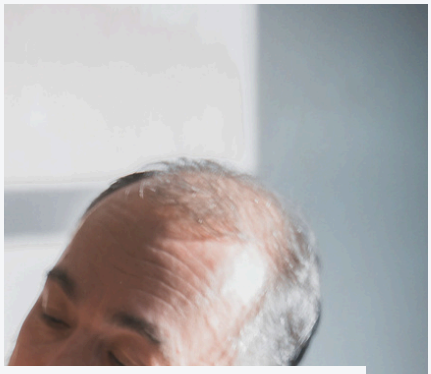
MEDICARE RIGHTS CENTER
Getting Medicare right

Helpline Case Study

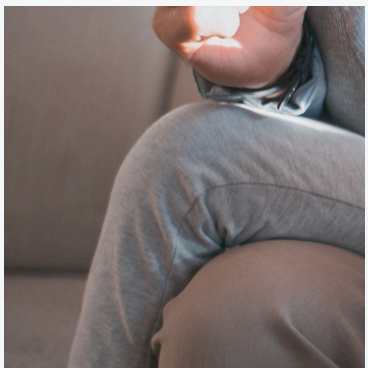
Challenges Faced by Dual Eligibles

Medicaid Renewal

This case study series was supported in part by Arnold Ventures. Medicare Rights Center maintains full editorial control over all of its policy analysis and communications activities.






Aims of the Case Study Series

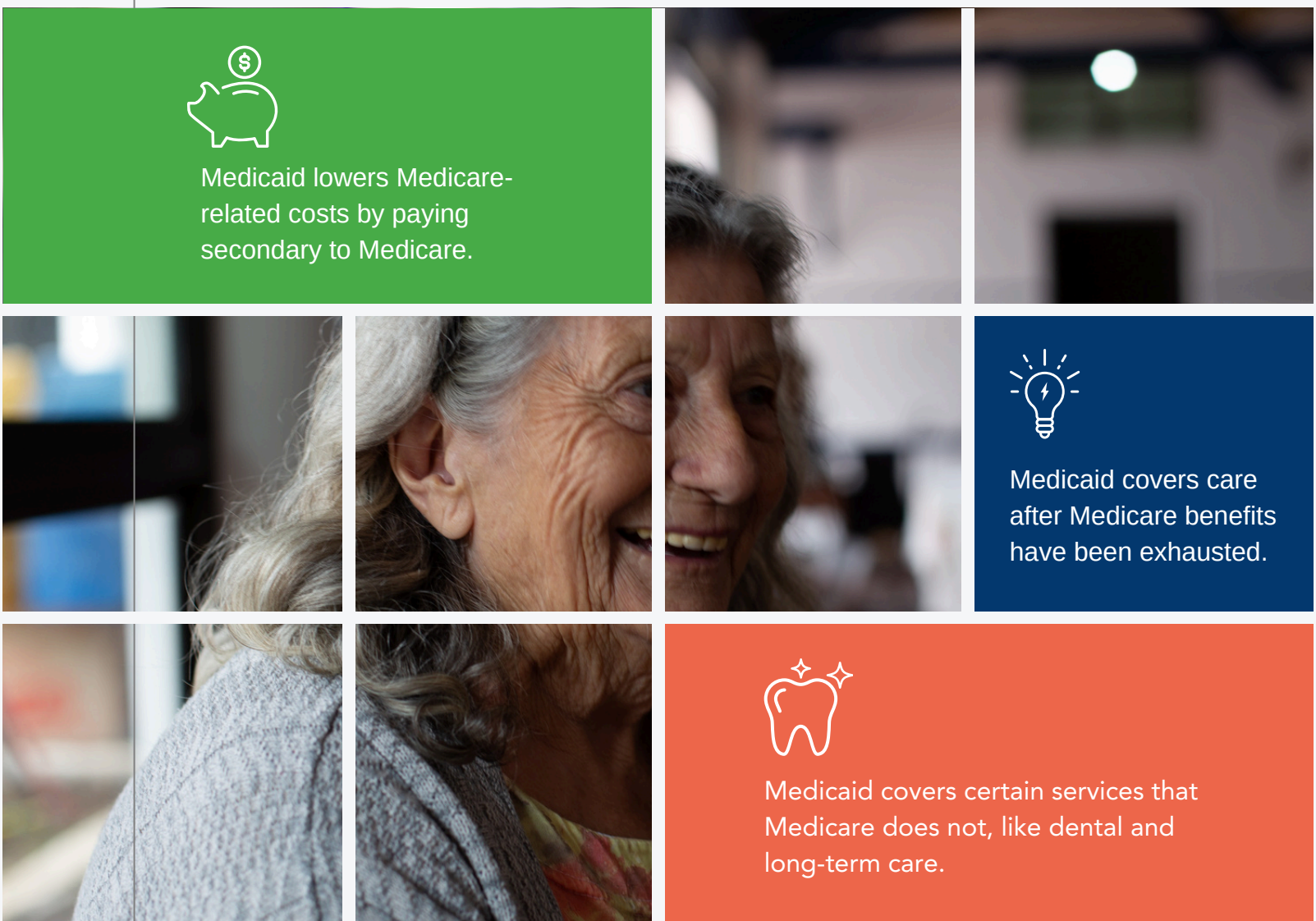
This case study series aims to help policymakers, advocates, and beneficiaries better understand the challenges faced by people with Medicare. Each case tells the story of a client who called the Medicare Rights Center's National Helpline for assistance. Cases highlight common obstacles and provide possible solutions.

