

FACT SHEET #19

End of the Medicaid Continuous Coverage Requirement – What People with Disabilities Need to Know

This factsheet is for those who want specific information on the end of the Medicaid Continuous Coverage Requirement as it relates to people with disabilities.

Introduction

This factsheet is for those who want specific information on the end of the Medicaid Continuous Coverage Requirement as it relates to people with disabilities. The information found in this fact sheet is subject to change as more updates come out about the end of the continuous coverage requirement and what individual states are doing. You can continue to visit CMS.gov or Medicaid.gov for accurate updates.

Q1. What is the Medicaid Continuous Coverage Requirement and what does it mean for me?

A. In the early days of the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) which acknowledged a Public Health Emergency (PHE) due to the COVID-19 pandemic. As part of that law, states that ensured all Medicaid enrollees maintained their enrollment status while the public health emergency was in effect received increased federal funding for their state Medicaid program. States that accepted this funding were only permitted to remove people from Medicaid if the individual moved out of the state.

This allowed Medicaid eligibility to remain constant for individuals regardless of fluctuating incomes, keeping almost 14 million Americans covered with access to health care services and COVID testing/treatment/vaccines.¹ If you are a current enrollee in your state's Medicaid program, you need to be aware of the upcoming redeterminations which began as early as February 2023 in some states. Terminations for people determined no longer eligible will occur starting as soon as April 1, 2023.

Q2. What is the PHE?

A. The Secretary of Health and Human Services declared a national PHE in early 2020 as part of the FFCRA due to the COVID-19 outbreak. Initially, the end of the continuous coverage requirement was linked to the PHE and would end when the PHE ended. The PHE has been extended multiple times during the pandemic, and the uncertainty this caused for the ongoing continuous coverage requirement led to Congress setting an end date independent of the PHE. This was changed by Congress in the year-end omnibus spending package passed in December 2022.

¹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

As part of the changes Congress made in December 2022, enhanced federal funding for Medicaid will ramp down slowly between April and December 2023. To continue receiving the enhanced funding during this period, states must comply with certain requirements, such as giving enrollees enough notice and minimize unnecessary terminations of coverage, and provide monthly reports to the Centers for Medicare and Medicaid Services with the total number of renewals and terminations.

Q3. What is the new timeline for the unwinding of the Medicaid Continuous Coverage Requirement?

A. With the passage of the year-end omnibus spending bill in December 2022, Congress established March 31, 2023 as the end of the continuous coverage requirement. From this date, states will have 12 months to start their redetermination process for all Medicaid enrollees.² In February 2023, CMS released a list of timelines which summarizes what all states are doing with regards to their timelines.³

Q4. Why is this important for PWDs?

A. The HHS's Assistant Secretary for Planning and Education reported that 37.2% of people with disabilities receive coverage through Medicaid which compares to 36.7% which had private coverage.⁴ PWDs are more likely to have health issues that require them to use healthcare services at a significantly higher rate than those without disabilities, especially BIPOC with disabilities, having experiences of lower socioeconomic status and greater lack of availability to quality healthcare services. Having continuous access to affordable healthcare coverage greatly increases quality of life and care for PWDs.

People with disabilities obtain Medicaid coverage through various means. While criteria vary from state to state, many people with disabilities become eligible through traditional Medicaid pathways⁵ due to their disability status. For individuals who receive their coverage through this method, there are both income and asset tests which the individual must meet in order to maintain their Medicaid coverage. A redetermination by the state Medicaid agency may include verifying that the individual still has limited income and assets and still meets the standard for coverage as a result of their disability status.

For those who have obtained coverage through the Medicaid expansion (or other income-based groups including children and pregnant people), the test is much simpler. Coverage for these individuals is simply based on their monthly income based on Modified Adjusted Gross Income (MAGI) rules. For these individuals, redeterminations will be limited to demonstrating their current income and number of people in their household.

² <https://nationaldisabilitynavigator.org/2023/01/09/medicaid-continuous-coverage-requirement-ending/>

³ <https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-02242023.pdf>

⁴ <https://aspe.hhs.gov/reports/health-insurance-coverage-among-working-age-adults-disabilities-2010-2018>

⁵ For simplicity's sake, this also includes people who have received their Medicaid coverage through a waiver program.

Q5. Is there anything I should do now?

