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Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey

Prepared by:

Tricia Brooks, Allexa Gardner, Aubrianna Osorio
Georgetown University Center for Children and Families

and

Jennifer Tolbert, Bradley Corallo, Meghana Ammula, Sophia Moreno
KFF

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Executive Summary

Enrollment in Medicaid has grown significantly during the coronavirus pandemic. Provisions in the Families First Coronavirus Response Act (FFCRA) require states to provide continuous coverage for Medicaid enrollees until the end of the month in which the public health emergency (PHE) ends in order to receive enhanced federal funding. Continuous enrollment has helped to preserve coverage and halted Medicaid churn. However, when the PHE ends, states will begin processing redeterminations and millions of people could lose coverage if they are no longer eligible or face administrative barriers despite remaining eligible. Existing state enrollment and renewal procedures, as well as their approaches to the unwinding of the continuous enrollment requirement, will have major implications for Medicaid enrollment and broader coverage.

The 20th annual survey of state Medicaid and Children's Health Insurance Program (CHIP) officials conducted by KFF and the Georgetown University Center for Children and Families in January 2022 presents a snapshot of actions states are taking to prepare for the lifting of the continuous enrollment requirement, as well as key state Medicaid enrollment and renewal procedures in place during the PHE. The Centers for Medicare and Medicaid Services (CMS) released new guidance on March 3, 2022, which emphasizes promoting continuity of coverage and avoiding inappropriate coverage terminations when the continuous enrollment requirement ends. While this recent guidance was released after the survey was fielded, state responses reported here illustrate how states expect to approach the unwinding of continuous enrollment and what the effects of the new guidance may be.

Plans for the End of the PHE

States are required to develop plans for how they will prioritize outstanding eligibility and renewal actions when the continuous coverage requirement is lifted; just over half of states (27) have determined their approach. At the time of the survey, given uncertainty around the timing of the end of the PHE, timing of additional guidance from CMS, and the future of the BBBA, it is perhaps not surprising that many states have yet to finalize their plans. However, having plans in place early will allow for better preparation and will enable states to communicate their plans to enrollees and other stakeholders in the state. Among the states with plans, eleven states indicate they will target individuals who appear to be no longer eligible first, while eight states plan to conduct fresh renewals based on the individual's renewal month, and eight have adopted a combination or hybrid approach. While most states plan to wait until the continuous enrollment requirement is lifted to resume disenrollments, three states have not yet decided whether they will forgo enhanced federal funding and begin disenrollments before the end of the PHE. However, even if states begin disenrollments prior to the end of the PHE, they must still follow the unwinding guidance CMS has issued.

Fifteen states indicate they will conduct electronic data matches to identify and target enrollees for priority action who may no longer be eligible after the continuous enrollment requirement is lifted. States are not required to conduct data matches in between renewal periods. While data matches can identify people who experienced a change in income or circumstance that makes them no longer

eligible, broad data searches may also identify inconsistent or inaccurate information that does not impact eligibility and could lead to eligible individuals losing coverage if they do not follow up.

The majority of states (41) plan to take up to a full year to process redeterminations and return to routine operations; however, seven states plan to resume normal operations more quickly. When states resume redeterminations at the end of the PHE, they will need to conduct a fresh review of eligibility based on current circumstances before disenrolling anyone from Medicaid. Current CMS guidance gives states up to 12 months to initiate and 14 months to complete all redeterminations and 41 states indicate they will take at least 9 months and up to the full year. The elimination of the enhanced federal Medicaid matching rate (at the end of the quarter in which the PHE ends) could put fiscal or political pressure on states to move more quickly. The risk of moving quickly is that there will be less time to conduct outreach to enrollees and develop staff capacity to process renewals. CMS encourages states to initiate redetermination on no more than 1/9th of their total caseload each month to minimize this risk.

When the continuous enrollment requirement is lifted, a majority of states (41) plan to follow-up with enrollees when action must be taken to avoid a loss of coverage due to missing information. States are not required to follow up with enrollees who do not respond to a renewal request and may simply send a termination notice if no response is received within 30 days. However, sending reminder notices via mail – and also through other communication modes, such as phone, text, and/or email – can increase the response rate to renewal requests and reduce the number of people who remain eligible but are disenrolled at the end of the PHE because they did not respond to a request for information.

In preparation for the end of the PHE, states are taking steps to update enrollee mailing addresses. The two-year COVID-19 emergency has likely exacerbated longstanding difficulties in reaching enrollees by mail. In response, the vast majority of states (46) are planning actions to update mailing addresses before the end of the PHE, including conducting data matches with the United States Postal Service (USPS) National Change of Address database; working with managed care organizations (MCOs); and conducting outreach campaigns. In addition, 35 states will follow-up on returned mail to attempt to locate an enrollee before terminating coverage.

Anticipating the need for additional staff resources at the end of the PHE, 30 states plan to take steps to boost staff capacity. Most states are taking multiple actions that include approving overtime, hiring new eligibility workers or contractors, or borrowing staff from other units or agencies.

Most states are able to report key metrics needed to monitor the unwinding process. Almost all states (50) report they are capable of tracking call center statistics and a majority (41) are able to report the share of disenrollments that were determined ineligible versus disenrollments due to procedural reasons. Having timely and reliable data from states will be needed to monitor the unwinding process and assess whether additional steps should be taken to avoid coverage losses among those who remain eligible. In recent guidance, CMS has indicated it will require states to report monthly data to monitor their progress on unwinding and compliance with current rules, although there is no indication the data will be released publicly.

In 20 states able to report, it is estimated that about 13% of Medicaid enrollees will be disenrolled when the continuous enrollment requirement ends. However, the estimates range widely across reporting states from about 8% to over 30% of total enrollees. Based on available data, most states report that an increase in income will be the primary reason for the disenrollment although several states also expect incomplete renewals or missing documentation will be a primary reason for disenrollment. If these estimates hold true, millions of people will lose Medicaid coverage in the months following the end of the PHE; however, many children will likely be eligible for CHIP and many adults will likely be eligible for Affordable Care Act (ACA) Marketplace or other coverage. Successfully transitioning these individuals into those other coverage options could avoid gaps in coverage and reduce the number who lose coverage altogether and become uninsured.

Enrollment and Renewal Policies During the PHE

Even during the PHE, states continue to streamline application processes and integrate non-MAGI and non-health programs into the system that determines MAGI Medicaid eligibility. In almost all states, applications can be submitted online, by telephone, in person, or by mail. Additionally, nearly all states (48) now offer online accounts for Medicaid and CHIP enrollees that make it easier for individuals to submit and access information about their coverage. States have taken steps to improve the mobile friendliness of their applications and online accounts. All states use electronic data matches from a variety of data sources to verify income eligibility and, as a result, most states (43) can provide eligibility determinations in real time (within 24 hours).

While states cannot disenroll people, as of January 2022, most states (42) report processing ex parte renewals and sending renewal forms (30 states) to reduce backlogs in renewals at the end of the PHE. By continuing ex parte renewals during the PHE, states have been able to renew coverage for 12 months for those who remain eligible. Of the 42 states actively processing ex parte renewals, nearly two-thirds (30 states) are sending renewal forms or requests for documentation when they are unable to confirm ongoing eligibility through electronic data sources, although they may not disenroll anyone during the PHE. By processing ex parte renewals and sending out renewal forms, states will have a smaller backlog of delayed renewals or pending actions when the PHE ends.

Medicaid and CHIP Eligibility

As of January 2022, Medicaid and CHIP eligibility was stable as the PHE protections remained in effect for the entirety of 2021. Oklahoma and Missouri implemented the ACA Medicaid adult expansion in 2021, leaving only 12 states that have not filled the coverage gap for low-income adults. In the 12 states that have not implemented the Medicaid expansion, eligibility for parents remains extremely low (ranging from 16% to 100% of the poverty level) and only Wisconsin covers adults without dependent children (through a waiver of standard Medicaid eligibility rules). Eligibility levels for children and pregnant women held constant with median eligibility at 255% of the federal poverty level (FPL) and 205% FPL respectively.

Looking Ahead

Recent CMS guidance provides guardrails and flexibilities for states to promote continuity of coverage during the unwinding period; however, state decisions and actions will have implications for Medicaid enrollment. Recently released guidance emphasizes strategies to promote continuity of coverage. The guidance reiterates existing options for states, such as adopting 12-month continuous eligibility for children and extending postpartum coverage for 12 months, and provides additional flexibilities, including using Supplemental Nutrition Assistance Program (SNAP) eligibility to renew Medicaid coverage. How states approach the unwinding of the continuous enrollment requirement will affect the extent to which eligible individuals retain coverage and those who are no longer eligible are able to transition to other coverage. Outcomes will differ across states as they make different choices and careful monitoring of state progress throughout the unwinding period can provide information to assess fiscal effects and state efforts to promote continuity of coverage.

The fate of the Build Back Better Act (BBBA) will have implications for overall coverage. The BBBA includes provisions to close the Medicaid coverage gap in states that have not adopted the ACA Medicaid expansion and to extend the enhanced Marketplace premium subsidies initially made available by the American Rescue Plan Act (ARPA), which have made coverage more affordable for millions of people. While the number of people who are uninsured has not increased during the PHE as many had predicted, millions of people could lose coverage if those who continue to be eligible for Medicaid are not able to retain coverage, and if the provisions in the BBBA that close the coverage gap and make Marketplace coverage more affordable are not enacted.

