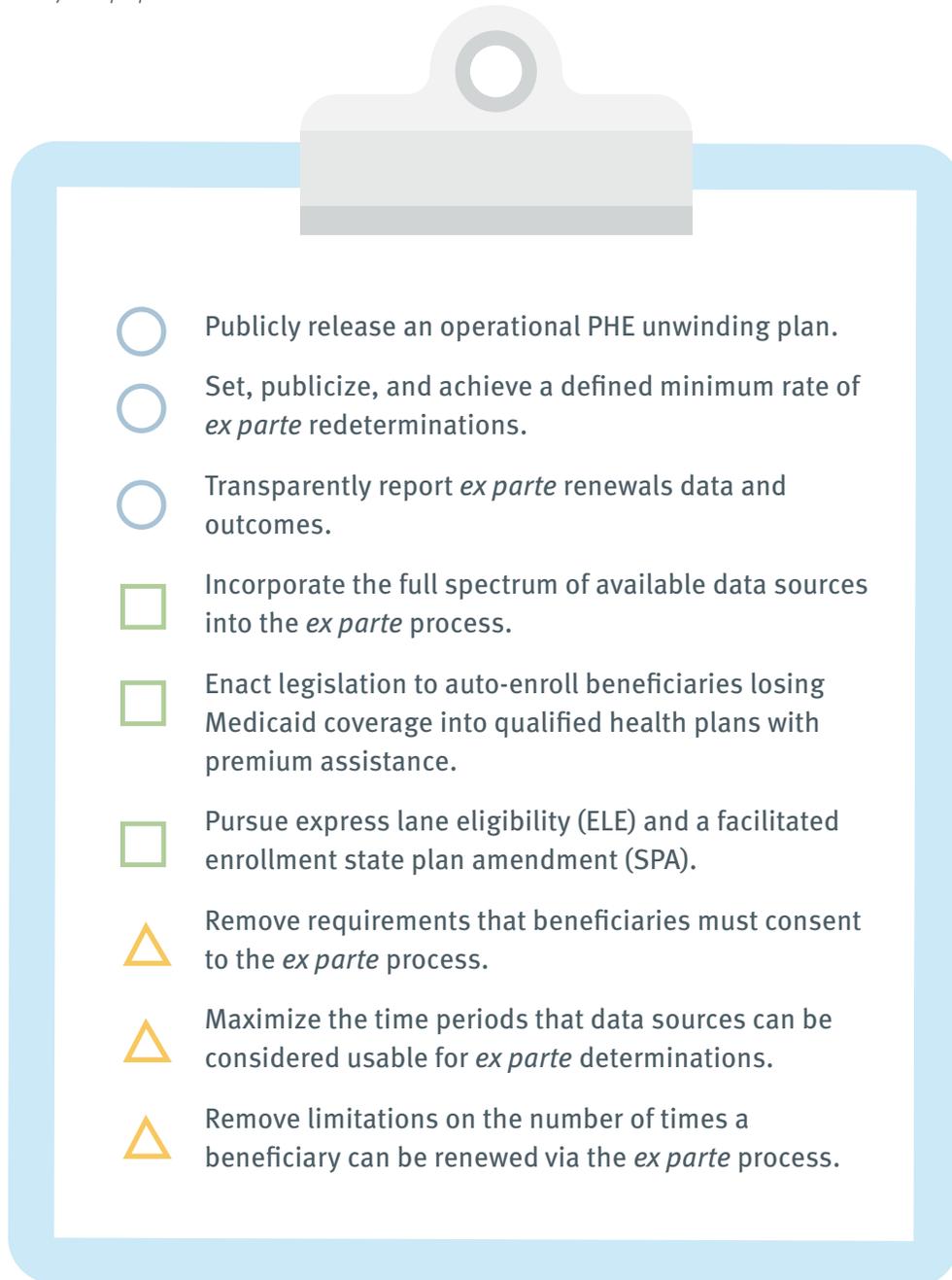


**Not a Moment to Lose:  
Critical Changes States  
Should Implement  
to Prevent Medicaid  
Coverage Losses**

If states do not act, many of the over 88 million people who rely on Medicaid and the Children's Health Insurance Program (CHIP) for their health insurance could lose their coverage when the federal COVID-19 public health emergency (PHE) expires.<sup>1</sup> Once the PHE's continuous coverage requirement ends, states will resume their pre-pandemic processes for establishing whether a person continues to qualify for Medicaid — known as redeterminations. If not done with considerable planning and care, this resumption could result in unnecessary coverage losses. Federal law requires states to maximize electronic eligibility redeterminations rather than requiring a mailed application.<sup>2</sup> As the end of the PHE and restart of redeterminations loom on the horizon, states should do everything in their power to renew coverage for people who remain eligible, especially when readily available data can often confirm eligibility.

## Key Policies To Prevent Coverage Losses Checklist

This checklist provides state advocates and policymakers with a summary of key policies their state should consider to prevent massive, unnecessary coverage losses, with more items and details provided in the rest of the paper.



- Publicly release an operational PHE unwinding plan.
- Set, publicize, and achieve a defined minimum rate of *ex parte* redeterminations.
- Transparently report *ex parte* renewals data and outcomes.
