

Continuous Coverage in Medicaid and CHIP

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Tenth in a series of papers from the Georgetown University Center for Children and Families on the future of children's health coverage.

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Executive Summary

Continuous health insurance coverage produces a broad array of benefits across the health care sector for individuals, states, health plans, and providers. In particular, Medicaid continuous eligibility promotes health equity by limiting gaps in coverage for low-income children and adults who experience disproportionate rates of health disparities. Consistent access to health care, including management of chronic conditions and care coordination, improves health status and well-being and drives more efficient health care spending. Importantly, continuous eligibility mitigates the negative effects of income volatility that disproportionately impact low-income families and essential workers. By reducing the administrative costs associated with enrollees cycling on and off of Medicaid due to temporary fluctuations in income, states can dedicate more of the Medicaid dollar to pay for health care. Moreover, continuous eligibility is necessary to fully measure the quality of health care in Medicaid and the Children's Health Insurance Program (CHIP), which also opens the door to improved accountability and oversight of insurers including Medicaid managed care plans.

Currently, all Medicaid enrollees are continuously enrolled until after the end of the COVID public health emergency (PHE), which is widely expected to continue through the entirety of 2021, if not longer.¹ But as states resume normal operations post-PHE, many beneficiaries will lose the benefit of this continuous coverage. Under current law, states have limited continuous coverage requirements and state plan options in Medicaid and CHIP. Pregnant individuals in Medicaid must be continually covered through pregnancy until 60-days postpartum, and their infants must be continuously covered for one year. States may also opt to cover children for up to a full year, regardless of income fluctuations, through a straightforward state plan amendment (SPA).

However, in order to extend continuous coverage to other eligibility groups, states must seek section 1115 demonstration authority from the federal government, an uncertain process that can be administratively complex, time-consuming, costly, and by no means assured. (For more information on SPAs vs. waivers, see page 5).



Medicaid primarily serves low-income individuals and families, who are more likely to experience income volatility. As a result, Medicaid enrollees often encounter gaps in coverage due to “churn” where they cycle on and off coverage due to temporary changes in income. Even short gaps in coverage can undermine their access to care, management of chronic conditions, and overall health. Research shows that individuals with continuous coverage experience fewer unmet health care needs and are in better health than those who cycle on and off coverage.² Providing continuous coverage can help avoid higher health care costs that can result when care is delayed or sought in hospital emergency rooms due to gaps in coverage.

Recognizing the many benefits of continuous eligibility, there has been growing interest in extending the policy to other eligibility groups in Medicaid, and in providing multi-year coverage for young children during their formative developmental years.

This brief provides an update on the current policy landscape and benefits of continuous eligibility. It describes administrative actions that promote continuity of coverage at renewal, and during the year between renewals. It also recommends policy strategies to advance continuous coverage in Medicaid such as:

- guaranteeing full-year coverage for all children;
- allowing states to provide multi-year continuous eligibility for children without a section 1115 waiver;
- extending federal continuous eligibility requirements following pregnancy from 60 days to 12 months; and
- creating a new state option to extend 12-month continuous eligibility to adults.

There will likely be important lessons learned by examining enrollment patterns before, during, and after the PHE. As states develop their plans for resuming normal eligibility and enrollment operations post-pandemic, it is critically important to take appropriate steps to maintain ongoing coverage for all eligible individuals. Moreover, the end of the PHE is an ideal time to take stock of opportunities in Medicaid and CHIP to expand continuous eligibility policies and implement administrative processes that have proven to promote continuity of coverage.

Benefits of Continuous Eligibility

- Drives more efficient health care spending
- Improves health status and wellbeing in the short and longer term
- Mitigates the impact of income volatility on families
- Promotes health equity
- Reduces administrative burden and costs
- Enhances the ability to fully measure the quality of care
- Provides states with better tools to hold health plans accountable for quality and improved health outcomes



Current State Options to Provide 12-Month Continuous Eligibility with Federal Funding

Continuous eligibility for a full year is often confused with 12-month renewal periods. To promote coverage stability, the Affordable Care Act (ACA) effectuated annual renewal periods for non-disabled, non-elderly enrollees in Medicaid and CHIP.³ States must redetermine eligibility once every 12 months, but not more frequently.⁴ However, unless a state chooses to implement continuous eligibility, it must act on changes in circumstances that may impact eligibility between renewals even when such changes are temporary.

Children

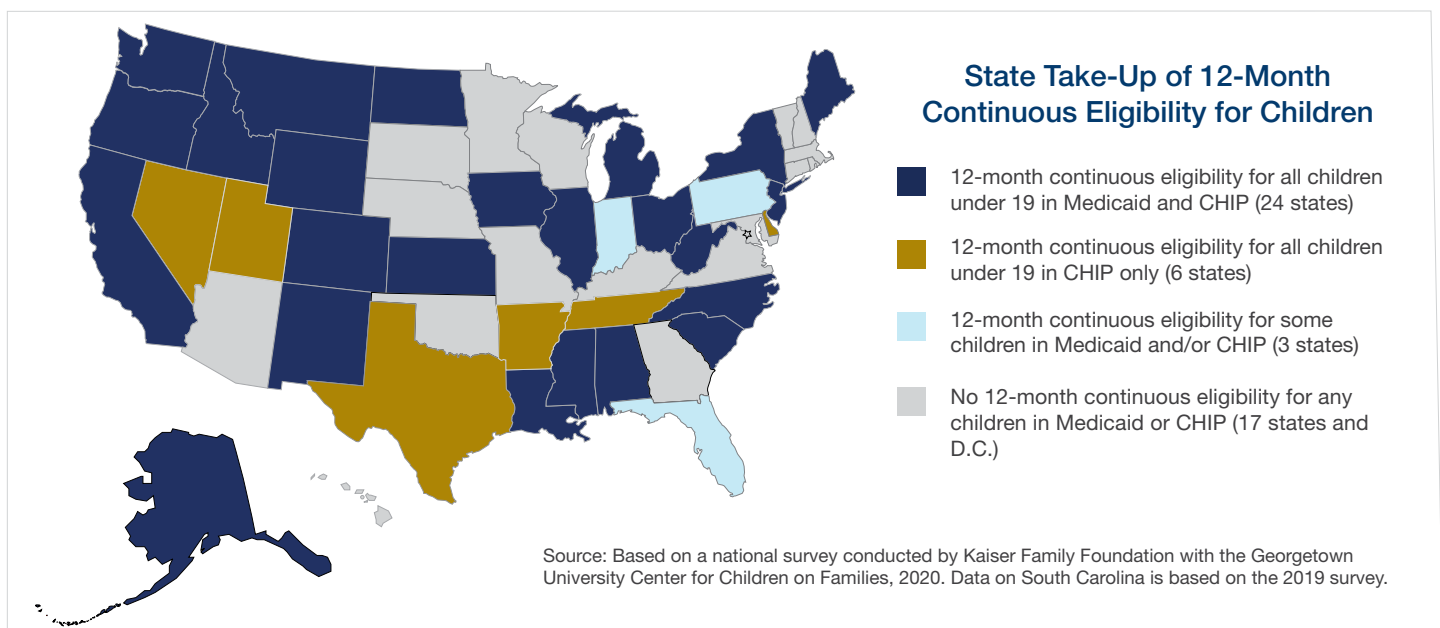
Continuous eligibility for children is a long-standing policy option in Medicaid and CHIP that allows states to cover children for up to a full year unless the child ages out, moves out of state, is disenrolled for nonpayment of premium, or requests voluntary disenrollment.⁵ States may limit the policy to a specific age group and apply a continuous eligibility period of less than one year. However, most states adopting the policy cover all children for a full year. As of January 2020, 32 states provide 12-month continuous eligibility to children in Medicaid and/or CHIP (see Appendix Table 1).⁶