Introduction

The extension of the coronavirus public health emergency through the entirety of 2021 had a significant impact on Medicaid and the Children's Health Insurance Program (CHIP). Since its emergence in early 2020, the coronavirus' twin economic and public health crises continued to expose significant disparities in the public health infrastructure and further highlighted the importance of health coverage. During this time, enrollment in Medicaid increased as people sought coverage after losing jobs or income because of the pandemic. Provisions in the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Security Act (CARES), require states to maintain eligibility standards and provide continuous enrollment in Medicaid until the end of the public health emergency (PHE) to qualify for a 6.2 percentage point increase in Federal Medical Assistance Percentage (FMAP). The continuous enrollment requirement and other economic factors resulted in Medicaid enrollment growth of 19.1% between February 2020 and September 2021 (the most recently available data), with much of the increase occurring in the first year of the PHE. States also adopted other temporary changes in their state Medicaid plans, through disaster-related authorities, to streamline processes and connect individuals to coverage more quickly, such as expanding the use of presumptive eligibility, waiving premiums and cost-sharing, and allowing self-attestation of certain eligibility criteria.

This 20th annual survey of Medicaid and CHIP program officials in the 50 states and the District of Columbia (DC) conducted in January 2022 by KFF and the Georgetown University Center for Children and Families provides data on state Medicaid and CHIP eligibility levels and presents a snapshot of key aspects of state enrollment and renewal procedures in place during the second year of the COVID-19 PHE. In anticipation of the likely end of the PHE in 2022, this year's survey also focuses on actions states are taking to prepare for the lifting of the continuous enrollment requirement. The report includes policies for children, pregnant women, parents and other non-elderly adults whose eligibility is based on Modified Adjusted Gross Income (MAGI) financial eligibility rules; it does not include policies for groups eligible through Medicaid pathways for adults over the age of 65 or on the basis of disability.

CMS released new guidance on March 3, 2022 that emphasizes promoting continuity of coverage and avoiding inappropriate coverage terminations when the continuous enrollment requirement ends (Table 1). While this recent guidance was released after the survey was fielded, state responses reported here illustrate how states expect to approach the unwinding of continuous enrollment and what the effects of the new guidance may be.

Table 1

CMS Guidance On Unwinding The Continuous Enrollment Requirement

Components of State Unwinding Plans	Requirements
Operational Plan	Plan must specify how states will complete redeterminations in a way that maintains coverage for eligible enrollees, ensures even distribution of renewals, and ensures timely processing of applications.
Timelines	States must be current in processing new applications within four months after the end of the PHE. States must also initiate renewals within 12 months and complete all pending actions within 14 months. To retain the enhanced federal matching funding, they must begin the unwinding period no later than the 1st day of the month after the PHE ends, but can initiate redeterminations up to two months before PHE ends (although they cannot disenroll anyone until after PHE ends).
Risk-Based Approach to Prioritizing Work	States must specify how they will prioritize pending actions: population-based (prioritize populations that are likely to no longer be eligible); time-based (conduct renewals based on renewal month or prioritizes older pending actions); hybrid (combine population and time-base approaches); state-developed (other approach that meets goals).
Distribution of Pending Actions	States are encouraged to initiate no more than 1/9 of total caseload each month.
Facilitating Transitions to the Marketplace	States must transfer accounts of individuals determined ineligible for Medicaid or CHIP to the Marketplace, including all account and eligibility information.
Monitoring State Progress	States will be required to submit monthly data for 14 months using a template under development by CMS; data elements have not been defined.

SOURCE: Centers for Medicare and Medicaid Services (CMS), SHO #22-001, "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" last updated March 3, 2022.

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Preparing for the End of the PHE

Resuming Redeterminations and Disenrollments

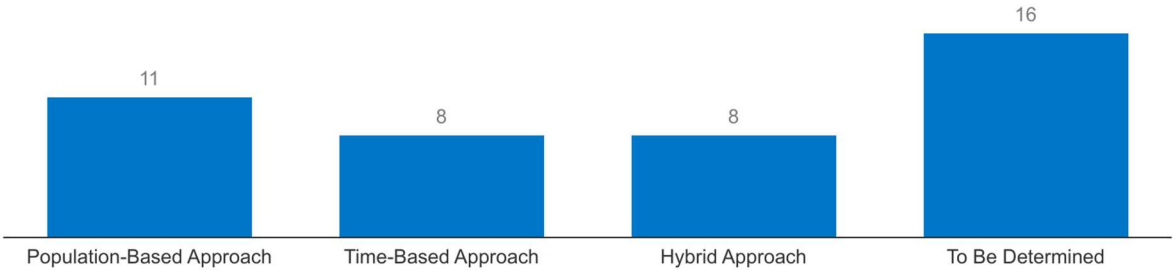
States are required to develop plans for how they will prioritize outstanding eligibility and renewal actions when the continuous coverage requirement is lifted; just over half of states (27) have determined their approach (Figure 1). Given uncertainty around the timing of the end of the PHE, additional guidance that CMS may issue, and the future of the BBBA, it is perhaps not surprising that many states have yet to finalize their plans. However, having plans in place early will allow for better preparation and will enable states to communicate their plans to enrollees and other stakeholders in the state. Among the states with firm plans, eleven states indicate they will target individuals who have been flagged with a change in circumstances and/or are no longer likely to be eligible (population-based approach) while eight states plan to conduct fresh renewals based on the individual's renewal month (time-based approach). Eight states plan to adopt a hybrid approach that combines the population- and time-based approaches. States adopting a population-based approach mentioned targeted strategies, including aligning renewals in some way with the Supplemental Nutrition Assistance Program (SNAP), prioritizing those with premiums in order to avoid unnecessary billing, processing individuals who have aged out of coverage, and deprioritizing pregnant women. Regardless of the approach a state adopts, the operational plan must consider ways to ensure continuity of coverage among those who remain eligible. While most states plan to wait until the continuous enrollment requirement is lifted to resume disenrollments, three states have not decided whether to forgo enhanced federal funding and begin

disenrollments before the end of the PHE. However, even if states begin disenrollments prior to the end of the PHE, they must still follow the unwinding guidance CMS has issued.

Figure 1

State Approaches To Prioritizing Renewals And Pending Actions Following The End Of The Continuous Enrollment Requirement, January 2022

Number Of States Reporting: 43



NOTE: Responses for two states could not be categorized into a risk-based approach and six states did not respond.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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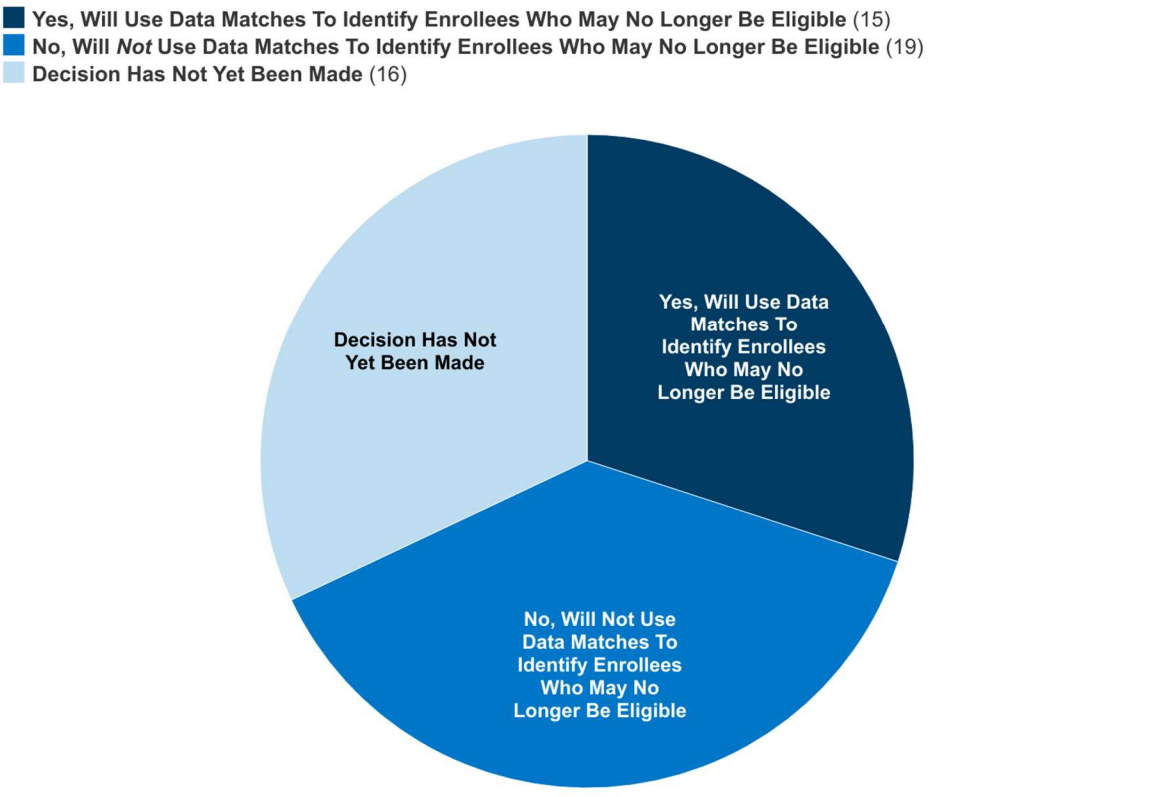
Fifteen states indicate they will conduct electronic data matches to identify and target enrollees for priority action who may no longer be eligible after the continuous enrollment requirement is lifted (Figure 2). Nineteen states do not plan to conduct these types of data matches and 16 states indicate that a decision has yet to be made. While taking steps to identify individuals whose income has increased above Medicaid thresholds may be a useful way to prioritize renewals, these data searches, if broad in nature, can result in unintended consequences. Wide-ranging data searches may identify inconsistent or inaccurate information that does not impact eligibility; however, states may be prompted to take action on these discrepancies, which could lead to eligible individuals losing coverage if they do not follow up. In the most recent guidance, CMS recommends states suspend periodic data matches as a way to improve coverage retention and reduce churn.

