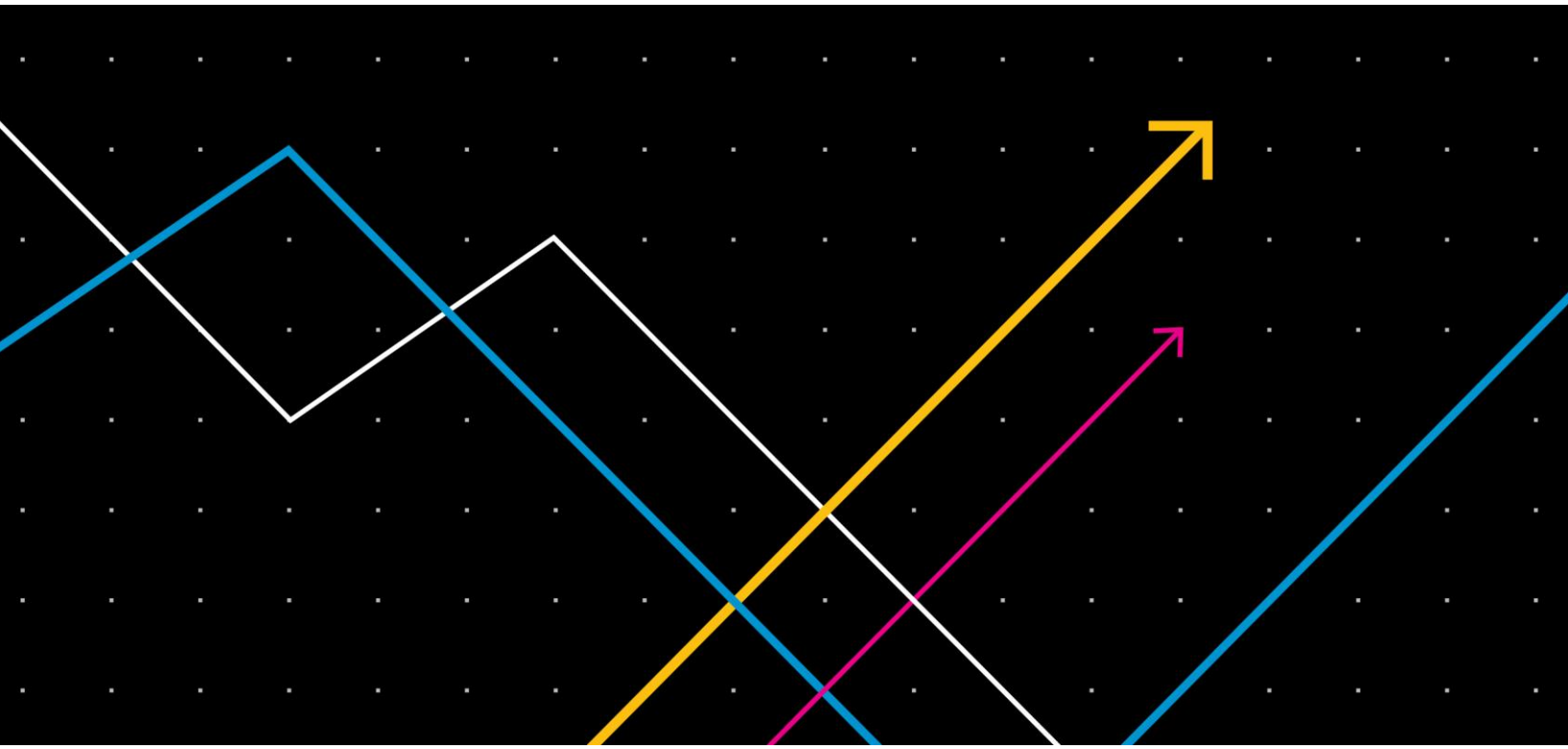

RESEARCH REPORT

Improving Medicaid/CHIP Redeterminations for Children

Lessons from Unwinding to Inform Federal and State Policy

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Contents

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Executive Summary

Federal rules require that enrollees in Medicaid and the Children's Health Insurance Program (CHIP) undergo periodic eligibility verifications to renew their coverage. Historically, children have been among the groups with the highest rates of "churn," defined as losing coverage at the time of renewal despite still being eligible and subsequently reenrolling (MACPAC 2021). During the COVID-19 pandemic, Medicaid churn was effectively eliminated as Congress enacted the Families First Coronavirus Response Act. The law prohibited Medicaid disenrollment during the public health emergency (PHE) for most enrollees, for which states received a higher federal matching rate. Consequently, between March 2020 and March 2023, states paused Medicaid eligibility renewals for all enrollees, and children's enrollment in Medicaid/CHIP grew by 7 million to 42 million (CMS 2023a). Starting in April 2023, states resumed processing renewals, known as "unwinding" the continuous coverage requirement. As of July 2024, net enrollment among children had fallen by more than 5.6 million,[1] with most losing coverage for procedural or administrative reasons, meaning Medicaid agencies could not verify their eligibility.[2]

Children's net enrollment declines varied widely by state; between the month each state resumed disenrollments and data available in July 2024, children's Medicaid/CHIP enrollment had declined by 15 percent or more in 20 states, while eight states had declines of less than 5 percent, with one state seeing a small enrollment increase.[3] States also varied widely in unwinding policies and practices, which built on existing variation in eligibility and enrollment systems and policy choices (Tolbert, Moreno, and Rudowitz 2023). Both unwinding-specific and long-standing policies may have affected the magnitude of enrollment declines experienced by different states.

Between September 2023 and June 2024, we interviewed 30 representatives of Medicaid agencies in eight states (Alabama, Connecticut, Illinois, Maryland, North Carolina, Ohio, Tennessee, and Washington). These states were selected based on either of two factors. First, the state was experiencing relatively low net enrollment declines for children compared to other states during unwinding based on available information early in 2024.[4] Second, the state was suggested by national stakeholders we interviewed as having adopted innovative practices or having helpful lessons on how to successfully support the retention of coverage for children covered by Medicaid. In addition, we considered study state diversity in terms of geography and Medicaid/CHIP policies. We also interviewed 40 stakeholders in those states—including provider and health plan representatives, consumer advocates, policy experts, enrollment assisters, and insurance navigators—to gather their perspectives on effective unwinding practices.[5] Overall, Medicaid officials indicated that relatively few

strategies and approaches were implemented with children specifically in mind, but because children represent a large share of Medicaid enrollees, many of the overall strategies states used affected children. State officials and key stakeholders identified the following approaches as key to minimizing unnecessary coverage losses among children:

1. a high-level commitment from state Medicaid officials with a **focus on planning and managing the unwinding process to minimize unnecessary coverage losses**
2. **effective eligibility and enrollment systems and processes** that maximize automated renewals, including building on prior investments in systems' improvements and compliance with federal rules
3. **vigorous, multimodal, and multitouch communications with enrollees** that rely on several data sources and strategies to obtain updated enrollee contact information
4. **strategic and wide-ranging partnerships** to inform state communications and outreach to enrollees and support direct assistance to enrollees from community-level grassroots organizations

Little research has specifically assessed the implications of unwinding for children's redeterminations, and the information we collected does not allow us to directly identify how individual unwinding approaches, federal flexibilities, or state policies contributed to minimizing inappropriate disenrollments among children during unwinding. The themes that emerged during interviews in study states suggest that a range of policies and strategies could reduce procedural churn and support continuous program enrollment among eligible children going forward. Based on the perspectives shared by key informants and findings from other research, we identified several priority actions for federal and state policymakers to consider to improve Medicaid redeterminations for children post-unwinding (see Appendix table 1 for more detail):

- **Federal policies and practices:**
  - » develop more detailed guidance on existing (and new) rules and strengthen federal oversight and enforcement strategies
  - » implement new policies and tools and increase technical support to states to enhance eligibility and enrollment systems
  - » permanently extend certain 1902(e)(14)(A) waivers, especially those related to renewals for families with low or no incomes or Supplemental Nutrition Assistance Program (SNAP) eligibility

- **State policies and practices:**
  - » implement available strategies that support children's coverage
  - » improve data systems, increase ex parte rates, align Medicaid and separate CHIP program enrollment processes, streamline transitions to Marketplaces, and develop data sharing with other programs like SNAP
  - » maintain policies adopted through 1902(e)(14)(A) waivers and implement additional related strategies as allowed by the Centers for Medicare & Medicaid Services
  - » conduct targeted outreach campaigns, continue to refine notices that go directly to enrollees, and use multiple communication modes to convey important information
  - » support ongoing partnerships with community partners, including enrollment assisters, and build on the momentum of the unwinding to connect eligible children to coverage

Improving Medicaid/CHIP Redeterminations for Children

Background

Medicaid and the Children's Health Insurance Program (CHIP) provide comprehensive health insurance coverage for children at higher income levels than other groups, with nearly all states offering coverage to children with family incomes over 200 percent of the federal poverty level (FPL); the median upper-income threshold for children is 255 percent of FPL (Brooks et al. 2024). Administrative data indicate that about half of the nation's children rely on Medicaid/CHIP for coverage, highlighting the programs' outsized opportunity to shape children's access to affordable health care and, ultimately, health outcomes.[6]

However, complicated enrollment and renewal processes have historically contributed to some eligible children remaining uninsured or losing coverage during redeterminations (Haley et al. 2021). Reasons could range from family income fluctuations to administrative challenges, such as confusing renewal notices, lost mail, and state processes, such as auto-closures. In 2018, before the COVID-19 public health emergency (PHE), 19 percent of children enrolled in Medicaid/CHIP were disenrolled within a year, including 8 percent who were disenrolled and subsequently reenrolled (MACPAC 2021**).** This suggests that nearly half of those who were disenrolled eventually returned to the programs. States also vary in how they have modernized and streamlined enrollment, renewal systems, and processes and the extent to which they have adopted policies to improve coverage continuity for children (Brooks, Roygardner, and Artiga 2019).

