

Understanding the Financial Implications of the Medicaid Unwinding

How Health Centers Can Prepare for the Financial Impact

NACHC Webinar July 24, 2023

[Access Slides and Recording](#)

Please contact federalpolicy@nachc.org for more information

Question and Answer Summary

Q1: Are there specific dates health centers need to be aware of for the Medicaid unwinding?

A1: States can take up to 12 months to initiate and 14 months to complete renewals for all Medicaid beneficiaries. While most states plan to take the full time provided to unwind, some states are taking less than 12 months, as indicated in the [anticipated timeline published by CMS](#). States could begin initiating renewals in February, March, or April 2023, but no states could terminate Medicaid coverage until April 1, 2023. Each state is on a slightly different renewal timeline, with all unwinding renewals expected to be completed by June 2024.

Q2: What are procedural disenrollments and why might they occur?

A2: Procedural disenrollments occur when an individual's Medicaid coverage is terminated for administrative reasons (like not returning a renewal form or not providing all required documentation) rather than being determined ineligible for Medicaid. There are many reasons procedural disenrollments occur including not receiving a renewal form in the mail, difficulty getting help to complete a renewal form, or errors by the agency, including lost paperwork. Many individuals disenrolled for procedural reasons will still qualify for Medicaid or CHIP coverage, especially children. Not all people disenrolled procedurally are eligible; some may know they are over income or have enrolled in employer sponsored insurance and chose to not return the form. However, the [HHS Assistant Secretary for Planning and Evaluation estimates that 45 percent of all people, and 74 percent of children will remain eligible despite being disenrolled.](#)

Health Centers, Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs) and other providers should monitor unwinding data in their state to identify whether there are high rates of procedural disenrollments, indicating greater outreach and education among Medicaid enrollees may be needed. Gaps in coverage may prevent patients from seeking the health care services they need.

Q3: Can the NACHC staff comment on [recent legislation in Iowa](#) that would integrate SNAP and Medicaid eligibility systems?

A3: Integrated eligibility systems are intended to ease the administrative burden on applicants and enrollees providing access to multiple benefits while creating efficiencies for state agencies. They allow individuals to submit information once that is used for multiple benefit programs. With or without integrated systems, CMS has highlighted that coordinating SNAP and Medicaid renewals is considered a best practice that can help reduce procedural disenrollments. Given the overlap in SNAP and Medicaid eligibility requirements, using data from SNAP determinations can eliminate the need to provide the same information multiple times.

Coordinating Medicaid with SNAP does not mean that someone loses Medicaid inappropriately. People reporting an income increase during the SNAP renewal would also become ineligible for Medicaid. If that is the case, unless the state offers 12-month continuous eligibility (more likely for children and postpartum), the individual should have reported the income increase directly to Medicaid and would lose eligibility accordingly. Moreover, the number of families benefiting, and the efficiencies achieved by the state makes integrated systems excellent strategies for states to adopt, [as 29 states have done](#). *Please note NACHC has not reviewed the Iowa legislation in full detail. Rather NACHC is providing background on integrating SNAP and Medicaid systems.*

Q4: Will NACHC be producing a calculator to show the financial impact the Medicaid unwinding could have on health centers?

A4: NACHC is in the process of developing and publishing a national calculator to show the financial impact of losing Medicaid patients on health center revenue. We are also reviewing the feasibility of developing a calculator at the state or individual health center level. NACHC will be releasing various resources over the coming weeks, we will keep the field updated when the materials are available. To stay in touch with NACHC on Medicaid redeterminations please connect with us via our [NoddlePod](#) where we post updates, resources and allow health centers to connect with one another on best practices.

Q5: When patients lose coverage but are later re-enrolled (known as churn), will Medicaid coverage be retroactive? If the coverage is retroactive could the health center, then get paid by Medicaid?

A5: Under federal law, states are required to provide Medicaid coverage retroactively up to 90 days prior to the date of application for individuals found eligible for Medicaid. Health centers may receive payment for covered services provided during this retroactive period. However, some states have section 1115 waivers which restrict or exclude retroactive coverage eliminating this financial protection for these enrollees and for health centers.

CMS has offered two [temporary waiver options](#) to address potential gaps in coverage.

First, states may opt to automatically reinstate coverage back to the termination date if they receive the needed forms or documents, or a new application, to reconsider eligibility during the 90-day reconsideration period.

Additionally, states may allow certain Medicaid providers (e.g. pharmacies, community-based organizations, and other providers like community health centers) to be “qualified entities” to make presumptive eligibility (PE) determinations exclusively for individuals who have been procedurally disenrolled during the unwinding. This strategy would allow health centers to bill Medicaid and be reimbursed for a patient visit if the individual has lost coverage due to procedural reasons and is currently submitting missing forms or documents or a new application for coverage. It should be noted that there is no financial liability if it is found the patient is not eligible for Medicaid when the state makes a final determination.

Importantly, policies like retroactive coverage, automatic reinstatement to the date of application, and adoption of the targeted PE strategy will vary by state so the financial impacts of churn will be different depending on where a health center is located.

Q6: How will a Medicaid beneficiary know they have lost coverage for procedural reasons?

A6: State Medicaid agencies must send Medicaid beneficiaries a notice informing them of loss of coverage and the basis of the determination. However, if the state does not have the correct contact information for an individual or the notice process was not followed (due to system error or other reasons), the individual may not be aware they have lost coverage until seeking care with a provider, like a health center, or attempting to refill needed prescriptions.

Q7: Are some states taking up the option to delay procedural terminations?

A7: As part of its [release of new and updated strategies to minimize procedural disenrollments](#), CMS established a new flexibility allowing states to provide an additional 30 days past the renewal date for additional targeted outreach to individuals who would have otherwise been disenrolled for procedural reasons. This strategy is especially helpful if states are providing managed care organizations and providers lists of individuals at risk for procedural terminations to assist in outreach efforts.

It is important to note that the flexibility to delay procedural terminations is separate from CMS action in certain states requiring a pause in procedural disenrollments for some or all eligibility groups. Some states have voluntarily paused procedural terminations for specific populations as part of an agreed-upon mitigation strategy where a state was not in compliance with federal renewal requirements. Other states (which have not been released at this time) have been forced to pause procedural terminations due to violations or failure to follow federal rules. NACHC is monitoring and will share more information as it is available.