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State Resource Center

Starting the Conversation: Continuous Eligibility in Medicaid

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- **ATI's Starting the Conversation series offers state policymakers Medicaid innovation ideas alongside top considerations to inform state decision making.**
- In this resource, we highlight provisions of and pose considerations for **continuous eligibility (CE).**

Key Questions

- What is continuous eligibility?
- Does continuous eligibility make sense for my state?
- What authorities can states use to pursue continuous eligibility?
- What challenges might states face when implementing continuous eligibility?

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1 What is continuous eligibility?

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Continuous eligibility allows individuals to remain eligible for Medicaid over an extended period by disregarding changes in income or household composition that otherwise make them ineligible.

Outcomes and Impacts

CE policies have been shown to **improve health outcomes**[1] for target populations and **decrease costs**:[2]

- → Minimizes lapses and gaps in health coverage
- → Improves utilization of preventive and primary care
- → Supports school readiness and early detection of developmental disorders among children
- → Reduces state administrative burden and cost associated with "churn," due to disenrollment and reenrollment activities

Targets Populations

States can prioritize continuous coverage to **specific populations**, including:

- → Children
- → Postpartum and pregnant individuals
- → Parents and caretaker relatives
- → Individuals experiencing homelessness
- → Individuals released from correctional settings
- → Other populations, such as adults with serious mental illnesses (SMI)s or substance use disorders (SUDs)

1. Brantley E, Ku L. Continuous Eligibility for Medicaid Associated With Improved Child Health Outcomes, Med Care Res Rev, 2022.
2. Wagner J, Solomon J. Continuous Eligibility Keeps People Insured and Reduces Costs, Center on Budget and Policy Priorities, 2021.

2 Does continuous eligibility make sense for my state?

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States can use continuous eligibility to address gaps in coverage and support other state goals. Policymakers can consider the following to determine if continuous eligibility is right for their state:

Factors	Key Questions
Magnitude	▪ What is the rate of uninsurance within the state? ▪ How severe are existing levels of churn within Medicaid? ▪ How significant is the administrative burden associated with Medicaid churn? Does this impact other state agencies or programs (e.g., state qualified health plan marketplace)?
Populations	▪ Who are the populations experiencing barriers to accessing to care (e.g., high rates of churn, high rates of uninsurance)? ▪ Who are the populations experiencing poor health outcomes that could be mitigated by improved continuity of care?
Community Perspectives	▪ How might perspectives differ among key stakeholders (e.g., Medicaid enrolled individuals, providers, health plans, state legislators, community-based organizations, etc.)?

3 What authorities can states use to pursue continuous eligibility? *(1 of 2)*

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States can use two authorities to implement continuous eligibility: State Plan and Section 1115 Demonstration. The appropriate authority depends on the target population and state goals.

Population	Authority	State Examples
Children	▪ ***State Plan:*** States *must* provide **1 year** of CE. ▪ ***Section 1115:*** CMS has approved **multiple years** of CE.	 **Oregon** provides CE from ages 0 to 6 and two years of CE ages 6 to 19 through a Section 1115 Demonstration.
Postpartum Individuals	▪ ***State Plan:*** States *may* provide 1 year of CE. ▪ ***Section 1115:*** States can pursue additional flexibilities for postpartum CE, such as including individuals with higher incomes or for longer CE timeframes than are allowable through the State Plan.	 **All but 4 states** have adopted or plan to adopt 1 year of CE for postpartum individuals. Most states are approved via State Plan, while others (e.g., Washington) use a Section 1115 Demonstration to cover those with higher incomes.
Parents and Caretaker Relatives	▪ ***Section 1115:*** CMS has approved 1 year of CE.	 **Kansas** provides 1 year of CE to parents and caretaker relatives with children through a Section 1115 Demonstration.

3 What authorities can states use to pursue continuous eligibility? *(2 of 2)*

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Population	Authority Pathway	State Examples
Former Foster Youth	▪ ***State Plan:*** States *must* provide CE until age 26 for youth who aged out of foster care as of January 1, 2023 (gaps exist for youth who aged out of foster care in a different state *prior* to January 1, 2023). ▪ ***Section 1115:*** States request coverage for those who fall in the gap noted above through a Section 1115.	 **Hawaii** requested authority through a Section 1115 Demonstration to provide CE for youth who aged out of another state's foster care system prior to January 1, 2023. This enables CE until age 26 for all former foster youth in the state.
Individuals Experiencing Homelessness	▪ ***Section 1115:*** CMS has approved **2 years** of CE.	 **Massachusetts** provides 2 years of CE to those ages 65 and over who are experiencing homelessness through a Section 1115 Demonstration.
Individuals Released from Correctional Settings	▪ ***Section 1115:*** CMS has approved **1 year** of CE.	 **Massachusetts** provides 1 year of CE to individuals released from correctional settings through a Section 1115 Demonstration.
Other Medicaid Populations	▪ ***Section 1115:*** States can pursue CE for other Medicaid populations, including expansion adults, individuals with SMI or SUD, dual eligible individuals, and others.	 **New York** provides 1 year of CE to a range of beneficiaries, including the adult expansion group, through a Section 1115 Demonstration.

4 What challenges might states face when implementing continuous eligibility?

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To assess the feasibility of continuous eligibility, states can consider the following:

Factors	Key Questions
Finances	▪ Does the state have a source of funding to cover the non-federal share associated with extended eligibility and coverage for targeted populations?
Operations	▪ Does the state Medicaid agency have sufficient capacity to apply for and negotiate federal authorities to implement CE provisions? If not, do resources exist to outsource these efforts? ▪ What Medicaid eligibility systems updates are required to implement CE policies? ▪ How should the state inform stakeholders, including plans and providers, of the policy change?
Infrastructure	▪ To what extent will the state need to conduct training or educational efforts for staff within the Medicaid agency or other partners (e.g., county-based enrollment offices)? ▪ What is the landscape of existing providers to support this population? Is there risk of insufficient provider networks to meet the demand of this population?

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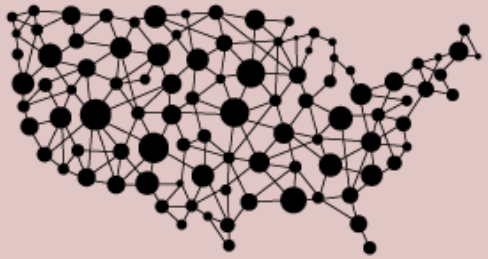

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