- Incorporate the full spectrum of available data sources into the *ex parte* process.
- Enact legislation to auto-enroll beneficiaries losing Medicaid coverage into qualified health plans with premium assistance.
- Pursue express lane eligibility (ELE) and a facilitated enrollment state plan amendment (SPA).
- Remove requirements that beneficiaries must consent to the *ex parte* process.
- Maximize the time periods that data sources can be considered usable for *ex parte* determinations.
- Remove limitations on the number of times a beneficiary can be renewed via the *ex parte* process.

## Background

### What are “*ex parte*” renewals?

The *ex parte* (also known as automated or passive) renewals process is a crucial tool states must use (under federal law) to adequately protect Medicaid coverage for their low-income residents during redeterminations. This process enables Medicaid agencies to renew beneficiaries’ coverage based on existing and accessible beneficiary data without having to contact beneficiaries for updated information.

**States need to utilize every moment during the current PHE extension and any future extensions to go beyond federal guidance and improve their *ex parte* processes to ensure minimal coverage losses.**

#### This paper presents state advocates with:

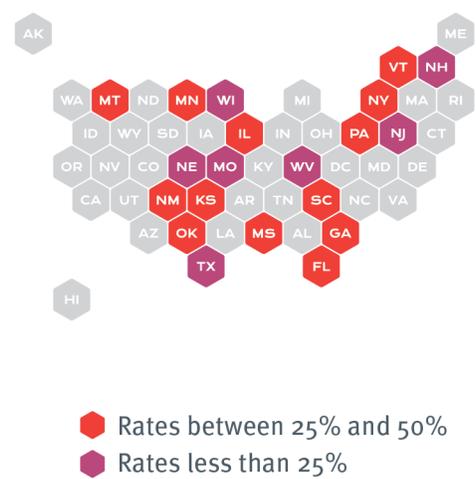
1. Pertinent information on the *ex parte* process and the PHE.
2. Clear, achievable goals to champion in their respective states.
3. A checklist of vital changes to pursue to increase *ex parte* rates in the time remaining before the PHE ends.

