

Administrator Brooks-LaSure
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

March 12, 2024

Dear Administrator Brooks-LaSure:

CC: Daniel Tsai, Anne Marie Costello, Hannah Katch, Melanie Fontes Rainer, Rachel Pryor, Jesse Cross-Call, Eden Tesfaye, and Perrie Briskin

Thank you for the intensive work that you and your team have done to try to ensure a smooth unwinding of the continuous eligibility provision in Medicaid. We are grateful for your leadership to date in minimizing losses, and appreciate the Biden administration's commitment to "doing everything in its power" to keep people enrolled in comprehensive health care coverage. We urge you and your staff to continue to dedicate resources to monitoring the unwind process throughout 2024, and to use all of your available enforcement tools to ensure that states comply with federal obligations and preserve Medicaid coverage for as many eligible individuals as possible.

With roughly half of renewals still to be completed, the next six months will prove challenging. Millions of *eligible* individuals and families — particularly people of color and children — are at risk of losing coverage due to administrative hurdles. With attention, this period of coverage transition also has the ability to lead to policy changes that strengthen the Medicaid program across states into the future.

During the pandemic, 23.3 million additional individuals were enrolled in Medicaid and the Children's Health Insurance Program (CHIP), leading to historically low uninsured rates and [amazing gains](#) reducing long standing health inequities. Medicaid remains a vital source of health coverage for more than 80 million people, particularly those from [systemically excluded communities](#), low-income communities, or who have intersecting needs and significant disabilities. The unwind of the continuous eligibility provision has already caused the largest Medicaid coverage losses in history — disproportionately felt by children, young adults, postpartum people, people of color, and immigrant communities. In 2023, more than [13 million people](#) lost Medicaid — the vast majority for procedural or administrative reasons. Projected losses are estimated to reach as high as [24 million](#) before the end of the unwind and the Department of Health and Human Services' own data [projects](#) that nearly half will lose coverage despite remaining eligible.

Under the leadership of the Biden administration, CMS has made significant improvements to the Medicaid program. We are specifically grateful for your recent guidance to states that elected Section 1902(e)(14) waivers, which often focus on ensuring that eligible enrollees are automatically renewed into coverage, would be able to remain in effect throughout 2024, your reminding states of their ability to request section 1115

demonstration authority to extend the continuous coverage period for children beyond 12 months and to adopt continuous coverage for adults eligible for Medicaid, and options to improve 12-month postpartum coverage for critical immigrant populations. We are also thankful for the work of your team to identify and remedy issues with ex parte renewals, helping to mitigate unnecessary coverage losses among children and immigrant families. Lastly, we appreciate your efforts to post preliminary state unwinding data in a more timely way as the unwind has progressed, which has helped advocates better understand the coverage losses in their states.

As you know, this remains a very stressful time for families, providers and communities.

We believe the Biden administration can further minimize coverage losses and ensure the re-enrollment of eligible individuals into 2024 through the additional recommended efforts below.

CMS should enforce requirements that states provide clear and accessible communications about eligibility determinations and provide template notices that will help states improve their enrollee communication.

Based on reports from our state partners, enrollees continue to experience excessively long call center hold times, especially for non-English-speaking callers, lack consistent language access for people with proficiency in a language other than English, and receive unintelligible “Notice of Action” letters. To illustrate: our partners report that Medicaid enrollees have received letters that, within the same document, designate the member as ineligible, eligible, and again ineligible, and notices with multiple pieces of paper in the envelope, with one of the pieces of the paper saying, ‘ignore the other notices in this envelope’. In fact, one recent state audit report found that 90 percent of Medicaid correspondence in the state contained a problem with clarity, accuracy or completeness of information.