In response to the COVID-19 pandemic, Congress enacted the Families First Coronavirus Response Act in March 2020, which included a provision to maintain coverage for Medicaid enrollees through the end of the PHE as a condition for receiving enhanced federal matching funds. The requirement did not apply to separate CHIP programs but did apply to CHIP-funded Medicaid (M-CHIP).[7] Although some states continued reviewing eligibility and sending notices to enrollees throughout the PHE (but were not allowed to terminate coverage for anyone unless enrollees died, moved out of state, or asked to be disenrolled), others paused redeterminations altogether. During the continuous enrollment period from March 2020 to March 2023, children's enrollment in Medicaid/CHIP grew by 7 million to about 42 million, and uninsurance among children fell (Alker and Osorio 2023; CMS 2023a).

After three years, Medicaid began resuming routine operations in April 2023. States started renewing enrollees who remained eligible and disenrolling ineligible individuals and individuals for whom they could not verify eligibility through the renewal process. The Centers for Medicare & Medicaid Services (CMS) provided states with a range of temporary federal flexibilities to facilitate efficient renewals and protect eligible beneficiaries' coverage. These included tools available through 1902(e)(14)(A) waivers to minimize burdens for agencies and enrollees. However, the use of these strategies varied. Nearly all states and territories adopted at least one waiver, and some adopted up to 15. As of September 2024,

- 51 states and territories had adopted waivers to increase ex parte renewals,
- 46 states and territories had adopted waivers to update enrollee contact information,
- 31 states and territories had adopted waivers to help enrollees complete and submit forms, and
- 20 states (no territories) had adopted waivers to help individuals reenroll if they were disenrolled for procedural reasons.[8]

Nearly all states selected waivers designed to advance automated or "ex parte" renewals using available data, such as wage data, to assess and confirm ongoing eligibility without beneficiary action. Doing so reduces administrative burdens on both enrollees and state agency staff. Most states experienced increased rates of ex parte renewals after the start of the Medicaid unwinding; however, some states' rates remained below 50 percent.[9] CMS also provided states flexibility concerning managing renewal caseloads, such as when to begin unwinding, how much time they could use to complete the process, or how to prioritize renewals for various enrollees. Some states were also permitted to use 1902(e)(14)(A) waiver flexibility to push out children's redeterminations for another year, an option that Kentucky and North Carolina elected to adopt.

Unwinding of the Medicaid continuous coverage requirement created a heavy administrative workload on Medicaid and human services agencies, which are often understaffed and underresourced, causing widespread concerns about eligible enrollees losing coverage because of communication challenges and system glitches.[10] Millions of children were projected to lose Medicaid, with many at risk of becoming uninsured, because even though children are more likely than adults to remain eligible for public coverage, they are more likely than adults to be disenrolled for "procedural" reasons because of administrative barriers rather than lack of eligibility (Alker et al. 2024; Buettgens and Green 2022).[11] Differences in eligibility for children and adults, including higher income levels to qualify for Medicaid/CHIP coverage for children and state options to cover lawfully residing immigrant children, may lead to confusion among families about children's coverage.

In addition, the unwinding process revealed a lack of compliance with federal redetermination requirements in many states' systems and processes.[12] Some compliance issues disproportionately affected children. For instance, in August 2023, CMS announced that eligibility systems in 29 states were conducting ex parte renewals at the household rather than individual level, resulting in tens of thousands of enrollees being erroneously disenrolled, most of them children.[13] Coverage interruptions for children have consequences for access to and use of vital health services and can contribute to delays in health care receipt and unmet health needs, which, in turn, can also have long-term repercussions for children's growth and development (Center on the Developing Child 2010; Sugar et al. 2021).

As of July 2024, children's net enrollment in Medicaid/CHIP had fallen by over 5.6 million since the start of unwinding, though the magnitude of change ranged widely across states.[14] One analysis found that net enrollment declines relative to projections among children exceeded that for adults nationwide as of November 2023 (Buettgens et al. 2024). No definitive information is yet available to gauge how renewal outcomes and coverage have changed among children as states have completed unwinding. Available data suggest that the increases in Marketplace and separate CHIP enrollment among children are insufficient to compensate for Medicaid losses, but only limited data exists on changes in child enrollment in employer-sponsored insurance.[15] Early data available from national surveys have not yet clarified how the unwinding is affecting coverage for children (Cohen and Briones 2024), and because of data lags, it will not be until the second half of 2025 that national survey data will be available to assess the full unwinding period.

The following section provides more information on the national- and state-level interviews we conducted to surface promising approaches and strategies and inform future eligibility and enrollment policies for children and other enrollees nationwide.

Methods

Between September 2023 and November 2023, we conducted 10 interviews with national-level experts representing research and policy organizations, national provider and health plan organizations, health law organizations, and children's health advocates to assess the national landscape of unwinding for children. We then selected eight states (Alabama, Connecticut, Illinois, Maryland, North Carolina, Ohio, Tennessee, and Washington) for further study based on either of two factors. First, the state was experiencing relatively low net enrollment declines for children during unwinding based on available information early in 2024.[16] Second, the state was suggested by national

stakeholders we interviewed as having adopted innovative practices or having helpful lessons on how to successfully support the retention of coverage for children covered by Medicaid. We also considered other characteristics, such as variation in geographic region, Affordable Care Act Medicaid expansion status, Marketplace type (federally facilitated or state-based), and CHIP program type (M-CHIP, a separate CHIP program, or a combination of these), to gather perspectives from a wide range of states. Notably, Washington was included largely because they adopted multiyear continuous eligibility for children.[17] The state began implementing the continuous eligibility waiver while unwinding was underway, so the waiver likely impacted the number of disenrolled children. We excluded from consideration states with less experience with unwinding as of early 2024 (like Oregon, which started disenrollments later than other states). A snapshot of unwinding strategies and renewal outcomes related to children in the selected study states is shown in table 1.

TABLE 1

Medicaid Unwinding Policies and Outcomes Based on Data Available in September 2024, Study States

State	AL	CT	IL	MD	NC	OH	TN	WA
Month of first unwinding terminations	June 2023	April 2023	July 2023	May 2023	June 2023	May 2023	May 2023	June 2023
Estimated last month of unwinding terminations	June 2024	April 2024	July 2024	May 2024	Nov. 2024	April 2024	May 2024	May 2024
Caseload strategy	Processing renewals based on renewal month with likely ineligible individuals renewed in months 5–12	Processing renewals based on renewal month	Processing renewals based on renewal month	Prioritizing likely ineligible individuals in the first six months	Processing adult renewals based on renewal month. Delayed children's renewals for 12 months	Processing renewals based on renewal month while prioritizing renewals for likely ineligible individuals	Aligned renewal dates by household using the date of the individual with the latest renewal month	Prioritizing likely ineligible individuals in the first three months
Number of 1902(e)(14)(A) waivers adopted	6	5	5	11	11	7	15	5
Household ex parte issue identified	No	Yes	Yes	Yes	No	Yes	No	No
Percent of all people who retained Medicaid through ex parte processes as of September 2024	55%	81%	76%	74%	99%	65%	73%	89%
Procedural terminations as percent of all disenrollments as of September 2024	87%	72%	64%	72%	85%	70%	79%	85%

State	AL	CT	IL	MD	NC	OH	TN	WA
Procedural terminations as a percent of all completed renewals as of September 2024	29%	14%	13%	17%	11%	18%	32%	23%
Net child Medicaid enrollment change as of June–August 2024	-109.6K	-4.9K*	-66.1K	-43.9K	3.9K	-146.5K	-95.7K	-80.8K
Net child Medicaid enrollment change as of June-August 2024 (%)	-15.5%	-1.4%*	-4.4%	-5.8%	0.3%	-10.7%	-10.3%	-8.7%

Sources: Unwinding timeline: "Scheduled State Timelines for Completing Unwinding-Related Renewals," Medicaid.gov, May 2024.
Caseload strategy: Key informant interviews; "2023 State Timelines for Initiating Unwinding-Related Renewals as of June 2023," Medicaid.gov, accessed August 29, 2024; and "State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions Renewals," CMS, accessed August 29, 2024.
1902(e)(14)(A) waivers: "COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals," Medicaid.gov, accessed September 25, 2024.
Ex parte issue: "Preliminary Overview of State Assessments Regarding Compliance with Medicaid and CHIP Automatic Renewal," Medicaid.gov, accessed August 29, 2024.
Ex parte and procedural disenrollment rates: "Medicaid Enrollment and Unwinding Tracker," KFF, accessed September 25, 2024.
Child enrollment: "How Many Children Are Losing Medicaid?," Georgetown University Center for Children and Families, accessed September 25, 2024.