Of the 32 states, 24 states guarantee full year coverage for children of all ages in both Medicaid and CHIP. Three states (Florida, Pennsylvania, and Utah) that provide full-year coverage for all CHIP children have taken steps to extend coverage to subsets of younger children in Medicaid. Florida and Pennsylvania provide 12 months of coverage in Medicaid for children under ages five and four, respectively.⁷ Utah approved 12-month continuous Medicaid eligibility for children under age six in 2020 but the COVID-19 pandemic has stalled the effort. Indiana also provides full-year Medicaid and CHIP coverage to children under the age of three.⁸

However, five states (Arkansas, Delaware, Nevada, Tennessee, and Texas) offer 12-month continuous coverage only in their separate CHIP program, leaving lower-income children in Medicaid more vulnerable to additional administrative burdens that can result in coverage gaps.⁹

Adults

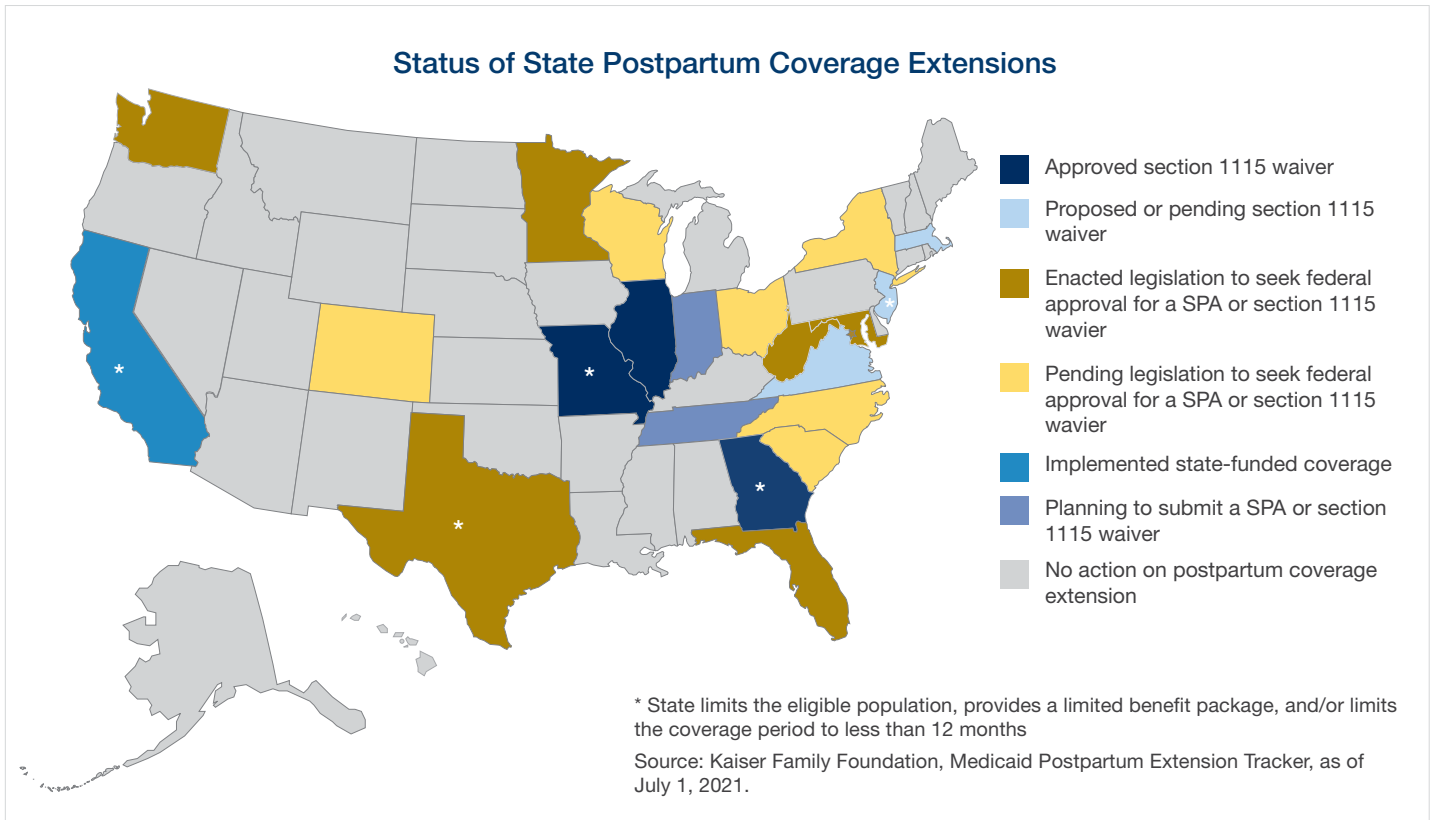
In general, federal law does not provide an easy option for states to extend continuous coverage in Medicaid to non-pregnant adults. In May 2013, the Center for Medicare & Medicaid Services (CMS) provided guidance to states seeking to extend continuous eligibility to adults.¹⁰ Citing all of the benefits of stable coverage for children, CMS noted that allowing states to extend 12-month continuous coverage will provide adults with the same advantages derived by children and result in better coordination for the entire family. This approach is not a state plan option under current law; section 1115 demonstration authority is required. Currently, two states—Montana and New York—have approved section 1115 waivers providing continuous coverage to adults.¹¹ However, recent efforts in Montana to discontinue 12-month continuous eligibility for adults appear to be moving forward.¹²



Post Pregnancy

Under current law, pregnant enrollees must be continuously covered in Medicaid and CHIP during their pregnancy but continuous eligibility extends only 60 days after the end of the pregnancy unless the individual is eligible under a different eligibility pathway.¹³ Prior to and during the COVID-19 continuous eligibility requirement, a number of states were actively exploring or pursuing longer periods of postpartum coverage through section 1115 demonstration authority. However, the American Rescue Plan Act (ARPA) of 2021 now provides a new state plan option to extend postpartum coverage for a full year following the end of the pregnancy, but not until April 2022. At least a dozen states have shown interest in extending postpartum coverage beyond 60 days. CMS has recently approved waivers in several states that extend postpartum coverage for less than a full year or to only a subset of individuals (e.g., individuals with substance use disorder or mental health issues).¹⁴ With the new ARPA state plan option, CMS should no longer approve section 1115 waivers unless they are as expansive as the new ARPA state plan option.¹⁵

To adopt the new ARPA state option, states must provide full benefits to pregnant people in both Medicaid and CHIP for 12 months. It applies to all pregnant citizens, regardless of their eligibility category, and to lawfully residing pregnant people in the 25 states that have adopted the option. It does not apply to pregnant people eligible for coverage through emergency Medicaid or the CHIP unborn child option. In the meantime, all individuals enrolled in Medicaid must be continuously covered through the end of the COVID-19 public health emergency (PHE), which is expected to be in place at least for the entirety of 2021.¹⁶ This allows time for CMS to promulgate rules and provide additional implementation support to states. If the PHE ends prior to April 2022, CMS guidance on resuming normal operations gives states flexibility to phase in delayed renewals and actions on changes in circumstances in a way that could bridge any gap between the end of the PHE and when the new state option becomes effective.¹⁷ Current law sunsets this option in five years unless Congress extends it in the future.