### Current federal law and guidance

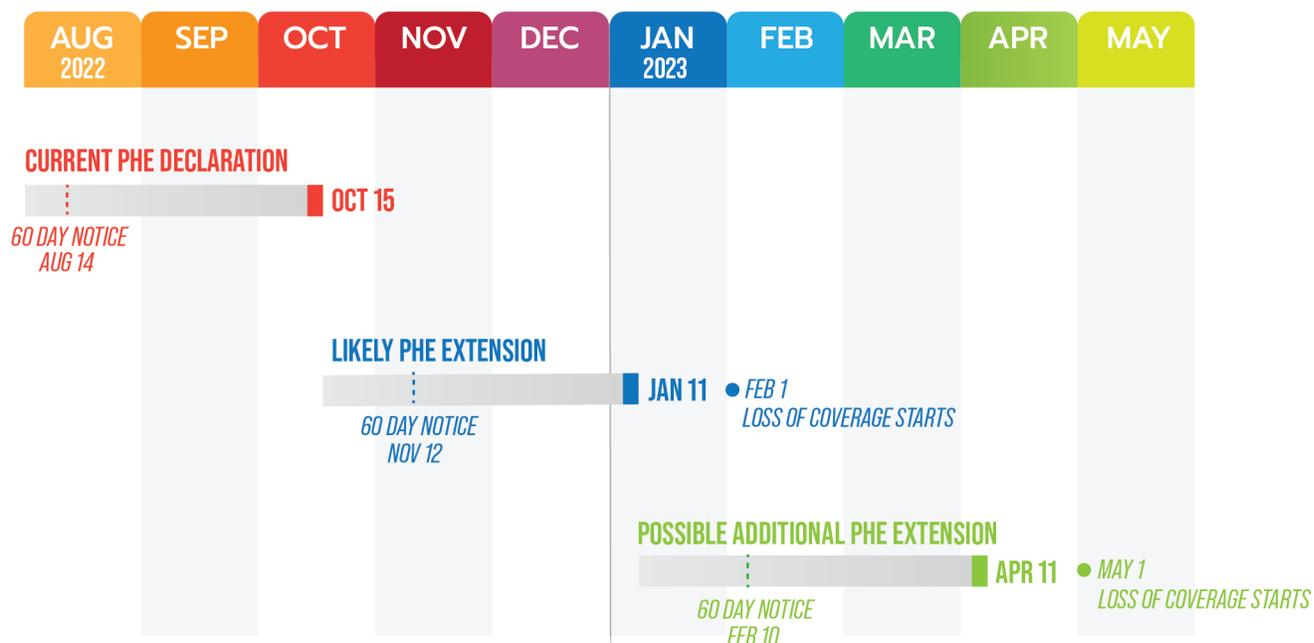
#### *ACA requirement and implementing regulation*

More than a decade ago, the Affordable Care Act and 42 U.S.C. §435.916(2) legally mandated that states use the *ex parte* process to assess individuals’ eligibility, “including but not limited to information accessed through any data bases accessed by the agency.”<sup>3</sup> Despite this mandate, states rely on the *ex parte* process to varying extents. Looking at data from before 2020, which is not shaped by the current continuous coverage requirements, just nine states completed greater than 75% of their renewals using the *ex parte* process, and 14 states did so with 50% to 75% of their renewals.<sup>4</sup>

### States That Need To Improve Their *Ex Parte* Rates<sup>5</sup>



## Estimated Time Remaining for States to Improve Their *Ex Parte* Rates Before Redeterminations Begin



### *CMS guidance regarding the end of the PHE – what advocates should know*

Since 2020, the federal Centers for Medicare & Medicaid Services (CMS) has released and consistently updated guidance to prepare states for the eventual end of the PHE. The latest guidance outlines the following:

- » The Biden administration will give 60 days' notice of the PHE's end date.
- » States can start initiating, but not finalizing, beneficiaries' renewals beginning with the administration's 60-day notice.
- » States have 12 months to initiate renewals and 14 months total to close out every case.
- » States can submit a section 1902(e)(14)(A) waiver request to renew Medicaid coverage for Supplemental Nutrition Assistance Program (SNAP) recipients without conducting a separate redetermination.<sup>6</sup>

The above timeline displays the estimated time remaining for states to improve their *ex parte* rates before redeterminations begin. Since renewals can be initiated following the administration's 60-day notice, **states do not have a moment to lose to start making these improvements.**

## Goals for states and state advocates

The vast majority of states still have much to do to prepare for the end of the PHE. While the task is daunting, there are clear, achievable policies states can implement now to proactively and transparently protect the Medicaid coverage of millions of their residents. Particularly if the PHE is extended further, states have time to improve their renewals systems before redeterminations start in addition to focusing on outreach. But even if the PHE ends soon, these are urgent priorities that states should strive to meet. As summarized in the checklist, critical policies for advocates to advance fall into the following categories.