Note: In August 2024, CMS released guidance that all states must complete unwinding renewals by December 31, 2025. https://www.medicaid.gov/federal-policy-guidance/downloads/cib08292024.pdf

* The most recent data available for Connecticut is from April 2024.

Between September 2023 and June 2024, we interviewed 30 state Medicaid agency representatives from the eight study states. These interviews with state officials were supplemented by 19 interviews with 40 stakeholders, including provider and health plan representatives, consumer advocates, policy experts, insurance navigators, and other stakeholders (referred to below as other stakeholders) to gather on-the-ground perspectives on how unwinding was unfolding in respective study states and which policies or practices were viewed as most effective in protecting children's coverage. Interview topics included state preparations for the unwinding; implementation of federal and state policies; perspectives on which unwinding flexibilities seemed most effective; experiences with ex parte processes; outreach and communication efforts; assistance available to enrollees to navigate renewal processes; transitions to other coverage; and challenges, successes, and lessons for broader Medicaid/CHIP eligibility, enrollment, and redetermination policies.

The research team took detailed notes on each interview and recorded and transcribed interviews when study participants granted permission. Team members analyzed interview notes to determine common themes across respondents and identify key insights or variation in insights across states and interviewees. The findings described here reflect insights from both state Medicaid officials and other stakeholders; where the specific circumstances of a state were not directly relevant to an insight that emerged, we did not identify states to maintain the confidentiality of study participants. Finally, in addition to collecting respondents' perspectives on needed changes in ongoing renewal policies, we reflected on the unwinding experiences and lessons learned from the study states and other literature on Medicaid renewals to present our perspectives on implications for future federal and state policy and practice. The Urban Institute's Institutional Review Board reviewed and approved the research study protocols.

Limitations

Where applicable, we include information on how much the perspectives of state Medicaid officials were confirmed or challenged by other stakeholders in the state. However, we conducted a limited number of interviews with other stakeholders in each state; thus, some important perspectives and experiences may not be captured, and others may be overrepresented. Interviews in Washington state occurred in the fall of 2023, early in the unwinding period, while interviews in other states took place in the spring and early summer of 2024, with the latter states having more experience with unwinding. However, we contacted state officials in Washington again in late April 2024 to learn whether they had new insights to share or if any insights we had obtained had changed and incorporated that information into this report. In addition, we selected the study states based on analysis of available data in early

2024, suggestions from national stakeholders, and whether state Medicaid officials were willing to be interviewed for the study. However, we recognize that other states could have fit these criteria, and our findings could have been different had we focused on a different mix of states. Furthermore, the findings are limited to eight states and cannot be generalized to a national level, and because they represent insights shared before unwinding was completed, those may change as the process continues and concludes, and the views of key informants may shift. Therefore, our findings and conclusions should be interpreted with these limitations in mind.

Findings

Overall, Medicaid officials in the eight study states shared a range of factors they believed contributed to the successful retention of eligible children in Medicaid. Notably, they indicated that very few state strategies and approaches were deployed specifically with children in mind, but because children represent a large share of Medicaid enrollees, many of the overall strategies states used affected children. Medicaid officials believed that a combination of strategies and evidence-informed management of the unwinding process contributed to their relative success in protecting coverage among eligible children and adults during unwinding. Other stakeholders noted that while agencies' efforts in these states were associated with lower procedural disenrollments than initially feared, some challenges remained, and several key subgroups of children were particularly vulnerable to losing coverage, such as those living in families with literacy and language barriers or experiencing housing instability. In the following sections, we describe the common approaches, experiences, and perspectives of interviewees in our study states in four areas: (1) planning and management of unwinding, (2) eligibility and enrollment systems and policies, (3) communications with enrollees, and (4) coordination with and outreach by partner organizations.

Planning and Management of Unwinding

Medicaid officials in our study states described their approaches to planning and managing the unwinding process as comprehensive and proactive. According to the officials we interviewed, this included a long planning and preparation process, ongoing engagement with key stakeholders, reliance on available data, systems performance monitoring, and agility in responding to identified problems under unprecedented circumstances. Officials also noted that CMS' evolving guidance added to the complexity of managing the unwinding. Other stakeholders in most study states gave Medicaid agencies credit for increased engagement and transparency in the renewal process but also identified

problems families continued to face. Common unwinding approaches and strategies that were deemed as contributing to success from our study states included the following:

STRATEGICALLY SELECTING FROM AVAILABLE FEDERAL FLEXIBILITIES

The number of 1902(e)(14)(A) waivers adopted by our study states to facilitate unwinding ranged from five in Connecticut, Illinois, and Washington to 15 in Tennessee (table 1). Most waivers adopted in our study states focused on improving automated ex parte processes, with zero income and SNAP strategies reported as particularly helpful by Medicaid officials.[18] One official emphasized that "a big impact for the children was the flexibility to use SNAP eligibility as a proxy for Medicaid eligibility," and another pointed to tens of thousands of enrollees whose coverage was retained because of SNAP data matches. Data sources, such as the United States Postal Service (USPS) and the National Change of Address (NCOA) databases and managed care organizations' (MCOs) beneficiary contact lists, were frequently used to find contact information and were valued among our study states. Medicaid officials reported that they evaluated and selected from available options only those waivers that they thought would benefit them most and were feasible to implement. However, system and capacity limitations may have prevented some states from adopting more waivers, with some officials expressing they wish they had more time and capacity to implement additional strategies. Many also expressed hope that waiver flexibilities would be extended permanently, such as waivers to facilitate automatic renewals.

"I cannot state enough how much [automatic renewals for people with zero income] should be the norm."
—State Medicaid official

Medicaid officials in the study states also acknowledged data limitations in assessing which specific strategies had the greatest impact on maintaining coverage among all eligible enrollees. They hypothesized that likely a combination of policies and robust communications and outreach campaigns contributed to their success. Box 1 provides more details on select federal flexibilities most frequently cited as beneficial by Medicaid officials and other stakeholders familiar with these strategies.

"This was a mountain. Every little piece that we did helped with our numbers and performance. There wasn't a single thing that was it."
—State Medicaid official

"I can't say that we can point to you what was the secret sauce. Was it the unwinding lever? Or was it this comprehensive communication strategy? …[We] think all those things were synergistic in terms of some of the success."
—State Medicaid official

BOX 1

Description of 1902(E)(14)(a) Waivers That Study Participants Commonly Found Most Useful

Strategies to Increase Ex Parte Renewal Rates

- **Zero income strategy** allows state agencies to renew an individual without further action or documentation required from the enrollee if the agency previously determined the enrollee to have no income and no income data sources are returned as part of the ex parte renewal process. Medicaid officials in study states believed this strategy considerably increased their ex parte rates and reduced administrative burden for state workers and beneficiaries. Other stakeholders expressed strong support for all strategies that facilitate automatic renewals. We heard similar support for a related 1902(e)(14)(A) waiver for people with incomes below the federal poverty level (known as the 100 percent income strategy).
- **SNAP strategy** allows state agencies to automatically renew coverage for individuals eligible for SNAP without reverifying eligibility. Although the two programs differ in how income is considered, there is a significant overlap between Medicaid and SNAP eligibility. Medicaid officials believed this strategy was helpful and well-suited to be considered a permanent Medicaid policy. However, many also acknowledged that more consistent uptake and maintenance of both benefits could be achieved if eligibility rules for both programs were better aligned. Some advocates pointed out that because immigrant families, in particular, may be underrepresented among SNAP beneficiaries because of the chilling effects of anti-immigration policies, this strategy may not equally benefit all Medicaid beneficiaries.
- **Asset verification system strategy** allows state agencies to complete the ex parte renewal process without requesting further documentation from enrollees to verify their assets if the asset verification system does not return any information. Several study states that adopted this strategy found that it helped streamline automated renewals and reduced verification and documentation burdens. Notably, since most children qualify based on income and are not subject to asset tests, this would only directly affect some children qualifying for Medicaid on the basis of a disability. But this strategy may have also indirectly benefited other children since it reduced burdens on state and county caseworkers.

