Health Care in Motion
Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

June 28, 2023

Medicaid Continuous Coverage Unwinding

More than one million have lost Medicaid coverage as pandemic era protections come to an end

This spring marked the end of an important COVID-19 era protection, the Medicaid continuous coverage requirement, which had prohibited states from disenrolling individuals from Medicaid for the duration of the federally declared public health emergency (PHE). In December 2022, Congress passed an omnibus spending bill that included a provision ending the Medicaid continuous coverage requirement on March 31, 2023, regardless of whether the PHE had ended. States are now well into the unwinding process. Although the rate of terminations varies widely by state, across the country more than one million Medicaid beneficiaries have already lost coverage, and millions more are expected to do so. Read on for a summary of what we know so far about how the unwinding is going and considerations for individuals with chronic conditions and disabilities as they navigate possible changes in coverage.

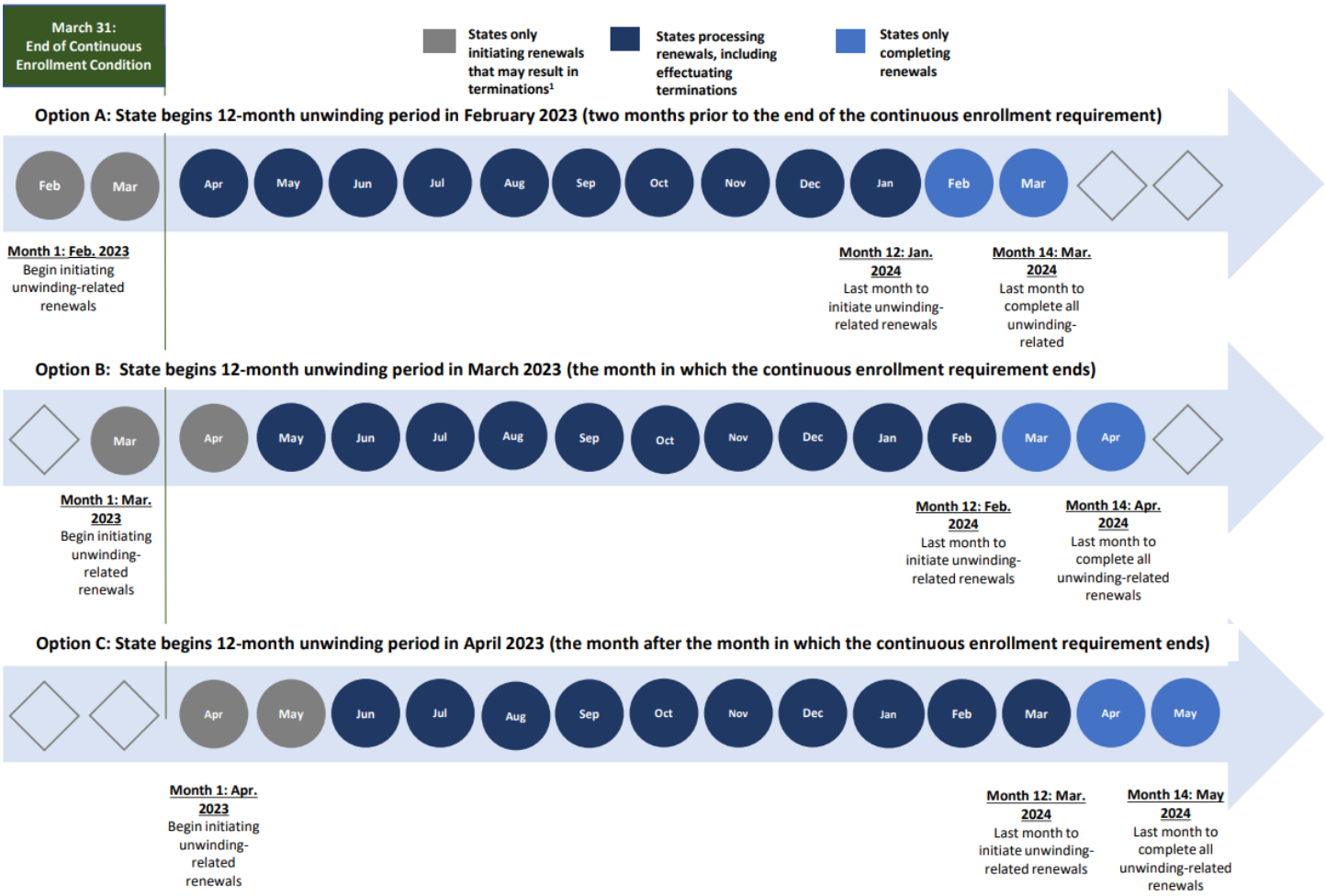
A Refresher on the Medicaid Unwinding Process

