National Rural Health Association Policy Brief

Impact of public health emergency unwinding on Medicaid disenrollment rates in rural America

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Introduction

The return to regular Medicaid operations after the public health emergency (PHE), otherwise known as the Medicaid unwinding, has raised concerns about the Medicaid redetermination process for rural populations and providers moving forward.

The continuous Medicaid enrollment requirement mandated by the Families First Coronavirus Response Act was tied to a temporary increase in federal assistance during the COVID-19 PHE.[2] During this time, Medicaid recipients were not required to complete the annual redetermination process necessary to verify ongoing eligibility. The easing of these requirements helped prevent coverage loss for many rural residents during the PHE, ensuring access to various health care services.[10]

As the continuous enrollment condition ended on March 31, 2023, states were required to resume normal operations, including restarting full Medicaid and Children's Health Insurance Program (CHIP) eligibility renewals and coverage termination for ineligible individuals effective April 1, 2023.[2] Many states and rural stakeholders have expressed significant concerns about the unprecedented nature of the unwinding process, particularly the potential disenrollment of eligible rural individuals due to procedural issues.

Medicaid is a crucial source of health care coverage for the 60 million Americans living in rural areas. Rural providers are more likely than their urban counterparts to participate in Medicaid coverage[10]. In addition, to critical health care services, Medicaid coverage can offer rural residents access to non-emergency medical transportation and telehealth technology, which are essential for delivering medical and other health services to patients. In 2021, nearly a quarter of individuals under age 65 residing in rural areas were covered by Medicaid, along with 22 percent of those dually enrolled in Medicaid and Medicare.[10] The Affordable Care Act (ACA) has helped reduce the national rate of uninsured rural individuals, decreasing from 19 percent in 2012 to 13 percent in 2019.[14] However, the rate of uninsured individuals living in rural areas in non-Medicaid expansion states has declined more slowly than in expansion states, dropping from 38 percent to 32 percent over the same period.[6,14] As of May 2024, 10 states have yet to adopt Medicaid expansion.[8]

Rural residents are more likely to be publicly insured or uninsured compared to urban residents.[7] The unwinding or resuming of regular operations following the PHE created uncertainty for rural health care providers and Medicaid recipients, as states were given 12 months to initiate redetermination on all Medicaid recipients.[2] Prior to the pandemic, in February 2020 about 71 million people, including about 35 million children, were enrolled in Medicaid and CHIP.[2,3] The number of eligible recipients increased to 88 million people, including nearly 40 million children and young people, as of September 2023.[2,3] The disproportionate patient-payer mix experienced by rural hospitals and clinics can contribute to the uncompensated care burden, as unreimbursed care is a leading factor in reduced operating margins, which contributes to hospital closures for rural communities.[7]

Rural hospitals and clinics already face significant financial pressures, and therefore any reduction in patient coverage may exacerbate this financial hardship. The closures of rural hospitals and clinics limit access to emergency care, primary care services, and specialty care, forcing individuals to travel greater distances. Medicaid plays a vital role in ensuring access to rural health care, with nearly 14 million Medicaid enrollees living in rural areas, representing 17 percent of all Medicaid beneficiaries. [10]

Analysis

As of July 2024, updated data on Medicaid disenrollments during the unwinding period indicates that approximately 24 million individuals have been disenrolled from Medicaid since the end of continuous enrollment.[8] In July 2024, 11 percent of individuals up for renewal were disenrolled for procedural reasons, and 6 percent were disenrolled based on a form (Figure 1).[4] Disenrollment rates at the state level varied significantly, ranging from 3 to 41 percent overall, with procedural disenrollment rates between 0.2 and 36 percent (Figure 2).[4]

Figure 1: July 2023 to July 2024: National Disenrollment Rates at Renewal, by Disenrollment Type

