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Careful Planning Now Can Reduce Health Coverage Losses When Medicaid COVID-19 Continuous Coverage Ends

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Millions of people have been enrolled in Medicaid without interruption during the COVID-19 public health emergency (PHE), through what's known as the "continuous coverage" requirement. Since early 2020, when continuous coverage took effect, states stopped terminating people from Medicaid as a condition of receiving additional federal Medicaid funding. This provision has kept millions of people covered during the pandemic, ensuring they have access to health care services, including COVID testing, treatment, and vaccines.

The PHE currently lasts through mid-April.¹ Once the federal government ends the PHE, which is expected to happen no sooner than mid-July, states will resume their regular processes and begin reviewing all enrollees' eligibility. The risk of mass coverage loss is high — experts estimated in recent months that over 15 million people will lose their coverage at the end of the PHE, and that number is likely higher today.² This is because once the PHE ends, Medicaid beneficiaries will be required to submit updated information about their circumstances and caseworkers will have to determine if they remain eligible for coverage. People who are eligible can lose coverage for a myriad of reasons, ranging from mailed notices not reaching beneficiaries (who may have moved multiple times since the start of the pandemic) so they don't know they need to submit new paperwork to understaffed state agencies missing information that is submitted. And many of those found ineligible will qualify for subsidized coverage in the Affordable Care Act (ACA) marketplaces, but if they aren't connected to that coverage they could become uninsured.

State agencies and other key stakeholders ranging from advocates to managed care organizations (MCOs) can reduce the risk that people become uninsured in this process. States, MCOs, and nonprofit organizations can help Medicaid enrollees understand the requirements for continuing

¹ Health and Human Services Secretary Xavier Becerra, "Renewal of Determination That A Public Health Emergency Exists," Office of the Assistant Secretary for Preparedness & Response, January 14, 2022, <https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx>.

² Tricia Brooks, "Loss of Medicaid After the PHE Will Likely Exceed 15 Million Estimated by Urban," Center for Children and Families, September 20, 2021, <https://ccf.georgetown.edu/2021/09/20/loss-of-medicaid-after-the-phe-will-likely-exceed-15-million-estimated-by-urban/>.

their coverage, submit needed paperwork, and connect those no longer eligible for Medicaid to new coverage sources, including subsidized coverage in the ACA marketplaces. States can minimize coverage loss by carefully planning the unwinding process and their approach to resuming Medicaid eligibility renewals, communicating as clearly and early as possible to beneficiaries and stakeholders, and reducing to the greatest extent possible the administrative burden that falls on both enrollees and caseworkers.

Continuous Coverage Has Benefited Millions in Need

The Families First Coronavirus Response Act, enacted in March 2020, provided for a temporary increase in the federal government’s share of Medicaid costs (known as the federal medical assistance percentage, or FMAP). The increase in federal Medicaid funding — a 6.2 percentage-point increase in the share of Medicaid costs paid by the federal government — helped states contend with rising Medicaid costs and reduced pressure on state budgets. Similar to temporary FMAP increases during economic downturns in 2003 and 2009, states accepting the enhanced federal funds had to meet certain maintenance of effort (MOE) requirements that prevent them from making their Medicaid eligibility standards and eligibility determination procedures more restrictive.³ In addition, states accepting the higher FMAP had to commit to end terminations in Medicaid during the PHE. The goal of this policy was to provide continuous coverage to Medicaid beneficiaries so that, during the pandemic, this group of people with low incomes would not be at risk of becoming uninsured.

During the pandemic, many people have turned to Medicaid after a sudden job loss or decrease in income. Others were already eligible and took steps to enroll due to increased awareness of the need for health coverage. Still others were already enrolled when the pandemic hit. The continuous coverage requirement has helped millions maintain coverage, protecting them from interruptions in coverage and access to care that often occur when income fluctuates. As a result, enrollment in Medicaid has increased by over 20 percent since February 2020, with nearly 78 million people enrolled as of September 2021.⁴

Continuous coverage has also helped ease the strain on state Medicaid agencies that have experienced pandemic-related disruptions. These include agencies being forced to adapt quickly to telework and modify their policies and practices to align with program changes such as suspending terminations, while applications increased due to job loss and other impacts of the pandemic. Agencies have also been dealing with staffing shortages throughout the pandemic as increasing numbers of employees resigned or retired. With continuous coverage in effect, staff were less burdened with these disruptions and with the typical churn associated with Medicaid enrollment.