Figure 2

Number Of States Planning To Conduct Electronic Data Matches To Identify Enrollees Who May No Longer Be Eligible When The Continuous Enrollment Requirement Is Lifted, January 2022

Number Of States Reporting: 50



NOTE: One state did not report their action.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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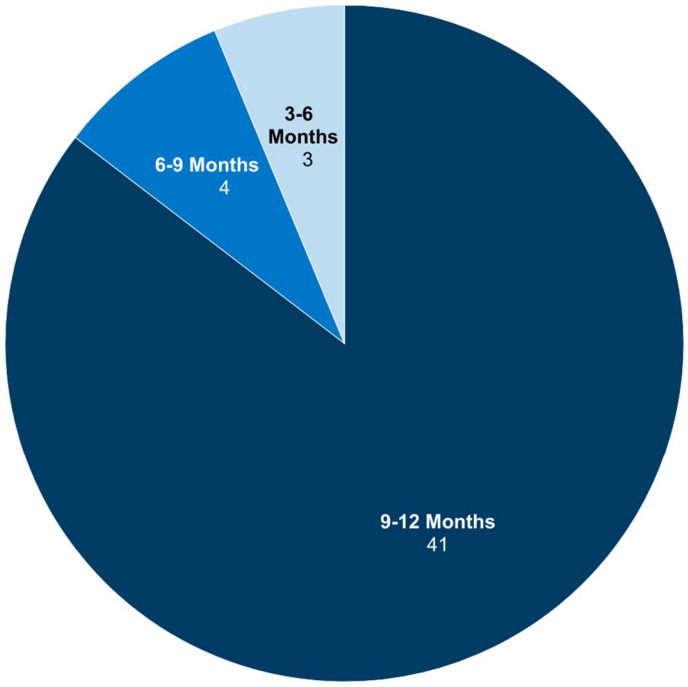
The majority of states plan to take up to a full year to process redeterminations and return to routine operations (Figure 3). When states resume redeterminations at the end of the PHE, they will need to conduct a fresh review of eligibility based on current circumstances and consider eligibility for all eligibility pathways before disenrolling anyone from Medicaid. Current CMS guidance, released after the survey was fielded, gives states up to 12 months to initiate and 14 months to complete the backlog of redeterminations. Of the 48 states that have established a timeframe for processing redeterminations, 41 states plan to take 9-12 months; four states plan to take 6-9 months; and three states plan to take 3-6 months. No state currently plans to take less than 3 months. Importantly, the enhanced federal Medicaid matching rate will end at the end of the quarter in which the PHE ends, which could put fiscal or political pressure on states to move more quickly. The risk of moving quickly is that there will be less time to conduct outreach to enrollees and develop staff capacity to process renewals. CMS encourages states to initiate redeterminations on no more than 1/9th of their total caseload each month to minimize this risk.

Figure 3

Estimated Length Of Time States Will Take To Process Redeterminations And Return To Normal Operations, January 2022

Number Of States Reporting: 48



NOTE: Three states did not report the estimated length of time the state will take to process determinations.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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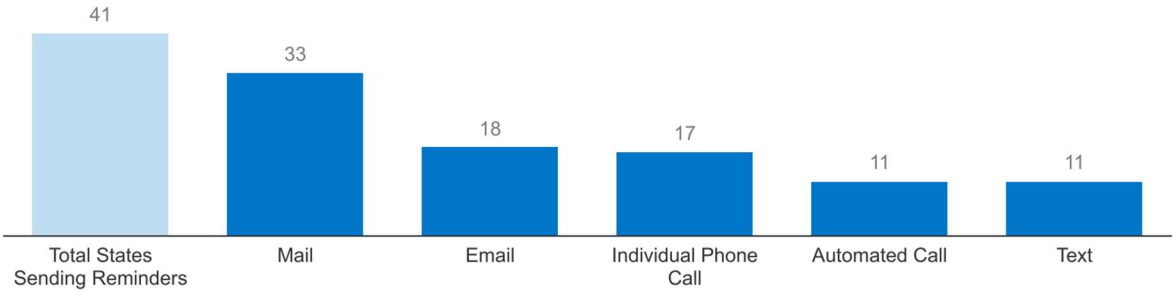
When the continuous enrollment requirement is lifted, a majority of states (41) plan to follow-up with enrollees when action must be taken to avoid a loss of coverage due to missing information (Figure 4). States must give individuals 30 days to respond to a renewal request but there is no federal requirement for states to do more than send the renewal form, followed by a termination notice if the individual does not respond. However, sending reminder notices via mail and also through other communication modes, such as phone, text, and/or email, can increase the response rate to renewal requests. Follow-up reminders can be key to reducing the number of people who remain eligible but are disenrolled at the end of the PHE because they did not respond to a request for information. Of the 41 states that plan to send reminders, about half (25) will attempt to contact enrollees at least two times and most plan to use a variety of communication modes ranging from mail (33 states), email (18), individual phone call (17), automated call (11), and text (11).

Figure 4

Number Of States Sending Reminders When Action Is Required To Retain Coverage, January 2022

Number Of States Reporting: 50



NOTE: One state did not respond.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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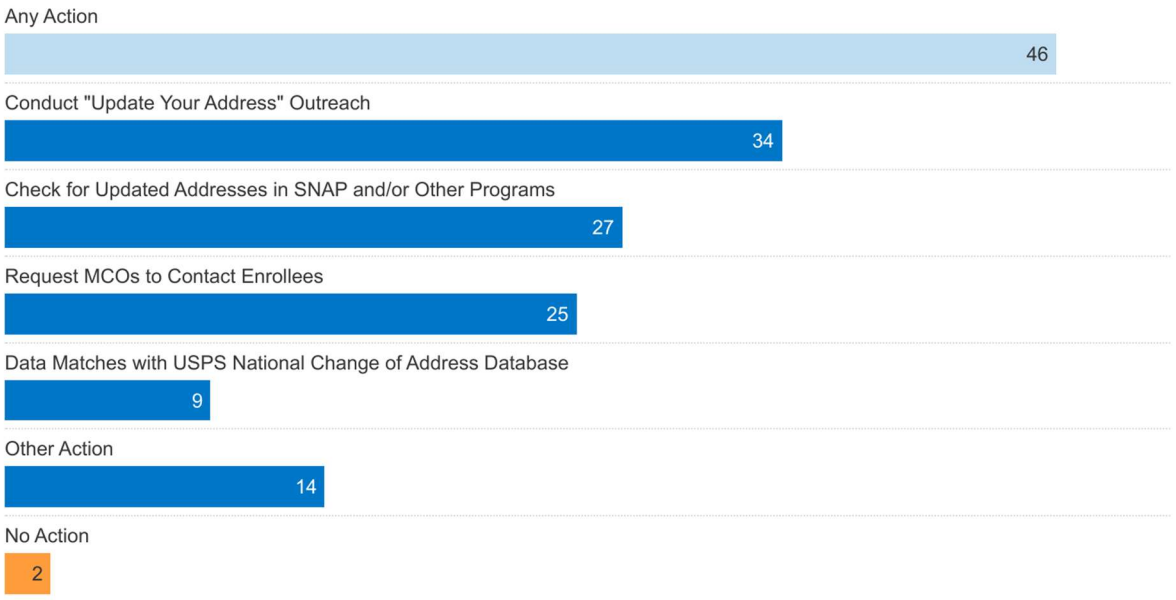
Updating Contact Information

The vast majority of states (46) are planning actions to update mailing addresses before the end of the PHE (Figure 5). Outdated mailing addresses and returned mail have long been a problem in Medicaid and the impact of the more than two-year COVID-19 emergency is expected to exacerbate difficulties in reaching enrollees by mail, the primary method states use to send renewals and requests for information. Most states are taking proactive steps to update mailing addresses before the end of the PHE, including conducting “update your address” outreach (34 states); checking for updated addresses in SNAP or other benefit programs (27 states); working with managed care organizations (MCOs) (25 states); and conducting data matches with the United States Postal Service (USPS) National Change of Address database (9 states). Two states have not yet made a final decision on what actions they will take. The total number of states taking steps is higher than the 19 states indicating they were taking proactive steps to update mailing addresses in the 2021 survey.

Figure 5

State Actions To Update Mailing Addresses Before The End Of The Continuous Enrollment Requirement, January 2022

Number Of States Reporting: 50



NOTE: Two states indicated that a decision had not yet been made and one state did not respond. SNAP: Supplemental Nutrition Assistance Program; MCO: Managed Care Organization; USPS: United States Postal Service.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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Over two-thirds of the states (35) take steps to follow-up on returned mail beyond re-mailing a notice to the same address. Returned mail has been a persistent problem in Medicaid, and CMS has provided guidance to the states on dealing with returned mail, depending on whether mail is returned with an in-state, out-of-state, or no forwarding address. Of the 35 states that take action on returned mail, almost all (32) follow up by telephone, while 12 states indicate they use email, 8 states check other programs and data sources, and 3 states use text to contact enrollees about the need to update their mailing address. Once the PHE expires, under current federal rules, states that do not have follow-up procedures in place may automatically terminate coverage without the advance ten-day notice when an enrollee cannot be located. However, using alternative methods for following up on returned mail can help reduce the number of disenrollments that occur when regular mail does not reach an enrollee.