Congress has passed important protections aimed at preventing Medicaid beneficiaries from losing coverage erroneously. In addition, the Centers for Medicare and Medicaid Services (CMS) has released reems of guidance to state Medicaid programs over the past two years to help states comply with these rules, and to increase the likelihood that states will act equitably and efficiently as they undertake the massive task of initiating renewal processes for every Medicaid beneficiary. For example, CMS required states to develop an unwinding plan and submit it to CMS last year. Each unwinding plan laid out the state's plan for communicating with beneficiaries as well as the approach the state would use to stagger renewals over the course of the 12-month unwinding period, since CMS recommends that states initiate no more than one-ninth of the total renewals in any given month. Many states made their unwinding plans public.

Two important federal requirements that states must follow during the unwinding are the use of *ex parte* renewals, which allow the state to renew a beneficiary's Medicaid without the beneficiary having to take any action, and protections for beneficiaries when their mail is returned as undeliverable. To reduce the burden on Medicaid beneficiaries, states must streamline the renewal process as much as possible, including by conducting renewals *ex parte* using data that the state already has available. States must also make multiple attempts to contact beneficiaries before terminating them. Also known as the "returned mail condition," this

protection requires states to undertake a good-faith effort to contact an individual using more than one method prior to terminating their enrollment on the basis of returned mail.

The entire unwinding process will last for 14 months. States had some flexibility to determine when they would start the renewal process and when terminations would begin, but all unwinding-related renewals must be completed by May 2024 (see figure 1 below).



Source: Center for Medicaid & CHIP Services Informational Bulletin (January 5, 2023), available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf.

Update: How Is the Unwinding Going?

Early Data Indicates Many Individuals Are Losing Medicaid Coverage for Procedural Reasons

For many beneficiaries, their state Medicaid program will have access to data needed to determine whether they are still eligible for Medicaid. If the data confirms their eligibility, these beneficiaries will receive a notice that their Medicaid has been renewed and that they should only contact their state Medicaid agency if they have changes to report that could affect their eligibility. For other beneficiaries, their state Medicaid agency

will need documentation to determine whether they are still eligible. These beneficiaries should receive a pre-populated renewal form from their state Medicaid agency at some point during the unwinding process and will need to respond with any requested information to avoid termination of their Medicaid coverage.

Many Medicaid beneficiaries are at risk of not responding to these requests for renewal information. There are a host of reasons why this could occur, such as that a beneficiary has moved and not updated their address with their state Medicaid agency, they lack a stable address, or they have a disability or limited English proficiency (LEP) that makes it harder to understand and respond to these requests. In these cases, the state Medicaid agency may ultimately terminate the beneficiary's coverage for failure to comply with the renewal process. These terminations are known as "procedural terminations" to distinguish them from terminations that occur following a full determination that a beneficiary is no longer eligible for the program.

States are required to submit to CMS monthly reports documenting their progress on the unwinding, including the numbers of renewals completed and terminations for procedural reasons. High numbers of procedural terminations are concerning because these numbers could indicate that many Medicaid beneficiaries are losing coverage due to difficulty completing the renewal process—even though they may still be eligible for the program.

CMS will eventually publish this data but is not expected to do so until later this summer. For now, to assess the impact of the unwinding process in real time advocates and researchers are relying on the more limited data individual states are making publicly available. Although some states have not yet begun procedural terminations, the early data reported by states and compiled by Kaiser Family Foundation paint a bleak picture of the unwinding so far. For example, as of June 22, 2023:

- South Carolina reported that 95% of terminations were for procedural reasons.
- Kansas reported that 89% of terminations were for procedural reasons.
- Connecticut and West Virginia reported that 87% of terminations were for procedural reasons.
- Indiana reported that 85% of terminations were for procedural reasons.

Overall, 73% of disenrollments so far are due to procedural reasons. These high numbers are even more alarming given Kaiser Family Foundation's recent poll results indicating that most Medicaid enrollees are not aware that states are now permitted to resume Medicaid terminations, and that many beneficiaries have never been through a renewal process before.