CMS should extend the definition of violations of “all Federal requirements applicable to such [Medicaid] redeterminations,” to include incomprehensible notices, notices that are not accessible to people with disabilities and notices that are not adequately translated. This would allow CMS to hold states accountable for the clarity of their notices and take enforcement actions against unclear notices, including imposing financial penalties. We further recommend that CMS create standard or template state notices that are thoroughly reviewed with Medicaid enrollees and transcreated into commonly-read languages. Transcreation goes beyond simply translating messages from one language to another and is focused on conveying the same message and concept in a new language including the necessary cultural context in order to make sense to people who read in that language.

CMS should enforce application processing timeliness requirements for Medicaid and SNAP. Federal regulations already quantify state standards around application processing timelines, which are a comprehensive measure of state eligibility and enrollment performance. Yet, dramatic state variation exists in the meeting of these standards. CMS must enforce these standards universally across states. Holding states to existing regulatory standards is within the administration’s current authority and would help people (including people who were procedurally terminated) access benefits more quickly.

CMS should ensure that states follow-through on commitments they made, during negotiations around mitigation plans, to rectify Medicaid violations. In exchange for these commitments, states were relieved of sanctions that Congress specifically authorized in the Consolidated Appropriations Act. Those commitments should be published, with specific and aggressive timelines for states to come into compliance with federal legal requirements.

CMS should make permanent some of the flexibilities states initiated under Section 1902(e)(14) waivers, including all flexibilities that promote ex parte renewal. The flexibilities that states have taken up during the unwind through Section 1902(e)(14) waivers have simplified enrollment and redetermination procedures – reducing state workload, decreasing red tape, and maintaining the enrollment of eligible individuals. [State Medicaid Agencies have expressed significant interest](#) in maintaining these flexibilities. We urge CMS to use its authority to make as many of these waiver flexibilities as possible ongoing features of the Medicaid program. Offering states a clear pathway to maintaining their system changes beyond the unwinding period will encourage states to dedicate the staff resources necessary to make these critical system improvements – especially those that CMS has found are most helpful at maintaining enrollment among eligible individuals.

For example, we believe that states should be able to continue to automatically renew individuals with no income, when no data is returned. CMS should also continue the 100% income strategy beyond the unwinding period. In addition, CMS should permanently allow states to continue to renew individuals based on SNAP, TANF, or other means-tested benefit programs eligibility determinations, starting with approving [Maryland’s pending waiver request, an approach that is much more feasible for states administratively than the facilitated enrollment option for adults](#). We also encourage CMS to develop expedited approval pathways for states that want to continue to allow managed care plans to provide assistance to enrolled individuals to complete and submit their Medicaid renewal forms, including through the collection of their members’ telephonic or electronic signatures. Careful guardrails around marketing and influencing plan choice can make this an effective pathway of maintaining Medicaid coverage.

CMS should encourage states to focus considerable energy on identifying people who have been terminated for procedural reasons, reaching out to them, and enrolling them in Medicaid or other programs for which they qualify. Nearly 12 million people lost Medicaid for procedural reasons as of [February 1](#) — a number that rises with each passing month. Re-enrolling disenrolled individuals should now be a top priority. States should be encouraged to pursue these efforts using their own program staff, Medicaid managed care organizations, and funding for trusted, community agencies. For this work to succeed, communications alone will not suffice. Hands-on help is what will move the needle.

CMS should work closely with the Department of Labor (DOL) to help individuals who are losing their Medicaid or CHIP coverage enroll into their employer-sponsored plans. Our state partners have shared stories of individuals who have struggled to enroll into employer-sponsored coverage when they lose their Medicaid or CHIP coverage due to notices that do not use specific language around “termination of coverage.” As employer open enrollment ends at the beginning of the year, we request that CMS and DOL work together to provide guidance to employers about Medicaid terminations and the variation in terminology about coverage termination used across and within state notices.