Boosting Staff Capacity

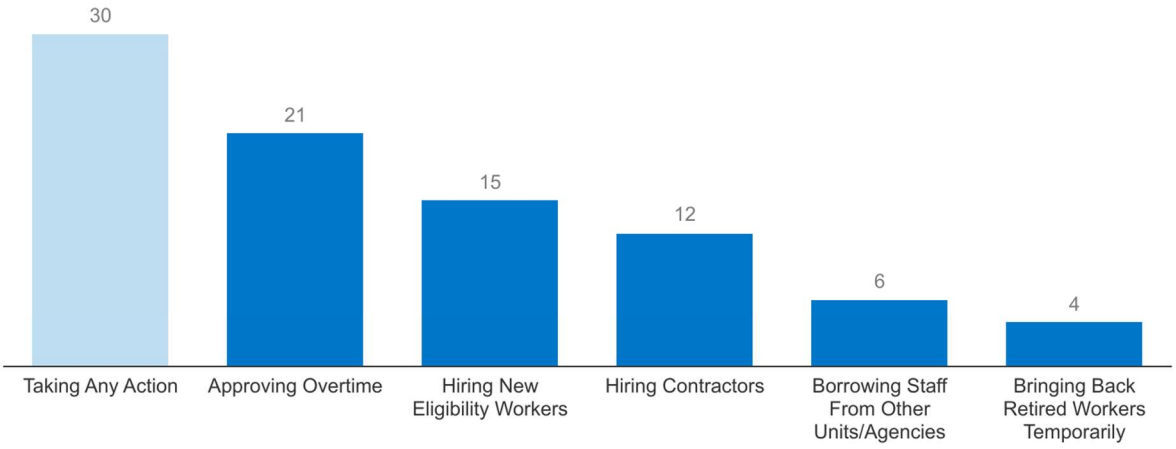
More than half of states (30) plan to take steps to boost staff capacity at the end of the PHE (Figure 6). Like many employers, state eligibility agencies have experienced challenges in retaining and recruiting eligibility workers during the pandemic. Staff hired in the past two years are not experienced in processing renewals, and even workers with more tenure need refresher training. Of the states planning

to boost workforce capacity, 21 states plan to approve overtime, while 15 states plan to hire new eligibility workers, and 12 states plan to hire contractors to boost capacity. Fewer states plan to borrow staff from other units/agencies or bring back retired workers on a temporary basis.

Figure 6

Planned Actions To Boost Eligibility Staff Capacity At The End Of The PHE, January 2022

Number Of States Reporting: 49



NOTE: Five states reported a decision had not yet been made and three states reported decisions regarding staffing are made at the local level. Two states did not respond.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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Monitoring the Return to Normal Operations and Estimating Coverage Impacts

Almost all states (50) report they are capable of tracking call center statistics and a majority (41) are able to report the share of disenrollments that were determined ineligible versus disenrollments due to procedural reasons. Having timely and reliable data from states on key metrics will be needed to monitor the unwinding process and assess if the state needs to take additional steps to avoid coverage losses among those who remain eligible. Unreasonable call wait times and increasing loss of coverage due to procedural reasons can signal early problems that could warrant oversight from CMS. States have been required to report data on call wait time and reason for disenrollment along with other metrics to CMS through the Performance Indicator Project. However, most of these data are not publicly reported by CMS, making them less useful for monitoring the immediate effects of the unwinding of the continuous enrollment requirement on coverage unless a state chooses to voluntarily share key data. In recently released guidance, CMS has indicated it will require states to report monthly data on their progress with the unwinding, although it has not yet identified the data elements that states will be required to report.

In 20 states able to report, it is estimated that about 13% of Medicaid enrollees will be disenrolled when the continuous enrollment requirement ends. However, the estimates range widely across reporting states from about 8% to over 30% of total enrollees. Based on available data, most states report that an increase in income will be the primary reason for the disenrollments, but several states also expect incomplete renewals or missing documentation to be a primary reason for disenrollment. If these estimates hold true, millions of people will lose Medicaid coverage in the months following the end of the PHE; however, many children will likely be eligible for CHIP and many adults will likely be eligible for Marketplace or other coverage. Successfully transitioning these individuals into those other coverage options could reduce the number who lose coverage altogether and become uninsured.

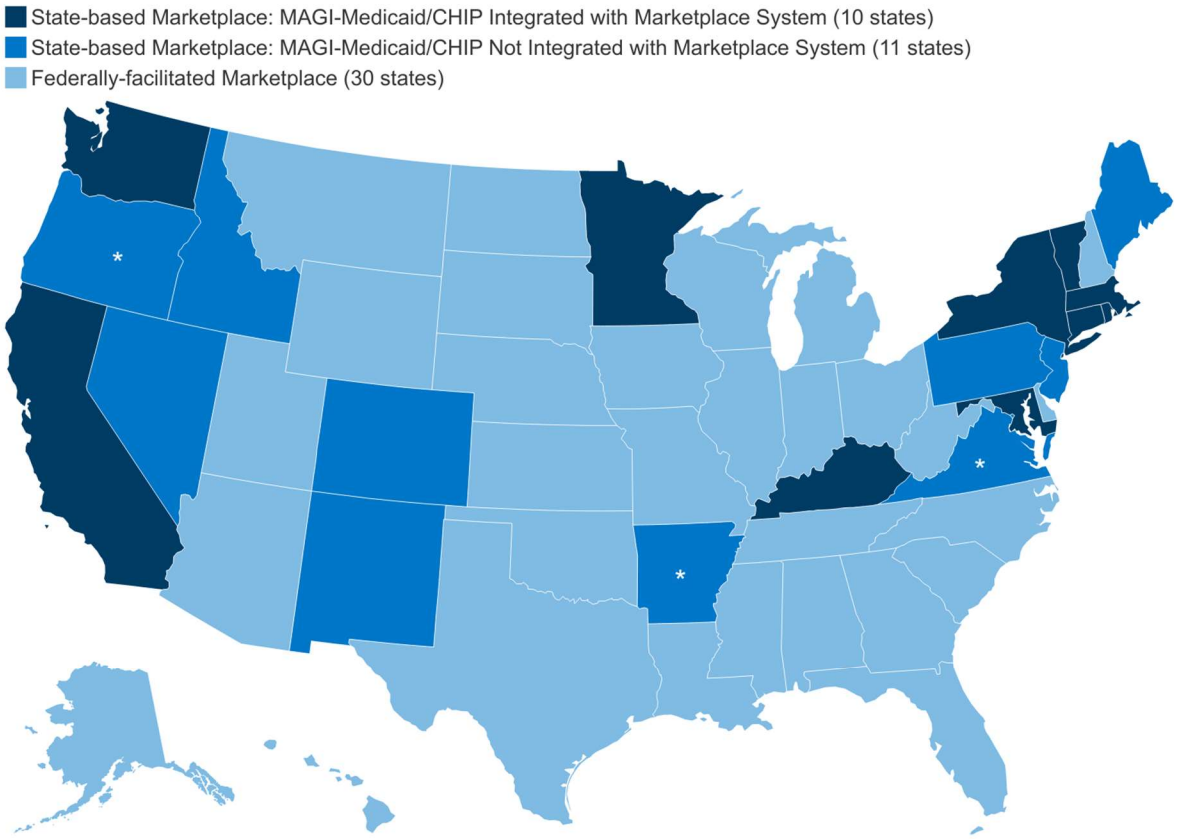
Enrollment and Renewal Processes during the PHE

Eligibility System Integration

While more states are moving toward managing their own State-based Marketplaces (SBM), not all SBM states have integrated Medicaid and CHIP into their Marketplace eligibility and enrollment system (Figure 7). Since 2020, six states transitioned to SBM status, bringing the total number of SBMs to 21, which includes 18 states that operate their own Marketplace eligibility systems and three states that rely on the federal healthcare.gov platform (SBM-FP). The remaining 30 states rely on the Federally-facilitated Marketplace (FFM) for some or all Marketplace functions. SBM states can choose to integrate Medicaid and CHIP into their Marketplace eligibility system, which can facilitate transitions of coverage between Medicaid, CHIP, and the Marketplaces. However, not all states have done so, particularly states that transitioned to full SBM status more recently. In 10 of the 18 SBM states with their own systems, the Marketplace eligibility system also determines eligibility for MAGI Medicaid and CHIP, but eight SBM states have yet to integrate Medicaid and CHIP into their Marketplace system. These eight SBM states, along with the three SBM-FP states and 30 FFM states that use healthcare.gov, have separate Medicaid and CHIP eligibility systems (41 states in total).

