
April 6, 2023

Advocates' Guide to Understanding States' Actions as They Unwind From Medicaid Continuous Coverage: Requirements and Best Practices

Maani Stewart

States have been prohibited from ending Medicaid coverage for most enrollees since March 2020 under what is known as the continuous coverage requirement. That requirement officially ended on March 31, 2023, which means states must “unwind” by resuming normal Medicaid operations and conducting eligibility redeterminations for all enrollees.¹ States may begin ending coverage as soon as April 1, 2023, for those found ineligible.

In setting a firm end date to the continuous coverage requirement, Congress reaffirmed states' responsibilities to follow long-standing federal redetermination regulations.² It also set new expectations for how states should maintain up-to-date contact information and how they must attempt to contact enrollees prior to disenrollment. Congress tied the continued availability of enhanced federal funding (through December 31, 2023) to compliance with these standards.

The Centers for Medicare & Medicaid Services (CMS) has issued unwinding guidance with information on what states must (or must not) do during the unwinding and what states should do to preserve coverage for eligible people (but aren't required to do).

With unwinding underway, it is important for advocates to know what's required, what's prohibited, and what's recommended so that they can better advocate for a streamlined unwinding process that promotes continuity of coverage for eligible enrollees in their state. Further, partners may need to point to these requirements and best practices during unwinding and advocate for a course correction if large numbers of eligible enrollees are incorrectly losing coverage.

¹ Farah Erzouki, “States Must Act to Preserve Medicaid Coverage as End of Continuous Coverage Requirement Nears,” February 6, 2023, <https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverage>.

² Allison Orris, “Year-End Bill Invests in Kids' Health Coverage, Makes Tradeoffs in Area of Medicaid Continuous Coverage,” December 21, 2022, <https://www.cbpp.org/blog/year-end-bill-invests-in-kids-health-coverage-makes-tradeoffs-in-area-of-medicaid-continuous>.

What States Must/Must Not Do

CMS regulations and unwinding guidance outline various requirements and prohibitions around redeterminations. Although these standards are longstanding, many states are not in full compliance with renewal requirements outlined in the regulations; CMS is working with these states to establish mitigation plans and utilize mitigation strategies designed to protect enrollees while states work to come into compliance. Advocates can ask their states for information about these plans to understand how their states are conducting redeterminations during the unwinding period.

Unwinding Timeline

- Agencies **must not** disenroll most Medicaid enrollees prior to April 1, 2023.³
- Agencies **must not** act on renewals initiated before February 2023.⁴
- Agencies **must** begin initiating renewals and post-enrollment verifications for Medicaid beneficiaries in February, March, or April 2023.⁵
- Agencies **must** complete all renewals as part of the unwinding process by May 2024 (within 14 months following the month the continuous coverage requirement ends).⁶

Renewals

- Agencies **must** first attempt an *ex parte* renewal (a renewal that uses available data source without requiring an enrollee to take action) for all beneficiaries, including non-MAGI cases and joint Medicaid and SNAP cases before sending a pre-populated renewal form.⁷
- Agencies **must not** require a beneficiary to provide consent before attempting an *ex parte* renewal.⁸
- Agencies **must not** exclude cases from the *ex parte* renewal process because the individual has not consented to the use of federal tax information (FTI), which is tax return information subject to special federal safeguards.⁹

³ Consolidated Appropriations Act, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/2617>.

⁴ *Ibid.*

⁵ *Ibid.*

⁶ CMS, “SHO#22-001 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>.

⁷ 42 C.F.R. § 435.916(a)-(b). MAGI stands for “modified adjusted gross income” and is used to determine eligibility for most, but not all, Medicaid eligibility categories. For more information, see: <https://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/>, and CMS, “Medicaid Eligibility,” <https://www.medicaid.gov/medicaid/eligibility/index.html>.

⁸ CMS, “Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts,” October 20, 2022, <https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf>.

⁹ *Ibid.*

- Agencies **must** attempt to verify assets for non-MAGI renewals using an asset verification system (AVS).¹⁰
- Agencies **must** give MAGI beneficiaries at least 30 days to return their renewal form and any requested information if an *ex parte* renewal cannot be completed.¹¹
- Agencies **must** allow beneficiaries to submit renewals online and by phone (and accept electronic and telephonic signatures).¹²
- Agencies **must** make renewal forms and notices sent to beneficiaries accessible to people with limited English proficiency and people with disabilities.¹³
- If a MAGI beneficiary’s coverage is terminated for not returning the renewal form or providing other requested information, agencies **must** reconsider eligibility without requiring the individual to complete a new application if the renewal form and/or requested information is returned within 90 days of the date of termination.¹⁴
- Agencies **must** determine eligibility on all bases of eligibility categories during a renewal in accordance with all federal requirements.¹⁵
- Agencies **must** timely submit to the Health and Human Services Department (HHS) a monthly report that HHS will make publicly available on data related to renewals and call center operations.¹⁶

Communication

- Agencies **must** attempt to ensure that they have up-to-date contact information (mailing address, phone number, and email address) using the National Change of Address Database, state health and human services agency records, or other reliable source of contact information.¹⁷
- Agencies **must** make a good-faith-effort to contact a beneficiary using more than one modality (such as telephone and email) before terminating coverage based on returned mail.¹⁸

¹⁰ 42 U.S.C. § 1396w(a)-(b)

¹¹ 42 C.F.R. § 435.916(a)(3)

¹² 42 C.F.R. § 435.916(a)(2); 42 C.F.R. § 435.916(b)

¹³ 42 C.F.R. § 435.916(g)

¹⁴ 42 C.F.R. § 435.916(a)(3)(iii)

¹⁵ Consolidated Appropriations Act, 2023.