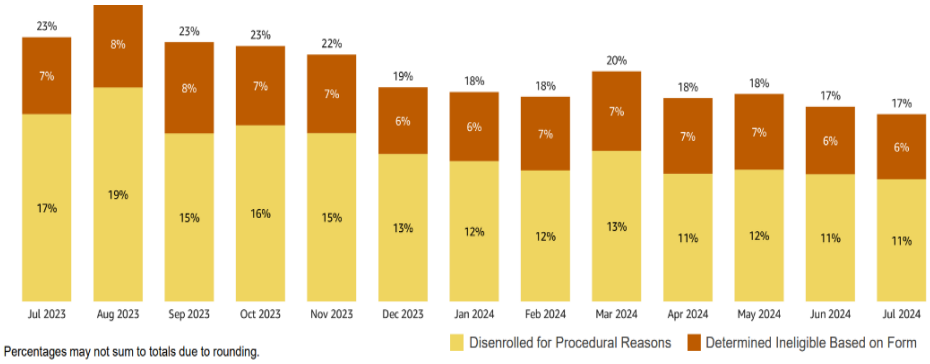
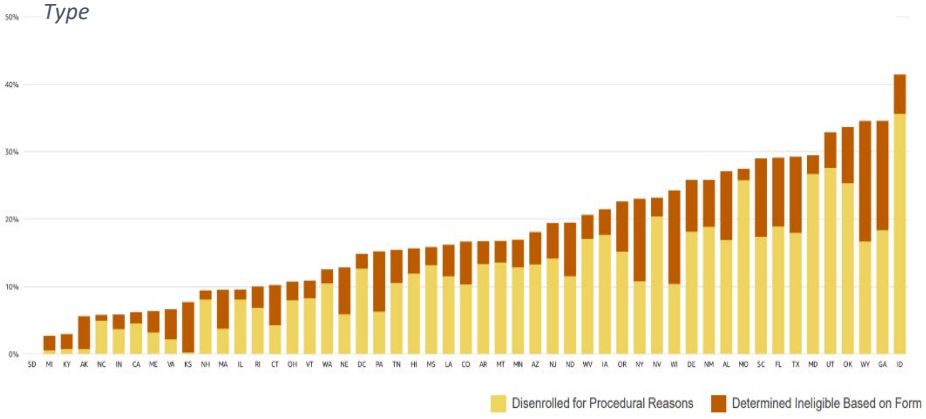


Figure 2: July 2024: States' Coverage Disenrollment Rates at Renewal, by Disenrollment Type



The unwinding of Medicaid redetermination has raised concern that the Medicaid enrollment process could disproportionately impact certain populations, including those that reside in rural communities. In September 2023, 72 percent of people who lost Medicaid coverage as part of the unwinding process were disenrolled for procedural reasons, such as enrollees not receiving renewal notices.[13] Research shows that rural communities rely on Medicaid to support their health care systems for children and families and identify significant barriers to renewal, including longer distances to eligibility offices, limited broadband access, and lack of access to navigators to assist enrollees.

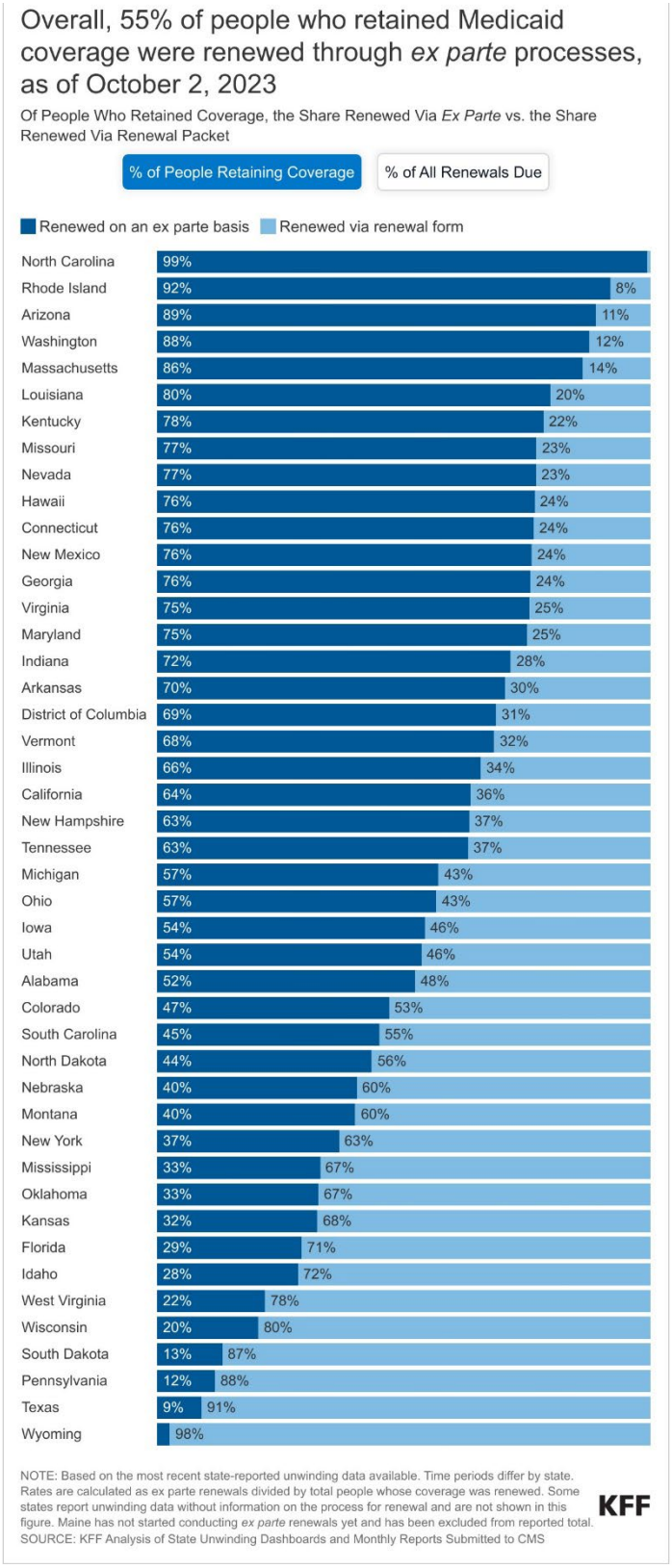
Unwinding strategies and approaches vary by state and are dependent on their priorities, systems functionality, prior adherence to federal renewal regulations, and political and fiscal environments.[1] As states unwind, they must comply with federal renewal requirements, including conducting ex parte or automated renewals, which can help reduce administrative burden and address the longstanding issue of Medicaid enrollees losing coverage at renewal.[8] Drastic differences in ex parte rates exist across states among individuals who had their coverage renewed to date during the continuous enrollment provision unwinding process, ranging from 99