Figure 7

Integration Of Marketplace And MAGI-Medicaid/CHIP Eligibility Systems, January 2022



NOTE: *AR, OR, and VA operate state-based marketplaces that use the federal platform.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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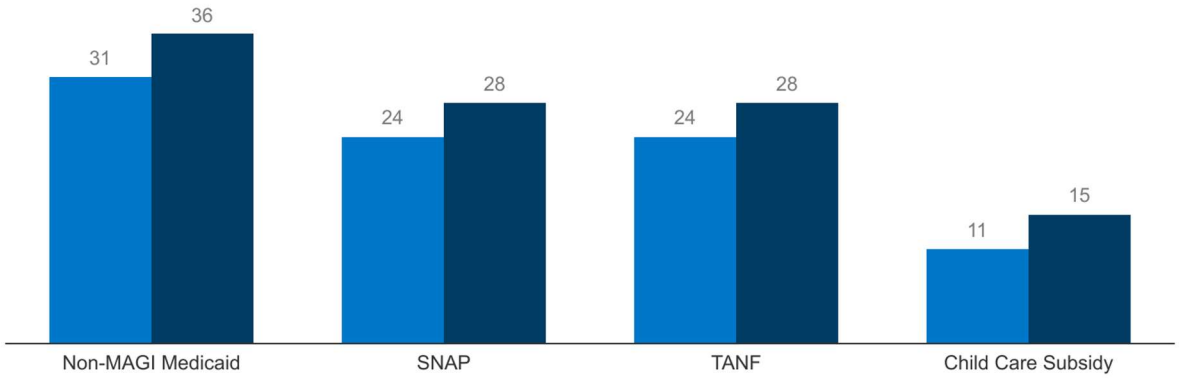
States continue to integrate non-MAGI and non-health programs into the system that determines MAGI Medicaid eligibility. When the ACA Medicaid expansion and other changes were implemented in 2014, many states delinked their Medicaid eligibility systems for MAGI groups (children, pregnant women parents, and expansion adults) from their systems for seniors and individuals with disabilities (non-MAGI groups) and from non-health programs, including Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and child care subsidies. Since then, however, many states have reintegrated these programs. Systems that integrate eligibility for all health programs, as well as non-health programs, make it easier for individuals to apply for multiple assistance programs and for states to consolidate eligibility tasks, increasing administrative efficiency. It also allows for the sharing of information across programs to verify eligibility and facilitate renewals for Medicaid. In January 2022, over two-thirds of states (36) reported having integrated non-MAGI Medicaid with the MAGI Medicaid and CHIP eligibility system. SNAP and TANF are integrated in the system that determines eligibility for

Medicaid in 28 states while 15 states have also integrated child care subsidies into their MAGI Medicaid eligibility systems (Figure 8). These counts include Kentucky and Rhode Island, the only SBM states that have fully integrated their Marketplace eligibility system with eligibility for MAGI Medicaid, non-MAGI Medicaid, and non-health programs.

Figure 8

Number Of States That Have Integrated Non-MAGI Medicaid And Non-Health Programs Into The System That Determines MAGI-Medicaid Eligibility, 2020 And 2022



NOTE: MAGI = Modified adjusted gross income; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance For Needy Families. Data are as of January 2020 and January 2022.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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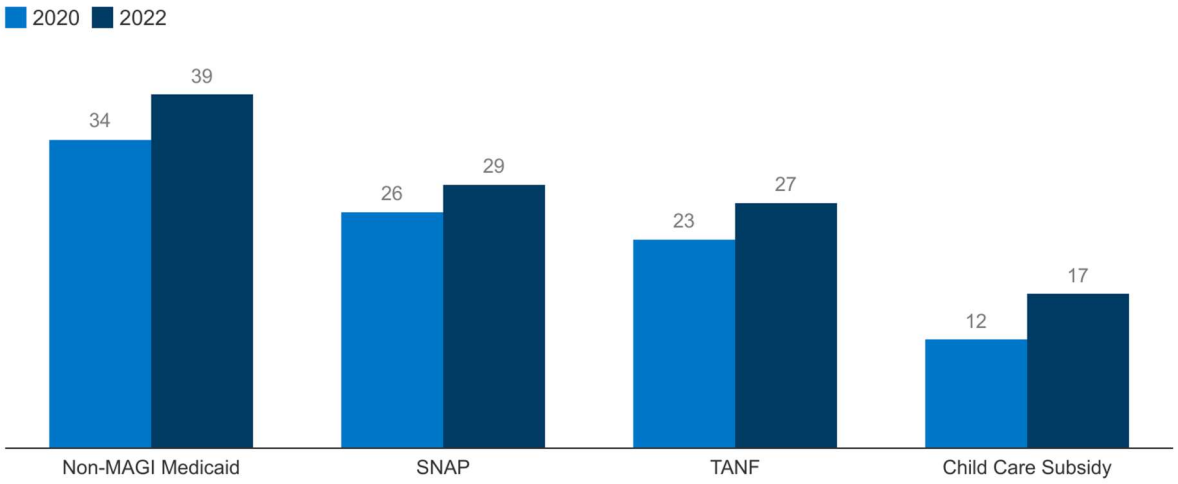
Applications, Online Accounts, and Mobile Access

In almost all states, applications can be submitted online, by telephone, in person, or by mail. All states accept applications online and in person (subject to COVID restrictions) while 50 states offer paper applications that can be mailed in, and 49 states accept applications by telephone without requiring a written signature. More than half of the states (28) accept applications through other modes, most frequently fax or email.

Several states have added non-MAGI Medicaid and non-health programs to their applications during the pandemic. Thirty-nine states allow applicants to apply for both MAGI and non-MAGI Medicaid through a single application, up from 34 states in 2020. Multi-benefit applications now include SNAP in 29 states (up from 26 states in 2020) and TANF in 27 states (up from 23 states in 2020). In addition, 17 states include child care subsidies in their multi-benefit applications, up from 12 in 2020 (Figure 9). Multi-benefit applications are more common in states that have Medicaid eligibility systems that are integrated with non-MAGI Medicaid and non-health programs.

Figure 9

States With Multi-Benefit Applications, Including Medicaid And Non-Health Programs, 2020 And 2022

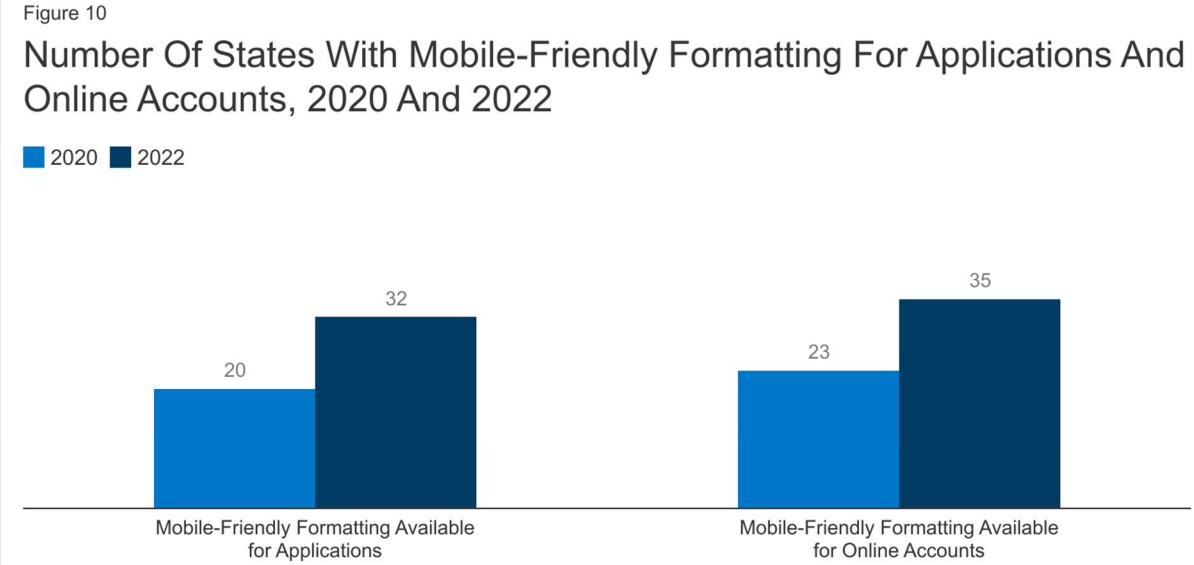


NOTE: MAGI = Modified adjusted gross income; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance For Needy Families. Data are as of January 2020 and January 2022.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

Nearly all states (48) now offer online accounts for Medicaid and CHIP enrollees that make it easier for individuals to submit and access information about their coverage. Five states (Arkansas, Iowa, Kansas, Missouri, and North Carolina) launched online accounts since January 2020. Almost all states that have online accounts allow individuals to check application status, report changes, and view notices while slightly fewer permit individuals to renew coverage through their account. Since January 2020, several states have expanded the features offered, including the ability to upload documentation and the option to receive notices electronically (41 states up from 33 states in 2020).

States have taken steps to improve the mobile friendliness of their applications and online accounts. As more individuals use smart devices, such as phones and tablets, states are increasingly working to ensure that applications and online accounts can be used on multiple technology platforms. As of January 2022, 32 states report their online applications are mobile friendly compared to just 20 states in 2020. Similarly, 35 of the 48 states with online accounts report mobile-friendly formatting, an increase of 12 states since 2020 (Figure 10).

Figure 10



Eligibility Verification Processes

All states use electronic data matches from a variety of data sources to verify income eligibility. Under the ACA, states must first attempt to verify eligibility (both income and other criteria) before requiring the individual to complete a form or submit documentation. Data-driven eligibility determinations at application and renewal are faster and reduce the burden of submitting and processing paperwork for both individuals and states. Data sources used by more than 40 states include the Federal Data Services Hub, state wage databases, and state unemployment databases. Two-thirds (34) of states also use commercial databases (like TALX or the Work Number) that provide wage information from large employers and 30 states access SNAP income data. Nearly all states access multiple sources to verify income.

The use of electronic data enables most states to process at least a small number of eligibility determinations in real time (defined as 24 hours); however, there is significant variation across states in the share of real-time determinations. Forty-three states report being able to make real-time eligibility determinations but some states indicate that while a small share of applications may be processed in 24 hours, their "systems are not programmed" to make real-time determinations; determinations made within 24 hours in these states require eligibility worker intervention. Since 2018, CMS has released an annual report showing the share of MAGI applications processed within five timeframes: within 24 hours; 1 – 7 days; 8 – 30 days; 31 – 45 days; and over 45 days.