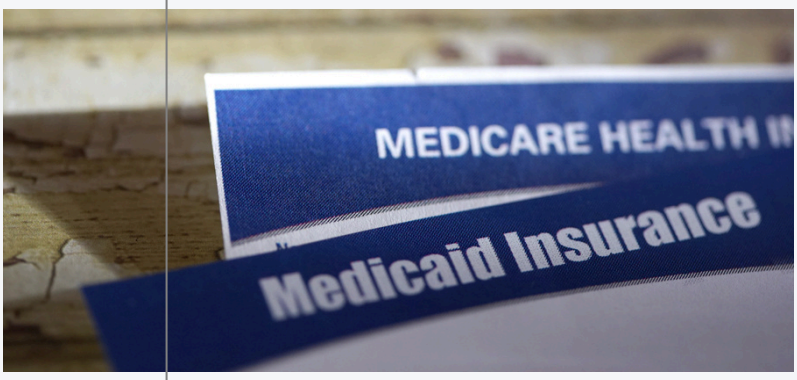
The two-part case study below explores common issues with Medicaid recertification and Medicaid transition. Medicaid is a federal and state program that provides health coverage for people with limited income and assets. Each state runs different Medicaid-funded programs for different groups of people, including older adults, people with disabilities, and children. Under federal law, individuals enrolled in Medicaid must recertify their eligibility once every 12 months.

Medicaid Renewal

Medicaid provides vital coverage for many people who are also enrolled in Medicare, known as dually eligible individuals. It covers services that Medicare does not, such as dental and long-term care. Medicaid acts as a secondary payer, lowering Medicare-related costs for enrollees. In some situations, Medicaid also covers an enrollee's care after they have exhausted their Medicare benefits.

An intensive annual Medicaid renewal process can cause needless benefits churn, forcing beneficiaries—the majority of whom live on fixed incomes—to re-attest their income and assets just 12 months after they began receiving benefits and to complete new paperwork in order to keep Medicaid. A variety of solutions exist to ease or even eliminate the need for active recertification on the part of the beneficiary. States should leverage these solutions—including attestation, passive recertification, and data sharing—to ensure that beneficiaries maintain seamless coverage from year to year and have all the support they need to afford their health care.





