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Medicaid Programs Should Protect Health Care for Millions of Families by Implementing a New Federal Option for SNAP-Based Electronic Renewal

Introduction

The Centers for Medicare & Medicaid Services (CMS) recently released guidance that gives states a powerful new tool that can prevent millions of people from losing Medicaid. The tool can also help states cope with overwhelming administrative burdens and strengthen Medicaid's program integrity.[1] Specifically, when Medicaid redeterminations begin after the end of the COVID-19 public health emergency (PHE), states are allowed to automatically renew Medicaid eligibility for beneficiaries under age 65 who receive assistance from the Supplemental Nutrition Assistance Program (SNAP). Nearly all SNAP participants qualify for Medicaid, which is why this new option makes so much sense. To achieve the greatest possible efficiency gains, states should immediately begin developing automated systems to identify beneficiaries who participate in SNAP and to renew them electronically.

Medicaid beneficiaries are likely to experience huge coverage losses when their eligibility is redetermined after the PHE ends. In this brief, we show how SNAP-based auto-renewal can:

- Preserve Medicaid for roughly half of all beneficiaries, extending especially significant protection to many families of color and white children in rural areas.
- Greatly lower administrative burdens facing often understaffed state and local agencies that are now facing the largest number of redeterminations in Medicaid program history.
- Strengthen program integrity by preventing eligible people from being terminated because of missing paperwork and by protecting states from unwarranted findings of payment error.

Background

CMS and states are grappling with the monumental challenge of resuming Medicaid redeterminations for the first time since early 2020. Before the pandemic, Medicaid programs were required to redetermine eligibility every 12 months. They would sometimes do so more frequently — for example, when matches with quarterly wage information suggested that income may have risen above Medicaid eligibility levels. In such cases, states would often send families notices requesting information. Families frequently were terminated after not returning the requested paperwork. This pattern was a key contributor to millions of families and children losing Medicaid from 2017 through 2019.[2]

Section 6008 of the Families First Coronavirus Response Act (Families First)[3] temporarily halted this redetermination practice. It gave Medicaid programs a 6.2% increase in their Federal Medical Assistance Percentage (FMAP) for the duration of the PHE. But in exchange, states were required to follow maintenance of effort requirements, including a prohibition against terminating families' Medicaid coverage so long as the PHE continued.[4]

Soon after President Biden ends the PHE, states will stop receiving these extra federal dollars and will once again begin redetermining eligibility. Many families are likely to lose coverage as a result.

Unless states take immediate and effective action, Medicaid coverage losses are likely to exceed any experienced in the past.

As of September 2021, 85 million people relied on Medicaid or the Children's Health Insurance Program (CHIP) for health care, including 78 million people who had Medicaid, by far the largest number of beneficiaries in the program's history.[5] Once Medicaid programs begin updating their eligibility status, state agencies will be required to conduct far more eligibility assessments than ever before, despite significant workforce shortages in much of the country.[6] As a recent NPR story concluded, a "tsunami of work approaches," but "many state and local offices are short-staffed."[7]

Unless states take immediate and effective action, Medicaid coverage losses are likely to exceed any experienced in the past. Urban Institute researchers project that between 12.9 million and 15.8 million people will lose Medicaid if typical pre-pandemic patterns apply.[8] This projection underestimates probable coverage losses, since the forthcoming start to redeterminations will likely see higher termination levels than were typical before the pandemic.[9] Yet even a 12.9 million person drop in Medicaid coverage would be more than five times the largest previous annual loss ever recorded.[10]

When Medicaid coverage isn't renewed electronically, significant burdens fall on families and Medicaid agencies.