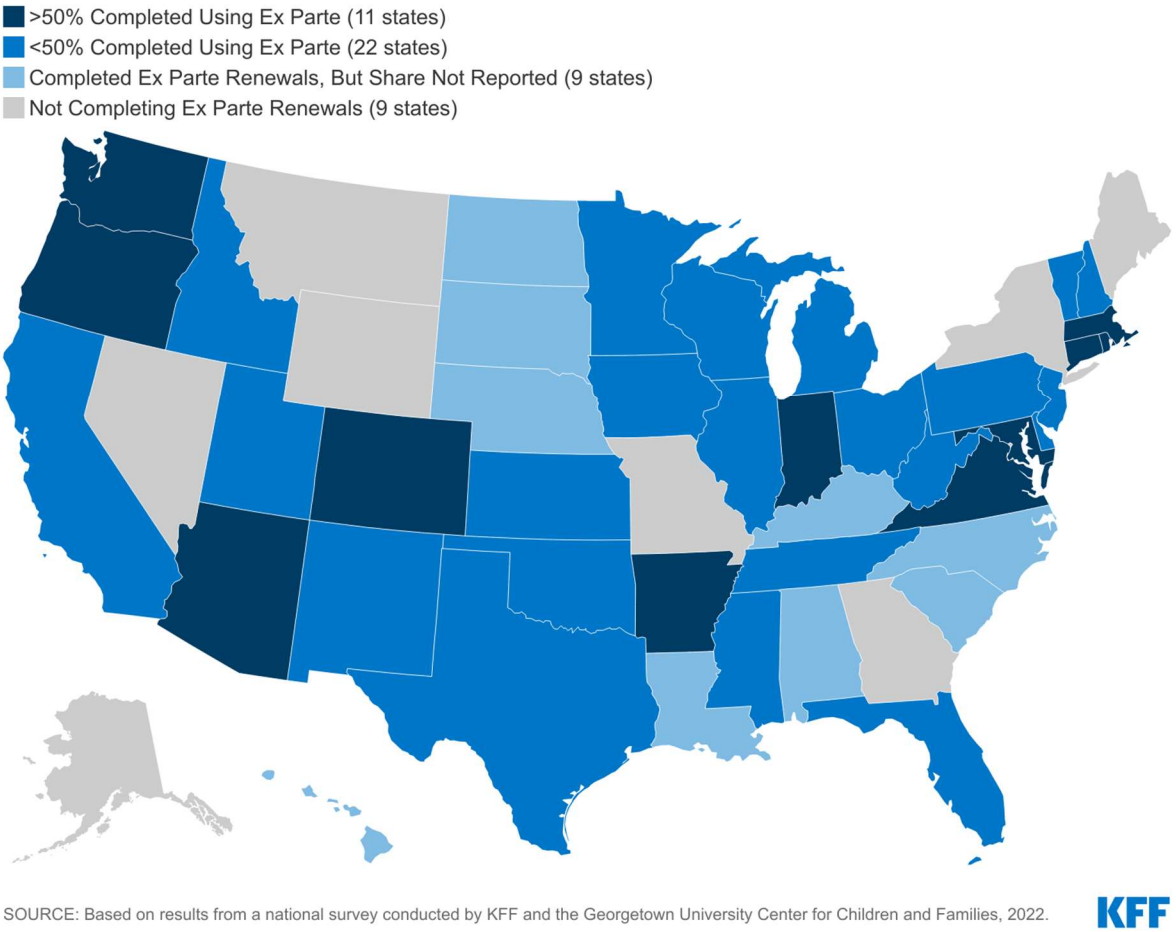
Renewal Processes During the PHE

As of January 2022, most states (42) report processing ex parte renewals to extend coverage for individuals during the PHE. Under the ACA, states must seek to complete administrative or ex parte renewals by verifying ongoing eligibility through available data sources, such as state wage databases, before sending a renewal form or requesting documentation from an enrollee. Some states suspended renewals as they implemented the MOE continuous enrollment requirement and made other COVID-related adjustments to operations. Under normal circumstances, if a state cannot determine that an individual remains eligible based on available information, it must send the enrollee a pre-populated form with the renewal information and provide at least 30 days for the enrollee to provide the necessary information and correct inaccuracies. During the PHE, states have been encouraged to continue using data to conduct ex parte renewals and extend coverage for 12 months for those who remain eligible. Of the 42 states actively processing ex parte renewals, nearly two-thirds (30 states) are sending renewal forms or requests for documentation when they are unable to confirm ongoing eligibility through electronic data sources, although they may not disenroll anyone for eligibility or procedural reasons during the PHE. By processing ex parte renewals and sending out renewal forms, states will have a smaller backlog of delayed renewals or pending actions when the PHE ends.

The share of renewals completed using ex parte processes varies across states and is low in many states. Completing renewals by checking electronic data sources to verify ongoing eligibility reduces the burden on enrollees to maintain coverage. Of the 42 states processing ex parte renewals, only 11 states report completing 50% or more of renewals using ex parte processes. Twenty-two states complete less than 50% of renewals on an ex parte basis, including 11 states where less than 25% of renewals are completed using ex parte processes (Figure 11). CMS notes in recent guidance that states can increase the share of ex parte renewals they complete without having to follow up with the enrollee by expanding the data sources they use to verify ongoing eligibility.

Figure 11

Share Of Medicaid Renewals Completed Using Ex Parte Processes, January 2022



SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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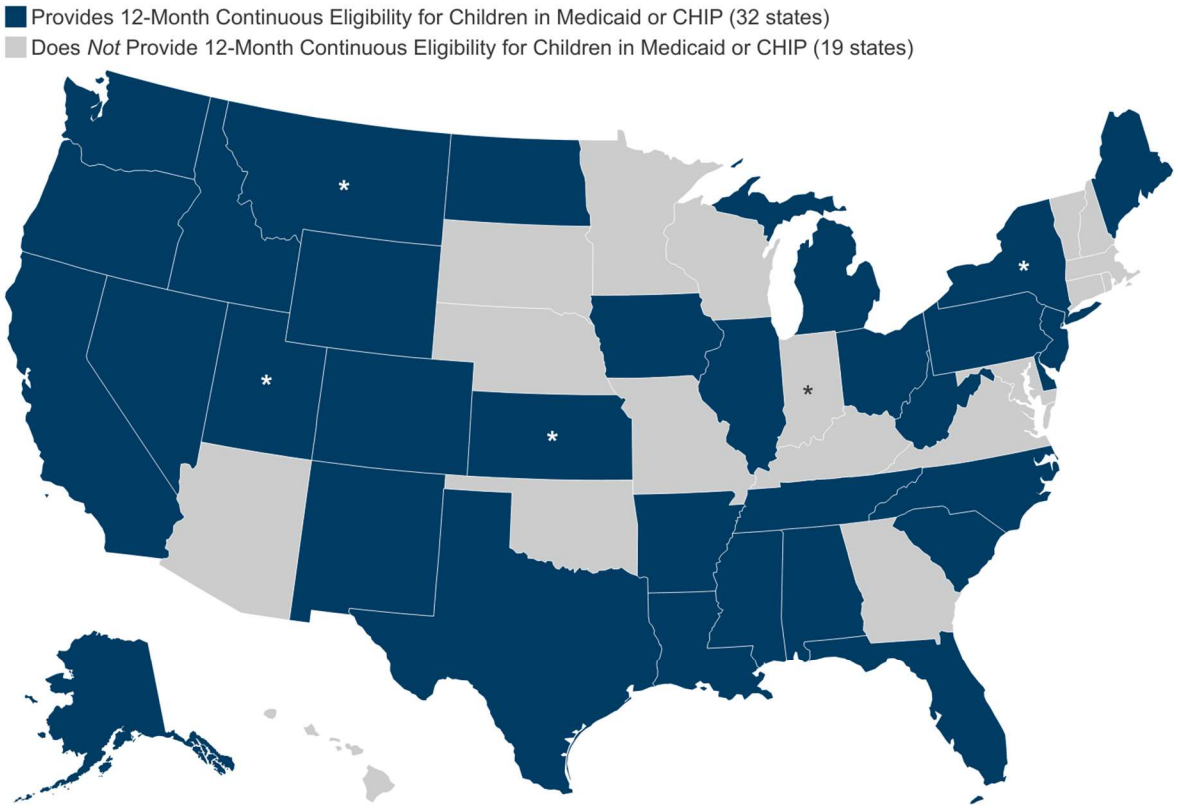
Under the ACA, states are expected to accept renewals through four modes: online, by telephone, in person, and by mail. When renewals can be completed via ex parte or administrative processes, there is no need for enrollees to take action unless the information used to renew coverage is inaccurate. However, if a state is unable to renew coverage using data available to the agency, it is likely that documentation will be needed to confirm ongoing eligibility. Almost all states (50) accept information needed at renewal via mail and in person, with slightly fewer states accepting missing information over the phone (39 states) with a telephonic signature. As states add or expand online account functionality, more states are allowing enrollees to provide missing renewal information or documentation through their online accounts (41 states compared to 39 states in 2020). Most states (49) also allow renewal information to be submitted by fax.