Strategies to Update Enrollee Contact Information

- **NCOA and/or USPS strategy and MCO beneficiary contact update strategy** allow states to accept enrollee contact information from USPS and NCOA databases and health plans as reliable without verifying the information with enrollees. Medicaid officials commonly reported that these sources were useful in updating enrollee records and reducing returned mail.

Strategies to Support Enrollees with Renewals to Reduce Procedural Terminations

- **Telephonic signature strategy** allows beneficiaries to verbally authorize their assisters to complete renewal forms over the phone. Officials in a couple of study states highlighted this strategy as effective in facilitating more hands-on assistance to enrollees from navigators and other community partners.

Sources: Key informant interviews in study states; "COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals," Medicaid.gov, accessed August 27, 2024; Kinda Serafi, Kaylee O'Connor, and Patricia Boozang, "Leveraging Section 1902(e)(14) Waiver Authority Amid Unwinding," State Health and Value Strategies, August 5, 2022; MaryBeth Musumeci, Molly O'Malley Watts, Meghana Ammula, and Alice Burns, "Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey," KFF, July 11, 2022; and "Available State Strategies to Minimize Terminations for Procedural Reasons During the COVID-19 Unwinding Period," Medicaid.gov, June 2023.
Note: MCO=managed care organization; USPS = United States Postal Service; NCOA = National Change of Address.

MAKING THOUGHTFUL DECISIONS ABOUT CASELOADS AND TIMELINES

Medicaid officials in several study states reported taking steps to minimize agency administrative burdens and processing errors, including the following:

- ***Allowing sufficient time for processing redeterminations***: All study states elected to use the full 12–14 months permitted by CMS to process renewals and redeterminations, which allowed flexibility to pause and fix issues and avoid overwhelming state systems.
- ***Reducing burdens on counties***: Two study states rely on county-based Medicaid administration systems. Ohio officials reported that maximizing ex parte processing allowed county caseworkers to focus on more complex cases. North Carolina Medicaid officials determined that most children would likely remain eligible and obtained a waiver from CMS to delay processing children's redeterminations for a full year to ease the burden on county workers who could focus on processing adult renewals while implementing Medicaid expansion for adults.
- ***Choosing caseload strategies to improve efficiency***: Officials in a few of the study states reported choosing to process renewals in enrollees' typical renewal month to spread the caseload more evenly across the year so that large shares of enrollees would not lose coverage simultaneously. Others chose to prioritize likely ineligible beneficiaries early or during certain months of the unwinding. Across the study states, procedural disenrollments were relatively low, suggesting that a thoughtful approach and preparations may have resulted in administrative efficiency while avoiding unnecessary coverage losses regardless of specific caseload strategy.

"From a foundational perspective, planning was key for us… [We] started having conversations to prepare for unwinding about 18 months in advance... there's a lot of work that underpinned all of this to really ensure all of our agencies were working in lockstep on these issues, which I think was really key to our success."
—State Medicaid official

DEPLOYING RESOURCES EFFICIENTLY

Medicaid officials in several states noted they used PHE relief funding to prepare for and manage the extraordinary demands of unwinding. In addition to supporting communication campaigns, resources were often used for process improvement and to hire and train additional caseworkers and call center staff. For instance, among other changes, Ohio's legislature appropriated $30 million to counties to support unwinding (Ohio Department of Medicaid 2024). In other states, officials indicated they used the pause in redeterminations during the PHE period to optimize eligibility and enrollment procedures and workflows.

REMAINING CHALLENGES

Despite careful preparations and additional investments, other stakeholders in some study states reported that additional staffing and system updates were insufficient to keep up with the high volume of renewals, resulting in long call center wait times and backlogs in processing renewal forms and new applications. For instance, one stakeholder referred to a requirement that enrollees update their address through local Departments of Health, which had backlogs even before unwinding began. They also shared that even permanent availability of federal unwinding flexibilities will not solve all challenges enrollees encounter. For instance, one stakeholder shared that though the SNAP flexibility is very helpful, if families face barriers to SNAP enrollment, like immigration restrictions or related barriers, that strategy alone will not help them retain Medicaid coverage.

"We did a lot of work on our system during the public health emergency. And some of it was to strategize for the end of the public health emergency…it did give us some time to shore up some things. We made changes to our redetermination process, like when we mail the form, when we prepare them for mailing to get ready for the unwinding…That way, we weren't delaying the mailing of our redetermination in order to get them printed."
—State Medicaid official

Eligibility and Enrollment Systems and Policies

Medicaid officials frequently pointed to the importance of high-functioning eligibility systems that are compliant with federal rules for maximizing the retention of eligible children during unwinding. Specifically, high rates of ex parte renewals were overwhelmingly credited as essential for reducing administrative burdens on both enrollees and state agency staff. In some states, the success of eligibility and enrollment systems was attributed to improvements done under pre-PHE efforts to help more eligible children retain coverage or correct existing system deficiencies and compliance issues. Medicaid officials also noted the importance of integrated Medicaid, CHIP, and Marketplace systems. Some highlighted the importance of CMS guidance and technical assistance related to eligibility and enrollment systems and policies. Still, several limitations to eligibility and enrollment systems remained.

INCREASING EX PARTE RENEWAL RATES AND AUTOMATION

High-performing ex parte systems that use multiple data sources to process renewals automatically were repeatedly cited by interviewees as critical to managing unwinding. Many of the 1902(e)(14)(A) waivers states adopted were used to improve ex parte rates (Box 1). Medicaid officials thought that zero income, SNAP, and asset verification system strategies were particularly valuable to increasing ex parte rates, with some states noting they hoped these strategies could become permanent. One state retained a third-party data vendor to improve and maximize its ex parte renewals during the unwinding and implemented several bots to automate tasks that otherwise would have to be processed manually. For example, the so-called "SNAP fast track bot" would nightly review SNAP cases that were recertified the previous day and autorenew all corresponding Medicaid cases. Another innovation related to automating the processing of renewals, the "renewal receipt bot," allowed the state to avoid autotermination and refer individuals who did not return their renewal packets to county workers for processing if data showed the person was very likely eligible. According to Medicaid officials in this

state, the system enhancements significantly reduced procedural terminations. Notably, some officials brought up the importance of automation for both Modified Adjusted Gross Income (MAGI) and non-MAGI populations, noting that not all children are enrolled through MAGI pathways. Although other stakeholders were not uniformly familiar with unwinding waivers and flexibilities, those knowledgeable about ex parte processes regarded automated renewals as an important mechanism for safeguarding children's coverage.

"Our whole goal was to ex parte [automatically renew] as many as possible. We want anybody who's eligible to stay enrolled and not have to engage."
—State Medicaid official

BUILDING ON A LONG-STANDING COMMITMENT TO FACILITATING AND MAINTAINING CHILD ENROLLMENT

The unwinding took place under a broader Medicaid/CHIP policy ecosystem in each state, and Medicaid officials often attributed the relatively smooth functioning of their eligibility and enrollment systems to pre-PHE efforts to streamline enrollment and renewals and policy choices to promote children's coverage, such as adoption of Express Lane Eligibility.[19] Most study states have relatively high Medicaid/CHIP income thresholds for children above or at the national median income limit of 255 percent of FPL (table 2) (Brooks et al. 2024). Most also adopted 12-month continuous eligibility as a state option for children well before it became a state requirement in 2024. Washington was the first state in the nation to implement multiyear continuous eligibility for children through age 6 as of July 2023, which state Medicaid officials noted helped reduce churn among children during unwinding. Officials reported that implementing systems changes with these policies in place helped protect against unnecessary loss of coverage during unwinding.

TABLE 2

Medicaid/CHIP Program Characteristics and Selected Policies Implemented before or during Unwinding, Study States

State	AL	CT	IL	MD	NC	OH	TN	WA
Adoption of Medicaid expansion for adults	No	Yes	Yes	Yes	Yes	Yes	No	Yes
CHIP program type	Combination	Separate	Combination	Medicaid expansion	Medicaid expansion	Medicaid expansion	Combination	Separate
Upper Medicaid/CHIP threshold for children (% of FPL)	317%	323%	318%	322%	216%	211%	255%	317%
12-month continuous eligibility before 2024	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Multiyear continuous eligibility for children	No	No	In development	No	Pending CMS approval	In development	No	Implemented (up to age 6)

Sources: Key informant interviews in study states.