State Plan Option vs. Waiver

State Plan Amendments

Federal law sets broad requirements for the Medicaid program, mandating coverage of some populations and benefits while providing a variety of state options, such as 12-month continuous eligibility for children. Each state specifies the nature and scope of its Medicaid program through the state plan, which serves as a formal, written agreement between a state and the federal government. As federal requirements and state policies change over time, updates are made via state plan amendments (SPAs). Generally, SPA templates (a checkbox/fill-in-the-blank form) are available to facilitate state adoption of allowable options.

Once a SPA is submitted, CMS has 90 days to make a decision. Otherwise, the proposed change automatically goes into effect, although the agency can “stop the clock” by requesting additional information. Upon approval, changes can take effect retroactively to the first day of the quarter in which the SPA was submitted. Unlike waivers, most SPAs are not subject to federal notice requirements that provide an opportunity for stakeholder comment on proposed changes, although states may have their own requirements. Also, SPA approvals are not contingent on meeting any budgetary target or budget neutrality as required in waivers.

Waivers

States seeking additional flexibility may apply to the Secretary of the U.S. Department of Health and Human Services (HHS) for formal waivers of certain statutory requirements if such actions promote the objectives of the Medicaid program. Section 1115 Medicaid waivers are granted at the discretion of the Secretary to test or demonstrate new concepts. Although not in federal statute, CMS requires section 1115 waivers to be budget neutral to the federal government, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Section 1115 waivers are subject to special terms and conditions, including reporting and evaluation. Typically, they are granted for a limited period of time and then must be renewed if the state wishes to continue the demonstration.

Unlike most SPAs, waivers require lengthy application and public comment processes at both the state and federal level, which promote consideration of stakeholder input. To assist with this lengthy process, CMS may develop templates to renew existing section 1115 demonstrations and to expedite approval of targeted actions, such as waivers to address the COVID-19 pandemic.

The extensive use of waivers (almost every state now has at least one section 1115 waiver agreement in place) has contributed to wide variations in program design, covered services, and eligible populations among states and even within states.¹⁸



The Benefits of Continuous Coverage

The primary and most obvious impact of continuous eligibility is that it limits the cycling of children and adults on and off Medicaid and CHIP due to fluctuations in income, but the implications are far broader. Changes in income eligibility are often temporary, and a large share of individuals who lose coverage re-enroll within a matter of weeks or months.¹⁹ This pattern of short-term enrollment, disenrollment, and re-enrollment—known as churning—drives up administrative costs and diminishes access to timely and appropriate health care services.

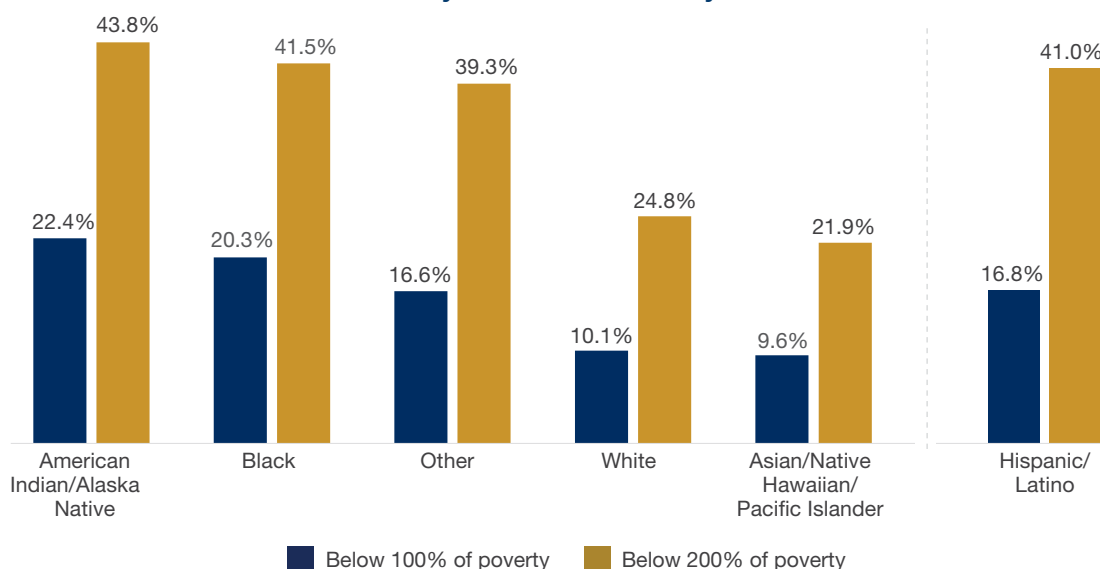
► Improves Health Status and Well-Being

Individuals with continuous coverage experience fewer unmet health care needs and are in better health. A study by the Government Accountability Office (GAO) found that beneficiaries covered by Medicaid for a full year reported fewer difficulties in obtaining necessary medical care and prescription medicine, similar to those with private insurance for a full year. Individuals with partial year health insurance—coverage for between one and 11 months—were more likely to report problems obtaining needed care, whether covered by Medicaid or private health insurance.²⁰

► Promotes Health Equity

Continuous eligibility policies are one way to address the health disparities and inequities that exist for people of color and low-income or rural communities as a result of gaps in health coverage. Black, Hispanic, and Indigenous individuals and families are more likely to live in poverty and therefore have higher rates of income volatility than Whites (see figure 1).²¹ More than half (54 percent) of families living in poverty and a third of low-income families (under 200 percent of the Federal Poverty Level (FPL)) experience volatility in monthly household income.²² Losing coverage, even temporarily, compounds other challenges these families encounter as a result of structural racism in the health care system. It also puts individuals in the untenable situation of choosing health care over other basic needs such as providing adequate food and safe, stable housing for their families.

Figure 1. Share of Individuals Living on Poverty or Near Poverty, by Race and Ethnicity



Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey (ACS) data using Public Use Microdata Sample (PUMS). "Other" includes individuals who indicated that they were of "Some other race" or "Two or more races." The Census Bureau distinguishes between race and Hispanic origin/Latino ethnicity. Individuals of Hispanic/Latino origin can be of any race and individuals of any race can be Hispanic/Latino.