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ CMS, “SHO#23-002 RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023,” January 27, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>.

- Agencies **must not** terminate a beneficiary’s coverage due to mail returned with an in-state forwarding address, even if the state does not receive confirmation of the in-state address change.¹⁹
- Agencies **must** send communications to beneficiaries using the beneficiary’s preferred method of communication (i.e., mail or electronic notice).²⁰
- Agencies **must** send a follow-up notice by regular mail if electronic notification fails to deliver to a beneficiary.²¹
- Agencies **must** send the beneficiary a notice at least ten days prior to the date of action, which is when a Medicaid or Children’s Health Insurance Program (CHIP) agency makes a decision affecting a beneficiary’s eligibility, such as termination of coverage, and **must** provide fair-hearing rights prior to termination.²²

What States Should Do

CMS has provided states with several documents, including *Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts*, and the *State Health Official (SHO) #22-001 Letter*, that offer guidance on recommended actions states **should** take to promote continuity of coverage during unwinding of the continuous coverage requirement.²³

Renewals

- Agencies **should** take actions to bolster their *ex parte* capabilities prior to expiration of the continuous coverage provision.²⁴ Strategies include:
 - Reviewing eligibility system design documents and data to ensure they accurately identify when a case can and can’t be renewed *ex parte* and adjust systems if needed.
 - Incorporating all federal, state, and commercial data sources that are reliable and relevant into the *ex parte* search process.²⁵
 - Adopting principles that maximize *ex parte* success, such as including AVS in *ex parte* for non-MAGI populations and not disregarding a data source because of its age.²⁶

¹⁹ CMS, “SHO#22-001.”

²⁰ 42 C.F.R. § 435.918.

²¹ *Ibid.*

²² 42 C.F.R. § 431.211; 42 C.F.R. § 431.206

²³ CMS, “Ex Parte Renewal.” CMS, “SHO#22-001.”

²⁴ Jennifer Wagner, “Streamlining Medicaid Renewals Through the *Ex Parte* Process,” March 4, 2021, <https://www.cbpp.org/research/health/streamlining-medicaid-renewals-through-the-ex-parte-process>.

²⁵ CMS, “Ex Parte Renewal.”

²⁶ Farah Erzouki, “States Should Streamline Medicaid Enrollment and Renewal for Older Adults and People With Disabilities Ahead of Unwinding,” February 14, 2023, <https://www.cbpp.org/blog/states-should-streamline-medicaid-enrollment-and-renewal-for-older-adults-and-people-with>. CMS, “Ex Parte Renewal.”

- Using information obtained for other programs, such as the Supplemental Nutrition Assistance Program (SNAP), for *ex parte* renewals.
- Agencies **should** try to align non-MAGI renewal requirements with MAGI requirements, implementing policies for non-MAGI renewals such as:
 - Providing a pre-populated renewal form when an *ex parte* renewal cannot be completed;
 - Providing a minimum of 30 days to return the pre-populated form; and
 - Allowing a 90-day reconsideration period if coverage is terminated for not returning the renewal form or providing other requested information.
- Agencies **should** adopt Express Lane Eligibility to rely on data from other programs (e.g., SNAP; Temporary Assistance for Needy Families, or TANF; the Special Supplemental Nutrition Program for Women, Infants and Children, or WIC; Head Start) to determine eligibility factors for renewals.²⁷
- Agencies **should** attempt to align renewal periods with other programs, such as SNAP.²⁸

Communication Strategies ²⁹

- Agencies **should** establish procedures for and attempt to communicate with beneficiaries through multiple channels such as by phone, email, or text message to communicate that their redetermination is coming due.³⁰
- Agencies **should** partner with MCOs to ensure the agencies have accurate beneficiary mailing addresses.³¹
- Agencies **should** take actions to bolster call center capacity in response to anticipated increase in call volume.
- Agencies **should** update social media and mobile-friendly web pages with key information such as how beneficiaries can update their contact information and who to contact for assistance.

²⁷ CMS, “Express Lane Eligibility for Medicaid and CHIP Coverage,” August 6, 2021, <https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html>.

²⁸ CMS, “SHO#22-001.”

²⁹ CMS, “Unwinding and Returning to Regular Operations after COVID-19,” <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>.

³⁰ Code for America, “Recommendation and tips for texting clients of safety net services,” <https://codeforamerica.org/programs/social-safety-net/texting-playbook/>.

³¹ CMS, “Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations,” January 2023, <https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf>.