Mr. C Loses His Medicaid During the Public Health Emergency Unwind

Mr. C is a 68-year-old New Yorker who contacted the Medicare Rights Center's National Helpline after he received a notice from the New York State of Health (NYSOH), New York's health insurance exchange, explaining that he was no longer eligible for Medicaid. Mr. C had Medicare and Medicaid and was enrolled in a type of Medicare Advantage Plan specifically designed for dual-eligibles, a Dual-eligible Special Needs Plan (D-SNP). He first enrolled in Medicaid in 2015 at the age of 60 and became eligible for Medicare during the public health emergency (PHE) in 2021. In 2022 and 2023, his Medicaid was automatically recertified owing to the PHE, and he did not have to do anything to keep his benefits. He did not realize that this continuation of eligibility and automatic recertification was the result of temporary policy changes and not something he could rely on indefinitely.

He was very surprised, therefore, when he received the New York Marketplace notice saying that now that the PHE had ended, his Medicaid case was being transferred from New York Marketplace, the office he recertified with annually

pre-PHE, to his local Medicaid office, or local Department of Social Services (DSS). Mr. C had never been in contact with that office and was confused – Why was his Medicaid ending suddenly when there had been no changes to his income or savings? And how would a Medicaid termination impact his D-SNP enrollment?

A Medicare Rights Center counselor explained to Mr. C that there are different "types" or categories of Medicaid, and people in different age, disability, and family situations are eligible for different categories. As a person ages, or develops a disability, or their family status changes, they may be required to transition from one category to another. However, during the PHE, states were given the flexibility to keep beneficiaries continuously enrolled in their current category of Medicaid coverage.

As a result, Mr. C was not required to transition from the category he was in – Medicaid for single adults and childless couples who are not over age 65 and not determined to be disabled (often called MAGI Medicaid because it uses income guidelines based on Modified Adjusted Gross Income (MAGI) to determine eligibility).

Before the PHE, Mr. C's Medicaid category would have switched from MAGI to the aged, blind, and disabled (ABD) category when he turned 65. Because this did not happen during the PHE, it needed to happen during what became known as the "PHE unwind," when temporary rules that had been in effect during the pandemic were phased out. During the PHE unwind, states started identifying and disenrolling people like Mr. C, who remained in a Medicaid category for which they no longer qualified.

The delayed nature of this change added to the confusion around this change for Mr. C.

Mr. C was worried because the person he spoke to at NYSOH when he called about the notice said that the notice meant he was no longer eligible for Medicaid. This information was inaccurate – the Medicare Rights Center counselor was able to reassure him that though he was disenrolled from MAGI Medicaid, he should expect to receive additional information from the local Medicaid/DSS office about ABD Medicaid, which has different eligibility criteria. The counselor explained that he should respond to any paperwork from that office, as additional information from him is needed to complete the application for this new kind of Medicaid. The DSS renewal packet for people who have lost MAGI Medicaid is essentially an application for a new category of Medicaid. If Mr. C failed to return the packet with the required documentation, he would not have Medicaid going forward.

Mr. C was glad that he had not actually lost his coverage yet but was anxious about the idea of dealing with a new office, a different application, and a different type of Medicaid. Fortunately, because New York changed the income requirements for ABD Medicaid in 2022 to more closely match the income requirements for MAGI Medicaid, it was very likely that Mr. C would remain eligible for Medicaid. His only income was from Social Security Retirement Benefits, and those had remained about the same since he started getting them when he was 62 years old.

Mr. C's counselor explained to him that even though his income hadn't changed and he met the eligibility requirements, he still had to submit the full packet he was sent—including supplying documentation of his income from Social Security—to be reassessed at the Medicaid/DSS office.

The counselor suggested Mr. C also complete a recertification for his Medicare Savings Program (MSP) to ensure he retained all his benefits. MSPs are assistance programs for Medicare beneficiaries with lower incomes and resources. Mr. C's MSP paid his Part B premium of $174.70 per month and prevented in-network providers from billing him for Medicare cost-sharing, even if they were not Medicaid providers.

Mr. C was surprised to learn that his Medicaid and MSP recertification processes were going to take place through the mail, fax, or in person. He had applied for Medicaid nearly 10 years ago using a simple application on the NYSOH website and renewed that coverage online or on the phone in the years before the PHE. Why was this category so much more cumbersome and outdated? He also wondered why NY Medicaid could not get information about his income directly from Social Security.