► **Mitigates the Impact of Income Volatility on Families**

Seasonal employment, variable work hours, or occasional overtime pay can easily drive temporary changes in eligibility even if annual income remains below the Medicaid threshold.²³ The U.S. Financial Diaries project determined that low- and moderate-income households experience 2.6 months a year in which their income was more than 25 percent above their average monthly income. Families with variable income are more likely to experience churn in Medicaid eligibility, and they also encounter other adverse consequences such as food insecurity, unstable housing, greater parental stress, and reduced child academic attainment.²⁴ Consistent access to health care can help mitigate these negative effects while ensuring that medical debt, the most common cause of bankruptcy, does not compound the difficulties these families face.²⁵

► **Drives More Efficient Health Care Spending**

Ongoing health insurance coverage is effective at achieving better health outcomes and lower costs when it promotes appropriate preventive, primary, and condition-specific care. Continuous coverage can help avoid higher health care costs that can result when care is delayed or sought in hospital emergency rooms due to gaps in coverage.²⁶ Consistent access to prescription drugs helps to manage multiple chronic conditions and lower the cost of treating acute episodes of care. Continuous coverage minimizes disruptions in care coordination or care management services, which are critical to the health and well-being of children with special health care needs and adults with chronic health conditions. As a result, research has shown that monthly health care expenditures for continuously covered individuals are lower than for those who experience disruptions in coverage.²⁷

► **Reduces Administrative Burden and Costs**

Continuous coverage reduces the administrative cost of handling changes in circumstances, processing terminations, and mailing disenrollment notices, only to have individuals reapply for coverage. Churning creates substantial administrative costs for the Medicaid program in general and Medicaid managed care plans in particular. A 2015 study estimated the administrative cost of one person churning off and back on to

Medicaid to be between \$400 and \$600.²⁸ Churning-related administrative costs, multiplied by the number of people who churn in a year, can add up quickly leaving a smaller share of the Medicaid dollar to pay for health care.²⁹

The administrative burden extends to managed care organizations (MCOs) which cover 82 percent of Medicaid enrollees.³⁰ MCOs must take steps to disenroll individuals, including sending notices of disenrollment, only to re-enroll and replace insurance cards when eligibility is reinstated. Frequently moving in and out of eligibility makes it difficult for MCOs to coordinate care for enrollees with chronic conditions or children with special health care needs. It also adds to other administration burdens such as researching and reconciling billing issues or delivering duplicative new member services when individuals are auto-enrolled in a different health plan. In turn, different plan assignments can disrupt access to usual sources of care and preferred providers.³¹ Enrollment churn also creates confusion, adding to administrative workloads with an increased need for member and provider support services.

► **Enhances the Ability to Measure the Quality of Care**

Measuring the quality of health care accurately is essential to improving health outcomes, addressing health equity concerns, and ensuring that public funds are being spent responsibly. Continuous enrollment with no more than a one-month gap in coverage is a prerequisite for most health care quality measures such as preventive care, immunization rates, and appropriate medication management.³² Individuals with gaps in coverage are excluded from the data used to assess the quality of care, thus providing an inadequate picture of how well our public health insurance programs are performing on key quality indicators. Beginning in 2024, states will be required to report on the Child Core Set of Health Care Quality Measures in Medicaid and CHIP and the behavioral health measures in the Adult Core Set. Without continuous enrollment, assessing the quality of care in Medicaid will be incomplete and may misrepresent how well Medicaid and CHIP are performing. (See text box on page 8 for more information about the Child Core Set of Quality Measures.)



► Supports Accountability in Managed Care

Health care quality measures are also tools for holding managed care plans accountable for providing the services they are contracted to deliver. However, churning in Medicaid excludes plan members from the accountability system for managed care when they do not meet continuous enrollment criteria for measuring the quality of care.³³ Accurate and complete quality measurement in Medicaid and CHIP is indispensable in pinpointing specific areas in need of quality improvement, prioritizing performance improvement goals, and establishing performance targets for health plans and providers. Quality data is also essential in fairly and effectively administering incentive-based payment arrangements for health plans and providers and in assessing and monitoring overall MCO performance.

About the Child and Adult Core Set of Health Care Quality Measures in Medicaid and CHIP

The CHIP Reauthorization Act of 2009 called for the development and maintenance of a set of health care quality measures for children in Medicaid and CHIP, known as the Child Core Sets of Health Care Quality Measures. The following year, the ACA initiated a companion set of quality measures for adults. Currently reporting on quality measures for all Medicaid and CHIP beneficiaries is voluntary for states but, beginning in 2024, states will be required to report all Child Core Set measures and the behavioral health measures in the Adult Core Set. Improving the completeness and accuracy of Medicaid and CHIP quality measurement data is important in advance of mandatory reporting.³⁴

Cost Considerations in Extending Continuous Eligibility

Short Term Cost of Continuous Eligibility

Adopting 12-month continuous eligibility does come with a cost in additional coverage months, as well as one-time implementation costs such as changes to a state's eligibility and claims payment systems. However, the reduction in health care costs over time, coupled with administrative savings in processing temporary changes, can help offset these costs. Estimating the fiscal impact of continuous coverage requires detailed knowledge of Medicaid eligibility and enrollment policies, as well as access to the available enrollment data. It is important to exclude any additional costs for the share of enrollees who move out of state, age out of coverage, or request voluntary disenrollment.

Twelve-month continuous eligibility does not extend coverage for individuals who lose coverage at renewal due to ineligibility or procedural reasons. It also does not apply to individuals enrolled for limited time periods such as presumptive eligibility, or those who are covered for limited benefits such as emergency services for immigrants. In order to project the cost of extending continuous coverage, enrollment data must include reasonable assumptions about disenrollment patterns including whether a disenrollment

occurred at renewal or another time. Cost estimates should be based on only paying for the gaps in coverage for full benefit enrollees who cycle off and back on within the 12-month renewal period. Moreover, some determination should be made as to the impact of continuous coverage on overall health care costs over time, which decline with longer periods of continuous coverage. However, there must be a mechanism to reconcile declining monthly costs with contractual capitated payments to managed care plans.

Return on Investment

Gaps in coverage lead to the delay or avoidance of preventive, routine, and acute care, and disrupt efforts to effectively manage costly chronic conditions. Gaps in Medicaid coverage have been associated with increased hospitalization for heart failure, diabetes, chronic obstructive pulmonary disease, and other ambulatory sensitive conditions.³⁵ Studies have shown that skipped or delayed health care can lead to unnecessary illness or death, and can result in inefficient and expensive use of emergency room or hospital care for preventable conditions like asthma or diabetes.³⁶



Notably, early life Medicaid coverage is associated with fewer chronic conditions in adulthood such as high blood pressure, heart disease, obesity, and diabetes.³⁷ A number of studies find that Medicaid eligibility for children is associated with a greater likelihood of on-time graduation from high school and a decrease in the high school dropout rate, particularly among children of color. In turn, educational attainment improves health status in adults and can be a ticket out of poverty.³⁸ Children's health status can impact spending on special education, child welfare, and juvenile justice, among other social issues. Accounting for Medicaid's effects over the life course changes the cost-benefit calculation. Research shows that Medicaid can have positive long-run effects on health, human capital, earnings, and tax payments.³⁹ These longer-term and cross-sector impacts make continuous eligibility a sound public policy investment.

To this end, a handful of states have recently taken initial steps toward multi-year continuous coverage for some children. California recently budgeted \$1.8 million annually to provide continuous eligibility for children from birth to age five. Legislators in Washington state have directed the state's Health Care Authority to assess the feasibility and fiscal impacts of a section 1115 waiver to extend continuous eligibility for children through age five. Oregon is considering five-year continuous eligibility for children and adolescents in its proposed section 1115 waiver renewal.