Recent history suggests that most Medicaid terminations will result from families not providing requested paperwork. This happened as Utah redetermined eligibility for children in its separate CHIP program, when more than 40% of all covered children were terminated.[11] It also happened when states like Texas,[12] Louisiana,[13] Arkansas,[14] Missouri[15] and Tennessee[16] terminated hundreds of thousands of Medicaid families from 2017 through 2019 because of short-term income spikes. The states sent notices requesting information, and the vast majority of coverage terminations resulted when people did not provide the requested paperwork. Families moved and never got the notices, did not open the mail, did not understand the notice, did not understand what they needed to do to preserve coverage, or were unable to fulfill burdensome administrative requirements for retaining health care. As explained by the Office of Management Budget:

> The onerous experiences that individuals and entities can encounter when trying to access a public benefit are known as 'administrative burdens.' These burdens include time spent on applications and paperwork, but also factors like time spent traveling to in-person visits, answering notices and phone calls to verify eligibility, navigating web interfaces, and collecting any documentation required to prove eligibility. Research indicates that where there are administrative burdens, they do not fall equally on all entities and individuals, leading to disproportionate underutilization of critical services and programs, as well as unequal costs of access, often by the people and communities who need them the most. Burdens that seem minor when designing and implementing a program can have substantial negative effects for individuals already facing scarcity. ...[A]ny additional hurdle in an application process can lead to drop-off in program participation..."[17]

One analysis by Cindy Mann, who ran the Medicaid program at CMS under the Obama administration, and her colleagues at Manatt Health concluded, "increasing the proportion of renewals that a state conducts electronically — without sending paperwork to beneficiaries — will likely be the most important single step states and CMS can take to avoid coverage losses.[18]

When Medicaid coverage isn't renewed electronically, significant burdens fall on families and Medicaid agencies. A family's ability to keep their Medicaid coverage depends on how well they are able to cope with administrative demands for paperwork. But it also depends on whether their state's Medicaid agency has accurate contact information, drafts easily understood notices in multiple languages, sends the notices in a timely fashion, provides quality consumer education and customer assistance via fully accessible and rapidly available call center operations, and has a strong fair hearings and appeals process. Electronic renewal protects families from all of those contingencies. As we show next, the protection extended by the recently approved option for SNAP-based electronic renewal would be remarkably broad.

By Automatically Renewing Eligibility Based on SNAP Receipt, States Can Protect Millions of Families Who Rely on Medicaid for Their Health Care

CMS's new guidance substantially clarifies state duties and options involving Medicaid redeterminations when the PHE ends. One key feature of the guidance authorizes states to automatically renew Medicaid for beneficiaries under age 65 who receive SNAP. According to research cited by CMS,[19] **97% of SNAP recipients under age 65 qualify for Medicaid,** including children everywhere and adults in states with expanded eligibility. Receipt of SNAP is thus reliable proof of Medicaid eligibility.

Indeed, **implementing the CMS-approved option for SNAP-based electronic renewal may be the most consequential step a state can take to protect families** who rely on Medicaid for health care. **In 2020, more than 23 million Medicaid beneficiaries under age 65 received SNAP benefits, including 12 million children.[20]** Among them were:

8.2 MILLION

white beneficiaries, including 3.5 million children.

6.7 MILLION

Latino beneficiaries, including 3.2 million children.

6.0 MILLION

African American beneficiaries, including 3.2 million children.

According to Census Bureau data, 42% of all Medicaid beneficiaries under age 65, including 46% of children, received SNAP in 2020. But because those data significantly undercount the number of SNAP beneficiaries,[21] it seems likely that SNAP reaches at least half Medicaid beneficiaries, making SNAP-based auto-renewal an even more powerful tool for protecting low-income families.

Using SNAP in this way will protect health care for diverse communities. For example, it would safeguard coverage for the 56% of African American Medicaid beneficiaries under age 65 who receive SNAP, including 60% of all African American children who rely on Medicaid. Another Medicaid group protected by this new strategy would be white children living in rural areas, 45% of whom receive SNAP. As noted earlier, these percentages are likely too small, because they are based on Census Bureau data that underestimate SNAP receipt.[22]

Table 1 shows the number of Medicaid beneficiaries who received SNAP in 2020 (according to Census Bureau data) and whose coverage would therefore be protected if their state implemented SNAP auto-renewal. Tabulations with state-specific information by race, ethnicity and residence outside metropolitan areas are available upon request.