Risks for People with Chronic Conditions and Disabilities

Losing access to Medicaid can be destabilizing for anyone, but it is particularly dangerous for people living with chronic conditions and disabilities, who often depend on access to regular care and treatment to remain healthy.

During the unwinding, states are required to release data reflecting their numbers of pending applications based on Modified Adjusted Gross Income (MAGI) eligibility categories (including the ACA Medicaid expansion group) or non-MAGI categories (including disability). But they are not required to report

In March 2023, CHLPI released a podcast about the Medicaid unwinding that discussed implications for people with chronic conditions and how providers and others who work with these individuals can support them during this process.

on the proportion of beneficiaries in each category who are being terminated. This is a major gap in data, making it difficult to tell how people living with chronic conditions and disabilities are faring during the unwinding.

There are also reasons to be concerned that people with disabilities, as well as older adults and those with limited English proficiency (LEP), may be at elevated risk for procedural terminations. The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) released guidance to state Medicaid programs reminding them of their obligations under federal civil rights laws to ensure that programs are providing meaningful language access and effective communication to people with disabilities and LEP. However, without formal data reporting obligations on how these communities in particular are faring during the unwinding, it may be difficult to determine if Medicaid programs are abiding by these federal requirements. Organizations and assisters who work with these communities and who are concerned about lack of meaningful access should track any examples of noncompliance and consider filing a complaint with OCR.

Spotlight: HIV Programs

People living with HIV are at especially high risk during insurance transitions, since effective HIV care requires consistent access to medications and treatment protocols. Therefore, Ryan White HIV/AIDS Program (RWHAP) assisters have been preparing clients for the possibility that they may transition off Medicaid, including through client outreach and education, partnerships with state Medicaid programs to identify individuals who may lose coverage, and education campaigns to ensure that Medicaid programs, Medicaid managed care organizations, and other non-HIV systems are aware of assistance for people living with HIV through RWHAP and AIDS Drug Assistance Programs (ADAPs). The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) also released guidance in March 2023 encouraging RWHAP recipients to take steps to help clients protect their Medicaid coverage or transition to other coverage as necessary. The existing outreach and enrollment infrastructure of many HIV programs and the close relationships of RWHAP recipients to state Medicaid programs may bode well for this group during the unwinding.

CMS Actions to Protect Beneficiaries

In response to early data indicating a high number of procedural terminations from Medicaid, Secretary of HHS Xavier Becerra issued a letter to state governors on June 12, 2023. The letter reminded governors of their responsibilities to ensure that Medicaid beneficiaries do not lose coverage erroneously. It also emphasized policy strategies that states may use to increase the likelihood of a smooth unwinding, especially:

- Spreading renewals across 12 months;
- Maximizing use of data sources and matches to reduce burden on beneficiaries;
- Allowing Medicaid managed care organizations to complete renewal forms; and
- Using temporary waiver authority through Section 1902(e)(14)(A) of the Social Security Act to facilitate renewals, for instance allowing individuals to renew coverage based on SNAP and/or TANF eligibility.

As more data becomes available and as advocates and patient advocacy groups respond to the high numbers of procedural terminations, there will likely be calls on CMS to push states to take action to drive down these numbers. Strategies could range from encouraging increased beneficiary outreach and education efforts to more aggressive steps, such as pausing procedural terminations in states that are not complying with Medicaid rules. It

will be particularly important to request additional data about how the unwinding is impacting different eligibility groups to better target outreach efforts.

What Happens Next?

We still have a long way to go before the end of the Medicaid continuous coverage unwinding. There will likely be continued pressure on both CMS and state Medicaid agencies to oversee renewals and terminations in ways that ensure individuals maintain access to care and treatment.

Subscribe to all Health Care in Motion Updates

Health Care in Motion is written by Kevin Costello, Litigation Director; Elizabeth Kaplan, Director of Health Care Access; Maryanne Tomazic, Clinical Instructor; Rachel Landauer, Clinical Instructor; Johnathon Card, Staff Attorney; and Suzanne Davies, Clinical Fellow. This issue was written with the assistance of Amy Killelea of Killelea Consulting.

*For further questions or inquiries please contact us at **chlpi@law.harvard.edu**.*