Factors to Consider in Estimating the Cost of Continuous Eligibility

Cost estimates should exclude cost for the share of enrollees, on average, who:

- move out of state
- age out of coverage
- request voluntary disenrollment
- are disenrolled for nonpayment of premiums
- lose coverage at renewal
- are not subject to continuous eligibility provisions, including individuals
 - enrolled on a temporary basis through presumptive eligibility
 - receiving limited benefits such as emergency services for immigrants

Cost estimates should:

- include only the gaps in coverage for people cycle off and back on within the continuous eligibility period
- be offset by:
 - the cost of coverage for enrollees would otherwise move to different eligibility pathways with different federal matching rates (e.g., Medicaid to CHIP, or pregnancy coverage to adult expansion)
 - savings in administrative costs associated with reduction in churn
 - declining monthly health care costs over time
 - savings in financial assistance to purchase higher cost Marketplace plans

Children Enrolled in Medicaid



Miss fewer school days



Do better in school



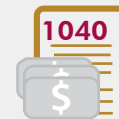
Graduate and attend college



Become healthier adults



Earn higher wages



Pay more in taxes

Recommendations



State



Federal

These recommendations range from actions that can be taken by a state, the Center for Medicaid and CHIP Services (CMCS), and/or Congress. See detailed recommendations on pages 15 and 16 on steps each governing unit can take to promote continuity of coverage and reduce administratively-costly churn.

Expand Continuous Eligibility Policies



Guarantee 12-months of continuous eligibility for all children in Medicaid and CHIP.



Children in the lowest-income families remain eligible for much of their childhood. Despite frequent but temporary income fluctuations, the lowest income families whose children rely on Medicaid have significantly less income mobility than higher income families. Between 1975 and 2011, when overall family income increased by an average of 37 percent, family income actually declined for the poorest one-third of children.⁴⁰ Of all children currently covered by Medicaid or CHIP, nearly 80 percent have a median income of less than 149 percent FPL (\$38,144 for a family of four)—well below the median upper income limit of 255 percent FPL (\$67,575 for a family of four) for both programs.^{41, 42} These data suggest that very few children in Medicaid are likely to become income-ineligible.



Permit multi-year coverage for young children via a state plan option.

The science is strikingly clear—early childhood is the most critical developmental period in a child’s life, building a lifelong foundation for learning, behavior, and health. Continuous coverage for young children promotes consistent access to health care and the preventive services needed to identify and address physical, behavioral, and developmental concerns before they impede a child’s performance in school. Thus, health and school readiness are inextricably linked, which is why Head Start Program performance standards require that each enrolled child has a source of continuous health care and health insurance coverage.⁴³ As the primary source of health coverage for young children—serving four out of every five children under age six living in poverty—Medicaid has a key role to play in assuring school readiness, which is a predictor of success in school and beyond.⁴⁴



Create a state plan option to provide 12-month continuous eligibility to adults.

Ideally, all individuals in Medicaid and CHIP should receive continuous coverage no matter where they live. As an incremental approach, states should be given the option to cover adults for a full year through a state plan option. Allowing states to provide 12-month continuous eligibility for adults will also reduce administrative burden by aligning enrollment policies between children and parents.



Extend continuous coverage requirements for pregnant enrollees in Medicaid and CHIP from 60 days to one year post pregnancy.



Maternal mortality and morbidity are shockingly far worse in the United States (U.S.) than all other developed countries, and wide racial and ethnic disparities exist.⁴⁵ Women face considerable risks to their health and life during the postpartum period with one-third of pregnancy-related deaths occurring postpartum.⁴⁶ Extended postpartum coverage allows mothers to better manage their own health and build strong relationships with their infants, which is critical for their child’s healthy social and emotional development.⁴⁷ ARPA is a good start allowing states the flexibility extend postpartum coverage for a full year. However, as seen with other state options, it may not be enough to ensure uniform adoption across the states. To assure access to services across all states without imposing an unfunded mandate, the Medicaid and CHIP Payment and Access Commission (MACPAC), in its March 2021 report, urged Congress to require all states to extend the postpartum period 12 months with 100 percent federal financing.⁴⁸



Align Medicaid and CHIP Policy.



The CHIP statute does not allow states to establish eligibility standards or premium and cost-sharing structures that favor children in higher income families.⁴⁹ But unlike Medicaid, CHIP programs are not required to direct families to report changes between renewals, which contributes to churn.⁵⁰ Current law also allows states to provide more favorable treatment of higher income children by permitting CHIP to provide 12-month continuous eligibility without adopting similar policies for lower income children in Medicaid. As noted above, ARPA recognizes the importance of aligning extended postpartum coverage in both Medicaid and CHIP, a concept that should be applied to continuous eligibility for children. If states want to adopt policies that promote continuity of coverage for children in CHIP, they should be required to do so for children in Medicaid. Families will also obtain the full benefit of ongoing and coordinated access to health care if enrollment policies are aligned between children and parents.

Improve Retention of Coverage at Renewal

Continuous eligibility for a full year does not protect eligible individuals from a loss of coverage at renewal. To ensure ongoing coverage for enrollees who remain eligible, states should take steps to minimize the loss of coverage at renewal due to procedural (“red-tape”) reasons.



Increase the share of enrollees who are successfully redetermined at renewal using ex parte and other data driven processes without requiring families to take action.

Some states report they are able to renew coverage automatically for a majority of enrollees, while other states report that only a small share of renewals are successfully determined via ex parte processes. Best practices include expanding data sources and exploring eligibility system changes that will increase the share of beneficiaries renewed automatically.⁵¹ Additionally, states have the option to use Express Lane Eligibility (ELE) to renew Medicaid and CHIP for children based on the data obtained through other public benefits such as the Supplemental Nutrition Assistance Program (SNAP). Coordinating Medicaid with other benefits reduces the administrative burden on state agencies and families, and assures that eligible families continue to receive the public benefits that support healthy families. Congress could also take steps to incentivize states to achieve specific performance standards on renewal related data, such as a specified threshold of ex parte and data-driven renewals, through an enhanced administration Federal Medicaid Assistance Percentage (FMAP) or performance payment.



Improve beneficiary communications and follow-up to promote retention.

There are numerous strategies states can deploy to improve retention of coverage for eligible individuals when ex parte processes are unsuccessful. Encouraging enrollees to use online accounts, maximizing the use of cost-effective electronic communications, following up with people when action is needed to maintain coverage, allowing adequate time to provide information or proof of eligibility, and improving the readability of notices are among the many steps that can be taken to improve retention.



Boost consumer assistance at the state and community-level.

States are required to provide consumer assistance in person and over the phone at application and renewal.⁵² Too often, especially during peak workloads, state call centers lack the capacity to provide timely assistance and enrollees encounter long wait times resulting in high call abandonment rates. States are also required to outstation eligibility workers to assist with applications, but not renewals, at all or most disproportionate share hospitals and federally qualified health centers, and have the flexibility to establish other outstation locations where potentially eligible pregnant women or children receive services.⁵³ Outstationing could be expanded to include assistance with renewals. Additionally, states could pick up the option to establish certified application counselor programs to provide consumer assistance at community-based organizations, an approach that is more likely to be successful in reaching targeted populations. Lastly, Congress should permanently fund and expand the CHIPRA outreach and enrollment grants that are intended to provide critical support for the effective and targeted strategies needed to enroll and retain eligible children.⁵⁴

Take proactive steps to update mailing addresses.