Table 1. Medicaid beneficiaries who received SNAP in 2020, by state and age

State	Medicaid-Enrolled Children Who Received SNAP		Medicaid-Enrolled Adults Under Age 65 Who Received SNAP		Medicaid-Enrolled People Under Age 65 Who Received SNAP	
	Number of Children	% of All Medicaid-Enrolled Children	Number of Adults	% of All Medicaid-Enrolled Adults Under Age 65	Number of Beneficiaries	% of All Medicaid-Enrolled People Under Age 65
Alabama	198,000	45%	147,000	39%	345,000	42%
Alaska	19,000	31%	23,000	27%	43,000	29%
Arizona	244,000	37%	276,000	35%	520,000	36%
Arkansas	117,000	32%	83,000	27%	201,000	30%
California	1,344,000	39%	1,547,000	31%	2,891,000	34%
Colorado	128,000	31%	158,000	33%	286,000	32%
Connecticut	110,000	37%	140,000	31%	250,000	33%
Delaware	24,000	32%	29,000	32%	53,000	32%
District of Columbia	29,000	51%	41,000	44%	70,000	47%
Florida	820,000	49%	684,000	54%	1,504,000	51%
Georgia	427,000	42%	233,000	43%	660,000	42%
Hawaii	65,000	62%	57,000	54%	122,000	58%
Idaho	57,000	34%	47,000	40%	103,000	36%
Illinois	441,000	50%	461,000	50%	902,000	50%
Indiana	214,000	46%	207,000	35%	421,000	40%
Iowa	92,000	36%	109,000	43%	201,000	40%
Kansas	64,000	37%	38,000	29%	103,000	33%
Kentucky	239,000	56%	225,000	41%	464,000	47%
Louisiana	266,000	49%	265,000	41%	531,000	45%
Maine	48,000	51%	56,000	47%	104,000	49%
Maryland	175,000	45%	205,000	47%	380,000	46%
Massachusetts	265,000	55%	294,000	32%	559,000	40%
Michigan	393,000	54%	541,000	49%	934,000	51%
Minnesota	125,000	39%	106,000	34%	230,000	36%
Mississippi	133,000	43%	106,000	54%	239,000	47%
Missouri	206,000	46%	98,000	44%	303,000	45%

Table 1. Medicaid beneficiaries who received SNAP in 2020, by state and age, continued

State	Medicaid-Enrolled Children Who Received SNAP		Medicaid-Enrolled Adults Under Age 65 Who Received SNAP		Medicaid-Enrolled People Under Age 65 Who Received SNAP	
	Number of Children	% of All Medicaid-Enrolled Children	Number of Adults	% of All Medicaid-Enrolled Adults Under Age 65	Number of Beneficiaries	% of All Medicaid-Enrolled People Under Age 65
Montana	32,000	35%	35,000	34%	68,000	34%
Nebraska	69,000	54%	35,000	42%	104,000	49%
Nevada	137,000	48%	133,000	44%	269,000	46%
New Hampshire	22,000	34%	28,000	38%	50,000	36%
New Jersey	221,000	38%	202,000	29%	423,000	33%
New Mexico	159,000	60%	167,000	58%	326,000	59%
New York	688,000	43%	735,000	29%	1,423,000	34%
North Carolina	462,000	48%	275,000	43%	737,000	46%
North Dakota	15,000	40%	11,000	31%	26,000	35%
Ohio	640,000	65%	609,000	51%	1,249,000	57%
Oklahoma	159,000	33%	95,000	37%	255,000	34%
Oregon	122,000	46%	184,000	44%	306,000	44%
Pennsylvania	425,000	54%	594,000	55%	1,019,000	54%
Rhode Island	25,000	40%	52,000	41%	77,000	40%
South Carolina	209,000	46%	118,000	38%	327,000	43%
South Dakota	37,000	65%	15,000	63%	52,000	65%
Tennessee	265,000	47%	233,000	39%	498,000	43%
Texas	1,410,000	51%	532,000	46%	1,942,000	49%
Utah	49,000	28%	31,000	20%	80,000	24%
Vermont	18,000	39%	22,000	33%	40,000	35%
Virginia	183,000	45%	153,000	36%	336,000	40%
Washington	212,000	38%	221,000	37%	433,000	38%
West Virginia	70,000	50%	114,000	55%	184,000	53%
Wisconsin	181,000	54%	180,000	52%	360,000	53%
Wyoming	13,000	31%	9,000	30%	22,000	31%
United States	**12,068,000**	**46%**	**10,957,000**	**39%**	**23,026,000**	**42%**

Source: Analysis of data from the Census Bureau's 2021 Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC), accessed through IPUMS, University of Minnesota, www.ipums.org (IPUMS).