Medicaid expansion: "Status of State Medicaid Expansion Decisions: Interactive Map," KFF, May 08, 2024.

CHIP program type and income eligibility threshold for children: Tricia Brooks, Jennifer Tolbert, Allexa Gardner, Bradley Corallo, Sophia Moreno, and Anna Mudumala, "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond." San Francisco: KFF, June 20, 2024.

12-month continuous eligibility policy adopted before the January 1, 2024, national requirement: "Table 5: State Adoption of 12-Month Continuous Eligibility for Selected Populations, January 2023," KFF, accessed August 27, 2024; and ASPE, New Federal 12-Month Continuous Eligibility Expansion: Over 17 Million Children Could Gain New Protections from Coverage Disruptions, ASPE, March 27, 2024.

Multiyear continuous eligibility: Elizabeth Hinton, Amaya Diana, and Jennifer Tolbert, "Section 1115 Waiver Watch: Continuous Eligibility Waivers," KFF, February 15, 2024.

Notes: CHIP = Children's Health Insurance Program; FPL = Federal Poverty Level; CMS = Centers for Medicare & Medicaid Services. Policies refer to status as of the end of 2023; some states' policies changed between the beginning of unwinding and the end of 2023.

BUILDING ON PRIOR EFFORTS TO IMPROVE THE ACCURACY AND FUNCTIONING OF ENROLLMENT SYSTEMS IN COMPLIANCE WITH FEDERAL RULES

Officials in one of our study states reported that CMS guidance on unwinding reassured them that the state's systems and processes were compliant with federal redetermination rules and did not require major changes or mitigation strategies, which facilitated smoother unwinding. Medicaid officials in some study states pointed to prior system updates and efforts to address compliance issues that allowed their systems to be more efficient. Specifically, three of our study states had made earlier systems changes necessitated by other external events, including revelations of noncompliance, rather than state policy choices. A federal audit in Ohio identifying late renewal redeterminations resulted in three years of reprogramming state systems, which led to improved ex parte rates before unwinding. Officials in Tennessee credited lessons from making its system ACA-compliant before the PHE as key to informing decisions about unwinding. Tennessee had prior experience with a redetermination pause in 2014–15 to implement several provisions required by the ACA; state Medicaid officials said that one of the lessons learned from processing a large number of renewals at once was to align TennCare MAGI and non-MAGI renewal rules, which reduced administrative complexity and streamlined renewals during unwinding. North Carolina[20] was subject to a lawsuit related to their system in 2022, leading the state to make extensive and detailed changes to its procedures, forms, and notices as the state prepared for the unwinding. An official in one of these three states indicated that the prior required changes were a "blessing in disguise" because they contributed to readiness for unwinding and helped the state more quickly address issues that arose, such as the household ex parte eligibility issue mentioned earlier.

INTEGRATING MEDICAID WITH MARKETPLACE AND CHIP SYSTEMS FOR MORE SEAMLESS TRANSFERS

In addition to the importance of high-functioning Medicaid eligibility and enrollment systems, officials in states with state-based Marketplaces pointed to Medicaid systems' integration with Marketplace systems as key for avoiding unnecessary coverage loss, and several officials raised the importance of seamless transfers to separate CHIP programs. One state official referred to the state as well positioned to handle coverage transitions largely because of the integrated eligibility system shared with the state-based Marketplace that generates real-time determination decisions. In particular, automated transfers to CHIP, bidirectional account transfers, and allowing the federally facilitated Marketplace to "determine" Medicaid eligibility (as opposed to "assessing" eligibility)[21] were each specifically mentioned by at least one state as supporting seamless coverage transitions.

RELYING ON CMS GUIDANCE, COMMUNICATIONS, AND TECHNICAL ASSISTANCE

Medicaid officials in the study states noted CMS' important role in providing additional tools and resources and guiding the implementation of unwinding policies. A few officials were grateful for CMS's technical assistance to the states and appreciated regular communications and guidance, including collecting feedback from the states. As one official explained, "CMS was incredibly generous with the amount of time they provided to each state for technical assistance." However, several officials noted that more robust and detailed guidance early on could have prevented some initial compliance issues, such as the household ex parte issue, and that they would welcome still more guidance and clarification from CMS on existing rules and the new eligibility and enrollment rules[22] that were finalized in May 2024.

CLOSELY MONITORING AND CONTINUOUSLY IMPROVING SYSTEM PERFORMANCE

In several states, officials noted they continued to refine their approaches and systems throughout the unwinding period. Some reported they monitored system performance closely and made tweaks when issues were discovered. For example, officials from one state reported meeting with their systems contractor weekly to review performance and troubleshoot problems. We also heard about the important role of other stakeholders in identifying systems issues. Health insurance navigators in one state shared that they reported any system glitches they discovered when trying to assist people with renewals via enrollment portals to the Medicaid agency and that the agency reacted quickly to remedy the issues.

IMPLEMENTING NEW POLICIES AMID UNWINDING CHALLENGES

We heard mixed opinions about the implications of making other eligibility changes simultaneously with unwinding. North Carolina officials noted that recent policy changes, such as the shift to managed care and the adoption of Medicaid expansion, were associated with increased efforts to reach out to enrollees, which helped improve the quality of enrollees' contact information. On the other hand, Washington's implementation of multiyear continuous eligibility through age 6 coincided with unwinding, and state officials noted they did not have time and capacity to fully update their systems before rollout. For several months early in the unwinding, some eligible children in Washington were disenrolled and had to be manually reinstated before system changes were in place to administer multiyear coverage. Similarly, officials in another state reported that implementing 12-month postpartum extensions and other eligibility changes posed challenges to updating eligibility systems.

REMAINING CHALLENGES

Medicaid officials expressed the need for more guidance from CMS for data systems issues, including how to effectively reverse changes if waiver flexibilities expire, and shared that they had not had an opportunity to implement all the eligibility and enrollment systems enhancements they thought would be beneficial. Officials in one state wished they had more time and resources to further streamline systems, saying, "We could have gotten farther faster if we had that kind of nimble technology available to us." Stakeholders in some states reported ongoing problems with the renewal process, such as online applications and renewal portals requiring a Social Security number to update information, which posed challenges for mixed immigration status families who did not wish to provide information for parents.

Communications with Enrollees

Medicaid officials in all study states identified communications with enrollees as one of the most influential strategies when asked which policies or approaches have been most effective in maintaining continuous enrollment of eligible children during unwinding. Some highlighted that unwinding communications and outreach have far exceeded any past efforts. In particular, they shared that requirements to contact enrollees through multiple modes of communication, broad social and traditional media advertising campaigns, and the ability to draw on various data sources to update enrollees' contact information contributed to higher rates of completed renewals. Although other stakeholders acknowledged state communications were robust and comprehensive, many noted that some populations were difficult to reach, and the language used in notices and forms remained complex and confusing.

ENGAGING KEY STAKEHOLDERS IN PLANNING FOR THE UNWINDING AND INFORMING COMMUNICATIONS

Officials noted that they began regular meetings with key state and external stakeholders, including advocates, health insurance navigators, community-based organizations, providers in underserved communities, MCOs, and Medicaid advisory committees as early as 18 months before unwinding to provide regular policy updates on key unwinding decisions and collaborate on developing enrollee outreach and communication strategies. These coalitions of stakeholders were often built on partnerships and community engagement established during the pandemic or other recent policy changes (such as the transition to managed care in North Carolina). To inform its communications strategies, one state conducted focus groups to test which messages resonated most with Medicaid beneficiaries; state officials noted that "the opportunity to really workgroup … with individuals who

were going to receive the message" was helpful. Several states have continued stakeholder meetings throughout the unwinding to quickly disseminate new information and assess how unwinding unfolds. The ability to preview upcoming policies and communication materials or notices, for example, allowed partner organizations to better serve community members because they could recognize forms and understand their intent. Although in most states, advocates and other stakeholders appreciated the bidirectional nature of these regular meetings and felt their input was heard, in at least one state, advocates noted that while the Medicaid agency invited input from stakeholders, their feedback was rarely acted on in time to impact the unwinding.

States and their community partners used a variety of modes and avenues to spread the message about redeterminations resuming, using multiple outlets and messengers (box 2).