A. Make sure that your contact information is up to date with the state Medicaid office through these steps:

- i. Make sure your state Medicaid program has your current mailing address, phone number, email, or other contact information so they will be able to contact you about your Medicaid or CHIP coverage. You can find more information about how to contact your state Medicaid Agency at [Medicaid.gov](https://www.Medicaid.gov).⁶
- ii. Be on the lookout for important information and renewal forms from the state Medicaid offices via mail, email, or telephone. Your state Medicaid program will attempt to renew your coverage based on information in state and federal databases. They will send you a letter about your Medicaid coverage, letting you know if they were able to renew your coverage automatically, or you need to complete a renewal form to see if you still qualify for Medicaid.
- iii. If the Medicaid agency requests additional information from you, make sure to complete your form right away to help avoid a gap in your Medicaid coverage. If you miss the state's deadline to return paperwork and your Medicaid is terminated, but you believe you are still eligible, you can get your Medicaid coverage reinstated to the date it was terminated if you return the necessary paperwork within 90 days.
- iv. If you need help understanding the letters you receive from the Medicaid agency or help getting coverage reinstated or transitioning to another form of coverage, you can find local enrollment assisters within your community, who provide unbiased assistance free of charge, through [GetCoveredAmerica.org](https://www.GetCoveredAmerica.org). Additionally, Centers for Independent Living are a local resource for the disability community and have staff that provide information and referral and peer to peer counseling. You can find a local CIL in your area through the [Independent Living Research Utilization website](https://www.IndependentLivingResearchUtilization.org).⁷

Q6. Why might I lose coverage?

A. You might lose your coverage due to procedural reasons such as not completing the proper paperwork or the state Medicaid agency not receiving proper documentation which would prove your eligibility. This is why it is important to make sure your state Medicaid agency has accurate contact information with your most up-to-date phone number, mailing address, and email. Another process reason for losing coverage would be submitting your renewal form incorrectly or not returning it to your state Medicaid agency on time.

Your Medicaid coverage could also be terminated if you no longer qualify based on your state's eligibility rules. This could be due to a change in income or a change in household size. As explained in question #4 above, people become eligible for Medicaid through different methods. If your eligibility is based on the Medicaid expansion, then it is determined solely by income, and it could be that your income is now too high to qualify for the Medicaid program. If you

⁶ <https://www.Medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/renew-your-medicaid-or-chip-coverage/index.html>

⁷ <https://www.ilru.org/projects/cil-net/cil-center-and-association-directory>

receive Medicaid due to a disability determination, losing Medicaid coverage could be due to your income being too high, having too many assets or having a temporary disability end.

Q7. What are my options if my Medicaid coverage is terminated?

A. If you lost your coverage due to a process reason as described in Question #6, re-obtaining coverage through Medicaid may be as simple as providing the information the state requested and getting your coverage reinstated. You can do this up until 90 days after your coverage was terminated. If more than 90 days has passed, you can reapply for Medicaid by completing the full application. Medicaid enrollment is open year-round, so individuals can apply for Medicaid at any time. However, some states may have a waiting period before you are able to re-enroll. Check with your state Medicaid agency for more information.⁸

If you are no longer eligible for Medicaid coverage because you no longer meet the eligibility requirements, you can see if you qualify for free or low-cost healthcare coverage through the ACA Marketplace at HealthCare.gov. Marketplace plans have different benefit plans, prescription drug coverage, provider networks, and cost-sharing policies than Medicaid. To make sure that your continuity of care continues, make sure to select the correct plan for your healthcare needs.

1 in 3 adults who lose their Medicaid coverage might be eligible for subsidized coverage through the ACA Marketplace with the help of premium tax credits.⁹ But in order to get Marketplace coverage, you will have to go to HealthCare.gov (or your state's marketplace, if they run their own¹⁰) and start a new application. This will not happen automatically when your Medicaid is terminated. You will need to provide current information about your income and the number of people in your tax household. You will also be asked whether you lost Medicaid coverage since March 31, 2023; it is important to answer this question to ensure that you can enroll in Marketplace coverage as soon as possible.¹¹ Enrollees should also be aware that enhanced premium tax credits are extended through 2025 and can make a huge difference in the cost of Marketplace plans.