Note: Totals may not sum due to rounding. These estimates do not adjust for CPS-ASEC's undercounting of SNAP participation rates. Therefore, they likely underestimate the number and percentage of Medicaid beneficiaries whose coverage could be renewed automatically based on SNAP receipt. However, the table includes adults under age 65 in states that have not expanded income-based adult eligibility as permitted by the ACA, even though most such adults' financial eligibility for Medicaid ends below applicable SNAP thresholds.

By Acting Quickly, States Can Maximize Efficiency Gains

CMS must grant a waiver under Social Security Act §1902(e)(14)(A) for a state to implement SNAP-based auto-renewal.[23] To obtain such a waiver, a state need only submit a letter to its CMS state lead.

Even though most Medicaid programs already access SNAP data to verify eligibility, many states would benefit from starting work soon to improve information systems. Ideally, such systems will automatically (a) "ping" SNAP case records when a Medicaid redetermination is about to occur, and (b) renew coverage for 12 months, generating appropriate notices, if the beneficiary receives SNAP.[24] Once such systems let states renew eligibility for numerous beneficiaries without a Medicaid worker needing to "touch the case," understaffed state and local agencies will find it much easier to cope with the enormous task of redetermining eligibility for the remaining Medicaid families.

Unfortunately, information technology development takes time. If a state does not operate an integrated Medicaid-SNAP eligibility system, the state will need to obtain or develop protocols for determining whether identities match despite minor differences in identifying information (for example, when SNAP calls someone "James" and the Medicaid program calls the same person "Jim," or when one of the two program's files has transposed adjacent digits in a social security number). CMS officials have made clear that they are willing to provide technical assistance to states grappling with such issues.

Starting that work quickly will help fully automated systems come online faster, providing states with significant administrative relief. Even before the PHE ends, some states could begin auto-renewing SNAP beneficiaries' Medicaid coverage for 12 months, reducing the number of people whose eligibility must be evaluated manually when the PHE sunsets.

It is possible that in states with highly prescriptive and detailed Medicaid statutes governing redeterminations, legislative action will be needed to authorize these changes. However, most states should be able to implement this option through administrative action.

Some states that are unable to fully automate SNAP-based renewal before redeterminations begin could nonetheless implement effective "work-arounds" that realize significant administrative gains, pending systems changes. For example, matches between Medicaid and SNAP records could produce a list of Medicaid beneficiaries slated for redetermination who receive SNAP. Case workers could rapidly renew everyone on the list, automatically generating appropriate notices. Even in a worst-case scenario, Medicaid workers handling a redetermination could use "look-up rights" to see whether a beneficiary receives SNAP and, if so, immediately renew the beneficiary. Even that scenario would generate savings, based on past state experience. When Alabama was first implementing Express Lane Eligibility (ELE) to automatically renew children's coverage based on SNAP receipt, it realized modest administrative savings during an initial phase that required case workers to exercise "look-up rights," then very significant savings once full automation took effect.[25]

This CMS-Approved Option Improves Both the Reality and the Appearance of Program Integrity

According to Medicaid regulations,[26] program integrity is damaged when "eligible individuals [are] denied coverage," not just when "ineligible individuals [are] approved." A state that automatically renews SNAP beneficiaries, nearly all of whom qualify for Medicaid, prevents numerous incorrect eligibility outcomes. An eligible family whose Medicaid is renewed based on SNAP receipt cannot suffer the erroneous eligibility outcome of termination for not providing requested paperwork.