"Just getting out there in the community, getting our information out there. Our information is printed to grade levels they can understand... Food pantry boxes, bulletin boards, Kroger's, laundromats—we go where we think they're asking for information, and they'll grab it and call us."
—Health insurance navigator

"Having it be somebody who is not a bureaucrat from the state but is someone who looks like you, sounds like you, and is approaching you at a health center, or a community fair, or a farmer's market, a YMCA, or places where people gather, was really helpful."
—Community health center representative

BOX 2

Methods for Communicating with Enrollees about Medicaid Unwinding

- physical mail, including both renewal packets and shorter notices such as postcards
- text messaging
- robocalls
- social media campaigns
- print, radio, and television advertisements
- newsletters
- MCO outreach, including in-person enrollment assistance in the community

- community partner outreach, including developing and sharing uniform messaging and attending community events
- provider outreach, such as through state agencies sharing with providers a list of patients who were up for redeterminations
- sister agency outreach (public school systems, departments of health, departments of education, and other health and human services departments such as SNAP)
- community health worker engagement
- printed information in grocery stores, barber shops, food banks, religious institutions, and laundromats
- messages on receipts from store partners and on bookmarks available in libraries

Sources: Key informant interviews.
Note: MCO=managed care organization; SNAP = Supplemental Nutrition Assistance Program.

USING AVAILABLE DATA SOURCES TO UPDATE CONTACT INFORMATION

Medicaid officials from two states indicated that their agencies continued to send information to enrollees regularly during the PHE continuous coverage period. This helped staff ramp up to regular operations smoothly, kept Medicaid enrollees aware of the renewal process and accustomed to having regular touchpoints with the Medicaid agency, and helped improve the accuracy of contact information for enrollees when unwinding began. Medicaid officials in study states reported drawing on several available data sources, namely the NCOA and USPS databases and information from MCOs, to update enrollee contact information, which they felt reduced the amount of returned mail.

NUDGING ENROLLEES MULTIPLE TIMES AND IN MULTIPLE WAYS THROUGH THE RENEWAL PROCESS

Officials in study states reported that their agencies contacted enrollees multiple times through individualized direct outreach via mail, robocalls, emails, and text messaging. For example, one study state sent enrollees up to 14 "nudges" with short text messages asking them to update contact information, letting them know renewal packets were on the way, reminding them of due dates, and encouraging them to return the paperwork even if the due date had passed. State officials believed the addition of text messaging was a valuable enhancement to traditional communications, and in some cases, Medicaid agencies embedded links in text messages for enrollees to access enrollment portals and provide required information.

USING DATA TO TARGET OUTREACH

Several states were able to use data to inform outreach strategies to specifically reach people at risk of or after procedural disenrollment and other groups vulnerable to disruptions in care. For example, one state reportedly used claims data to identify people with complex care needs and chronic health

conditions for enhanced outreach to ensure they were informed about the renewal process to help them retain access to care. Another state used data to identify geographic areas with higher procedural disenrollments and directed more resources to outreach and communications in those areas. Representatives from multiple MCOs interviewed for the study reported using data on procedural disenrollments to identify communities for additional outreach and assistance. For example, one MCO set up an enrollment assistance booth at a local laundromat in a zip code with high procedural disenrollments.

REMAINING CHALLENGES

Though robust, state communications were not always clear and sometimes fell short of reaching populations most at risk of churn. One Medicaid official wished they had access to contact information databases beyond physical mail, such as phone numbers for texting. Another said enrollee notices remain complex partly because of federal requirements. Advocates concurred with this assessment, reporting that renewal forms and termination notices were not always available in families' preferred languages or were written in complex and confusing language, leaving some enrollees overwhelmed and unsure about what to do. Other stakeholders we interviewed commended state agencies for robust communications and increased transparency through regular meetings and, in some cases, enrollment dashboards. However, many also pointed out shortcomings, such as the overall reliance on paper and mail as primary communication methods with enrollees.

"We struggle to update [notices that go to enrollees]… [N]otices are… really hard for us to manipulate still, to get changes, and they're longer than we'd like; there's a lot of things that we have to include."
—State Medicaid official

According to advocates and navigators, populations most at risk of missing state communications and losing coverage procedurally were those unstably housed, in mixed immigration status families, with low literacy or limited English proficiency, and with limited Medicaid experience. For example, campaigns focused on contact information updates in some states occurred early in the unwinding period, so if an enrollee's renewal was not slotted until months later, their address might have changed again, even if they had updated their contact earlier. These enrollees often needed personalized, hands-

on assistance to navigate the unwinding, highlighting the important role of enrollment navigators and community outreach workers, described in more detail in the next section.

Coordination with and Outreach by Partner Organizations

Our study states relied on wide-ranging partnerships comprised of advocacy organizations, legal aid, provider groups, MCOs, navigator entities, and other state and community-based organizations. States kept partners informed so they could echo states' unwinding messages and reinforce outreach to enrollees. Most study states with managed care programs obtained 1902(e)(14)(A) waivers and used other strategies to enable more alignment and coordination with MCOs to support enhanced outreach and assistance to Medicaid members. Advocates and community-based partners drew on communication materials and updates from state Medicaid agencies while tailoring messaging and approaches to provide culturally and linguistically effective outreach and assistance to specific populations. Trusted organizations that have traditionally provided enrollment assistance in underserved communities played a pivotal role during the unwinding in providing hands-on assistance to Medicaid enrollees. At the same time, informants outside of state agencies shared challenges with supporting outreach to Medicaid enrollees, such as gaps and delays in receiving helpful information from state agencies and strained organizational capacity to assist families with renewals.

COORDINATING WITH MCOS

For several study states, coordination with MCOs was reported to be invaluable for communicating the redetermination message within communities, including because MCOs often had more direct or recent contact with Medicaid enrollees. One Medicaid official highlighted that MCOs have a "tighter connectivity to their customer base and membership" and emphasized the need to use them "as an avenue to disseminate the message of 'renew today.'" For instance, some Medicaid agencies reportedly gave MCOs a list of people with upcoming redetermination dates so that MCOs could provide additional outreach to beneficiaries and encourage them to look for enrollment packets and return them. The MCO outreach supplemented state text messaging campaigns and special mailings that often began 90 days before a person's redetermination date. Some states also shared with MCOs the lists of members who were procedurally disenrolled, which MCOs used for outreach to individuals to help those who were still eligible to reenroll. One state also required MCOs to report back on whom they could reach and renewal outcomes.

Some MCOs also coordinated with providers and community-based organizations to support targeted outreach to their members. For example, one MCO coordinated with faith-based groups and

other influential community groups who could encourage members to complete redetermination paperwork. This same MCO also reported hosting community redetermination events and making use of the events to provide other resources, such as fresh produce boxes and health screenings. Under 1902(e)(14)(A) waiver authority, MCOs in some study states were also authorized to help members complete renewals. However, one state reported electing not to engage MCOs in direct outreach or assistance to enrollees out of concern that MCOs would only engage members they did not anticipate would be as costly to serve.

ENGAGING PROVIDERS

Medicaid agencies and MCOs also encouraged providers to spread the word about renewals to their patients and ask them to update their contact information and fill out renewal forms. In one state, the Medicaid agency hosted presentations with providers on using the eligibility verification system and shared provider-specific flyers and talking points to help facilitate conversations with patients about renewals. Another state included information on specific unwinding milestones in the provider portal, such as the date when a renewal packet was sent and when it was due, so providers could share this information with patients at the time of visit. In another state, an MCO trained provider groups in their networks on how to do outreach within their offices, such as texting and mailing campaigns. A general sentiment among state officials and other stakeholders was that families trust providers more than health plans or state agencies, and therefore, supporting providers in outreach and enrollment assistance to Medicaid members could improve renewal outcomes. However, some informants also noted that many providers might not have the capacity to support patients with renewals, and providers and other stakeholders in some states believed that state agencies could have done more to engage the provider community in patient outreach. For example, a stakeholder in one state reported that their state only distributed electronic copies of flyers to providers, with instructions to print them, rather than providing printed materials.

COMMUNITY-BASED OUTREACH EFFORTS

Several stakeholders in our study highlighted the value of direct outreach and one-on-one assistance by trusted, community-based organizations, such as community health centers, navigator entities, and public school systems (see box 3 for one example). Typically, community-based partners tailored state flyers and other communications as needed or created materials aligned with the state's redetermination campaigns. In some cases, we learned that community-based organizations relied on CMS and national advocacy organizations or trade associations to learn more about unwinding policies, developments, and best communication practices. In particular, those traditionally involved in benefit

enrollment assistance, such as navigators, hospital and community health center outreach workers, and school-based benefits coordinators, often conducted outreach and leveraged trusted, long-standing relationships to help community members understand state communications, complete renewal forms, or navigate appeals of denials and transitions to other coverage. These outreach workers were embedded in their communities and available to provide individualized assistance to families who often faced challenges obtaining help from state or county caseworkers or getting through to Medicaid helplines.

"[The state's unwinding] information was great, but it was too complicated to present on paper. Partnering with community-based organizations and having trusted [entities] communicate that information was a strength."
—Community outreach worker

BOX 3

Chicago Public Schools' Children and Family Benefits Unit

Chicago Public Schools (CPS) served over 320,000 students enrolled in 634 schools across Chicago in the 2023–24 school year. According to CPS data, over two-thirds of students (70.7 percent) are economically disadvantaged, and our key informants reported that about 84 percent of CPS students are enrolled in Medicaid.