If you are unenrolled, your Medicaid coverage changes, or you disagree with your state Medicaid agency's decision, you may appeal however keep in mind that this process will differ from state to state. Appeals can be conducted by your state Medicaid agency, the Exchange/Exchange Appeals Entity, or another state agency. You can find more information about appeals at the Centers for Medicare and Medicaid Services.¹²

⁸ <https://medicaiddirectors.org/who-we-are/medicaid-directors/>

⁹ <https://www.commonwealthfund.org/blog/2022/mitigating-coverage-loss-when-public-health-emergency-ends>

¹⁰ The following states operate their own marketplace and do not use HealthCare.gov: CA, CO, CT, DC, ID, KY, ME, MD, MA, MN, NV, NJ, NM, NY, PA, RI, VT, and WA. VA is also transitioning to operate its own marketplace in 2023-24.

¹¹ You can read more about this Special Enrollment Period in our news item:

<https://nationaldisabilitynavigator.org/2023/02/02/cms-announces-new-sep-coming/>.

¹² <https://www.medicaid.gov/state-resource-center/downloads/eligibility/medicaidchip-eligibility-appeals.pdf>

Q8. How will redetermination be conducted?

A. As mentioned above, states can begin redeterminations starting February 1, 2023 and can begin terminating coverage for people determined no longer eligible on April 1, 2023. States will have 12 months to complete the process. States will be communicating with enrollees via mail, email, or telephone, so make sure that your contact information is up to date. States are required to provide public reporting on the redetermination process to CMS. As that information becomes available, we will update this fact sheet to indicate where that reporting can be found.

Some states are creating communication campaigns to reach out to Medicaid enrollees about how to keep their coverage or transition into a new form of coverage if they are no longer eligible for Medicaid. Most states will utilize Medicaid managed-care organizations, Marketplace plans, navigators, and offer technical and enrollment assistance.¹³

While states will have up to 14 months to conduct renewals and redeterminations, fiscal pressure maybe force them to speed up this process. In fact, at the time of the publishing of this fact sheet in early April 2023, four states have already started terminating coverage.¹⁴

Q9. Where can I learn what my state is doing?

A. You can visit the National Association of Medicaid Directors, which oversees Medicaid and CHIP programs in all 50 states, the District of Columbia, and all U.S. territories.¹⁵ Additionally, as states file their plans with CMS and more information becomes available, we will provide updates on the NDNRC website.¹⁶ As mentioned above, CMS has also provided information about states' anticipated timelines for starting renewals and terminations.¹⁷

If you need help with enrolling in Medicaid or an ACA Marketplace plan, use local enrollment assisters, which can be found at GetCoveredAmerica.org. These organizations provide individualized help with completing coverage applications, verifying eligibility, understanding letters from your state Medicaid agency or the ACA Marketplace, and referring you to other resources. Assisters can provide help in person, via telephone, or on Zoom, and can often provide assistance in multiple languages.

Q10. Are there any other resources?

Here are some helpful resources to help follow what is going on with the Medicaid unwinding:

1. CMS: Communications Toolkit (available in 7 languages)¹⁸

¹³ <https://www.rwjf.org/en/insights/our-research/2022/03/preparing-for-the-biggest-coverage-event-since-the-affordable-care-act.html>

¹⁴ Arizona, Arkansas, Idaho and New Hampshire started terminating coverage as of April 1, 2023.

¹⁵ <https://medicaidirectors.org/who-we-are/medicaid-directors/>

¹⁶ <https://nationaldisabilitynavigator.org/>

¹⁷ <https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reldt-ren-02242023.pdf>

¹⁸ <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>

2. Center on Budget and Policy Priorities: FAQ: Unwinding Medicaid Continuous Coverage and Tips for Community Partners (available in 8 languages)¹⁹
3. Georgetown: 50-State Unwinding Tracker²⁰

You can also check out our NDNRC blog post which we will be regularly updating with more resources.²¹

Conclusion

As the Medicaid continuous coverage requirement comes to an end, people need to make sure that their information is up to date, such as household income, address, email, and phone number for their state Medicaid program to contact them as the unwinding process begins. By using the resources provided in this factsheet, people with disabilities can ensure that they continue to have healthcare coverage.

** The American Association on Health and Disability would like to acknowledge the Center on Budget and Policy Priorities for providing the resources to make this fact sheet available.*

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¹⁹ <https://www.healthreformbeyondthebasics.org/medicaid-unwinding-tips-for-community-partners/>

²⁰ <https://ccf.georgetown.edu/2022/09/06/state-unwinding-tracker/>

²¹ <https://nationaldisabilitynavigator.org/2023/02/21/medicaid-unwinding-resources/>