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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 and Farah Erzuoki, Center on Budget and Policy Priorities

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

In March 2020, as part of COVID-19 relief enacted in the Families First Coronavirus Response Act (FFCRA), 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 prohibited states from terminating most Medicaid enrollees’ coverage until after the end of the public health emergency (PHE), as determined by the U.S. Department of Health and Human Services.

During the continuous coverage requirement, Medicaid agencies couldn’t disenroll anyone from Medicaid unless they asked to be disenrolled, moved out of state, or died. Continuous coverage allowed millions of people to stay covered without any interruption during the pandemic — and it’s a major reason why there wasn’t an increase in the uninsured rate during the height of the pandemic.

In December 2022, Congress passed an omnibus spending bill that delinked the Medicaid continuous coverage requirement from the PHE and ended the continuous coverage protection on March 31, 2023, allowing states to resume Medicaid coverage terminations effective April 1, 2023.

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

“Unwinding” is the term for states’ resumption of annual Medicaid eligibility reviews after the end of the continuous coverage requirement. Medicaid agencies must first attempt to complete an automated renewal based on information available to them — such 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 get the request for information due to having changed their address or phone number or don’t understand what they are supposed to do and don’t respond, their coverage will end.

Guidance from the Centers for Medicare & Medicaid Services (CMS) gives states an unwinding period of up to 12 months to initiate renewals for all enrollees.¹ 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?

At the end of 2022, Congress delinked the continuous coverage requirement from the PHE and allowed states to begin ending coverage as early as April 1, 2023. For the duration of the continuous coverage requirement, states paused most Medicaid terminations and eligibility reviews. The end of this pause is leading to an extraordinary workload for states to determine eligibility and renew coverage for the millions of people enrolled in the program. During unwinding, Medicaid agencies have 12 months to initiate renewals and 14 months to complete them, allowing them to spread out the workload.

Five states — Arizona, Arkansas, Idaho, New Hampshire, and South Dakota — chose April 1, 2023, as the effective date for their first coverage terminations; 15 states set a date of May 1, and all but one of the remaining states set a date for beginning coverage terminations in June or July.⁴ Medicaid unwinding will not occur as one single event — the process will take most states significant time through the rest of 2023 and well into 2024.

4. What standards did the 2022 legislation include to mitigate coverage losses?

In addition to setting a date certain, the enacted legislation gives states additional financial support during the unwinding period.⁵ While the enhanced Federal Medicaid Assistance Percentage (FMAP) under FFCRA included a full sunset of the enhanced funding at the end of the quarter in which the PHE ends, the year-end legislation instead gradually phases out the enhanced FMAP through 2023. This additional funding will support states as they work through the large number of eligibility reviews. To receive the enhanced match, states must follow federal redetermination requirements or other strategies approved by CMS, maintain updated enrollee contact information, and make good-faith efforts to contact enrollees before their coverage is terminated due to returned mail.

CMS regulations and unwinding guidance outline the federal redetermination requirements. Although these standards are long-standing, many states are not in full compliance with renewal

¹ Centers for Medicare & Medicaid Services (CMS), “SHO# 22-001 RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency,” March 3, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

² CMS, “Unwinding and Returning to Regular Operations after COVID-19,” <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html>.

³ CMS, “Resources to Support State Implementation of Renewal Mitigation Strategies,” posted March 23, 2023, <https://www.medicaid.gov/resources-for-states/downloads/support-resources-state-imp-rms.pdf>.

⁴ Oregon will begin unwinding-related terminations in October. CMS, “Anticipated 2023 State Timelines for Initiating Unwinding-Related Renewals,” February 24, 2023, <https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-02242023.pdf>.

⁵ CMS, “SHO# 23-002 RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023,” January 27, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>.

requirements outlined in the regulations; CMS is working with these states to establish mitigation plans and utilize mitigation strategies designed to protect enrollees while states work to come into compliance.

The year-end legislation also lays out clear procedures for CMS to enforce the policies that states are required to follow as they unwind.⁶ States must submit, and the Department of Health and Human Services (HHS) must make publicly available, monthly reports of key unwinding metrics such as number of renewals completed *ex parte*, coverage terminations due to procedural reasons, and call center metrics such as volume, wait times, and abandonment rates (callers who hang up before reaching a worker). Such transparency is key to ensuring that states and the public can identify problems during the unwinding period and hold states accountable for fixing them. States that fail to meet reporting requirements will experience a modest FMAP reduction for each quarter of noncompliance.