### ○ TRANSPARENCY AND GOAL SETTING

The PHE's timing and state redetermination processes involve complicated details impacting Medicaid beneficiaries. Advocates should push their states to take the actions listed below to provide clarity on the coming changes and consistent updates on redetermination outcomes to help all stakeholders protect coverage for those who rely on Medicaid.

- ***Publicly release an operational PHE unwinding plan.***
  - › Federal guidance from 2021 and 2022 requires states to develop an “unwinding operational plan” and submit it to CMS. But few states have made public a robust operational unwinding plan that details the planned upcoming changes for stakeholders, including Medicaid beneficiaries, health plans, health care providers, community-based organizations, enrollment assisters, and others. **This is a crucial first step, and states should work with stakeholders to develop and release a plan without delay.** Given that renewals can be initiated 60 days before the official end of the PHE, states should not wait to develop and release their plan. State advocates can look to the operational unwinding plans released by [Arizona](#) and [California](#) for guidance.
- ***Set, publicize, and achieve a defined minimum rate of ex parte redeterminations.***
  - › Prior to the pandemic, 20 states completed less than 50% of their renewals using the *ex parte* process, with seven of those states completing less than 25%.<sup>7</sup> This was, and is, clearly out of compliance with the federal requirement to maximize *ex parte* redeterminations. These and other states should strive for

## ○ TRANSPARENCY AND GOAL SETTING, CONTINUED

a minimum *ex parte* renewal rate of 50% that strengthens over time to be greater than 60%. States should include their target *ex parte* rates in their operational unwinding plans with the necessary implementation strategy. Pursuing a defined minimum rate will be instrumental in protecting Medicaid coverage and alleviating burdens on both the state and beneficiaries once the PHE is over.

### ○ **Transparently report *ex parte* renewals data and outcomes.**

- › CMS' latest State Health Official letter requires states to submit monthly data on their eligibility and enrollment actions.<sup>8</sup> State advocates should push their respective states to publicly release this data in addition to sending the required reports to CMS. This will allow advocates to work together with state officials in real time to identify problems and implement solutions that prevent avoidable coverage losses. Additionally, states should commit to continually update and release *ex parte* outcome information — the ratio of successful *ex parte* renewals to renewals that require beneficiaries to receive a notice and take action. This outcome data will inform both the progress still needed to achieve a defined minimum *ex parte* renewal rate and the needed amount of outreach to Medicaid beneficiaries.

## □ HIGH-IMPACT LEGISLATIVE AND SYSTEMS CHANGES

While the changes below may be time-intensive to enact or implement, they have great potential to protect Medicaid beneficiaries' coverage. Given that these policies take longer to implement, advocates should push their states to consider these changes immediately.

### □ *Incorporate the full spectrum of available data sources into the ex parte process.*

- › This is the number one systems-based strategy for increasing ex parte rates. With a full complement of data sources providing information, there is a lower likelihood that states will need to contact a beneficiary. As detailed in the Families USA publication titled [Case Study: Strategies for States to Maximize Medicaid Ex Parte Renewals and Limit Coverage Losses](#), states with higher *ex parte* rates consult records and data from the Social Security Administration, the Internal Revenue Service, Unemployment Insurance, SNAP, Temporary Assistance for Needy Families (TANF), and states' departments of motor vehicles.
- › States should pursue a temporary Section 1902(e)(14)(A) waiver to deem SNAP beneficiaries eligible for Medicaid coverage without conducting an additional modified adjusted gross income (MAGI)-based redetermination.<sup>9</sup> As Families USA explained in the publication titled [Medicaid Programs Should Protect Health Care for Millions of Families by Implementing a New Federal Option for SNAP-Based Electronic Renewal](#), state advocates should urge their respective states to contact their CMS state lead to review sample waiver language and begin the application process.
  - As of August 5, 2022, CMS has granted six states the ability to perform targeted SNAP renewal through Section 1902(e)(14)(A): **Alabama, Delaware, Kentucky, Louisiana, New Mexico and, Ohio.**<sup>10</sup>