Low-income individuals and families are more likely to experience housing instability and face barriers in keeping their mailing addresses up-to-date. With current issues facing the U.S. Postal Service, mail is often delayed, particularly if the individual has filed a change of address form to have mail forwarded to a new address. This is acutely problematic when states limit the response time for individuals to update their mailing address to 10 days. Some states go so far as to interpret current regulations to allow the disenrollment of an individual when a single piece of mail is returned and make no further attempt to locate the individual. States should be required to take steps to keep mailing addresses up-to-date and to locate the individual through other means (e.g., electronic communications or phone call) when mail is returned. While most states offer online accounts that allow enrollees to report changes electronically, other options also exist. These include giving enrollees 30 days to verify their new address, providing online forms or interactive voice response systems to simplify reporting of address changes, engaging MCOs in keeping addresses current, and identifying changes through the U.S. Postal Service Change of Address Database (USPS NCOA).

Adopt Administrative Actions that Promote Continuity of Coverage between Renewals

The ACA was intended to improve continuity of coverage by adopting annual renewal periods and eliminating unnecessary paperwork for states and enrollees, and by using technology to verify eligibility electronically. But without continuous eligibility, states must process changes in circumstances that may impact eligibility, even if they are temporary. Moreover, states are not restricted from aggressively trying to identify data discrepancies through electronic data searches that are known to accelerate churn.

Adopt policies to smooth out income fluctuations.

States have the option to take into consideration reasonably predictable income variability such as seasonal employment for both new applicants and current enrollees. As a starting point, states need to prompt applicants and enrollees to report anticipated income changes so they can be dealt with appropriately. States also have the option to keep beneficiaries enrolled until the end of the calendar year following a change in income if annual projected income remains under the Medicaid limit. In addition to smoothing out temporary fluctuations in income, extending coverage to the end of the calendar year can provide time for individuals to obtain other coverage. This is particularly important for enrollees who may have to meet a waiting period before becoming newly eligible for employer-based health insurance.

Eliminate or disallow periodic data checks.

Although states cannot conduct full renewals more than once a year, they may take actions to identify changes or discrepancies in eligibility data between renewals. This approach was encouraged by the Trump Administration at a time when child enrollment in Medicaid and CHIP declined and the uninsured rate for children began to rise after more than a decade of progress.⁵⁵ Conservative interests also have been pushing model state legislation that creates duplicative eligibility data collection systems to identify data discrepancies that inevitably increase administrative costs and escalate churn.⁵⁶ Such actions are specifically intended to erect administrative burdens, and often limit response times to 10 days, making it difficult for low-income families to maintain continuity of coverage and access to health care.⁵⁷

Promote continuity of coverage when processing changes in circumstances.

When processing a change in circumstances, states have the option to push out renewal dates if other eligibility criteria is not subject to change (e.g., citizenship or date of birth) or can be reverified without requesting information from the enrollee. States also have the flexibility to extend a 90-day reconsideration period when an individual does not respond to a request for information when the state has identified such a change. This allows the individual to provide proof of eligibility or other required information without having to submit a new application.

Improve Retention-Related Data Collection and Transparency



Develop a standardized methodology for estimating the cost of 12-month continuous eligibility.

State-level data is often inadequate to take into consideration all of the factors needed to project the cost of continuous eligibility. Even with dependable data, eligibility and enrollment expertise is essential to accurately analyzing the data to estimate the cost of continuous eligibility. Fiscal notes associated with proposed state-level legislation to adopt continuous eligibility have often over-estimated the cost, thereby discouraging adoption of the policy. Addressing data deficiencies and developing a standardized methodology would ensure that estimates of the cost of continuous eligibility are reliable.



Develop and standardize measures of churn and retention rates.

Currently, there are no standardized measures of retention, churn, or continuity of coverage in Medicaid.



Researchers must conduct extremely complex analyses of enrollment data on a month-to-month basis in order to identify gaps in continuous enrollment. Standardized measures are needed to assess the extent to which churn drives up administrative costs and undermines access to timely and appropriate health care for eligible beneficiaries.



Improve and report retention-related performance indicators.

As a condition of enhanced federal funding to support Medicaid IT systems, states are required to have the ability



to produce specific data or performance indicators that are necessary for oversight, administration, evaluation, integrity, and transparency.⁵⁸ Currently, the performance indicators differentiate disenrollment data when ineligibility is established versus when ongoing eligibility could not be established (i.e., procedural reasons). States are also expected to report specific eligibility change reasons through the federal Transformed Medicaid Statistical Information System (T-MSIS); however, these data are not currently included in the T-MSIS analytic files that are available to researchers. A starting point is public reporting of disenrollment reason codes that can be used to monitor trends and pinpoint ways to improve retention.⁵⁹ Tracking reasons of ineligibility such as aged out or moved out of state is fairly straightforward if states take care to accurately record the reason. These data are important to understanding retention and estimating the cost of continuous eligibility.

To address churn, however, it is important to identify the underlying reasons why procedural disenrollments occur. According to the T-MSIS data dictionary, states report three eligibility change reasons associated with non-eligibility related procedural disenrollments: missing verification, nonpayment of premium, and lack of response. If a large share of disenrollments is due to missing verifications, the state should explore ways to improve data sources and ex parte processes. If a large share of individuals did not respond to a request for information, the state should examine whether or not notices are easy to understand and test different strategies to see if reminder notices, enrollee outreach, or more time to respond will improve the response rate. Surveys of recently disenrolled people can help identify actions the state can take to remove barriers, reduce churn, and improve retention. Additionally, the T-MSIS eligibility reason codes should be expanded to assess the extent that returned mail has led to the disenrollment.



Expand the definition of an eligibility error to include state disenrollment of eligible individuals.

The Payment Error Rate Measurement program (PERM) is the federal process for auditing eligibility and improper



payments in Medicaid. Currently PERM identifies payment errors when an ineligible individual is enrolled or there is insufficient documentation to confirm how eligibility was determined. However, disenrolling an eligible individual (as well as denying new applicants erroneously) should also be an administrative error. States are more likely to take additional steps to make sure an eligible individual is not denied or disenrolled from coverage if such actions would increase the state's eligibility error rate. While inaccurate eligibility denials or disenrollments do not result in improper payments, they do call into question the reliability of the eligibility process and whether states are providing the coverage that Medicaid guarantees to eligible individuals.



Conclusion

Continuous coverage drives more efficient health care spending and improves health status and well-being. Gaps in coverage are associated with financial exposure for the family, and disrupt access to needed care for children and adults. A majority of states have adopted at least one of the limited options to provide 12-month continuous eligibility but guaranteeing full-year coverage for all children in Medicaid and CHIP and full-year post-pregnancy coverage would extend these benefits to children and pregnant women regardless of where they live.⁶⁰ Allowing states to offer continuous coverage to adults and extend multi-year continuous coverage to young children through a simple SPA process would encourage states that are interested in improving continuity of coverage to move forward.

As the state Medicaid agencies prepare for resuming normal operations in advance of the end of the COVID public health emergency, it is an ideal time for states to strengthen continuity of coverage by taking up available opportunities to adopt continuous eligibility. It is also a good time for Congress to consider how it can strengthen continuity of coverage and for CMS to consider how best to use its rulemaking or waiver authority to further support state efforts to promote continuous coverage.