The CPS' Children and Family Benefits Unit (CFBU) in the Office of Health and Wellness assists students and families in accessing available benefits and community resources, including enrolling in Medicaid and SNAP programs. The program currently employs 17 coordinators placed across schools with the highest shares of families eligible for public benefits. Families can see coordinators within schools who are trained and certified application assisters and can help families apply for public benefits, including assisting with submitting required documentation or reporting changes in circumstances. Coordinators also help families understand notices and other communications from public programs and educate them on how to access benefits and communicate with agencies. In addition, CFBU coordinators conduct outreach throughout the district, sharing information about the program and available resources with school administrators and families.

CFBU participated in regular calls with Illinois' Medicaid agency, disseminated information about unwinding to families throughout the district, and provided hands-on assistance to families seeking help understanding state notices and completing renewals. According to key informants, regular updates from the Medicaid agency helped CFBU be well-informed and proactive and ensured that CPS students

and families were not adversely affected by the unwinding. For example, CFBU began notifying families about upcoming changes to the Medicaid program well before the Medicaid agency to reach as many families as possible before the end of the 2022–23 school year and help them prepare for redeterminations.

While CFBU did not track redetermination outcomes specifically, the staff monitored changes in Medicaid enrollment among the CPS student population, and according to key informants, enrollment remained steady throughout unwinding.

Sources: Key informant interviews in study states; "Stats and Facts," Chicago Public Schools, accessed August 29, 2024; and "CFBU: Connecting Families to Medicaid and SNAP," Chicago Public Schools, accessed August 29, 2024.

REMAINING CHALLENGES

Although community partners and other stakeholder groups often reported working synergistically with state agencies to support enrollees during unwinding, doing so often added to the workload of organizations that were already stressed. Additionally, communication between state agencies and other organizations sometimes fell short or was delayed. For instance, one pediatric provider shared that the state never communicated with their office regarding unwinding to encourage communication with families about the looming change. Relatedly, another stakeholder indicated that limited data from state agencies about how unwinding was proceeding or which subgroups were being disenrolled and for what reasons sometimes prevented them from knowing how to act effectively to support their target population.

Discussion

The states included in this analysis are among those deemed as adopting innovative practices, having lessons to share about how to successfully support coverage retention for children covered by Medicaid, or experiencing low net enrollment declines for children during unwinding compared with other states based on available information early in 2024.[23] State Medicaid officials' perspectives, often confirmed by perspectives of other stakeholders in the respective study states, were that the relative success of Medicaid unwinding for children in these states was attributed to several deliberate actions, including a strong state commitment to planning and managing unwinding to reduce coverage losses, high-functioning eligibility and enrollment systems (often because of previous efforts to improve system functioning and compliance with federal rules), multimodal communications efforts, and coordination with community partners.

Many of these lessons are not new. For instance, fixing data systems problems, increasing ex parte renewals, and utilizing community partnerships were identified as critically important well before unwinding began (Stephens and Artiga 2013; SHADAC 2018).[24] However, the unwinding process revealed a lack of compliance with federal redetermination requirements in many states' systems (GAO 2024). As described in this report, some study states had significantly improved their eligibility and enrollment systems in response to litigation and audits, which, in turn, better prepared them for unwinding. This reveals just how instrumental oversight and enforcement tools can be. While CMS took steps to address some compliance issues by allowing states to implement mitigation strategies,[25] more robust oversight to ensure permanent fixes and full compliance with federal requirements is perhaps the single most important action CMS could take to improve redetermination processes and reduce churn going forward (GAO 2024).[26]

Even in the states studied here—which likely reflect experiences where efforts to maintain coverage among eligible enrollees were aggressive—there were generally few efforts to maximize coverage retention specifically for children. However, over the course of the unwinding, many states significantly improved their renewal processes, particularly by increasing ex parte rates and establishing multimodal communications. This progress lays the groundwork for CMS and states to continue to improve administrative efficiency, enhance the enrollee experience, reduce churn, and promote continuity of access to health care for eligible children.

Based on the perspectives shared by key informants and findings from other research, we identified several priority actions (Appendix table 1) for federal and state policymakers to consider aimed at improving Medicaid redeterminations for children post-unwinding, including the following:

FEDERAL POLICIES AND PRACTICES

- ***Develop more detailed guidance on existing (and new) rules and strengthen federal oversight and enforcement strategies.*** The unwinding highlighted the need for CMS to continue proactively supporting states while doubling down on guidance and oversight. Federal eligibility, enrollment, and redetermination guidelines will be substantially more likely to achieve their intended outcome of supporting enrollment and retention of eligible children if states understand them and know they will be held accountable for compliance. As part of detailed guidance, CMS could highlight innovative state practices and strategies that have proven successful in improving the efficiency and accuracy of eligibility and renewal processes. CMS could also provide greater monitoring, oversight, and enforcement of existing requirements, including deploying comprehensive diagnostic tools to test eligibility and renewal systems'

capacity and accuracy and holding states and/or vendors accountable for system performance and outcomes.[27]

- ***Develop new policies and tools and increase technical support to states to enhance eligibility and enrollment systems.*** CMS could introduce new policies designed to streamline and optimize Medicaid/CHIP eligibility, enrollment, and renewal policies and procedures, as well as consider ways that policies and processes with other human services programs would be aligned and coordinated. For instance, CMS could develop a standardized MAGI system design that states could customize for their use. Federal lawmakers could provide additional funds to CMS to bolster its ability to support states in achieving full compliance with federal eligibility and enrollment rules, such as by expanding technical assistance to states, supporting states' efforts to hold vendors accountable for system performance and outcomes, and increasing the federal match for state systems work beyond 90 percent.
- ***Permanently extend certain 1902(e)(14)(A) waivers, especially those related to renewals for families with low or no income or SNAP eligibility.*** If states know these options will be permanently available, they could be much more likely to implement them. Although increases in ex parte rates under these flexibilities helped states address prior limitations, Medicaid officials noted several challenges, including adapting their systems quickly, understanding and correctly interpreting CMS guidance, and managing other aspects of their Medicaid/CHIP programs simultaneously. Moreover, their temporary nature and states' limited ability to attribute renewal outcomes directly to specific policies made state officials wary of adopting more waivers than they could quickly implement.

STATE POLICIES AND PRACTICES

- ***Implement available strategies that support children's coverage.*** Previous improvements and investments in integrated eligibility and enrollment systems, compliance with existing rules and regulations, and other strategies like Express Lane Eligibility were viewed by state Medicaid officials as critical to facilitating efficient ex parte processes, reducing burden on state workers and enrollees, and maintaining continuous coverage for children and adult beneficiaries.
- ***Improve data systems, increase ex parte rates, align Medicaid and separate CHIP program enrollment processes, streamline transitions to Marketplaces, and develop data sharing with other programs like SNAP***. Because of the considerable overlap between SNAP and Medicaid program enrollment, state officials noted strong support for policies aligning or integrating enrollment

and renewals in both programs. They also reported that streamlined transitions to separate CHIP and the Marketplace helped avoid coverage lapses.

- ***Maintain policies adopted through 1902(e)(14)(A) waivers and implement additional related strategies, as allowed by CMS.*** With action by CMS to authorize these flexibilities as permanent options, states could adopt additional flexibilities they may have passed on during the unwinding because of the constrained timeline (CMS 2023b).
- ***Conduct targeted outreach campaigns, continue to refine notices that go directly to enrollees, and use multiple communication modes to convey important information***. Ongoing and targeted outreach campaigns could reach families of eligible children who were disenrolled during unwinding and those who are eligible but have not yet been enrolled. This would likely require working with state legislatures and other partners (such as philanthropic funders) to provide sufficient resources for such efforts, and tapping other available resources, such as CHIP Health Services Initiatives[28] and Connecting Kids to Coverage grants.[29] In addition, multiple stakeholders in study states reported that state notices were confusing and unavailable in languages other than English or Spanish, helpful information such as where to seek assistance was often not included, and information was not always available in formats that suited busy families. States that want to improve their notices and other communications could consider involving Medicaid enrollees, advocates, providers, community-based organizations, and new Medicaid Advisory Committees and Beneficiary Advisory Councils[30] in designing and evaluating them.
- ***Support ongoing partnerships with community partners, including enrollment assisters, and build on the momentum of the unwinding to connect eligible children to coverage.*** Medicaid agencies often lack the capacity and resources to provide high-touch enrollment assistance to all enrollees. But culturally and linguistically effective face-to-face outreach and hands-on assistance from trusted community-based organizations can help families understand agency communications and complete renewals. States could also work to maintain data-sharing partnerships with MCOs and providers. These partnerships can also serve as important feedback loops for Medicaid agencies to learn about the experiences and challenges of Medicaid beneficiaries to inform policy and practice. Given the Medicaid coverage losses occurring among children during unwinding, continuing to leverage community partners could be critical to reenrolling eligible children and minimizing gaps in coverage.

