



Strategies to Improve Continuous Medicaid Coverage for Children and Youth with Special Health Care Needs (CYSHCN)

Continuous health insurance coverage is critical for ensuring access to care for children and youth with special health care needs (CYSHCN), who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require more health services than children generally.¹ Lapses in coverage for CYSHCN can result in forgone medical care, unmet health needs, and family financial hardship.² This explainer provides an overview of state strategies to ensure continuous coverage for children enrolled in Medicaid and presents opportunities for Title V to partner to promote continuous coverage for CYSHCN in particular.³

Public insurance (Medicaid and CHIP) is the single largest source of insurance coverage for CYSHCN in the United States. Within Medicaid, approximately 10% of all enrollees experience churn, meaning they are disenrolled and re-enrolled within a short period of time.⁴ Several factors contribute to churn, including short term changes in employment status or earnings, and challenges completing the process of renewing Medicaid coverage, sometimes known as administrative burden. Administrative burden contributes substantially to Medicaid coverage churn; families may face barriers related to understanding renewal forms or may not receive notices of renewal due to changes in address or phone number or loss of phone service.⁵ These administrative burdens disproportionately impact people of color, exacerbating inequalities in access to care and financial hardship.⁶

Under the Families First Coronavirus Response Act (FFCRA), states received an enhanced federal matching rate if they maintained continuous enrollment for all Medicaid beneficiaries during the period of the Public Health Emergency (PHE). Largely due to the continuous coverage requirement, the number of uninsured children declined during the COVID-19 pandemic, reversing the previous increasing trend from 2016 to 2019.⁷ The federal enrollment protections prevented beneficiaries from losing coverage due to administrative reasons or income increases, highlighting the importance of permanent policies that promote continuous coverage.⁸

State Strategies to Promote Continuous Coverage

Continuous Eligibility

The Consolidated Appropriations Act of 2023 requires all states to provide 12-month continuous eligibility for children enrolled in Medicaid and CHIP.⁹ This means that children maintain their coverage for 12 months regardless of any changes in their family's income. This requirement will take effect on January 1, 2024.

Prior to the implementation of this provision of the Consolidated Appropriations Act, states can implement 12-month continuous eligibility for children enrolled in Medicaid or CHIP through a state plan option.¹⁰ As of January 2023, 24 states have implemented 12-month continuous eligibility for all children using the existing

state plan option.¹¹ An additional three states offer continuous eligibility for children under a specified age or for a period of less than 12 months.¹² Currently, there is not a state plan option available to provide continuous eligibility for adults or for a period longer than 12 months, though some states have utilized 1115 Demonstration Waivers to implement such policies. In September 2022, Oregon became the first state to receive waiver approval from the Centers for Medicare & Medicaid Services (CMS) to provide multi-year continuous coverage for young children. Other states have similar waivers in development or pending approval from CMS.¹³

State Spotlight: Oregon

Oregon's 1115 waiver will provide continuous eligibility for children up to age six, and two-year continuous eligibility for all people over age six. In order to make the case for continuous eligibility, the Oregon Health Authority (the state Medicaid agency) analyzed rates of uninsurance by race/ethnicity among Oregon residents before and during the COVID-19 public health emergency, during which the state could not disenroll beneficiaries, and found a significant decline in uninsurance among Black residents. Their data analysis also examined rates of churn among children enrolled in Medicaid, and they found a decline in churn during the PHE. This analysis pointed to the potential impacts of continuous eligibility on racial equity and continuity of coverage for children. Title V CYSHCN programs can bring their data analysis expertise, knowledge of the system of services for CYSHCN, and program data to demonstrate the potential impacts of continuous eligibility in their states.¹⁴

Express Lane Eligibility

Express Lane Eligibility is designed specifically to improve enrollment and retention among eligible children in Medicaid and CHIP.¹⁵ Created under the Medicaid and CHIP Reauthorization Act of 2015 and reauthorized in 2017, this state plan option allows states to determine children's eligibility using data from other programs and agencies.¹⁶ Sources of data may include the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), the Women, Infants, and Children program (WIC), the National School Lunch Program, and others.¹⁷ This data can be used to determine initial eligibility for Medicaid and to renew Medicaid eligibility.

