mhpa
Medicaid Health Plans of America

Issue Brief

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Making the Case for Continuous Eligibility for Medicaid Populations Receiving Long-Term Services and Supports

Continuous Eligibility

Continuous eligibility (CE) is a Medicaid enrollment policy that allows for designated populations to continue to remain Medicaid eligible regardless of changes in circumstances, such as fluctuations in income, that might otherwise disrupt coverage and access to care. Federal law sets minimum standards for how states must conduct redeterminations of Medicaid eligibility requiring Medicaid beneficiaries to renew their eligibility approximately every 12 months and to proactively report "changes in circumstances" that may impact their eligibility. CE supports continuity of care and coverage for Medicaid beneficiaries by reducing churn, the cycling on and off of Medicaid coverage during the year, while reducing administrative costs for states.

Federal Medicaid policies have included CE requirements for specific populations as well as for limited time periods. During the COVID-19 federal public health emergency (PHE), Congress created a continuous coverage requirement keeping Medicaid eligible individuals enrolled in the Medicaid program in exchange for enhanced federal funding.[1] The American Rescue Plan Act of 2021 provided for 12-month postpartum continuous eligibility as an option for states with nearly 40 states enacting or planning to enact this policy.[2] Most recently, with the passage of the Consolidated Appropriations Act, 2023 (CAA, 2023), states are required, as of January 1, 2024, to provide 12 months of CE for children under the age of 19 in Medicaid and the Children's Health Insurance Program (CHIP).[3] Prior to the passage of CAA, 2023, states had the option to provide children with 12 months of continuous coverage under CHIP and Medicaid, with 21 states implementing CE for children in both Medicaid and CHIP and an additional 11 states implementing CE in at least one program.[4]

Benefits of CE

Individuals with continuous coverage are more likely to have access to preventive care, experience fewer unmet health care needs, and are in better health than those who cycle on and off coverage.[5] Continuous coverage is also a valuable approach for addressing health disparities and supporting health equity. Notably, "Black, Hispanic, and Indigenous individuals and families are more likely to live in poverty and therefore have higher rates of income volatility than Whites"[6] and are at increased risk for experiencing churn.

Providing continuous coverage can also help avoid higher health care costs that can result when care is delayed or sought in hospital emergency rooms due to gaps in coverage.[7] Studies have found that monthly health care expenditures for continuously covered individuals are lower than for those who experience disruptions in coverage.[8] Additionally, state administrative costs related to churning—processing terminations, notifications, and reapplications—can be considerable. The Commonwealth Fund studied potential changes in state spending if states were to extend 12-month continuous eligibility to adults in 2024 and found that state administrative savings of $51 million and savings of $118 million for state and local governments on uncompensated care. [9]

Medicaid & Long-Term Services and Supports

Medicaid is the largest single payer of long-term services and supports (LTSS) in the United States covering all home and community-based services (HCBS) such as personal care, social engagement, work supports, adult day care, home-delivered meals, and transportation services, as well as institutional services. Medicaid eligibility determinations for LTSS consider an individual's finances, their income and assets, if any, and measures of functional status, referred to as level-of-care (LOC) criteria, rather than the existence of a specific clinical condition.

Unlike many Medicaid beneficiaries, who qualify for Medicaid based on the modified adjusted gross income (MAGI) methodology, most LTSS users qualify on the basis of disability or age (65 and older) although they must still provide documentation of income and resources to be deemed financially eligible for Medicaid services.

MHPA Position & Recommendations

MHPA supports CE as a valuable policy for minimizing disruptions in care while being prudent fiscal policy for states. We also believe that LTSS represents one of the most essential services the Medicaid program offers. As previously noted, most LTSS users qualify for Medicaid on the basis of disability or age and their financial circumstances and would benefit from a CE policy that supports continued coverage particularly given the complexities of assessing Medicaid eligibility for the LTSS population.

Given the evidence-based benefits of CE for health outcomes, health equity, and overall costs, and the care needs of individuals qualifying for LTSS under Medicaid, MHPA encourages the development, broad availability, and implementation of CE policies for Medicaid populations receiving LTSS. Our specific recommendations for policymakers include:

Establishing a Statutory State Option. Federal regulations establish the basic outline of Medicaid eligibility policy, including mandatory and optional eligibility groups, and set minimum rules related to enrollment. The U.S. Congress can change Medicaid policies, including eligibility standards, by amending federal Medicaid laws. MHPA encourages federal policymakers to establish a state option for CE for Medicaid populations receiving LTSS. MHPA encourages federal and state policymakers to engage with individuals and communities comprised of Medicaid enrollees receiving LTSS when developing CE policies for this population.

Encouraging Section 1115 Demonstration Waivers. States have considerable flexibility related to the administration of the Medicaid program including waivers that allow for the testing of new approaches in Medicaid outside of what is required under federal Medicaid law. In the absence of a state option, MHPA recommends that policymakers encourage states to apply for a section 1115 demonstration waiver to extend CE for Medicaid populations receiving LTSS.

Conclusion

Enabling stable health care coverage for Medicaid enrollees is a meaningful step forward toward addressing gaps in coverage and supporting continuity of care. Our Medicaid health plan members are encouraged by the recent implementation of 12 months of continuous coverage required for children enrolled in Medicaid and CHIP. We believe Medicaid enrollees receiving LTSS would similarly benefit from CE policies and are working with federal and state partners to support the expansion of this impactful policy.

Endnotes

1 Families First Coronavirus Response Act, https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf

2 American Rescue Plan Act of 2021, https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf

3 Consolidated Appropriations Act, 2023, https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.

4 For a list of states that provided continuous eligibility in Medicaid and CHIP prior to January 1, 2024, **see** https://www.medicaid.gov/chip/eligibility/continuous-eligibility/index.html.

5 Sarah Sugar, Christie Peters, Nancy De Lew, Benjamin D. Sommers, Assistant Secretary for Planning and Evaluation (ASPE), Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, (ASPE Issue Brief, April 12, 2021). https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf (accessed February 2024).

6 Tricia Brooks, Allexa Gardner, Continuous Coverage in Medicaid and CHIP, (Georgetown University Health Policy Institute, Center for Children and Families, July 2021), https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf (accessed February 2024).

7 Brooks et al., Continuous Coverage in Medicaid and CHIP.

8 Brooks et al., Continuous Coverage in Medicaid and CHIP.

9 Matthew Buettgens, Commonwealth Fund, Ensuring Continuous Eligibility for Medicaid and CHIP: Coverage and Cost Impacts for Adults https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/ensuring-continuous-eligibility-medicaid-impacts-adults

About Medicaid Health Plans of America (MHPA)

Founded in 1995, the **Medicaid Health Plans of America (MHPA)** represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its **152**-member health plans, known as managed care organizations (MCOs), that serve more than **51** million Medicaid enrollees in **42** states, the District of Columbia, and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.