Research suggests that whenever a group of people is known to have at least an 80% likelihood of being eligible for Medicaid, automatic renewal reduces overall eligibility errors by preventing eligible beneficiaries from being terminated for procedural reasons.[27] When, as in the case of SNAP, the likelihood of eligibility exceeds 90%, electronic renewal cuts total eligibility errors by more than 50%. Relying on SNAP eligibility for Medicaid renewals under ELE has thus been an attractive approach implemented by more conservative states, not just more progressive states.[28]

CMS has made clear that it will consider renewals based on 1902(e)(14)(A) waivers to comply with Medicaid statutes and regulations for the purposes of Payment Error Rate Measurement and Medicaid Eligibility Quality Control programs.[29] Maximizing renewals under such waivers will thus lower states' reported error rates, in addition to substantially increasing the overall accuracy of eligibility outcomes.

Conclusion

Medicaid beneficiaries are likely to experience huge coverage losses when states begin redetermining eligibility. State eligibility workers are also likely to be overwhelmed at a time when hiring additional staff may be difficult, given tight labor markets. If states do business as they have in the past, a surprisingly small proportion of those who lose Medicaid will actually be found ineligible. Rather, numerous beneficiaries will be sent notices, not provide requested paperwork, and, as a result, lose their health care. In many cases, they will reapply for the program later. State short-term procedural terminations will thus needlessly raise administrative costs when Medicaid must process new applications that could have been avoided through earlier auto-renewal.

States can protect millions of eligible Medicaid beneficiaries from procedural terminations of essential health coverage, while saving taxpayer dollars otherwise spent on program administration and strengthening program integrity. One particular step will yield tremendous gains: implementing the new CMS-approved option to electronically renew beneficiaries whenever SNAP agencies have already found them to be sufficiently indigent to qualify for SNAP.

Endnotes

[1] Center for Medicaid and CHIP Services, 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, SHO #22-001, (Center for Medicaid and CHIP Services, March 3, 2022), https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[2] See, for example, Emmett Ruff and Eliot Fishman, The Return of Churn: State Paperwork Barriers Caused More than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018 (Families USA, April 2019), https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf; Stan Dorn, Joe Weissfeld, and Emmett Ruff, America's Children Are Losing Health Insurance, Putting Their Futures at Risk: How National Lawmakers Can Help, (Families USA, September 2019),

https://familiesusa.org/wp-content/uploads/2019/10/COV_Child-Health-Emergency_Report-Part-I-1.pdf.

[3] Pub. L. No. 116-127 (2020).

[4] Terminations are allowed for beneficiaries who move out of state, who request termination, or who die.

[5] Centers for Medicare and Medicaid Services, August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot (CMS), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf.

[6] Megan Messerly, "Next Big Health Crisis: 15M People Could Lose Medicaid When Pandemic Ends," Politico, February 2, 2022, https://www.politico.com/news/2022/02/02/medicaid-states-pandemic-loss-00004153.

[7] Rachana Pradhan, "Why Millions on Medicaid Are at Risk of Losing Coverage in the Months Ahead," NPR, February 14, 2022, https://www.npr.org/sections/health-shots/2022/02/14/1080295015/why-millions-on-medicaid-are-at-risk-of-losing-coverage-in-the-months-ahead.

[8] Matthew Buettgens and Andrew Green, What Will Happen to Medicaid Enrollees' Health Coverage After the Public Health Emergency? Updated Projections of Medicaid Coverage and Costs (Urban Institute, March 2022), https://www.urban.org/sites/default/files/publication/105507/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf.

[9] Address changes are likely to affect a higher proportion of beneficiaries now than in the past, for two reasons. First, much more time has passed since consumers initially enrolled in coverage compared to pre-pandemic Medicaid operations. Second, the pandemic worsened housing instability, forcing a higher proportion of low-income families to change addresses. As a result, more state notices are likely to go to the wrong address, and a higher proportion of families will not provide requested information simply because they never receive a notice making the request.

Moreover, many Medicaid agency staff and Medicaid beneficiaries have never gone through a Medicaid redetermination. Unfamiliarity is likely to increase the proportion of beneficiaries who lose coverage by mistake.

Finally, state and local agencies administering Medicaid programs have significant workforce shortages. At the same time that they have an unusually depleted program staff, Medicaid agencies will face the largest backlog of redeterminations experienced in the program's history. The combination of greatly increased demands and greatly reduced capacity is likely to yield worse results than were common under pre-pandemic conditions.