### □ *Auto-enroll beneficiaries losing Medicaid coverage into qualified health plans with premium assistance.*

Rhode Island's recently enacted 2022-2023 budget authorized the creation of a program to enroll individuals losing Medicaid coverage following the PHE in qualified health plans on the state's exchange. Rhode Island also permitted

## □ HIGH-IMPACT LEGISLATIVE AND SYSTEMS CHANGES, CONTINUED

allocation of American Rescue Plan funds to provide individuals enrolling in this new program with two months of premium assistance.<sup>11</sup> When state legislative and budget sessions begin next year, this legislation should serve as model language for states looking to ease transitions to affordable marketplace coverage. A recent report by the Medicaid and CHIP Payment and Access Commission (MACPAC) highlighted the importance of Rhode Island's legislation as only 3% of those disenrolled from Medicaid or the CHIP in 2018 regained coverage on the marketplace within the following year.<sup>12</sup>

### □ *Pursue express lane eligibility (ELE) and a facilitated enrollment state plan amendment (SPA).*

- › These changes would result in longer-term versions of the temporary Section 1902(e)(14)(A) waiver option described above. Through sections 1902(e)(13) and 2107(e)(1), states can use ELE authority to consider the eligibility findings of a designated state entity related to income, household size, or other factors of eligibility from another program to enroll children in Medicaid or CHIP.<sup>13</sup> In addition to SNAP, express lane agencies include TANF; Head Start; the National School Lunch Program; and Women, Infants, and Children.<sup>14</sup> Currently five of the seven states using ELE consider SNAP information to assist with Medicaid enrollment.<sup>15</sup> Additionally, states can request a facilitated enrollment SPA for both adults and children to use income determinations from another program if there is high certainty an individual would be eligible with MAGI-based income. States and state advocates should consult with State Health Official letters [SHO #10-003](#) and [SHO #15-001](#) for more information on adopting these strategies to protect Medicaid coverage.<sup>16</sup>

### □ *Extend ex parte renewals to both MAGI and non-MAGI populations.*

- › States restricting *ex parte* assessments to just their MAGI populations are unnecessarily limiting their *ex parte* rates. Non-MAGI populations include people with disabilities and those eligible for Supplemental Security Income (SSI), individuals over age 65 and below 100% of the federal poverty level, individuals with medical needs, children in foster care, and people using home and community-based services, among others. While these individuals have their eligibility assessed differently than MAGI individuals, states are still required to

## □ HIGH-IMPACT LEGISLATIVE AND SYSTEMS CHANGES, CONTINUED

use the *ex parte* process to consider their eligibility for Medicaid. States should alter their business rules to ensure the *ex parte* process is available to this population and verify their eligibility using the asset verification system (AVS).<sup>17</sup> If no AVS data is returned within a reasonable time frame, states can also use Section 1902(e)(14)(A) waiver authority to renew beneficiaries.<sup>18</sup>

- CMS has granted 10 states the ability to perform streamlined asset verification through Section 1902(e)(14)(A), including: **Arizona, California, Hawaii, Kentucky, Missouri and, Tennessee.**<sup>19</sup>

### □ *Examine data sources' hierarchy to consider all information.*

- › A state's *ex parte* process will include business rules defining how beneficiary information should be considered to determine a threshold of eligibility. State advocates should encourage states to revisit their business rules to ensure the hierarchy of data assesses all information in a step-wise fashion rather than only comparing the highest income data source against the eligibility threshold.<sup>20</sup> It may take time to alter a system's data logic, so states should quickly examine this change.

### □ *Fully automate the ex parte process.*

- › Ex parte renewals are most efficient and effective when the process is fully automated and not dependent on caseworker involvement. Fully automated processes will alleviate the burdens and delays caused by the staffing shortages many Medicaid agencies will be grappling with as the PHE ends. For example, North Carolina's *ex parte* process is semi-automatic with some caseworker involvement at certain data-matching steps; however, the state is currently making progress on fully automating its process.<sup>21</sup> Similar to the recommendation above, this change will also take significant time to implement, so states should begin that process now.

