

NACHC Medicaid Unwinding Webinar

8-Month Renewal Update

November 16, 2023

Access [Slides](#) & [Recording](#)

Please contact federalpolicy@nachc.org for more information

Question and Answer Summary

Q1: What are key messages to share with patients relating to unwinding?

A1: NACHC has encouraged health centers to remind patients to update their contact information with their Medicaid agency and respond to Medicaid renewal forms. Health center staff need to be aware of the special enrollment periods for individuals no longer eligible for Medicaid and remind families that children can still be eligible for Medicaid/CHIP despite parents losing coverage. Between March 31, 2023, and July 31, 2024, Marketplace-eligible consumers who are losing Medicaid and/or CHIP coverage due to the unwinding can report their loss of coverage up to 60 days before their last day of Medicaid or CHIP coverage.ⁱ

As the unwinding continues, it will be vital for health centers to continue to educate patients on renewal-related requirements within their states. Additionally, connecting patients to other levels of coverage through the federal or state-based marketplaces will be key to ensuring continuity of care. Some patients who transition to marketplace coverage may be eligible for lower monthly premiums due to their income level and eligibility for premium tax credits.

Health Centers should also encourage their patients to complete renewal packets sent to them even if they are no longer eligible. Under certain circumstances, state Medicaid or CHIP agencies can send an individual's application/renewal information to the marketplace through an inbound account transfer. This transfer can help connect beneficiaries to other levels of coverage at the conclusion of their Medicaid benefits.ⁱⁱ

Q2: Have the problems with automatic terminations at the household level been resolved?

A2: CMS sent a [letter](#) to all states, the District of Columbia, and Puerto Rico regarding an eligibility system error related to automatic renewals for the Medicaid and CHIP programs in August 2023. The letter urged states to assess whether their eligibility systems were conducting automatic renewals at the individual level regardless of the eligibility of other household members. The assessment found that thirty states were not conducting renewals at the individual level. Thus, these states are out of compliance with federal requirements.

As a result of the assessment, CMS required all thirty states with this identified issue to pause procedural disenrollments for the impacted populations. Nearly half a million individuals nationwide had their coverage reinstated because of this system error being identified.ⁱⁱⁱ It will be necessary for Primary Care Associations (PCAs) and health centers in these states to monitor communications from the state in how the state is restoring coverage and how this will be communicated to patients.

Q3: Are FQHCs losing Medicaid enrollments at a lower rate than the other providers?

A3: Early estimates during the unwinding predicted that up to 2.5 million health center patients were at risk of losing Medicaid coverage.^{iv} Nationally, we will not have a full picture into the health center patient impact until Uniform Data Systems (UDS) data is released for the 2023 reporting year in July of 2025.

UDS reporting runs a year behind the calendar year. The next round of UDS data will be released in July of 2024 and will show an incomplete view of the patient impact throughout the unwinding. Data released in July of 2025 will include UDS data reporting from the calendar year 2024 and will be the most accurate representation of patient coverage impacts.

One key aspect of UDS reporting that is important to note: UDS reporting captures patient insurance status at the time of a countable visit. So, some patients may be listed in UDS as having Medicaid coverage despite losing their insurance later in the year. If a patient doesn't visit the health center after losing Medicaid coverage, their coverage transition may not be captured.

Q4: What unwinding flexibilities granted by CMS have the potential to remain permanent?

A4: It is unclear which temporary flexibilities granted under 1902(e)(14)(A) of the Social Security Act will remain permanent, if any. The most common flexibilities adopted by states include enrolling/renewing individuals based on SNAP and/or TANF eligibility, renewing Medicaid eligibility for individuals with no income on an ex-parte basis, partnering with the national change of address database and U.S. postal service forwarding address to update beneficiary contact information, and partnering with managed care plans to update in state beneficiary contact information.^v

Q5: Are there any key points FQHC finance departments should know about unwinding?

A5: One study conducted at the start of the unwinding estimated that health centers could lose between \$1.5 billion to \$2.5 billion in revenue nationally due to patients losing Medicaid coverage. This could result in health centers serving 1.2 to 2.1 million fewer patients and employing about 10,000 to 18,000 fewer staff members nationally. The impact could vary for every [health center](#) due to the unique distribution of payers within each organization's budget.^{iv}

NACHC encourages health centers to take the following actions to reduce the financial impact of the unwinding: enhance eligibility and enrollment processes, strengthen patient education and financial counseling, optimize billing and coding workflows, diversify payer mixes, improve denial management systems, monitor key performance indicators, and explore grant opportunities.