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Recommendations to Promote Medicaid Continuity of Coverage

Expand Continuous Eligibility Policies			
Policy	State	CMS/Administration	Congress
12-month continuous eligibility for children	<ul style="list-style-type: none"> Adopt state option 		<ul style="list-style-type: none"> Enact a federal requirement for 12-month continuous eligibility for children
Multi-year continuous eligibility for children	<ul style="list-style-type: none"> Apply for section 1115 waiver Adopt state option, if enacted by Congress 	<ul style="list-style-type: none"> Provide expedited section 1115 waiver template 	<ul style="list-style-type: none"> Enact a state option
12-month continuous eligibility post-pregnancy	<ul style="list-style-type: none"> Adopt new state option 	<ul style="list-style-type: none"> Provide guidance on using CHIP Health Services or section 1115 authority to extend postpartum coverage under emergency Medicaid and unborn child eligibility pathways Approve section 1115 waivers to extend postpartum coverage only if they are as expansive as state option 	<ul style="list-style-type: none"> Enact a requirement for 12-month postpartum coverage for all pregnancies covered by Medicaid and CHIP (adults, emergency Medicaid, CHIP unborn child) Provide a higher match for mandatory postpartum coverage Remove the five-year sunset on new state plan option that becomes effective April 2022
Requirement or state option for 12-month continuous eligibility for adults	<ul style="list-style-type: none"> Apply for section 1115 waiver Adopt state option, if enacted by Congress 	<ul style="list-style-type: none"> Expedite approval of state section 1115 waivers, if state requirement or option is not enacted 	<ul style="list-style-type: none"> Require states to provide 12-month continuous eligibility for everyone Alternatively, enact a state option allowing states to provide 12-month continuous eligibility for adults
Align Medicaid and CHIP policies	<ul style="list-style-type: none"> Align continuous eligibility and procedures in Medicaid and CHIP 		<ul style="list-style-type: none"> Require states to adopt 12-month continuous eligibility for children in Medicaid if adopted in CHIP
Improve Retention of Coverage at Renewal			
Improvement	State	CMS/Administration	Congress
Increase share of data-driven and ex parte renewals	<ul style="list-style-type: none"> Work with IT vendors to expand data sources and increase share of renewals successfully processed via ex parte Adopt express lane eligibility to facilitate renewals for children using SNAP or other public program data 	<ul style="list-style-type: none"> Share best practices for achieving high rates of ex parte renewals Add the share of ex parte renewals to state performance indicators and report publicly Provide guidance to states on ways to align renewal dates for all members of the family 	<ul style="list-style-type: none"> Require states to adopt express lane eligibility and/or other streamlined eligibility procedures which are currently a state option Provide states that use the express lane option in Medicaid and CHIP with an enhanced administrative FMAP to incentivize use Require the use of express lane eligibility in Medicaid if used in CHIP Provide states that meet a certain threshold of total ex parte renewals or increase their ex parte renewals by a certain threshold with an enhanced administrative FMAP
Beneficiary communications and follow-up	<ul style="list-style-type: none"> Send follow-up reminders via different modes (text, email, phone) when information is required at renewal Offer robust and encourage use of online accounts and mobile applications for beneficiaries to help manage their information Take steps to increase the number of enrollees actively using their account Work with stakeholders to improve notices Comply with federal rules regarding use of plain language Provide notices in required languages Ensure access to translation services in call centers 	<ul style="list-style-type: none"> Work with states to provide model notices Ensure that state notices meet requirements for plain language and translations 	<ul style="list-style-type: none"> Establish statutory minimums for beneficiary follow up for disenrollments (and denials) related to procedural issues Require state notices to meet certain minimums to ensure they are sufficiently tailored and individualized as appropriate Provide states with an enhanced administrative FMAP if they reduce procedural denials by a certain threshold
Consumer Assistance	<ul style="list-style-type: none"> Ensure that call center and eligibility staff have been trained on cultural competency Establish and fund certification application counselor programs Expand outstationed eligibility sites and incorporate assistance at renewal 	<ul style="list-style-type: none"> Report state call center performance indicators on call volume wait times, and abandonment rates Issue guidance on best practices in following up with enrollees when renewal information is needed 	<ul style="list-style-type: none"> Require a Government Accountability Office report on state compliance with outstationed eligibility workers requirements. Add a statutory requirement to add assistance at renewal to outstationing requirements. Expand and permanently fund outreach and enrollment grant funding



Recommendations to Promote Medicaid Continuity of Coverage (cont'd)

<i>Improve Retention of Coverage at Renewal (cont'd)</i>			
Improvement	State	CMS/Administration	Congress
Update mailing address	<ul style="list-style-type: none"> Use the USPS National Change of Address (NCOA) database to identify address changes Work with MCOs and providers to keep mailing addresses up to date Provide simple tools for easy reporting of address changes through online forms or interactive voice response system Take steps to connect beneficiaries via text, email or phone when mail is returned 	<ul style="list-style-type: none"> Issue guidance to states on best practices in keeping addresses current Issue guidance on acceptable sources of verifying updated addresses (e.g., MCOs, USPS NCOA, providers, navigators, etc.) Issue guidance on sources of address changes that do not require verification 	<ul style="list-style-type: none"> Require a Government Accountability Office report on the impact of returned and delayed mail on continuity of coverage
Adopt Administrative Actions that Promote Continuity of Coverage between Renewals			
Action	State	CMS/Administration	Congress
Income Fluctuations	<ul style="list-style-type: none"> Ensure that applications and eligibility processes can capture anticipated changes in income Adopt option to use annual income through calendar year-end when processing changes 	<ul style="list-style-type: none"> Provide technical assistance to states in smoothing out the income of temporary income fluctuations 	
Periodic data checks	<ul style="list-style-type: none"> Reduce churn by eliminating or limiting periodic data checks Align response times for all requests for information with the 30-day response requirement for renewals Send follow-up notices if periodic data checks are conducted 	<ul style="list-style-type: none"> Update rulemaking to align response times for all requests for information with the 30-day response requirement for renewals 	
Promote continuity of coverage when processing changes in circumstances	<ul style="list-style-type: none"> Push out renewal dates if all eligibility criteria can be verified without requesting additional information Offer a 90-day reconsideration period if individual does not respond to a request for information following a change in circumstances 	<ul style="list-style-type: none"> Require states to extend out renewal dates when processing a change in circumstances, if other eligibility criteria can be confirmed or is not subject to change Update rules to require a 90-day reconsideration period for processing requests for information following a change in circumstances 	
Improve Retention-Related Data Collection and Transparency			
Improvement	State	CMS/Administration	Congress
Estimating the cost of continuous eligibility policies	<ul style="list-style-type: none"> Consider all relevant factors when estimating the cost of continuous eligibility 	<ul style="list-style-type: none"> Work with researchers to develop a standardized methodology for estimating the cost of continuous eligibility 	
Standardized measures of churn and retention	<ul style="list-style-type: none"> Quantify and report churn in between renewals Quantify and report retention rate at renewal 	<ul style="list-style-type: none"> Work with measure developers and stewards to create standardized measures Incorporate churn and retention measures into performance indicators 	<ul style="list-style-type: none"> Require states to report churn and retention rates and the Secretary of HHS to publicly release state-by-state statistics (on a quarterly and annual basis)
Enrollment and retention-related performance indicators	<ul style="list-style-type: none"> Collect, report, and make publicly available all performance indicator data 	<ul style="list-style-type: none"> Add returned mail/unable to locate as a T-MSIS eligibility change reason Include eligibility change reasons in published T-MSIS research files Report all state Medicaid performance indicator data on a monthly basis 	<ul style="list-style-type: none"> Require state T-MSIS report and for the Secretary to issue regular enrollment and eligibility T-MSIS data reports
Define inaccurate disenrollments as eligibility errors		<ul style="list-style-type: none"> Revise PERM regulations to treat inaccurate disenrollments (and denials) as an eligibility error 	



