and treatments; telehealth services; health care access, and inpatient hospital care at home.

Eligibility : MACPAC: MACPAC details the history of Medicaid eligibility how Medicaid eligibility is determined today.

Medicaid Income Eligibility Levels as a Percentage of the FPL for Individuals Age 65 and Older and People with Disabilities by State: MACPAC shows how eligibility levels vary by state.

Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision: KFF provides details on how states are preparing for the unwinding of the pandemic era-continuous enrollment provision.

Medicaid Enrollment and Unwinding Tracker | KFF: KFF tracker to monitor changes to state Medicaid and Children's Health Insurance Program enrollment. The tracker also provides information on state Medicaid eligibility policies and policies related to the unwinding.

Georgetown Tracker: The Georgetown University Health Policy Institute's 50-state unwinding tracker examines what PHE unwinding information can be found on state Medicaid agency websites.

It's Here! Medicaid Redeterminations – What's Next? This blog from the National Association of Community Health Centers provides general information about Medicaid redeterminations and provides resources to help health centers in notifying patients about steps to avoid losing coverage.

Medicaid renewal and redetermination | UnitedHealthcare (uhc.com): UHC complied information to help consumers understand Medicaid redeterminations and how to find other coverage options if an individual needs a new plan.

Fact Sheet: Unwinding Medicaid Continuous Coverage Protections—What Advocates for Older Adults Need to Know: The Justice in Aging Fact Sheet identifies steps that advocates can take with their states to address the specific challenges facing dual eligible individuals during Medicaid redeterminations.

Public Health Emergency "Unwinding:" Changes to Medicaid Enrollment and Eligibility | ACL Administration for Community Living: Administration on Community Living resource website to support the redeterminations process.

HOMECARE & HOSPICE
National Association for Home Care & Hospice

United Healthcare