CMS should set targets for reducing state Medicaid churn and implement changes that increase ex parte renewal rates. Ex parte rates remain relatively low in many states and vary widely despite having myriad benefits such as reducing burdens and cost for both individuals and states, while promoting program integrity. As required by the Affordable Care Act, CMS should hold states accountable for maximizing ex parte renewals. We encourage CMS to implement the recent Medicaid and CHIP Payment and Access Commission (MACPAC) recommendations to increase rates of ex parte renewals for all states, including:

- establishing minimum acceptable ex parte rate “performance standards” (or thresholds) as laid out in § 42 C.F.R 435.912 and conducting reviews of states with rates below those thresholds, and
- providing clear, written guidance about the types of assets that are unlikely to appreciate over time and explains that states do not need to reverify those assets during annual renewals, as CMS has already done with citizenship re-verification.

CMS should continue enforcement action against poorly-performing states. Interstate variation is extraordinary. If all states were performing at the level of the states with the lowest levels of coverage loss, coverage losses would be a small fraction of what they have been. We’ve appreciated the partnership from CMS in investigating inappropriate state actions as they are identified by our state partners and we encourage this action to continue. Taking enforcement action against even a few states could encourage other states to improve their performance. CMS should also let advocates know what happens when state-specific complaints are brought to CMS. Without such looping back, it’s hard to motivate continued reporting from state and local partners.

CMS should require ongoing data reporting. CMS should require ongoing state reporting and federal publication of the unwinding metrics, including Medicaid termination and renewal rates across key populations and key demographics, after the end of unwinding, using CMS’s pre-CAA statutory authority. State advocates are able to effectively support access to health care only when they have consistent access to timely data. Many states do not report data publicly making it difficult to understand the full picture of coverage loss and enrollment at both the state and national levels. CMS should require reporting on key metrics for children, individuals that are dually eligible for Medicare and Medicaid, individuals that are pregnant and postpartum, as well as older adults, people with disabilities and those who are blind, and require that the data be disaggregated as much as possible including by race and ethnicity, income, language, and geography.

HHS should significantly increase ex parte renewals by removing barriers to state access to data critical for Medicaid redeterminations. First, we recommend that CMS add quarterly wage records from the National Directory of New Hires to the Federal Data Services Hub (Hub). Without costly or time-consuming changes to state eligibility systems, states could simply connect to the Hub and increase wage information by roughly 50 percent. Two different federal statutes (ACA § 1413(c)(2) and Social Security Act § 1942(a)) authorize this data access. Second, we express concern about the reinterpretation of the use of the Hub’s Verify Current Income (VCI) service to a state Medicaid and CHIP agency function, as proposed in the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program rule. This would shift the cost of this service from one fully borne by the federal government

to one shared by states and territories, increasing fiscal pressure on state Medicaid agencies, which may act as a barrier to ongoing state/territory efforts to streamline eligibility processes. We recommend that CMS consider the implications of this shift and ways to mitigate its potential impact of reducing use of this critical service.

CMS should pursue policy changes that continue to strengthen the Medicaid program. We are grateful for the historic attention that this administration has given to Medicaid, and we recognize that still more remains to be done. CMS should develop additional policies that invest in the enrollment and eligibility systems that determine the ability of eligible individuals to get the health coverage they want and need. The current implementation of eligibility and enrollment systems has led to systems that are not fully compliant with federal renewal requirements and to substantial coverage losses in states across the political spectrum during this unwind period.

In the medium-term, we must move towards a Medicaid program that dramatically reduces the administrative burdens put on people and families who need critical health services – including by simplifying and clarifying notices, using data-based renewals to eliminate administrative burdens, increasing access to trained staff to directly support filling out eligibility determination paperwork, and moving towards the use of more streamlined income and asset requirements.

We look forward to our continued work together.

Sincerely,

Alabama

Alabama Rise

Arkansas

Arkansas Advocates for Children and Families

California

Asian Resources, Inc.