Appendix Table 1. States With 12-Month Continuous Eligibility in Medicaid and/or CHIP

State	12-Month Continuous in Medicaid	12-Month Continuous in CHIP	12-Month Continuous in Medicaid or CHIP
TOTAL	24	25	32
Alabama	X	X	X
Alaska	X	N/A (M-CHIP)	X
Arizona			
Arkansas		X	X
California	X	N/A (M-CHIP)	X
Colorado	X	X	X
Connecticut			
Delaware		X	X
District of Columbia		(N/A M-CHIP)	
Florida	Under age 5	X	X
Georgia			
Hawaii		(N/A M-CHIP)	
Idaho	X	X	X
Illinois	X	X	X
Indiana	Under age 3	Under age 3	
Iowa	X	X	X
Kansas	X	X	X
Kentucky			
Louisiana	X	X	X
Maine	X	X	X
Maryland		(N/A M-CHIP)	
Massachusetts			
Michigan	X	N/A (M-CHIP)	X
Minnesota		(N/A M-CHIP)	
Mississippi	X	X	X
Missouri			
Montana	X	X	X
Nebraska		(N/A M-CHIP)	
Nevada		X	X
New Hampshire		(N/A M-CHIP)	
New Jersey	X	X	X
New Mexico	X	N/A (M-CHIP)	X
New York	X	X	X
North Carolina	X	X	X
North Dakota	X	N/A (M-CHIP)	X
Ohio	X	N/A (M-CHIP)	X
Oklahoma		(N/A M-CHIP)	
Oregon	X	X	X
Pennsylvania	Under age 4	X	X
Rhode Island		(N/A M-CHIP)	
South Carolina	X	N/A (M-CHIP)	X
South Dakota			
Tennessee		X	X
Texas		X	X
Utah		X	X
Vermont		(N/A M-CHIP)	
Virginia			
Washington	X	X	X
West Virginia	X	X	X
Wisconsin			
Wyoming	X	X	X

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2020. Data on South Carolina is based on the 2019 survey.



About this Series

This issue brief is tenth in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. Other briefs in the series include:

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[The Future of Children's Coverage: Children in the Marketplace](#). *Focuses on ways to improve marketplace coverage and the associated financial assistance for children.* (June 2016)



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- ⁴⁴ Wright Burak, E., "Promoting Young Children's Health Development in Medicaid and the Children's Health Insurance Program (CHIP)" (Washington DC: Georgetown Center for Children and Families, October 2018), available at <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>.
- ⁴⁵ "Maternal Mortality," National Center for Health Statistics, U.S. Centers for Disease Control and Prevention, available at <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.
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- ⁴⁷ "Young Children Develop in an Environment of Relationships," National Scientific Council on the Developing Child (Working Paper, October 2009), available at <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2004/04/Young-Children-Develop-in-an-Environment-of-Relationships.pdf>.



⁴⁸ Medicaid and CHIP Payment and Access Commission, “Report to Congress on Medicaid and CHIP” (Washington DC: Medicaid and CHIP Payment and Access Commission, March 2020), available at <https://www.macpac.gov/wp-content/uploads/2020/03/March-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.

⁴⁹ “Prohibited eligibility standards. In establishing eligibility standards and methodologies, a State may not—cover children with a higher household income without covering children with a lower household income within any defined group of covered targeted low-income children.” See 42 C.F.R. 457.320(b)(1) (2016); “General cost-sharing protection for lower income children. The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on household income only in a manner that does not favor children from families with higher income over children from families with lower income.” See 42 C.F.R. 457.530.

⁵⁰ “If the State requires reporting of changes in circumstances that may affect the enrollee’s eligibility for child health assistance, the State must: (a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and (b) Promptly redetermine eligibility when the State has information about these changes.” See 42 C.F.R. 457.960.

⁵¹ Wagner, J., “Streamlining Medicaid Renewals Through the Ex Parte Process” (Washington DC: Center on Budget and Policy Priorities, March 2021), available at <https://www.cbpp.org/research/health/streamlining-medicicaid-renewals-through-the-ex-parte-process>.

⁵² 42 C.F.R. 435.908 (2013)

⁵³ 42 C.F.R. 435.904 (1994)

⁵⁴ For more information on CHIPRA outreach and enrollment grants, see <https://www.insurekidsnow.gov/campaign-information/outreach-enrollment-grants/index.html>.

⁵⁵ Brooks, T., Park, E., and Roygardner, L., “Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again” (Washington DC: Georgetown University Center for Children and Families, May 2019), available at <https://ccf.georgetown.edu/2019/05/28/medicaid-andchip-enrollment-decline/>; Alker, J. and Corcoran, A., “Children’s Uninsured Rate Rises by Largest Annual Jump in More than a Decade” (Washington DC: Georgetown University Center for Children and Families, October 2020), available at https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.

⁵⁶ The Foundation for Government Accountability has been pushing model legislation that requires states to contract with third party vendors to establish duplicative eligibility verification systems and conduct frequent searches for data to identify discrepancies in eligibility data. For more information, see <https://www.vox.com/policy-and-politics/2019/9/4/20835692/conservative-think-tank-foundation-for-government-accountability-food-stamps-snap-poverty-welfare>.

⁵⁷ Herd, P. and Moynihan, D., “Administrative Burden: Policymaking by Other Means” (New York: Russell Sage Foundation, 2018).

⁵⁸ “Overview of the Medicaid and CHIP Eligibility and Enrollment Performance Indicators,” Centers for Medicaid and CHIP Services Medicaid and CHIP Learning Collaborative, September 2015, available at <https://www.medicicaid.gov/medicaid/downloads/overview-of-performance-indicator-project.pdf>.

⁵⁹ Harrington, M., Trenholm, C., and Snyder, A., “Using Data to Drive State Improvement in Enrollment and Retention Performance” (Mathematica Policy Research, National Academy for State Health Policy, and the Robert Wood Johnson Foundation, November 2011), available at <https://www.rwjf.org/en/library/research/2011/11/using-data-to-drive-state-improvement-in-enrollment-and-retentio.html>; Harrington, M., Trenholm, C., and Snyder, A., “New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance” (Mathematica Policy Research, National Academy for State Health Policy, and the Robert Wood Johnson Foundation, October 2012), available at <https://www.mathematica.org/download-media?MediaItemId=%7BD0A20EFB-CF70-4A89-9D2C-E2AC4D533217%7D>.

⁶⁰ Brooks, T. et al., op cit.