## △ CRITICAL TECHNICAL CHANGES

The changes listed below may not require the investment of the systems changes above, but they are critical actions states should take to close barriers to higher *ex parte* rates.

### △ *Remove requirements that beneficiaries must consent to the ex parte process.*

- › These requirements defeat the purpose of *ex parte* redetermination — to process renewals using existing data sources to confirm eligibility without having to contact beneficiaries — making it considerably slower and less effective. Moreover, these requirements are not allowable under 42 U.S.C. §435.916. States out of compliance with this federal regulation may be subject to higher scrutiny or corrective action plans from CMS to align their *ex parte* processes with legal requirements.<sup>22</sup>
- › States should also waive any requirement that beneficiaries' confirmation and consent be obtained when managed care plans share beneficiary contact information with the state. This would impede coordination efforts to preserve coverage. States can apply for and use temporary Section 1902(e)(14)(A) waiver authority to accept updated contact information provided by managed care plans without sending a notice and requesting confirmation from the beneficiary.<sup>23</sup>
  - CMS has granted 15 states the ability to partner with managed care plans to update contact information through Section 1902(e)(14)(A), including: **Kansas, Minnesota, Nevada, New Hampshire, New Jersey, and Virginia.**<sup>24</sup>

### △ *Maximize the time periods that data sources can be considered usable for ex parte determinations.*

- › Restricting how recent a data source must be to consider it during a renewal unnecessarily decreases a state's *ex parte* rates, especially since the pandemic disrupted some data reporting and collection. States should ensure the full spectrum of relevant existing data is available to make eligibility determinations. This includes assessing the average age of their data sources and altering their business rules to reflect the reality of data collection.

## △ CRITICAL TECHNICAL CHANGES, CONTINUED

### △ *Remove limitations on the number of times a beneficiary's coverage can be renewed via the ex parte process.*

- › States are legally mandated under 42 U.S.C. §435.916 to use the *ex parte* process to consider eligibility regardless of how many times it has previously been used with a given beneficiary. These limitations are not allowable and needlessly increase the future burden on both the state and beneficiary to certify Medicaid coverage with mailed notices.<sup>25</sup> States with these limitations in place should alter their business rules to be in compliance with federal regulation and ensure all beneficiaries are considered through the *ex parte* process.



## Conclusion

Once the PHE ends, the resumption of redeterminations on such a massive scale will threaten the Medicaid coverage that millions of people and families rely on to maintain their health. As the COVID-19 pandemic continues and costs continue skyrocketing for families, state advocates should push their respective states to implement the above transparency, systems, and technical changes to increase ex parte renewal rates and better ensure low-income people are protected from devastating, unnecessary coverage losses that may place their health and economic security in free fall.