As of January 2022, 32 states provide 12-month continuous eligibility for all children in Medicaid and/or CHIP and four states provide continuous eligibility for adults (Figure 12). Two states provide 12-month continuous eligibility to a limited group of younger children in Medicaid, and one states limits eligibility in both programs. The continuous coverage policy for children is more common in CHIP with 24 of 34 separate CHIP programs providing a full year of coverage compared to 24 of the 51 Medicaid programs that have adopted the option. Only New York provides 12-month continuous eligibility for all adults. Kansas covers parents and Utah covers a targeted group of adults with incomes 0-5% FPL for a full year under waiver authority. Montana received approval from CMS in December 2021 to eliminate 12-month continuous eligibility for expansion adults, although the coverage remains in effect during the PHE. The state also requested approval to eliminate 12-month continuous eligibility for parents; however, that request is still pending with CMS. Continuous eligibility eliminates coverage gaps due to income fluctuations, which are often temporary, and is referenced in recent CMS guidance as a strategy for promoting continuous coverage for eligible individuals and reducing churn. In states without continuous eligibility, enrollees are expected to report changes in circumstances, which will add to the state's workload as it resumes routine operations at the end of the PHE.

Figure 12

States That Provide 12-Month Continuous Eligibility For All Children In Medicaid Or CHIP, January 2022



NOTE: *IN provides 12-month continuous eligibility to a limited group of children in Medicaid and CHIP; KS, MT, NY, and UT also provide 12-months continuous eligibility for certain adults. CHIP = Children's Health Insurance Program.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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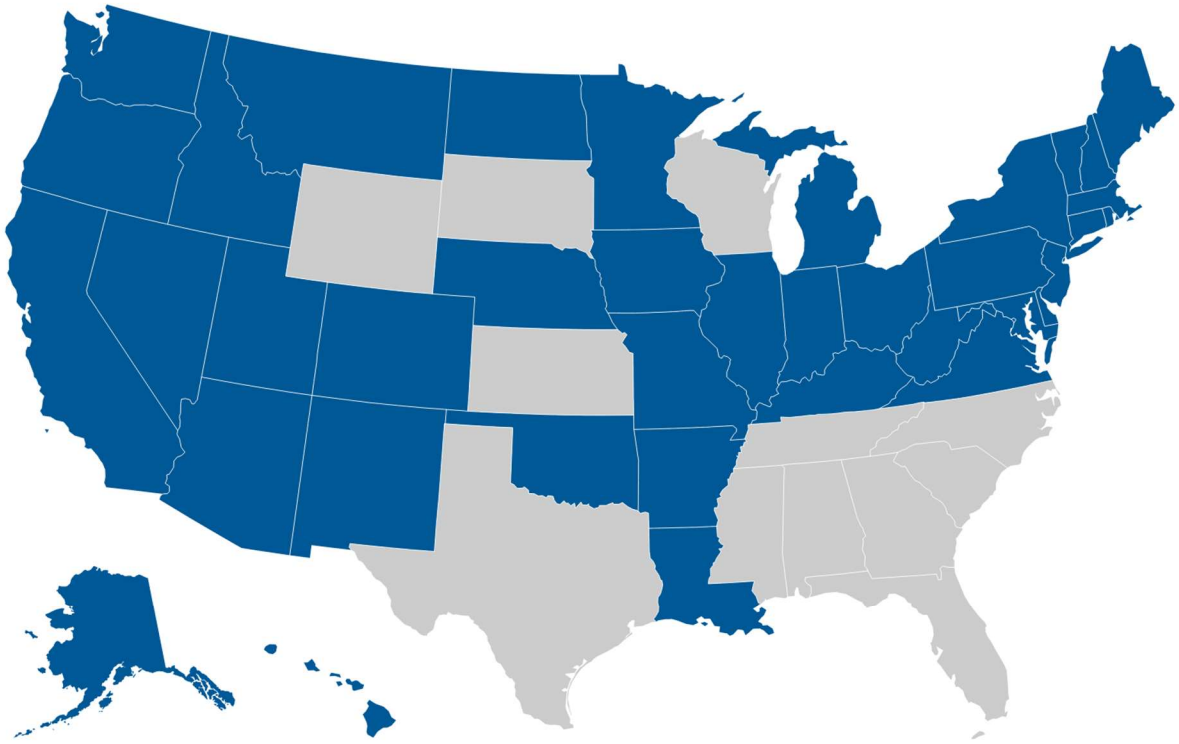
Medicaid and CHIP Eligibility

As of January 2022, Medicaid and CHIP eligibility were stable as the public health emergency protections remained in effect for the entirety of 2021. To provide economic relief to the states and promote stability of coverage during the COVID-19 pandemic, the FFCRA provides a 6.2 percentage point increase in the federal share (FMAP) of certain Medicaid spending if states meet MOE requirements. The MOE provisions prohibit states from reducing eligibility levels, implementing stricter enrollment procedures, or increasing premiums beyond policies in place as of January 1, 2020. States are also required to provide continuous enrollment through the end of the month in which the PHE ends and must cover COVID-19 testing and treatment for Medicaid enrollees**.** The COVID-related MOE does not apply to separate CHIP programs, but other MOE requirements remain in place for CHIP.

In 2021, Oklahoma and Missouri implemented the ACA Medicaid adult expansion, leaving only 12 states that have not filled the coverage gap for low-income adults (Figure 13). As of January 2022, 39 states cover parents and adults without dependent children with incomes at least up to 138% FPL (the FPL is $13,590 for an individual; $23,030 for a family of three in 2022). Just half of the states (25) and DC immediately expanded coverage to adults in January 2014. Since then, an additional 13 states have adopted the Medicaid expansion; six via state ballot initiatives, including Missouri and Oklahoma. In 2022, South Dakota will be the seventh state where voters will have a say in the state's decision to expand Medicaid.

Figure 13

Medicaid Income Eligibility For Expansion Adults, January 2022



NOTE: Eligibility levels are based on 2022 federal poverty levels (FPLs) for an individual. In 2022, the FPL was $13,590 for an individual. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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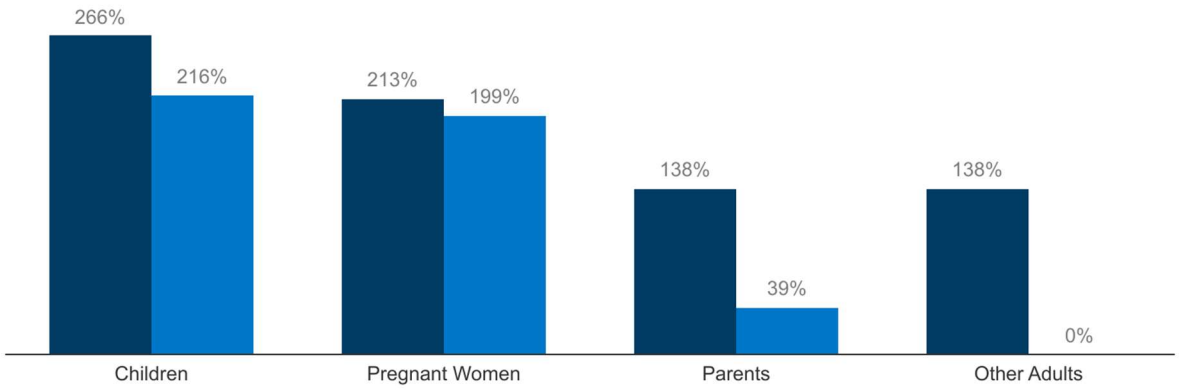
In the 12 states that have not implemented the Medicaid expansion, eligibility for parents remains extremely low, and only Wisconsin covers adults without dependent children (Figures 14 and 15). The median eligibility level for parents and caretakers in the 12 non-expansion states now stands at 38.5% FPL ($8,866 annually for a family of three), ranging from a low of 16% FPL in Texas to 100% FPL in Wisconsin. Nine non-expansion states base eligibility on a fixed dollar threshold that is converted to the

equivalent federal poverty level for comparison purposes. Over time, the equivalent eligibility level will decrease when annual updates adjust federal poverty levels upward to account for inflation. In a year when the jump in the federal poverty levels is more significant, as it was in 2022, this erosion is more evident. For example, Tennessee's parent eligibility declined from 93% FPL to 88% FPL between 2021 and 2022. Wisconsin is the only non-expansion that has aligned eligibility for adults without dependent children with that for parents at 100% FPL, through a waiver.

Figure 14

Median Medicaid Income Eligibility Limits Based On Implementation Of Medicaid Expansion, January 2022

Eligibility Limits Are Represented as % FPL:



NOTE: Eligibility levels are based on a family of three for parents and an individual for childless adults. In 2022, the FPL was $23,030 for a family of three and $13,590 for an individual. Threshold include the standard five percentage point of FPL disregard.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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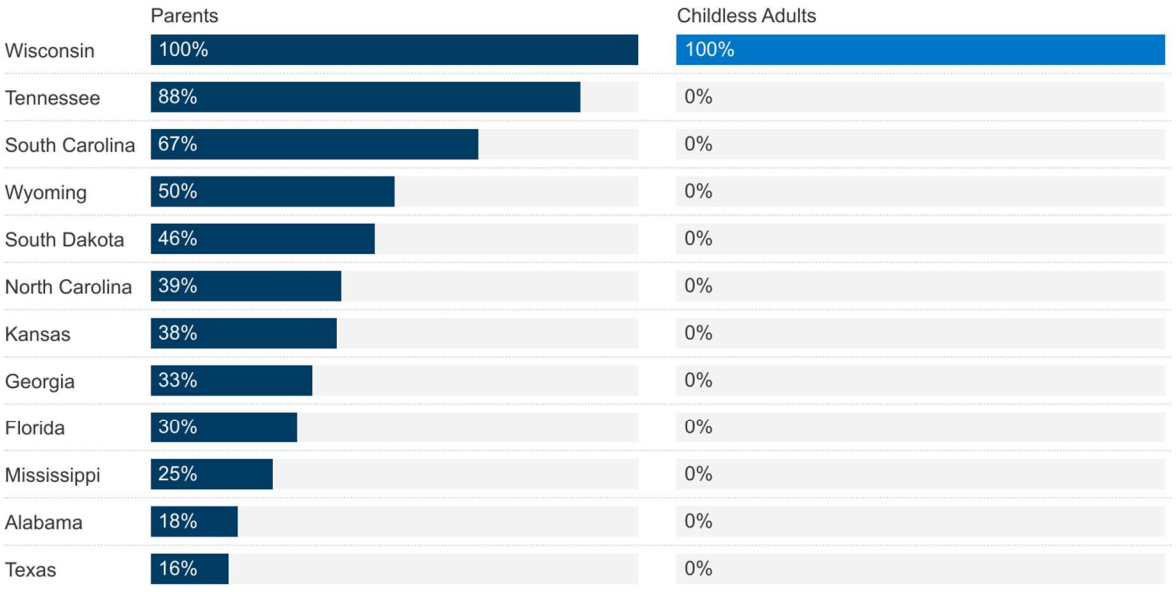
Figure 15

Medicaid Income Eligibility Limits For Adults In States That Have Not Implemented The Medicaid Expansion, January 2022



NOTE: Eligibility levels are based on 2022 federal poverty levels (FPLs) for a family of three. In 2022, the FPL was $23,030 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results of a national survey conducted by KFF and the Georgetown Center for Children and Families, 2022.

