



Preparing for Medicaid Changes When the Public Health Emergency Expires

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Government agencies have started reviewing policies that were put in place to meet the needs of states, localities, and the public during the height of the COVID-19 pandemic. When the federal declaration of a public health emergency (PHE) expires, many of the flexibilities initiated during the PHE will need to be rolled back. This return to pre-pandemic operations will have far-reaching impacts for older adults and people with disabilities. Changes in Medicaid enrollment and eligibility will be particularly important—and potentially confusing or disruptive—for current enrollees. The aging and disability networks can prepare in advance for the coming changes to best meet the needs of people who rely on Medicaid coverage for essential services and supports. This fact sheet will help address some common questions ACL grantees may have.

What temporary federal and state Medicaid changes were made to respond to the COVID-19 pandemic and Public Health Emergency?

The [Families First Coronavirus Response Act \(FFRCA\)](#), signed into law March 2020, provided states with an increase in the amount of federal funding contributed to their Medicaid programs provided they agreed to certain requirements surrounding Medicaid eligibility and enrollment. In exchange for accepting the extra federal dollars, FFRCA prohibited states from disenrolling anyone from their Medicaid programs (with limited exceptions). For example, states could not disenroll individuals due to an increase in income or change in “categorical eligibility” (e.g. pregnancy, age, disability) that would ordinarily make them ineligible for Medicaid. This continuous coverage provision included in the FFRCA is not indefinite and will end with the public health emergency.

When will the public health emergency end and what does that mean?

The PHE was declared on January 27, 2020 and has been reauthorized several times. While the Biden Administration has not officially said when the PHE will end, it has assured states that they will receive at least 60 days of advance notice. Upon the end of the PHE, states will have 12 months to evaluate the eligibility of virtually everyone in their Medicaid programs to make sure they still qualify for the program. This will present a lot of work for states and CMS has released [new materials](#) to help states prepare.

Five Things our Networks Should Know:

- 1) Medicaid beneficiaries should make sure their Medicaid agency has their current contact information. They should check their mail and be sure to mail back any Medicaid forms they receive.**

Making sure Medicaid agencies have the correct mailing address, phone number, and email address for all enrollees will ensure renewal and other eligibility paperwork gets to the right place. [Each state's Medicaid website](#) will have instructions for how to check an enrollee's contact information and update it if necessary. The state

Medicaid agency will reach out to Medicaid enrollees via mail to either confirm coverage is renewed or provide a renewal form to complete. Beneficiaries may also hear from their Medicaid managed care plan, social service provider, or health care provider with reminders, updates, and information.

2) All renewal forms and notices must be accessible to people with limited English proficiency and people with disabilities.

By law, Medicaid renewal information should be provided in plain language and in a way that is accessible to people with limited English proficiency and people with disabilities. Information from the Medicaid agency should be available in multiple languages and with free oral translation. For people with disabilities, states should provide appropriate auxiliary aids and services at no cost. This could include sign language interpretation and materials in braille or other accessible alternative formats.

3) Many people who are no longer eligible for Medicaid will have other coverage options.

As states perform renewal and redetermination actions for people with Medicaid, they will work to ensure people who are still eligible for Medicaid stay enrolled and those that may qualify for a private Marketplace plan are transitioned smoothly. For example, someone who no longer meets eligibility requirements for the Medicaid category they applied under initially may qualify under a different Medicaid category. State Medicaid agencies are required to automatically assess whether this is the case. Additionally, many people no longer eligible for Medicaid can enroll in an affordable Marketplace plan. The Medicaid agency is required to transmit eligibility information directly to the Marketplace and, because losing Medicaid is a Qualifying Life Event, individuals will be able to enroll outside a regular enrollment period.

Some older adults and people with disabilities have become eligible for Medicare over the last two years and, because they had Medicaid coverage, may have decided not to enroll in Medicare thinking they did not need it. Now they may be outside a Medicare enrollment period. In addition, some people with both Medicare and Medicaid may lose Medicaid and thus no longer be eligible for their Medicare Advantage plan (also called Dual Eligible Special Needs Plans or D-SNPs). Beneficiaries in these types of situations will need special counseling, including information on Medicare enrollment periods, penalties, and Medicare Advantage plan options. People with questions about their Medicare coverage should be referred to their [State Health Insurance Assistance Program](#).

4) If someone is disenrolled or their Medicaid coverage changes and they disagree with their state Medicaid agency's decision, they can appeal.

Medicaid beneficiaries who have their benefits mistakenly terminated or their eligibility reduced have the right to an appeal, also called a "fair hearing," to contest the state Medicaid agency's decision. In general, individuals can keep their Medicaid coverage while this hearing is pending. Because the continuous coverage provisions were due to a change in law, losing Medicaid on the basis of the PHE ending and the FFRCA's continuous coverage provisions sunseting is not a valid basis to request a fair hearing. However, Medicaid beneficiaries that believe the decision to disenroll them from the program was due to error can request an appeal. For example, someone who believes the Medicaid agency did not correctly assess their income or disability status can appeal their state's decision. People over the age of 60 may want to contact the [Eldercare Locator](#) for referral to a free legal services



program funded under the Older Americans Act. Similarly, people with disabilities may be able to receive assistance from local legal aid organizations, including Protection and Advocacy systems. The [Disability Information and Access Line \(DIAL\)](#) can help make referrals to these services.

5) The end of the Public Health Emergency may lead to an increase in utilization of services provided by Older Americans Act programs, Centers for Independent Living, Assistive Technology Act programs, and other ACL grantees.

While some people will stay on Medicaid or be transitioned to other coverage, other people will lose Medicaid coverage and the supports and services it provides. This could mean a greater reliance on programs offered by the aging and disability networks. ACL grantees can begin to prepare now by assessing capacity and evaluating how to best meet an increased need for services. Grantees may find it helpful to stay in contact with their state's Medicaid agency for the latest on the PHE unwinding timing and process, opportunities for collaboration, and Medicaid renewals and other eligibility determination actions.

The upcoming changes to Medicaid are historic and the aging and disability networks are critical partners in ensuring older adults and people with disabilities can continue to receive the supports and services they need without disruption.

[Find additional resources from Medicaid.gov including communication tools.](#)