CMS may require states that do not comply with federal eligibility redetermination requirements or reporting requirements to submit a corrective action plan.⁷ If a state fails to submit or implement a corrective action plan, CMS may require the state to pause all coverage terminations for procedural reasons and to pay financial penalties.

5. 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 what their other coverage options are, including employer-based coverage and coverage through the Affordable Care Act (ACA) 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.

⁶ *Ibid.*

⁷ *Ibid.*

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

States will face a significant increase in workload during the unwinding process. States have to conduct renewals on their entire caseloads, and they may not be able to keep up with deadlines for processing paperwork, which could cause coverage terminations for eligible people, contrary to federal rules. 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.⁸ All of these challenges could impact enrollees' ability to renew their coverage.

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.

7. 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.⁹ They can:

- Help Medicaid enrollees update their current mailing address and phone number with the Medicaid agency. 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 over the next year 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 navigate transitions to other forms of coverage. This could include employer-sponsored coverage as well as ACA marketplace coverage. People have 60 days after losing Medicaid to enroll in employer-sponsored coverage outside the employer's annual open enrollment period. People at all income levels who lose Medicaid coverage during the unwinding period qualify for a special enrollment period for marketplace coverage and can enroll at any time until July 31, 2024. People with income up to 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 that run their own health insurance

⁸ Farah Erzouki, "States Should Use Federal Matching Funds to Ensure Adequate Staffing During "Unwinding" of Medicaid Continuous Coverage," CBPP, February 22, 2023, <https://www.cbpp.org/blog/states-should-use-federal-matching-funds-to-ensure-adequate-staffing-during-unwinding-of>.

⁹ For a list of resources for enrollment assisters on unwinding the Medicaid continuous coverage requirement, see: <https://www.healthreformbeyondthebasics.org/category/new-laws-policies/unwinding-medicaid-continuous-coverage/>.

marketplace, policies vary. People with low incomes enrolling in marketplace plans are often eligible for significant financial help with premiums and out-of-pocket costs.

8. What are the key decisions states are making as they unwind?

States made a number of important decisions as they planned for unwinding and, as unwinding begins, will continue to adjust their policies, including:¹⁰

- How they communicate to people about unwinding, including the need to update address and contact information, when their case is being renewed, and what steps they need to take when they are due for renewal.
- How they attempt to update contact information (address, phone, email) for Medicaid enrollees. States may take contact information from other programs and entities, such as SNAP and managed care organizations, that have had more recent contact with the enrollee.
- How long they are taking 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 are prioritizing 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.
- Whether they plan to publicly post data they are required to submit to CMS — and will eventually be made public by CMS — so interested parties can get an earlier look at state-level trends and issues.
- How they will fill existing gaps in staffing capacity to ensure that key redetermination functions are conducted (and in a timely manner).
- How states that operate state-based marketplaces plan to handle transitions from Medicaid to marketplace coverage.¹¹

9. What key strategies should advocates encourage state agencies to implement if they have not yet done so?

Advocates can play a key role in ensuring that states adopt policies aimed at protecting coverage and in providing solutions to states that encounter challenges during the unwinding process. For a comprehensive guide for advocates on unwinding, see Georgetown University’s Center for Children and Families’ publication.¹² Issues to explore with states include:

¹⁰ Tricia Brooks *et al.*, “Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision,” KFF, April 4, 2023, <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/>.

¹¹ CMS, “The Marketplace in your state,” <https://www.healthcare.gov/marketplace-in-your-state/>.

¹² Tricia Brooks and Alexa 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>.