percent in North Carolina to 3 percent in Wyoming (Figure 3).[8] Increased focus on state renewal policies and procedures has assisted the Centers for Medicare and Medicaid Services (CMS) in identifying problems that have led to a significant number of enrollees being inappropriately disenrolled from Medicaid.

Children and youth have disproportionately fallen through the cracks in states that have not expanded Medicaid, especially those who reside in rural communities. Medicaid expansion has played a key role in expanding coverage for individuals in rural communities.[12] Among the 10 states that have not expanded Medicaid, more children have been disenrolled than all expansion states combined. In non-expansion states, youth who turned 19 while the continuous enrollment condition was in place were at risk of falling into the coverage gap and becoming uninsured.[3] These youth account for an average of 27.6 percent of disenrollments among children in non-expansion states since March 2023, compared to 12.1 percent of disenrollments in expansion as of December 2023.[3] In rural communities, uninsured rates were nearly twice as high in 2019 in non-expansion states compared to expansion states (Figure 4).[14]

Common challenges that have been identified in states experiencing capacity challenges include Medicaid churn, temporary loss of Medicaid coverage, and administrative backlogs. Medicaid churn creates a lapse in Medicaid coverage for individuals, with some states such as Louisiana identifying more than 60,000 people churned back onto Medicaid in four months.[13] This leads to significant barriers and challenges, creating not just a lapse in health insurance for the individual but also placing additional stress on state systems and employees.

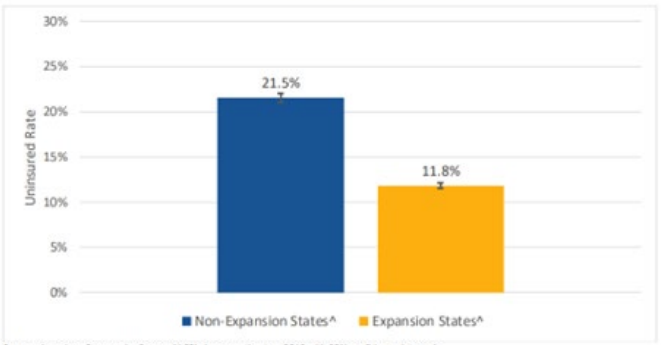
Figure 3



Policy recommendations

NRHA recommends establishing a comprehensive national policy to address potential consequences of Medicaid unwinding on rural populations and providers.