## Endnotes

- <sup>1</sup> U.S. Centers for Medicare and Medicaid Services, “Access to Health Coverage,” CMS.gov, last modified July 28, 2022, <https://www.cms.gov/pillar/expand-access>.
- <sup>2</sup> 42 U.S.C. §435.916(a)(2).
- <sup>3</sup> 42 U.S.C. §435.916(a)(2).
- <sup>4</sup> Tricia Brooks et al., *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings From a 50-State Survey* (San Francisco, CA: Kaiser Family Foundation, March 2022), <https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2022.pdf>.
- <sup>5</sup> Brooks et al., *Medicaid and CHIP*.
- <sup>6</sup> State Health Official Letter SHO #22-001, “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,” U.S. Centers for Medicare and Medicaid Services (CMS), March 3, 2022, <https://www.medicare.gov/federal-policy-guidance/downloads/sho22001.pdf>.
- <sup>7</sup> Brooks et al., *Medicaid and CHIP*.
- <sup>8</sup> CMS, SHO #22-001.
- <sup>9</sup> Stan Dorn, *Medicaid Programs Should Protect Health Care for Millions of Families by Implementing a New Federal Option for SNAP-Based Electronic Renewal* (Washington, DC: Families USA, March 2022), [https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48\\_SNAP-Issue-Brief\\_final.pdf](https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48_SNAP-Issue-Brief_final.pdf).
- <sup>10</sup> U.S. Centers for Medicare and Medicaid Services (CMS), “COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals,” Medicaid.gov, accessed August 5, 2022, <https://www.medicare.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>.
- <sup>11</sup> Rhode Island General Assembly, *An Act Making Appropriations for the Support of the State for the Fiscal Year Ending June 30, 2023*, H 7123, introduced in House January 20, 2022, <https://webserver.rilegislature.gov/BillText22/HouseText22/H7123Aaa.pdf>. According to Article 12, Section 10(d), “HealthSource RI automatic enrollment: The Executive Office shall work with HealthSource RI to establish a program for automatically enrolling qualified individuals who lose Medicaid coverage at the end of the COVID-19 Public Health Emergency into Qualified Health Plans (“QHP”). HealthSource RI may use funds available through the American Rescue Plan Act to pay the first two (2) month’s premium for individuals who qualify for this program. HealthSource RI may promulgate regulations establishing the scope and parameters of this program.”
- <sup>12</sup> *Transitions Between Medicaid, CHIP, and Exchange Coverage* (Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC), July 2022), <https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf>.
- <sup>13</sup> CMS, SHO #22-001.
- <sup>14</sup> U.S. Centers for Medicare and Medicaid Services (CMS), “Express Lane Eligibility for Medicaid and CHIP Coverage,” Medicaid.gov, updated August 6, 2021, <https://www.medicare.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicare-and-chip-coverage/index.html>.
- <sup>15</sup> CMS, “Express Lane Eligibility.”
- <sup>16</sup> CMS, SHO #22-001.
- <sup>17</sup> Manatt Health, *Improving Ex Parte Renewal Rates: State Diagnostic Assessment Tool* (State Health and Value Strategies, Princeton University School of Public and International Affairs, June 2022), <https://www.shvs.org/wp-content/uploads/2022/06/Improving-Ex-Parte-Renewal-Rates.pdf>.

<sup>18</sup> CMS, SHO #22-001.

<sup>19</sup> CMS, “COVID-19 PHE Unwinding.”

<sup>20</sup> Manatt Health, *Improving Ex Parte Renewal Rates*.

<sup>21</sup> Rebecca Gordon et al., *Case Study: Strategies for States to Maximize Medicaid Ex Parte Renewals and Limit Coverage Losses* (Washington, DC: Families USA, May 2022), [https://familiesusa.org/wp-content/uploads/2022/05/2022-27\\_Strategies-for-States-Maximize-Medicaid-Ex-Parte-Renewals.pdf](https://familiesusa.org/wp-content/uploads/2022/05/2022-27_Strategies-for-States-Maximize-Medicaid-Ex-Parte-Renewals.pdf).

<sup>22</sup> Manatt Health, *Improving Ex Parte Renewal Rates*.

<sup>23</sup> CMS, SHO #22-001.

<sup>24</sup> CMS, “COVID-19 PHE Unwinding.”

<sup>25</sup> Manatt Health, *Improving Ex Parte Renewal Rates*.

This publication was written by:  
Garrett Hall, Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Melissa Burroughs, Associate Director, Strategic Partnerships  
Justin Charles, Digital Media Associate  
Nichole Edralin, Senior Manager of Design and Publications  
Eliot Fishman, Senior Director of Health Policy  
Kevin Han, Strategic Partnerships Associate  
Lisa Holland, Senior Communications Manager  
Adina Marx, Communications Associate  
Bailey Reavis, Federal Relations Manager

The following professional to the preparation of this material:  
Erin Pinkerton, Editor



1225 New York Avenue NW, Suite 800, Washington, DC 20005  
202-628-3030 info@familiesusa.org FamiliesUSA.org facebook / FamiliesUSA twitter / @FamiliesUSA