Mr. C got the renewal packet from his local Medicaid/DSS office in July of 2023. He gathered the required documentation and submitted it, sending it by certified mail at an increased cost to have proof that it had arrived safely. Mr. C waited for over a month without hearing back from the Medicaid office. He contacted the office on three separate occasions, but each time, he was informed that his renewal had not been processed. After several months, Mr. C's Medicare Rights Center counselor resubmitted his renewal packet to the Medicaid office and requested via email to supervisors that the renewal be processed without further delay.

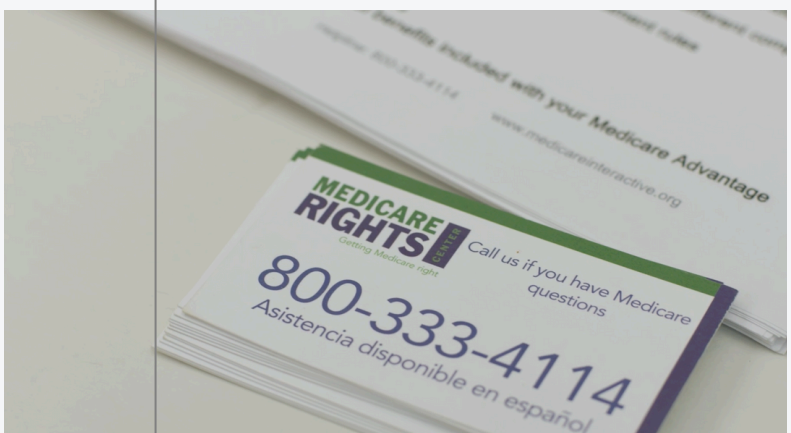
While Mr. C's Medicaid approval was delayed, he ran into numerous problems with his D-SNP coverage. His plan's customer service insisted that he was no longer eligible to remain in a D-SNP because he did not have Medicaid coverage. Though the delays in his renewal were no fault of his own, Mr. C was disenrolled from his D-SNP. He returned to Original Medicare and enrolled in a stand-alone prescription drug plan, which left him unable to access many of his preferred providers, pharmacies, and facilities. He also lost additional benefits he was entitled to through the D-SNP.

Mr. C waited five more months before receiving a notice in February 2024 stating he was approved for Medicaid and an MSP. This also meant that he could reenroll in his D-SNP and return to using his previous providers and facilities. However, the strain of uncertainty, the cost of Medicare premiums, and other expenses he bore while waiting for his application to be processed (which were ultimately reimbursed) were significant.

Moreover, Mr. C soon received another notice which said that his Medicaid renewal for 2024 was due by May 31. This date, based on when he first applied for Medicaid 10 years ago, did not consider the PHE unwind and the fact that his new Medicaid coverage had taken effect just three months before. As a result, Mr. C had to complete all the paperwork again. This added to Mr. C's frustration and stress, and he expressed anger that the process was wasting both his time and the time of the staff at the local Medicaid office.

Despite his chagrin, Mr. C submitted his renewal on time and was approved for Medicaid —but the notice he received did not mention the MSP. After his Part B premium was deducted from his Social Security check and he got a bill from his doctor for cost-sharing, he again called Medicare Rights for assistance. His counselor contacted the Medicaid office to correct the error and ensure that Mr. C had both Medicaid and an MSP.

While Mr. C's Medicaid office ultimately resolved all issues, it required an advocate's intervention and left Mr. C feeling vulnerable and unsure of what to do when his benefits again required renewal.



Mr. L's Renewal is Seamless and Low Stress Due to Pandemic-related Flexibilities

Mr. L's daughter called the Medicare Rights Center's National Helpline with questions about her father's Medicaid renewal. Her father is 88 and has dementia, so she typically handles his Medicaid and Medicare Savings Program recertification paperwork each year. Mr. L's only income is his Social Security retirement check. His check amount has remained consistent from year to year.

Despite her father's income being nearly unchanged, Mr. L's daughter must fill out a renewal form each year. The process makes her anxious because she worries about missing a notice from the Medicaid/DSS office, filling out paperwork incorrectly, turning the application in late, or anything that might mean her father's Medicaid renewal is delayed or denied. Her father needs help with bathing, dressing, eating, and other personal care services, all of which are currently covered by Medicaid. Losing that Medicaid coverage for even a month would greatly increase the burden on her as a caregiver and possibly compromise her ability to work and manage her other responsibilities.