Health Access California

The Children’s Partnership

Colorado

Caring for Colorado Foundation

Colorado Children’s Campaign

Colorado Consumer Health Initiative

Colorado Cross-Disability Coalition

Colorado Immigrant Rights Coalition (CIRC)

Youth Healthcare Alliance

Connecticut

Connecticut Oral Health Initiative, Inc.

Florida

Florida Policy Institute

Florida Voices for Health

Indiana

Hoosier Action

Kansas

El Centro

Kentucky

Kentucky Voices for Health

Maine

Consumers for Affordable Health Care

Maryland

High Note Consulting, LLC
The Parent's Place of MD

Massachusetts

Health Care For All
Massachusetts Organization for Addiction
Recovery
TRUE ALLIANCE CENTER INC

Michigan

Detroit Community Health Connection
Michigan Disability Rights Coalition

Mississippi

Mississippi Center for Justice

Missouri

Missouri Family Health Council, Inc.
Missouri Foundation for Health
Missouri Jobs with Justice
Paraquad

Montana

Montana Budget & Policy Center
Montana Women Vote

Nebraska

Nebraska Appleseed

Nevada

New Day Nevada

New Jersey

Camden Coalition
Family Voices NJ
SPAN Parent Advocacy Network

New Mexico

Health Action New Mexico

New York

Center for Independence of the Disabled, New York
(CIDNY)
Community Service Society of New York
Medicaid Matters New York
Southern Tier Independence Center

North Carolina

Kintegra Family Medicine

Ohio

UHCAN Ohio

Pennsylvania

Pennsylvania Health Access Network

Rhode Island

Protect Our Healthcare Coalition RI
RIPIN

South Carolina

South Carolina Appleseed Legal Justice Center

Tennessee

African American Clergy Collective of Tennessee
Black Clergy Collaborative of Memphis
Family Voices of Tennessee
Tennessee Disability Coalition
Tennessee Health Care Campaign
Tennessee Justice Center

Texas

Every Texan

Utah

Utah Health Policy Project

Vermont

Vermont Family Network

Washington

Northwest Health Law Advocates (NoHLA)

West Virginia

West Virginians for Affordable Health Care

Wisconsin

Citizen Action of Wisconsin

FREE

National

ACA Consumer Advocacy

ADAP Advocacy

American Academy of Family Physicians

American Association of Health and Disability

American Cancer Society Cancer Action Network

American Lung Association

American Psychological Association Services

Asian & Pacific Islander American Health Forum

Autistic Self Advocacy Network

Black Mamas Matter Alliance, Inc.

CareQuest Institute for Oral Health

Center for Health Law and Policy Innovation

Center for Medicare Advocacy

Community Access National Network

Community Catalyst

Disability Rights Education and Defense Fund (DREDF)

Disciples Center for Public Witness (Disciples of Christ)

Disciples Justice Action Network

Elephant Circle

Families USA

First Focus on Children

Hand in Hand Multicultural Center

Health Care for America Now (HCAN)

Health Care Voices

Help Not Handcuffs, Inc.

International Society of Psychiatric Mental Health Nurses

Jewish Federations of North America

Justice in Aging

Lakeshore Foundation

MomsRising

NASTAD

National Alliance on Mental Illness

National Association of Community Health Workers (NACHW)

National Association of Councils on Developmental Disabilities

National Association of Pediatric Nurse Practitioners

National Association of Social Workers

National Center for Medical-Legal Partnership

National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)

National Disability Rights Network (NDRN)

National Family Planning & Reproductive Health Association

National Immigration Law Center

National League for Nursing

National Women's Health Network

NETWORK Lobby for Catholic Social Justice

Network of Jewish Human Services Agencies

Not Dead Yet

Planned Parenthood Federation of America

PlusInc

Policy Center for Maternal Mental Health

Primary Care Development Corporation

Protect Our Care

The Aids Institute

The Arc of the United States

The Leadership Conference on Civil and Human Rights

UnidosUS

Union for Reform Judaism

United States of Care

Young Invincibles