Q6: Is the renewal timeline different for U.S. territories?

A6: Each state and territory will have 12 months to initiate and 14 months to complete a renewal for their Medicaid beneficiaries. Each state and territory are taking a slightly different approach and time period to conducting its renewal process. States that are delaying or pausing renewals may have their overall timeline extended to complete renewals. For a full list of state and territory timelines relating to the unwinding, please view the [CMS anticipated state timelines](#).^{vi}

Q7: How does CMS plan to address state non-compliance during redeterminations?

A7: On December 4th, [CMS issued an enforcement rule with penalties](#) for states that do not remain in compliance with Medicaid unwinding reporting requirements or with Federal Medicaid eligibility redetermination requirements during the unwinding period. These regulations are effective on December 6, 2023, and are open for public comment due February 2, 2024. This regulation applies to all 56 States and territories, regardless of whether a State continues to claim the FFCRA FMAP increase. The rule interprets/reiterates the state reporting requirements and CMS enforcement authorities that Congress enacted in the [Consolidated Appropriations Act, 2023](#). The rule codifies and builds on CMS' own prior sub-regulatory [guidance](#).

Medicaid agencies must report monthly data metrics to allow for federal monitoring and oversight of the unwinding process. States that fail to submit monthly reports to CMS will be required to create and follow corrective action plans (CAPs). States that do not create and/or follow CAPs may be ordered to pause some or all procedural disenrollments and be subject to penalties up to \$100,000 per day. Continued non-compliance by states will lead to cuts to the federal share of their Medicaid budgets, up to 1 percentage point. To view the full list of data metrics included in the monthly reports view this [NACHC summary](#).

Q8: Will individuals who fail to complete the redetermination process be eligible for presumptive eligibility?

A8: Under the new unwinding-related waiver, states can designate pharmacies, community-based organizations, and other providers (health centers) to make presumptive eligibility determinations for individuals disenrolled from Medicaid or CHIP for a procedural reason. This flexibility can allow health centers to screen for continuous eligibility of patients who have lost coverage and bill for services delivered under the state Medicaid program (only if the state has applied for this flexibility through a [1902\(e\)\(14\)\(a\) waiver](#)).

It should be noted that the health center is not at risk for covered services delivered if it turns out that the individual is over income (and neither is the patient). Services delivered during the presumptive eligibility period will be reimbursable to the provider and the state will receive the federal matching rate.^{vii}

Q9: Which unwinding data represents the most opportunity for health centers?

A9: The key data element that health centers should monitor throughout the unwinding are procedural disenrollments. This type of disenrollment from Medicaid coverage does not review a patient's eligibility one way or another and is strictly administrative.^{viii}

Individuals who are disenrolled from Medicaid due to procedural reasons can often still be eligible for coverage. It will be vital that health centers monitor the procedural

disenrollment rates within their states and ensure patients understand the needed steps to retain their Medicaid coverage.

Q10: What is the role that Managed Care Organizations (MCO) can play in outreach efforts?

A10: Managed Care Organizations (MCOs) have the potential to play a significant role in outreach efforts throughout the unwinding. State Medicaid agencies using [1902\(e\)\(14\)\(A\) waivers](#) can utilize MCOs to conduct direct outreach to Medicaid beneficiaries. Health Centers are partnering with MCOs in their state to support outreach and enrollment efforts.

Examples of MCO engagement with outreach efforts include: MCOs providing direct assistance to enrollees in completing renewal forms and states partnering with plans to update in-state beneficiary contact information. It is important to note that state Medicaid agencies must grant MCOs the ability to conduct direct enrollee outreach efforts using state Medicaid waivers.^{ix}

ⁱ <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>

ⁱⁱ <https://www.cms.gov/files/document/faqs-marketplace-unwinding.pdf>

ⁱⁱⁱ <https://www.cms.gov/newsroom/press-releases/coverage-half-million-children-and-families-will-be-reinstated-thanks-hhs-swift-action>

^{iv} <https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers>

^v <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>

^{vi} <https://www.medicaid.gov/sites/default/files/2023-06/ant-2023-time-init-unwin-reltd-ren-06292023.pdf>

^{vii} https://www.nachc.org/wp-content/uploads/2023/10/Presumptive_Eligibility_Summary.pdf

^{viii} <https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/#:~:text=Procedural%20disenrollments%20are%20cases%20where,packets%20within%20a%20specific%20timeframe.>

^{ix} <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html>