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Unwinding the Medicaid Continuous Coverage Requirement

Frequently Asked Questions

By Suzanne Wikle, Center for Law and Social Policy and Jennifer Wagner, Center on Budget and Policy Priorities

1. What is the Medicaid “continuous coverage” requirement?

In March 2020, as part of COVID-19 relief legislation, Congress provided increased Medicaid funding to states. States had to meet several conditions to receive the federal funds, collectively called a Maintenance of Effort (MOE) requirement, as well as a “continuous coverage” requirement that prohibits states from terminating most Medicaid enrollees’ coverage until after the public health emergency (PHE) ends, as determined by the U.S. Department of Health and Human Services.

During the PHE, Medicaid agencies can’t disenroll anyone from Medicaid unless they ask to be disenrolled, move out of state, or die. Continuous coverage has allowed millions of people to stay covered without any interruption during the pandemic — and it’s a major reason why there hasn’t been an increase in the uninsured rate during the pandemic.

The PHE is expected to end in mid-July, in which case the continuous coverage requirement would end July 31, 2022. When the requirement ends, states will begin the process of “unwinding” and reviewing all their enrollees’ eligibility for Medicaid.

2. What does “unwinding” the continuous coverage requirement mean?

“Unwinding” is the process by which states will resume annual Medicaid eligibility reviews after the PHE ends. Medicaid agencies should first attempt to complete an automated renewal based on information available to them — some as wage information from state databases or information in Supplemental Nutrition Assistance Program (SNAP) files. If that is not possible, agencies then send renewal notices and requests for information to enrollees. When enrollees respond, agencies will process the cases, renew coverage for those who remain eligible, and notify those who are no longer eligible that their coverage will end. If enrollees don’t respond, because they don’t get the request for information due to having changed their address or phone number, or they don’t understand what they are supposed to do, for example, their coverage will end.

Guidance [documents](#) from the Centers for Medicare & Medicaid Services (CMS) give states an unwinding period of up to 12 months to initiate renewals for all enrollees.¹ States can't take negative action based on older information the state may have obtained during the PHE. CMS has issued extensive guidance² and other materials that lay out best practices for states to consider when unwinding.³

3. When will states begin to unwind continuous coverage?

The timing of unwinding remains unclear. States can't disenroll enrollees until after the PHE ends (unless they choose to give up the enhanced federal medical assistance percentage, or FMAP — the 6.2 percentage point increase in the share of Medicaid costs paid by the federal government — associated with the continuous coverage requirement). The PHE has been extended numerous times due to the ongoing pandemic. The federal government has pledged to give states at least 60 days' notice before the end of the PHE. The current PHE expires in mid-April but is expected to be extended at least once more and then to expire by mid-July. If that occurs, states would begin to unwind and enrollees could lose coverage as soon as August 1, 2022.

4. What challenges will enrollees face in the unwinding of continuous coverage?

As states unwind, millions of people, including large numbers who are still eligible for Medicaid, could lose their coverage and become uninsured or experience gaps in coverage. Ending continuous coverage and reinstating renewals for Medicaid enrollees raises challenges for enrollees, including:

- **Knowing they must complete a renewal.** Some enrollees may have moved during the pandemic and won't receive notice that their renewal is due if they have not updated their mailing address or other contact information with the state.
- **Completing the renewal.** Renewal forms are often confusing and action steps for enrollees may not be clear. Further, not all states allow enrollees to complete their renewal online or over the phone.
- **Transitioning to other coverage.** Those no longer eligible for Medicaid may not know they can obtain coverage through the Affordable Care Act marketplace, or they may not be aware of what steps they must take to enroll.
- **Dealing with loss of coverage.** Due to paperwork barriers and other challenges, many people who remain eligible will lose coverage, experience a gap, and have to reapply to return to Medicaid.

¹ Centers for Medicare & Medicaid Services, "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>.

² Centers for Medicare & Medicaid Services, "Coronavirus Disease 2019 (COVID-19)," <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/index.html>.

³ Centers for Medicare & Medicaid Services, "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>.

5. What challenges do states face with the unwinding of continuous coverage?

States will face a significant increase in workload as they begin the unwinding process. When the PHE ends, they will have to conduct renewals on their entire caseloads, and they may not be able to keep up with deadlines for processing paperwork. Call centers may be overwhelmed, leading to long wait times. Many agencies have experienced high staff turnover during the pandemic, resulting in understaffing and new staff who haven't had experience processing Medicaid renewals.

States also face challenges reaching Medicaid enrollees who have moved and/or changed their phone number during the pandemic.

As renewals get underway, many people who remain eligible but lose coverage for procedural reasons (such as not returning a renewal form) will reapply. This will create an uptick in applications that states need to process on top of their high workload from renewals.

6. What can enrollment navigators and assisters do to support Medicaid enrollees?

Navigators and assisters will be critical to helping people successfully renew their Medicaid coverage. They can:

- Help Medicaid enrollees update their current mailing address and phone number with the Medicaid agency even before the PHE ends. Depending on the state, this could be through an online portal or by contacting the call center.
- Inform Medicaid enrollees that they will have to renew their coverage in 2022 and that they should watch for mail from the Medicaid agency and respond to any requests on a timely basis. Navigators and assisters should consider proactively contacting people they have helped enroll in Medicaid coverage to inform them of this upcoming change.
- Assist Medicaid enrollees through their renewal process such as by helping them complete the renewal form, gather necessary documents, and resolve any issues that arise.
- Help people who are no longer eligible for Medicaid apply for marketplace coverage. People at all income levels will have 60 days after their loss of coverage to apply for marketplace coverage, even though the annual open enrollment period for 2022 plans has ended. People with income below 150 percent of the poverty line may enroll in marketplace coverage at any time, if their state uses HealthCare.gov (the federal marketplace). In states with their own exchanges, policies vary.