According to a 2016 report by the Office of the Inspector General (OIG), which drew on qualitative data from interviews with state Medicaid officials, states that implemented this option saw increased enrollment among eligible children, increased retention of child enrollees, and decreased administrative costs associated with churn.¹⁸ As of August 2021, seven states have express lane eligibility in place: Alabama, Colorado, Iowa, Louisiana, Massachusetts, South Carolina, and South Dakota.¹⁹

Ex Parte/Administrative Renewals

State Medicaid agencies must redetermine eligibility for enrollees every 12 months, unless the state has an 1115 waiver that provides for multi-year eligibility.²⁰ The Centers for Medicare & Medicaid services (CMS) require that states attempt to determine eligibility based on information available through other sources, such as the Internal Revenue Service (IRS) and the CMS data services hub, before requiring a beneficiary to provide that information, a process known as ex parte renewals.²¹ The ex parte process is similar to Express Lane Eligibility; however, ex parte renewal applies to only the renewal process, not initial eligibility, for both adults and children.

Completing ex parte renewals has benefits for states and Medicaid enrollees. Determining eligibility through other data sources means that beneficiaries do not have to complete and return paperwork, reducing administrative burden at the family level, and eliminating opportunities for disenrollment for administrative reasons (such as failing to return a form in a specified timeframe, or not receiving a form due to an address change). Although ex parte processes are required by CMS, states complete different proportions of their renewals through this process. Only nine states complete 75% or more of their renewals via the ex parte process.²²

States can improve their rates of ex parte renewals by taking advantage of all available data sources and examining their data systems to ensure that the system criteria correctly identify beneficiaries whose redetermination cannot be completed ex parte.²³ States can also assess how they are implementing reasonable compatibility, a policy that allows states to complete ex parte renewals when income information from data sources does not exactly match, as long as data from all sources indicates that the enrollee is still eligible.²⁴ This means that enrollees do not have to submit income verification, streamlining the renewal process.²⁵

State Spotlight: Arkansas

In 2020, Arkansas Medicaid launched the Arkansas Integrated Eligibility System (ARIES). The system streamlines the application process for beneficiaries applying for Health Care, the Supplemental Nutrition Assistance Program (SNAP), or the Transitional Employment Assistance (TEA) program. To prevent disruptions in coverage, the system will evaluate beneficiary information against all categories of Medicaid and CHIP coverage and will flag when the beneficiary may be eligible for multiple categories. The integrated data system can also improve the ex parte renewal process by linking an individual's eligibility data for multiple programs.²⁶

Limiting Cost-Sharing and Premiums

States have the option to charge premiums and to establish cost sharing requirements, including copayments, coinsurance, and deductibles, for Medicaid enrollees. However, states may not establish cost-sharing for most Medicaid-enrolled children, [with some exceptions](#).²⁷

As of January 2020, four states charge premiums to children enrolled in Medicaid, and 26 states with separate CHIP programs charge either annual enrollment fees (4 states) or impose monthly or quarterly premiums for children (22 states).²⁸ In general, states may only charge premiums to those with incomes above 150% FPL, though several states have submitted and received approval for 1115 Waivers that allow them to charge premiums to those earning less than 150% FPL.²⁹

State Medicaid agencies must provide a grace period of at least 60 days between nonpayment of premiums and when a child's coverage is discontinued; some states offer longer grace periods.^{30,31} Research demonstrates that Medicaid premiums create a barrier to obtaining and maintaining Medicaid coverage, and are associated with a decrease in use of health care and poorer health outcomes.³² Additionally, administrative burdens mean that those who lose coverage due to nonpayment may be less likely to re-enroll in coverage.³³ Limiting premiums and cost sharing can promote continuous coverage for children by reducing barriers to maintaining coverage.³⁴

Opportunities for State Title V Programs

- Provide education to state Medicaid agencies about the benefits of continuous eligibility for children with special health care needs.
- Convene Medicaid, family leader, and community-based organization partners to examine the impacts of churn in the state and consider strategies to address it.
- Collect and disseminate qualitative data about the impact of continuous coverage during the COVID-19 PHE for families raising CYSHCN.
- Analyze and present data about inequities in continuity of coverage among children.
- Partner with family leader and community-based organizations to develop and disseminate information about premium assistance supports available in the state.
- Partner with pediatricians and other providers to support continuous eligibility. Providers are often receptive to continuous eligibility policies, as patients churning in and out of coverage impedes the provision of services and hinders billing and scheduling.

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