³ Judith Solomon, Jennifer Wagner, and Aviva Aron-Dine, “Medicaid Protections in Families First Act Critical to Protecting Health Coverage,” CBPP, April 17, 2020, <https://www.cbpp.org/research/health/medicaid-protections-in-families-first-act-critical-to-protecting-health-coverage>.

⁴ Centers for Medicare & Medicaid Services (CMS), “August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot,” Medicaid and CHIP Learning Collaborative, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.

Eligible Medicaid Enrollees Risk Losing Their Coverage

The Department of Health and Human Services promised that it would notify states of the end of the PHE 60 days prior so states could begin their planning.⁵ The PHE is expected to be extended again in mid-April and last until mid-July, meaning enrollees could lose coverage as soon as August 1. HHS would notify states in mid-May if the PHE will end in mid-July. Through Families First, the enhanced FMAP is in place until the end of the quarter in which the PHE ends — for example, if it ends in July, the enhanced FMAP would last through September 30. Though the exact end date of the PHE is uncertain, it is likely that Medicaid agencies will need to begin reviewing all enrollees' eligibility sometime this summer, and states should plan accordingly.

After the PHE ends, states will begin reviewing Medicaid eligibility for an unprecedented number of enrollees. The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, has given states up to 12 months to review their entire caseloads. Some states may attempt to conduct these reviews within a short period despite their capacity challenges. These reviews will place large burdens on enrollees and Medicaid agencies alike. Trying to do them too quickly raises the risk that millions of people who remain eligible for Medicaid will lose it and those who are no longer eligible won't get connected to other coverage.

There are many ways that people can lose coverage during this process. Many enrollees who remain eligible for Medicaid will likely lose their Medicaid coverage when eligibility reviews resume, because they don't receive notices from the Medicaid agency, don't submit required documents on time, or because short-staffed Medicaid agencies are unable to process renewal paperwork on a timely basis. Others will no longer be eligible and will need to transition to private coverage through an employer or the ACA marketplace. Many of these individuals will need guidance in navigating the marketplace plan enrollment process and selecting a plan, which can be confusing and is difficult to accomplish without a gap in coverage. Without help, many people will struggle to secure new coverage.

During the pandemic, people's addresses and contact information have changed as they faced housing instability or moved since first enrolling in coverage.⁶ Agencies may not have updated contact information for many Medicaid enrollees, which means that many people may not receive notice that they must renew their coverage, and thus fail to provide the information the agency needs to continue their coverage.

Some people who enrolled in Medicaid coverage during or in the year before the PHE may be going through the renewal process for the first time and not know what they need to do to stay enrolled. Others may not know how or where to update their contact information or may think that updating their address with the post office or their managed care plan is all they need to do. Additionally, understaffing may leave Medicaid agencies unable to process renewal documents on a timely basis, which could lead to coverage terminations for eligible people. Many agencies have

⁵ Norris Cochran, "Public Health Emergency Message to Governors," Department of Health and Human Services, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.

⁶ Will Fischer, Sonya Acosta, and Erik Gartland, "More Housing Vouchers: Most Important Step to Help More People Afford Stable Homes," CBPP, updated May 13, 2021, <https://www.cbpp.org/research/housing/more-housing-vouchers-most-important-step-to-help-more-people-afford-stable-homes>.

experienced such high turnover during the pandemic that a significant number of eligibility workers will be processing renewals for the first time.⁷

States Can Take Steps to Minimize Coverage Loss During Unwinding

With careful planning and stakeholder involvement, states can minimize the number of eligible enrollees who lose coverage and help facilitate a smooth transition to other coverage for those who are no longer eligible. CMS has released guidance throughout the pandemic outlining requirements for the resumption of normal Medicaid operations at the end of the PHE.⁸ The guidance says that states:

- May take up to 12 months to initiate renewals for all enrollees in their caseloads;
- Must conduct a full renewal of eligibility based on an enrollee’s current circumstances (as shown either through new information provided or through information recently provided to another program as discussed below) and can’t take negative action based on older information on their circumstances prior to the end of the PHE;
- Must take steps to ensure a smooth transition to the marketplace for enrollees found no longer eligible for Medicaid; for instance, sending notices that are clear and easy to understand, and transferring enrollee contact information to the marketplace to allow for direct outreach;
- Should maximize “*ex parte* renewals” — this is when an enrollee’s coverage is automatically renewed based on information in their case or electronic data sources and the enrollee isn’t required to return a form or take any action to maintain Medicaid coverage — and use SNAP information on household income and other circumstances when conducting Medicaid renewals. This would streamline the enrollment and renewal process, reduce administrative burden on beneficiaries and caseworkers alike, and ensure that eligible people maintain their coverage.⁹ Information the state is currently using to determine SNAP benefit eligibility and levels, even if it was provided a number of months previously, can be used as the basis of an *ex parte* renewal.