7. What are the key decisions states will make/are making?

States face many decisions as they prepare to unwind continuous coverage and reinstate Medicaid renewals, including:

- How they communicate to people about unwinding, including the need to update address and contact information.
- How they attempt to update contact information (address, phone, email) for Medicaid enrollees before the end of the PHE. States may take contact information from other programs, such as SNAP, that have had more recent contact with the enrollee. In addition, states may partner with managed care organizations (MCOs) and accept updated addresses from them.

- How long they will take to review eligibility for their caseloads. CMS is allowing states up to 12 months to initiate renewals for the entire caseload, but each state will determine its own timeline.
- How they will prioritize groups of enrollees for renewal. For example, whether they go alphabetically, by initial enrollment date, or start with populations that are more likely to have lost eligibility and defer populations that are most likely to remain eligible.

8. What questions should advocates be asking states?

Advocates can play a key role in ensuring that states take a strategic approach to unwinding continuous coverage and should prioritize engaging with their states to create an effective plan. For a comprehensive guide for advocates on unwinding, see Georgetown University’s Center for Children and Families’ publication.⁴ Issues to explore with the states include:

- What is the agency’s staffing plan for handling a large increase in casework, especially processing renewals and handling phone calls?
- Are there certain groups they plan to renew first?
- What is the state doing to collect and update new contact information for Medicaid enrollees before the PHE ends?
- Is the state partnering with MCOs to update enrollees’ contact information?
- Is the state partnering with other organizations, such as community health centers, to update enrollees’ contact information?
- What data will the state be tracking during the unwinding process? How will the data be shared with stakeholders?
- What is the state’s communication plan for informing advocates, providers, and other partners about the unwinding process?
- Will the state use the full 12 months allowed by CMS to initiate renewals?
- How will the state use information it already has from other programs (for example, SNAP) to keep eligible people enrolled?
- How will the state help people connect to other sources of coverage, such as the Children’s Health Insurance Program (CHIP) and marketplace plans?

⁴ Tricia Brooks and Allexa Gardner, “Unwinding the COVID Continuous Eligibility Requirement at the End of the Public Health Emergency: Tips for Advocates,” Georgetown University Health Policy Institute, Center for Children and Families, August 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/08/unwinding-phe-final.pdf>.

9. Who is at risk of losing Medicaid?

People often lose their coverage at the point of renewal, even when they remain eligible, due to burdensome processes and paperwork. The large number of cases that will need to be renewed in the months after the PHE ends puts many people at risk of losing coverage. People particularly at risk include:

- Those who have moved during the pandemic and have not updated their mailing address or other contact information with the state.
- Those who receive renewal information from the state but do not return it in time, perhaps because they are not familiar with the process after not completing a renewal in the past two years.

10. What should people do if they lose their Medicaid coverage?

Many people will lose their coverage because they don't complete the renewal process, though they remain eligible for Medicaid. Others will no longer be eligible for Medicaid but will be eligible for premium tax credits through the marketplace. If someone loses Medicaid coverage, they should:

- **Reapply for Medicaid if they think they are still eligible.** If they didn't complete all the steps required for the renewal and contact the state within 90 days of their Medicaid coverage ending, states must accept their renewal paperwork and process it without requiring a new application.
- **Enroll in health coverage through the marketplace.** Loss of Medicaid allows someone to enroll in marketplace coverage within 60 days after losing it, even if outside of the annual open enrollment period. People who are not eligible for Medicaid and whose income is at least 100 percent of the poverty line (or less than about \$13,000 for an individual) can qualify for subsidies to help pay premiums and reduce out-of-pocket costs. People with low incomes are eligible for significant assistance; in most cases they will be eligible for zero-premium plans.
- **Apply for CHIP.** Some children whose families may no longer be eligible for Medicaid may be eligible for CHIP. If a child loses Medicaid coverage, their guardians should apply for CHIP, which can be done directly with the state agency, the CHIP program, or through the marketplace. If the child is not eligible for CHIP, they are likely eligible for subsidized coverage through the marketplace.

Unfortunately, some people will lose Medicaid and not have a viable alternative for affordable health insurance because they live in one of 12 states that have not expanded Medicaid. These include young adults who have "aged off" Medicaid and because their state hasn't adopted the Medicaid expansion they don't qualify as an adult, parents with extremely low incomes who no longer have dependent children at home (and so no longer qualify for Medicaid under the "parent" category), and people who received Medicaid during their pregnancy but are past their state's postpartum eligibility timeline. People in these situations whose incomes are below the poverty line fall into the Medicaid "coverage gap." (To receive premium tax credits people must have income above the poverty line.)

Resources:

- Centers for Medicare & Medicaid Services – Unwinding and Returning to Regular Operations after COVID-19: <https://www.medicare.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>
- Center for Law and Social Policy – Advocacy Steps to Minimize Medicaid Coverage Losses when the Public Health Emergency Ends: <https://www.clasp.org/blog/advocacy-steps-minimize-medicare-coverage-losses-when-public-health-emergency-ends>