[10] The largest previous one-year loss of Medicaid coverage ever recorded took place in 2018, when the number of beneficiaries under age 65 fell by 2.2 million, according to CPS-ASEC data. Families USA analysis of 1980-2018 CPS-ASEC data, accessed through IPUMS, University of Minnesota, www.ipums.org (IPUMS); United States Census Bureau, Health Insurance: Tables 2018-Forward, Table H-01 for 2017, 2018, 2019, and 2020, https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi/hi.2020.html, last revised October 8, 2021. The American Community Survey (ACS) generally takes much larger samples than CPS-ASEC, providing increased reliability, but ACS did not track health coverage before 2008. Based on ACS data, the largest past loss of Medicaid coverage took place from 2018 to 2019, when the number of Medicaid enrollees under age 65 declined by 1.7 million. Families USA analysis of ACS data, 2008-2020, accessed through IPUMS.

[11] Utah provided a grim preview of what could happen in many if not most states when Medicaid redeterminations resume. In 2020, the state redetermined eligibility for children in its separate CHIP program after receiving approval to take that step in the closing days of the Trump administration. Utah terminated coverage for more than 40% of all children enrolled in CHIP. For 85% of children losing coverage, the state ended health care not because it found the children to be ineligible, but because their families did not respond to state notices by providing requested paperwork. Katie Workman, "41% of Utah CHIP Recipients Lost Coverage in May Due to Government Reversal," KSL.com, June 17, 2021, https://www.ksl.com/article/50188678/41-of-utah-chip-recipients-lost-coverage-in-may-due-to-government-reversal.

[12] When Texas ended health coverage for nearly 150,000 children, missing paperwork was the prime cause. The state mailed income update forms multiple times during each 12-month eligibility period, and only 30% of families responded. More than 90% of all terminations resulted from the state not receiving a response. Allie Morris, "Texas Kicks Thousands of Low-Income Children off Medicaid Over Missing Paperwork," San Antonio Express News, March 29, 2019, https://www.expressnews.com/news/politics/texas_legislature/article/Texas-kicks-thousands-of-low-income-children-off-13727929.php.

[13] At the legislature's behest, Louisiana began mailing "pre-closure" notices to Medicaid beneficiaries in mid-July 2021. Louisiana Department of Health (DOH), Some Medicaid Members May Receive Pre-Closure Notices, June 17, 2021, https://ldh.la.gov/news/6213. The notices told beneficiaries that, unless they provided information demonstrating their eligibility, they would be disenrolled when the public health emergency ended. Because 85% of past Medicaid terminations occurred not when people were found ineligible but when they did not respond to state notices, and because only 30% of families responded to those notices, the state anticipated that 160,000 people could lose Medicaid when redeterminations began. Louisiana DOH, Medicaid Quarterly Wage Check Process: Response to HCR 43 of the 2019 Regular Legislative Session (Louisiana Department of Health, September 2019), https://ldh.la.gov/assets/docs/LegisReports/HCR43Report.pdf; Philip Kiefer, "Many Louisiana Residents May Need to Renew Medicaid Benefits as COVID-19 Emergency Winds Down," The LENS, June 29, 2021, https://thelensnola.org/2021/06/29/many-louisiana-residents-may-need-to-renew-medicaid-benefits-as-covid-19-emergency-winds-down/.

[14] In Arkansas, the state terminated coverage for nearly 60,000 beneficiaries over an 18-month period in 2017 and 2018. Between 60% and 80% of these terminations were for procedural reasons, most often because the state had not heard from beneficiaries after sending them requests for information. Benjamin Hardy, "Scrubbed from the System: Why Medicaid Enrollment Has Dropped by Almost 60,000 People in 18 Months," Arkansas Times, August 9, 2018, https://arktimes.com/news/cover-stories/2018/08/09/scrubbed-from-the-system.

[15] In 2018, 70,000 people in Missouri lost coverage after the Medicaid program stopped collecting data from other agencies that could have shown whether beneficiaries remained eligible. Instead, the state sent beneficiaries forms asking for information about their current circumstances, even if the agency could have previously gathered that same information on its own. When families did not complete and return the forms, the state ended their Medicaid. Emmett Ruff and Eliot Fishman, The Return of Churn, 2019.