⁷ Medicaid and CHIP Payment Advisory Commission, “Panel Discussion: Update on Restarting Medicaid Eligibility Determinations,” Public meeting transcript, p. 103, January 2022, <https://www.macpac.gov/wp-content/uploads/2021/04/MACPAC-January-2022-Meeting-Transcript.pdf>.

⁸ CMS, “RE: Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency,” December 22, 2020, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>. CMS, “RE: Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency,” August 13, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>. CMS, “RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency,” March 3, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

⁹ CMS, “Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations,” November 2021, <https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf>. Farah Erzouki and Jennifer Wagner, “Unwinding the Medicaid Continuous Coverage Provision: What States Can Do Now to Keep Eligible People Covered,” CBPP, March 23, 2021, <https://www.cbpp.org/research/health/unwinding-the-medicaid-continuous-coverage-provision-what-states-can-do-now-to-keep>.

- Can make temporary streamlining improvements to their renewal processes through authorities such as section 1902(e)(14)(A) waivers that ensure continuity of coverage and minimize churn.¹⁰

State agencies can also implement these additional strategies to minimize coverage loss by:¹¹

- Communicating with enrollees before the end of the PHE about updating their address.
- Using multiple methods to reach individuals whose mail comes back as returned, such as through email or text.
- Exploring new data sources from non-traditional partners, such as the Department of Motor Vehicles or the Health Information Exchanges, which may have more up-to-date contact information to successfully reach enrollees.
- Leveraging partnerships with health insurance navigators and other community-based organizations to conduct outreach.

Other stakeholders, including advocates, health care providers, and community-based organizations, can play a critical role in an effective unwinding process, especially in raising public awareness. They can:

- Encourage enrollees to update their address and other contact information, assisting them in the process when possible.¹²
- Conduct outreach to ensure enrollees are aware that they will need to respond to the Medicaid agency once the PHE ends and prepare for potential changes to their coverage.
- Monitor the experiences of people on the ground to identify whether enrollees are receiving notices, how clear the notices are about what actions to take, and whether enrollee experiences with the agency are going smoothly. Establishing a feedback loop between state agencies and stakeholders in local communities before the end of the PHE will be critical in identifying barriers and gaps, which would allow for mid-course correction of agencies' processes.

¹⁰ CMS, March 3, 2022, *op. cit.*

¹¹ State Health & Value Strategies, "IT Systems and Data Strategies to Prepare for Medicaid Continuous Coverage Unwinding," November 10, 2021, https://www.shvs.org/wp-content/uploads/2021/11/IT-Systems-and-Data-Strategies-to-Prepare-for-Medicaid-Continuous-Coverage-Unwinding_Final-1.pdf.

¹² Jennifer Wagner, "States Can Act Now to Keep Medicaid Enrollees Covered When the Public Health Emergency Ends," CBPP, December 2, 2020, <https://www.cbpp.org/research/health/states-can-act-now-to-keep-medicaid-enrollees-covered-when-the-public-health>.

Medicaid MCOs can also play a unique role in connecting with enrollees and ensuring continuity of coverage. CMS recently released guidance identifying ways that MCOs can engage in the unwinding process.¹³ MCOs should:

- Share updated address and contact information for enrollees with the state Medicaid agency. MCOs can work with state agencies to establish a process that facilitates this information-sharing.
- Collaborate with the state agency to conduct outreach to enrollees whose coverage is due for renewal or whose coverage was terminated for procedural reasons and assist current or former enrollees with the process as needed.
- MCOs that also offer Qualified Health Plans through the marketplace should assist individuals who are no longer eligible for Medicaid to transition to marketplace coverage.

¹³ CMS, “All-State Medicaid and CHIP Call,” November 30, 2021, <https://www.medicaid.gov/state-resource-center/downloads/cmcs-all-state-call-11302021.pdf>.