During a conversation with her father's health insurance plan, Mr. L's daughter was told that she did not need to fill out a renewal form in 2020. However, when she contacted his local Medicaid/DSS office, she received conflicting information. Unsure of her father's renewal status, she reached out to Medicare Rights for assistance. A helpline counselor explained that because of the public health emergency Medicaid offices were automatically processing recertifications for Medicaid. The counselor contacted Mr. L's Medicaid office and confirmed that Mr. L's case would be auto renewed. Shortly after, Mr. L's daughter found out through a notice her father received that he had indeed been auto renewed for another 12 months.

Key Policy Recommendations

Under federal law, consumers enrolled in Medicaid must recertify their eligibility once every 12 months. However, states retain flexibility in determining how that process works. Many of the delays and obstacles that Mr. C faced in his case can be resolved if states tailor their recertification process to meet the needs of beneficiaries. Ideally, it should be easier for individuals to keep their benefits, as seen in Mr. L's case.

Medicare Rights recommends the following improvements to address problematic areas of Medicaid recertification:

Leverage existing data to automatically recertify certain individuals who are very likely to remain eligible.

1. States could utilize data already available through state and federal agencies to create an auto-renewal process for beneficiaries. Using existing eligibility documentation for benefits like SNAP, MSPs, and/or Extra Help would shift the recertification burden away from beneficiaries, especially those whose income and assets are unlikely to change.
2. States could identify individuals whose income is only from Social Security Retirement or Social Security Disability Insurance—or all individuals who have income that has not fluctuated for a certain number of recertification cycles—and test automatic recertification for this population, either on an open-ended basis or for a set number of years.

Increase and improve communications about the annual Medicaid renewal cycle

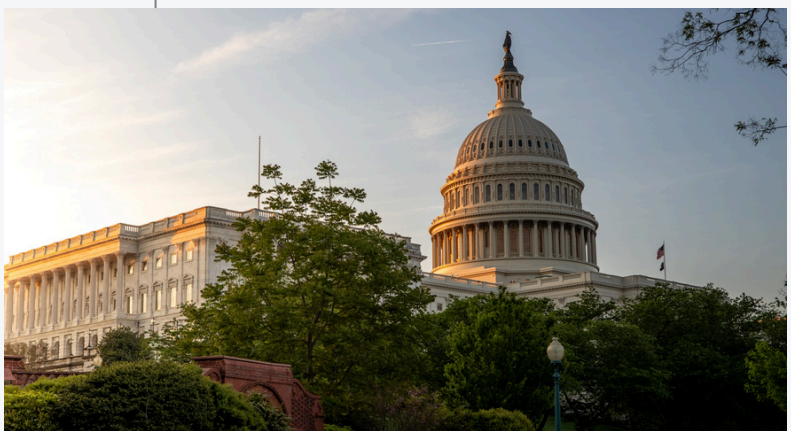
States should identify people at particular risk for non-renewal and conduct additional outreach via phone calls, texts, and/or emails to inform them that their renewal paperwork is being mailed and to be sure to complete it to stay enrolled in Medicaid. To the extent that states have engaged in such supplemental outreach during Medicaid PHE rule unwinding, evaluation of such outreach's ability to reduce churn and procedural disenrollment should be studied and shared if best practices are identified.

Allow for self-attestation for Medicaid recertification

Accepting self-attestation for all Medicaid eligibility criteria eliminates the annual burden on the beneficiary and their family of sending copious documentation—such as copies of an individual's Medicare card, government-issued ID, utility bills, and other income documentation—to the local Medicaid/DSS office.

Allow for online and telephone recertification

Opening additional avenues for recertification would help address shortcomings of paper-based renewals, such as individuals not receiving paperwork, not having access to paperwork in their preferred format or language, and facing delays in mail submission of documentation.



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The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

National Helpline: 800-333-4114

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