Figure 4: Uninsured Rate in Rural Areas by State Medicaid Expansion Status, 2019



Source: American Community Survey (ACS), 1-year estimates, 2019 with 95% confidence intervals
*Definition of rural and urban based on PUMA to CBSA (where CBSA metropolitan areas are defined as "urban" and non-metropolitan areas are defined as "rural").
^Definition of non-expansion and expansion states based on status of Medicaid expansion implementation as of 01/01/2019, obtained from KFF.[17]

Funding outreach and enrollment assistance: Continued outreach related to Medicaid enrollment is essential for rural populations, particularly given the geographic and infrastructural barriers such as limited broadband access and longer travel distances to eligibility offices. Rural residents need access to year-round enrollment. These efforts should be supported by marketing efforts tailored to rural areas, in-person enrollment assistance in community hubs, enhanced language access efforts, and expansion of in-person staff to assist with the application process. This will ensure rural individuals have the awareness, support, and resources they need to be properly informed.

More upfront resources to build rural capacity: Rural states and regions require appropriate staffing and resources to manage application and renewal volumes and reduce procedural disenrollments to prevent backlogs and minimize churn, particularly in areas with high Medicaid reliance.

Greater efficiency in program operations: States should prioritize reducing procedural disenrollments in rural areas by expanding ex parte renewals, enhancing outreach efforts, and leveraging existing data from other programs. Implementing longer continuous coverage and express lane eligibility for children is essential. Additionally, minimizing verification requests, streamlining administrative processes, continuously improving the enrollee experience, and enhancing the accessibility of online services are crucial steps to ensure smoother Medicaid renewals.

Continued federal oversight and rural-specific guidance: The involvement of CMS in states' unwinding efforts has assisted with re-enrollment and helped ensure sure states minimize backlogs and expedite access to support. CMS should provide rural-specific guidance and technical assistance to help rural providers manage the administrative complexities of Medicaid redetermination and prioritize reducing disenrollment rates in rural communities where health disparities are already more prevalent.

Data collection and regular reporting: States should be required to implement robust data collection and reporting systems that specifically monitor disenrollment trends in rural areas. Metrics should include geography-based indicators to identify disparities faced by rural populations and ensure these communities have equitable access to Medicaid. Regular, transparent reporting on rural disenrollment trends will inform targeted outreach efforts and help rural providers offer tailored assistance to prevent coverage losses.

Recommended actions

Increase flexibilities in renewals: Encourage CMS to build on the progress made during the Medicaid unwinding period by exploring and implementing ways to enhance and streamline Medicaid ex parte renewal rates in rural areas. CMS should leverage existing authorities to

permanently extend flexibilities for renewing Medicaid eligibility without requiring additional beneficiary information.

Data collection and rural reporting requirements: Incentivize states to continue to monitor and report rural Medicaid termination and renewal rate data to CMS. Leveraging this data will continue to strengthen each state's redetermination process and proactively identify potential compliance issues. Rural-focused data will allow for a proactive identification of challenges within the redetermination process, ensuring rural residents are not disproportionately affected by coverage lapses or terminations.

Greater efficiency in enrollment process: CMS should work to streamline enrollment processes and reduce administrative burdens for rural residents transitioning between Medicaid and other federal programs. This could involve creating centralized resources or online platforms accessible in low-bandwidth areas and training rural-based navigators to assist residents in completing enrollment with minimal administrative burden.

Support for premium tax credits: Congress should permanently extend ACA enhanced premium tax credits and related policy changes to ensure continued access to comprehensive insurance coverage through the federal Marketplace and state exchanges, supporting continuous access to affordable health care services. By reducing the financial burden of health care coverage, premium tax credits can help stabilize access to health services in rural areas, where coverage gaps can have severe consequences for both individual health and community health care providers.

Conclusion

The Medicaid redetermination process following the end of the PHE has significant implications for rural populations and health care providers.[7] The resumption of Medicaid redeterminations has led to substantial disenrollment disproportionately affecting rural communities, with many losing coverage due to procedural issues. This has created financial and operational challenges for rural health care providers, who already face significant pressures. Ensuring continued access to Medicaid for rural populations requires targeted policy recommendations, including funding outreach and enrollment assistance, building capacity to handle renewals, improving program efficiency, and maintaining federal oversight. These measures are crucial to support the health and stability of rural communities as they navigate the post-PHE landscape. By implementing targeted, rural-specific policy recommendations, we can protect the health and stability of rural America and ensure vulnerable populations retain access to essential Medicaid services.

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