[16] Between January 2016 and May 2019, Tennessee's Medicaid program ended 11,000 children's coverage after finding them ineligible. The state terminated nearly 13 times as many children – 140,000 — not because they were found ineligible, but because their families did not respond to lengthy renewal packets sent by the state. See Table 1 in Tennessee Comptroller of the Treasury, "Special Project: Division of TennCare's Redetermination Process and the Impact on Children's Enrollment," Performance Audit Report, February 2020, https://www.documentcloud.org/documents/6770443-TennCare-Audit.html.

[17] Executive Office of the President, Office of Management and Budget, Study to Identify Methods to Assess Equity: Report to the President (OMB, July 2021), https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-Report-on-E013985-Implementation_508-Compliant-Secure-v1.1.pdf.

[18] Kinda Serafi, Cindy Mann, and Nina V. Punukollu, The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends (Manatt Health for The Commonwealth Fund, September 23, 2021), https://www.commonwealthfund.org/blog/2021/risk-coverage-loss-medicaid-beneficiaries-covid-19?utm_source=alert&utm_medium=email&utm_campaign=Achieving+Universal+Coverage.

[19] See footnote 4 in Center for Medicaid and CHIP Services, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, SHO #13-003, ACA #26, May 17, 2013, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

[20] These results come from an analysis of 2021 CPS-ASEC data, accessed through IPUMS.

[21] Jonathan Rothbaum, Liana Fox, and Kathryn Shantz, Fixing Errors in a SNAP: Addressing SNAP Under-reporting to Evaluate Poverty (U.S. Census Bureau and Urban Institute, October 18, 2021), https://www.census.gov/content/dam/Census/newsroom/press-kits/2022/assa/assa-jan2022-paper-fixing%20errors-in-a-snap.pdf; Bilal Habib, How CBO Adjusts for Survey Underreporting of Transfer Income in Its Distributional Analyses, Working Paper 2018-07 (Congressional Budget Office, July 2018), https://www.cbo.gov/system/files/2018-07/54234-workingpaper.pdf.

[22] Analysis of 2021 CPS-ASEC data, accessed through IPUMS.

[23] This provision requires Medicaid agencies to base financial eligibility for beneficiaries who are neither elderly nor disabled on Modified Adjusted Gross Income, which differs from income methodologies used by SNAP. The subparagraph's final sentence provides, "The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries."

[24] Under 42 CFR §435.916(a)(2), such a notice must explain the basis for the eligibility determination and notify the family of their obligation to inform the agency if any information in the notice is inaccurate. The notice must also make clear that the recipient is not obliged to take action for coverage to continue.

[25] Margaret Wilkinson, Brigette Courtot, and Ian Hill. CHIPRA Express Lane Eligibility Evaluation: Case Study of Alabama's Express Lane Eligibility, Final Report. (Urban Institute, January 13, 2014), https://www.urban.org/sites/default/files/publication/59791/2000281-CHIPRA-Express-Lane-Eligibility-Evaluation-Case-Study-of-Alabama%E2%80%99s-Express-Lane-Eligibility.pdf.

[26] 42 CFR §435.952(c)(2)(ii).

[27] Stan Dorn and Matthew Buettgens, Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs (Urban Institute, October 2013), https://www.urban.org/sites/default/files/publication/24031/412921-Administrative-Renewal-Accuracy-of-Redetermination-Outcomes-and-Administrative-Costs.PDF.

[28] For example, Alabama, Louisiana and South Carolina have all used Express Lane Eligibility to automatically renew children's Medicaid eligibility based on SNAP receipt. Sheila Hoag et al., CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings (Mathematica Policy Research, Urban Institute, and Health Management Associates, December 2013), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//138071/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf.

[29] Kinda Serafini, New CMS Guidance on Expectations for Unwinding Federal Medicaid Continuous Coverage (Manatt Health, March 11, 2022), https://www.shvs.org/new-cms-guidance-on-expectations-for-unwinding-federal-medicaid-continuous-coverage/.

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