Several recent policy developments could shape ongoing redetermination processes for children and support coverage continuity. As of January 2024, states must implement 12 months of continuous

enrollment for all children in Medicaid/CHIP, improving the continuity of coverage for millions of children in states that previously did not implement this policy (Hogan et al. 2024). Several states are also implementing or pursuing multiyear continuous enrollment for children, seeking to extend the benefits of continuous eligibility throughout critical developmental periods.[31] Additionally, CMS recently finalized additional eligibility and enrollment rules that align renewal processes for enrollees, though most changes will not be fully implemented for several years. These include child-specific provisions to align eligibility and enrollment between Medicaid and CHIP and reduce barriers to CHIP coverage, such as eliminating waiting periods, disenrollment for premium nonpayment during a continuous coverage period, and enrollment lockouts.[32]

State Medicaid officials reported benefiting from enhanced resources at the state level available because of pandemic-related funding and increased technical assistance and collaboration provided by CMS during unwinding. But both will be reduced as state and federal attention and resources are shifted to other policies and priorities. This could mean some redetermination process improvements are at risk. Moreover, because these study states had low disenrollment rates for children compared with other states as of early 2024, the approaches described in this report may be informative for other states. As states complete unwinding and return to routine renewal procedures, prioritizing policies that reduce children's coverage losses, improving eligibility and enrollment systems, enhancing multimodal communications efforts, and strengthening coordination with philanthropic and community partners could be even more important for maximizing children's coverage.

Appendix

APPENDIX TABLE 1

Federal and State Actions to Improve Medicaid/Chip Redeterminations for Children Post-unwinding

Based on analysis of key informant interviews and research literature

Key area	Federal actions	State actions
Planning and management of redeterminations	▪ Make permanent key 1902(e)(14)(A) flexibilities, especially related to SNAP, $0 income, and 100% of FPL strategies ▪ Encourage state adoption of other policies to support coverage (e.g., make adult Express Lane Eligibility and multiyear continuous eligibility state plan amendment options) ▪ Establish state standards for key policies, such as setting minimum ex parte rates ▪ Strengthen oversight and enforcement of existing regulations ▪ Boost CMS funding to support key federal enforcement and accountability functions	▪ Develop or maintain a broad state commitment to prioritizing children's coverage continuity, with staffing and adequate funding ▪ Adopt a broad range of policies to support children's coverage (e.g., Express Lane Eligibility, multiyear continuous eligibility) as well as that of parents/adults ▪ Use available data and stakeholder feedback loops to monitor progress and identify problems ▪ Increase ex parte renewal rates ▪ Continue using and taking up 1902(e)(14)(A) strategies through current end time of mid-2025; as CMS permits, adopt such options permanently
Eligibility and enrollment systems	▪ Increase support for addressing systems deficiencies that have been identified, including diagnostic tools and testing, oversight of IT vendors, and standardized systems with options to customize ▪ Increase staff capacity for technical assistance to states ▪ Increase FMAP to states to improve eligibility systems ▪ Consider broader changes like alignment or integration of SNAP and Medicaid eligibility rules and systems ▪ Continue to require state data collection on redetermination outcomes; expand data monitoring to assess outcomes for children specifically and variation in disenrollments across subgroups	▪ Develop a broad state goal of continuing to streamline redetermination processes for both MAGI and non-MAGI eligibility ▪ Address systems limitations and capacity ▪ Streamline/integrate Medicaid/CHIP/Marketplace (if applicable) redeterminations for smooth coverage transitions or allow the Federally Facilitated Marketplace to process Medicaid/CHIP eligibility determinations ▪ Accept self-attestation of allowable eligibility criteria, such as residency and date of birth ▪ Continue or implement public ongoing reporting on enrollment and renewals, such as dashboards

Key area	Federal actions	State actions
Enrollee communications	▪ Expand guidance and ongoing training, including templates, for clear renewal notices ▪ Enforce requirements for plain language and multilanguage notices and other communications ▪ Allow states to permanently use available data sources (e.g., USPS, NCOA databases) to obtain, update, and verify enrollee contact information	▪ Develop clearer notices; eliminate extraneous information being requested; ensure information about the reconsideration period and other coverage options is included and easy to find ▪ Collect consumer feedback on notices (such as through user surveys and focus groups) and iterate ▪ Increase the use of texting and other forms of contact other than mail ▪ Ensure that call centers are adequately staffed and trained with assistance available in multiple languages; reduce wait times ▪ Share messaging with partner organizations to present a uniform message ▪ Ensure that communications are available in multiple languages and that materials are translated correctly ▪ Require MCOs to share with Medicaid agencies member contact information and/or updates to contact information
Coordination with partner organizations	▪ Increase funding opportunities for community-based organizations to support enrollees with applications and renewals ▪ Expand guidance and technical assistance for community-based organizations to support enrollees ▪ Maintain flexibilities related to MCOs and state agencies sharing information on enrollees' redetermination status ▪ Create and publicize toolkits, translated materials, and other resources for community-based organizations, providers, and other entities to support enrollees with redetermination processes	▪ Continue regular collaborations between state agencies and external partners that may have been established during the unwinding period; develop new partnerships and engage philanthropy in supporting outreach and enrollment assistance efforts ▪ Provide funding for partners such as school systems, community-based organizations, and other stakeholders ▪ Create and publicize toolkits, translated materials, and other resources for community-based organizations, providers, and other entities to support enrollees with redetermination processes ▪ Establish feedback loops on outreach campaigns, enrollment and renewal processes, and enrollee notices, such as through community advisory committees

Source: Interviews conducted with state Medicaid officials and key stakeholders in 2023–24.

Notes: CHIP = Children's Health Insurance Program; MCO = managed care organization; SNAP = Supplemental Nutrition Assistance Program; MAGI = modified adjusted gross income; PHE = public health emergency; USPS = United States Postal Service; NCOA = National Change of Address; FMAP = federal medical assistance percentage.

Notes

[1] Assessments of children's Medicaid/CHIP enrollment changes during unwinding vary based on timing and data sources and will likely change as unwinding concludes and more data become available. Data available to date suggest that enrollment declines during unwinding offset many of the enrollment gains children experienced during the continuous coverage period. According to CMS, children's enrollment in Medicaid and CHIP rose by 7.1 million between February 2020 and March 2023, and then fell by 4.6 million by June 2024. See CMS (2024).

[2] Procedural disenrollments occur when the state agency cannot determine whether a person remains eligible, such as if renewal notices do not reach enrollees or they do not complete renewal policies; such disenrollees may or may not remain eligible. See Jennifer Tolbert, Robin Rudowitz, and Patrick Drake, "Understanding Medicaid Procedural Disenrollment Rates," KFF, September 7, 2023; https://www.kff.org/policy-watch/understanding-medicaid-procedural-disenrollment-rates/; "What Is the Impact of Unwinding on Medicaid Enrollment?," Georgetown University Center for Children and Families, accessed August 28, 2024, https://ccf.georgetown.edu/unwinding-enrollment-data/; and "Medicaid Enrollment and Unwinding Tracker," KFF, August 23, 2024, https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/.

[3] Georgetown University Center for Children and Families, "How Many Children Are Losing Medicaid? accessed September 3, 2024, https://ccf.georgetown.edu/2023/09/27/how-many-children-are-losing-medicaid/.

[4] We used the latest available data for each date as of January 2024 and ranked states in percentage decline in child enrollment between the month unwinding began in the state and the latest month for which data were available. We then identified states in the lowest quartile of states to be considered inclusion in the study. Data were drawn from "How Many Children Are Losing Medicaid?," Georgetown University Center for Children and Families, and include a combination of state- and CMS-reported counts of enrollment for children for each month since unwinding began. We note that there is not a definitive way to assess how the unwinding has varied across states given differences in state reporting practices and data limitations, and categorization of states may differ if different data sources or measures were used.

[5] In fall 2023, we also interviewed 10 national experts on Medicaid and children's health, including those representing research and policy organizations, national provider and health plan organizations, health law organizations, and children's health advocates. Insights from interviews with national stakeholders are discussed elsewhere; see Jennifer M. Haley and Eva H. Allen, "How States Can Reduce Coverage Loss among Children during the Medicaid Unwinding," *Health Affairs Forefront*, December 4, 2023, https://www.healthaffairs.org/content/forefront/states-can-reduce-coverage-loss-among-children-during-medicaid-unwinding.

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[12] "Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023," Medicaid.gov, accessed on September 24, 2024.

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