- What steps is the state taking to increase *ex parte* renewal rates?
- How is the state monitoring the unwinding process and shifting its approach or tactics based on data?
- What is the agency’s staffing plan for handling a large increase in casework, especially processing renewals and handling phone calls?
- What groups are they renewing first?
- How is the agency handling mail that comes back returned?
- What is the state doing to collect and update new contact information for Medicaid enrollees?
- Is the state including enrollment assisters’ contact information on Medicaid notices?
- Is the state partnering with other organizations, such as community health centers, to support enrollees through unwinding (for example, by helping update contact information, or informing enrollees of the need to renew)?
- What data will the state be tracking during the unwinding process in addition to the data required by CMS? How and when will the data be shared with stakeholders?
- What is the state’s communication plan for collaborating with advocates, providers, and other partners during the unwinding process?
- How is the state conducting outreach and communication to enrollees about the unwinding (for example, mailed notices, text and email, public-facing outreach, social media campaigns)?
- How is the state using information it already has from other programs (for example, SNAP) to keep eligible people enrolled?
- How is the state helping people connect to other sources of coverage, such as the Children’s Health Insurance Program (CHIP) and marketplace plans?

10. Who is at risk of losing Medicaid coverage despite still being eligible?

People often lose their coverage at the point of renewal, even when they remain eligible, due to procedural reasons such as unnecessary paperwork requests, long call center wait times, and other burdensome processes. The large number of cases renewed during unwinding puts many people at risk of losing coverage, even if they continue to meet eligibility requirements. Researchers estimate that 6.8 million people could lose coverage for procedural reasons.¹³ 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, and in turn may not receive notices from the state about their coverage being due for renewal.

¹³ Office of the Assistant Secretary for Planning and Evaluation, “Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches,” U.S. Department of Health and Human Services, August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.

- 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 three years.
- People of color and children. A recent HHS study projects that these groups are much more likely to lose coverage for procedural reasons during unwinding, despite remaining eligible for Medicaid.¹⁴

People will also lose coverage due to no longer being eligible for Medicaid coverage because their income has increased or other changes to their circumstances that would deem them ineligible.

11. 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 or for employer-based coverage. If someone loses Medicaid coverage, they should:

- **Reapply for Medicaid if they think they are still eligible.** If an enrollee didn't complete all the steps required for the renewal and contacts 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.** In states that use HealthCare.gov, loss of Medicaid triggers a special enrollment period that allows someone to enroll in marketplace coverage at any time until July 31, 2024, even if outside of the annual marketplace open enrollment period. Additionally, in these states people with income up to 150 percent of the poverty line may enroll in marketplace coverage at any time. In states that run their own health insurance marketplace, policies vary. Most people losing Medicaid will qualify for financial help to lower the cost of premiums for marketplace coverage; in 2023, 4 out of 5 marketplace enrollees qualified for a plan for \$10 a month or less.
- **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.
- **Enroll in employer-sponsored insurance (ESI).** Some enrollees may have an offer of coverage through their employer. If this offer is considered affordable (does not exceed 9.12 percent of household income in 2023), the person is not eligible to get financial help to enroll in a marketplace plan; they should enroll in ESI instead. They must take action to enroll in ESI within 60 days of losing Medicaid coverage, or they will have to wait until their employer's annual open enrollment period to enroll.¹⁵ Due to changes in the affordability test for family members of an employee that took effect in 2023, some members who were not eligible for

¹⁴ *Ibid.*

¹⁵ U.S. Department of Labor, "FAQs on HIPAA Portability and Nondiscrimination Requirements for Employers and Advisers," <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.pdf>.

premium tax credits in the past (because they were considered to have an affordable offer of ESI) will now be eligible. People should apply for marketplace coverage and answer the applicable questions about their offer of ESI to determine whether they are now eligible for premium tax credits.¹⁶

Unfortunately, some people will lose Medicaid and not have a viable alternative for affordable health insurance because they live in one of the states that hasn't 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.medicaid.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-medicaid-coverage-losses-when-public-health-emergency-ends>.
- Center on Budget and Policy Priorities, End of the Pandemic-Era Medicaid Continuous Coverage Requirement, <https://www.cbpp.org/research/health/resource-lists/end-of-the-pandemic-era-medicaid-continuous-coverage-requirement>.
- Georgetown University's Center for Children and Families 50-State Unwinding Tracker, Georgetown Center for Children and Families, <https://docs.google.com/spreadsheets/d/1tOxmngYs7jDPTGltP-diD1SGvHvZVJOm3G2YuUq0btg/edit#gid=0>.

¹⁶ "FAQ: Transitioning from Medicaid to Employer-Sponsored Insurance," CBPP Beyond the Basics, April 2023, <https://www.healthreformbeyondthebasics.org/transitioning-from-medicaid-to-esi/>.