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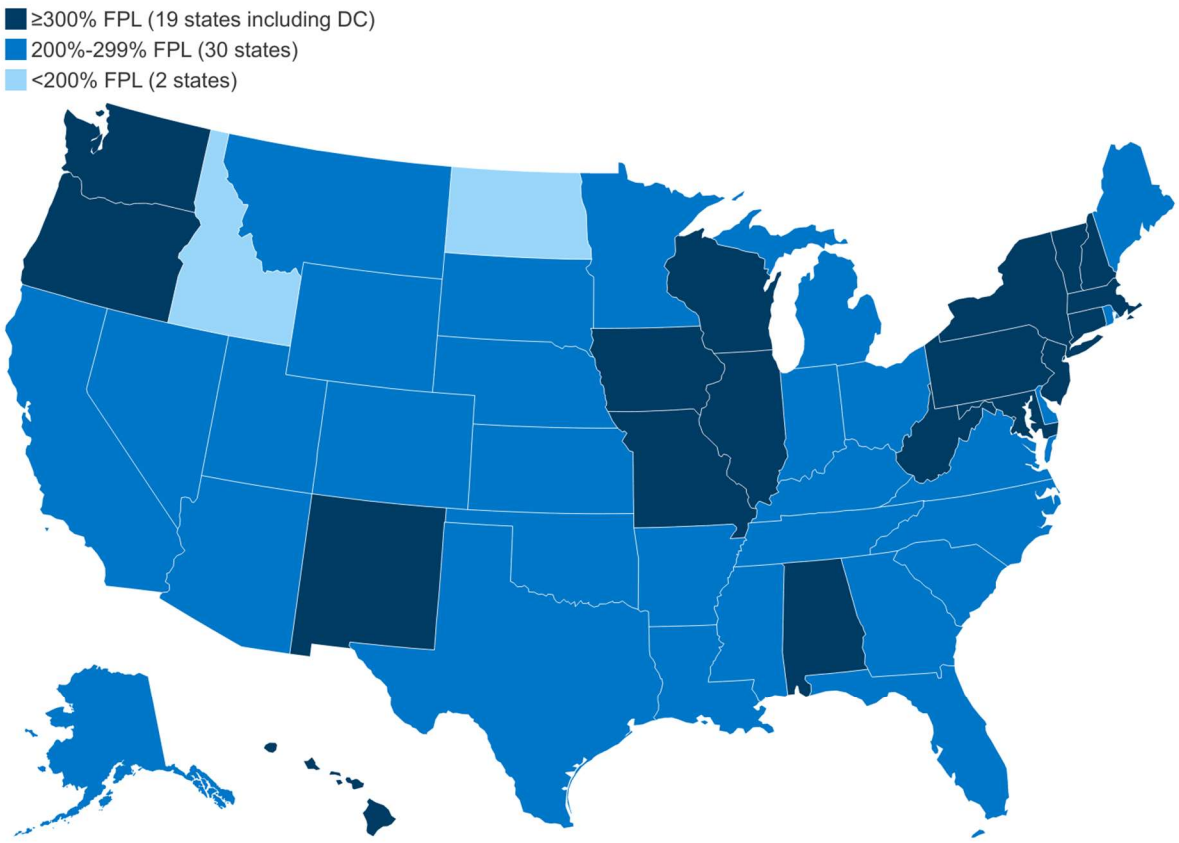
As of January 2022, children's upper income eligibility remains unchanged, with the median eligibility level stable at 255% FPL. Child eligibility in Medicaid and CHIP continues to be the highest of all eligibility groups with all but two states (Idaho and North Dakota) covering children at or above 200% FPL. (Figure 16). Eligibility levels for children range from a low of 175% FPL in North Dakota to a high of 405% FPL in New York. More than a third of the states (19) cover children at or above 300% FPL. The only change in eligibility levels for children's coverage was in Kansas, where CHIP eligibility is linked to a dollar-based income level tied to the 2008 FPL.

Figure 16

Income Eligibility Levels For Children In Medicaid/CHIP, January 2022



NOTE: Eligibility levels are based on 2022 federal poverty levels (FPLs) for a family of three. In 2022, the FPL was $23,030 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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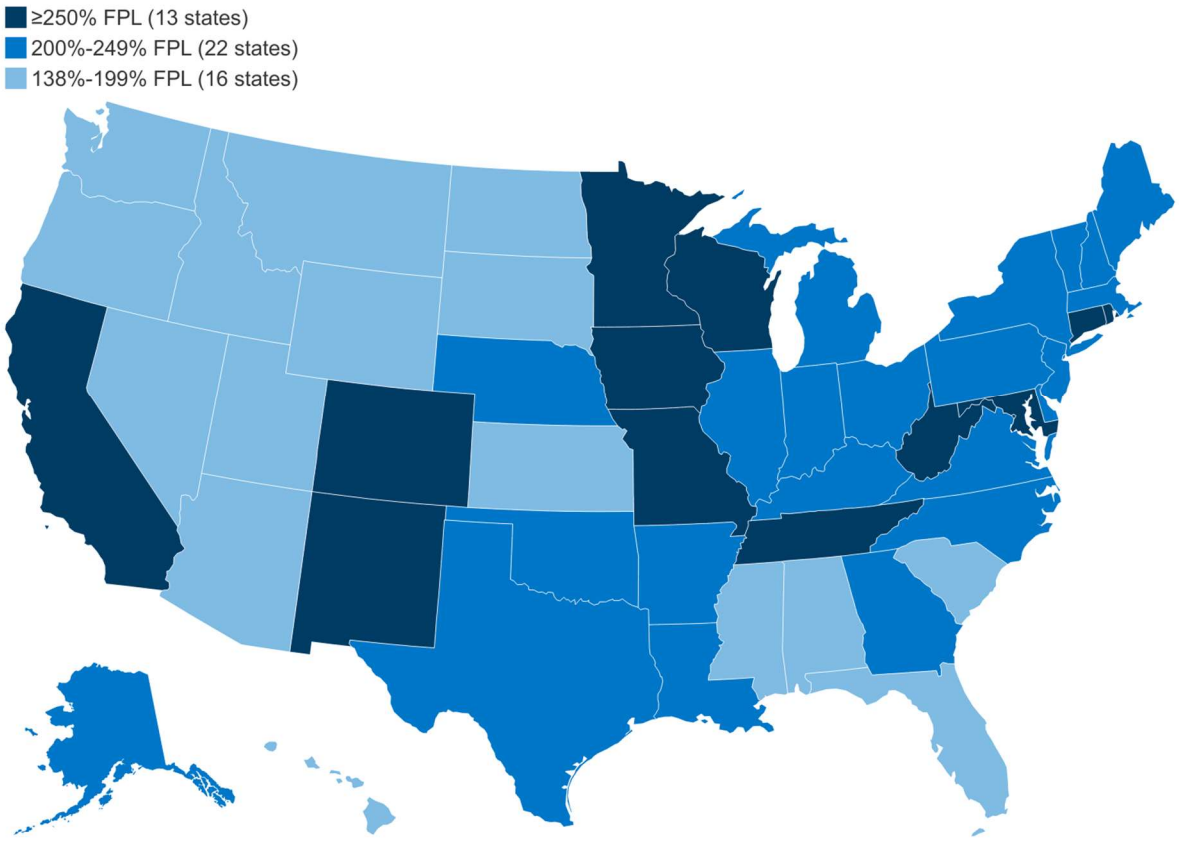
The median eligibility limit for coverage for pregnant women in Medicaid and CHIP remained steady at 205% FPL. States provide pregnancy coverage at higher income levels than coverage for parents or other adults. Across states, eligibility levels for pregnant women in Medicaid and CHIP range from a low of 138% FPL (the federal minimum level) in Idaho and South Dakota to a high of 380% FPL in Iowa. Two-thirds of the states (35) cover pregnant women at or above 200% FPL. Six states have expanded pregnancy coverage in CHIP, an option for states that cover pregnant women in Medicaid up to at least 185% FPL (Figure 17) while 18 states provide pregnancy coverage from birth to conception for targeted low-income children.

Figure 17

Income Eligibility Levels For Pregnant Individuals In Medicaid/CHIP, January 2022



NOTE: Eligibility levels are based on 2022 federal poverty levels (FPLs) for a family of three. In 2022, the FPL was $23,030 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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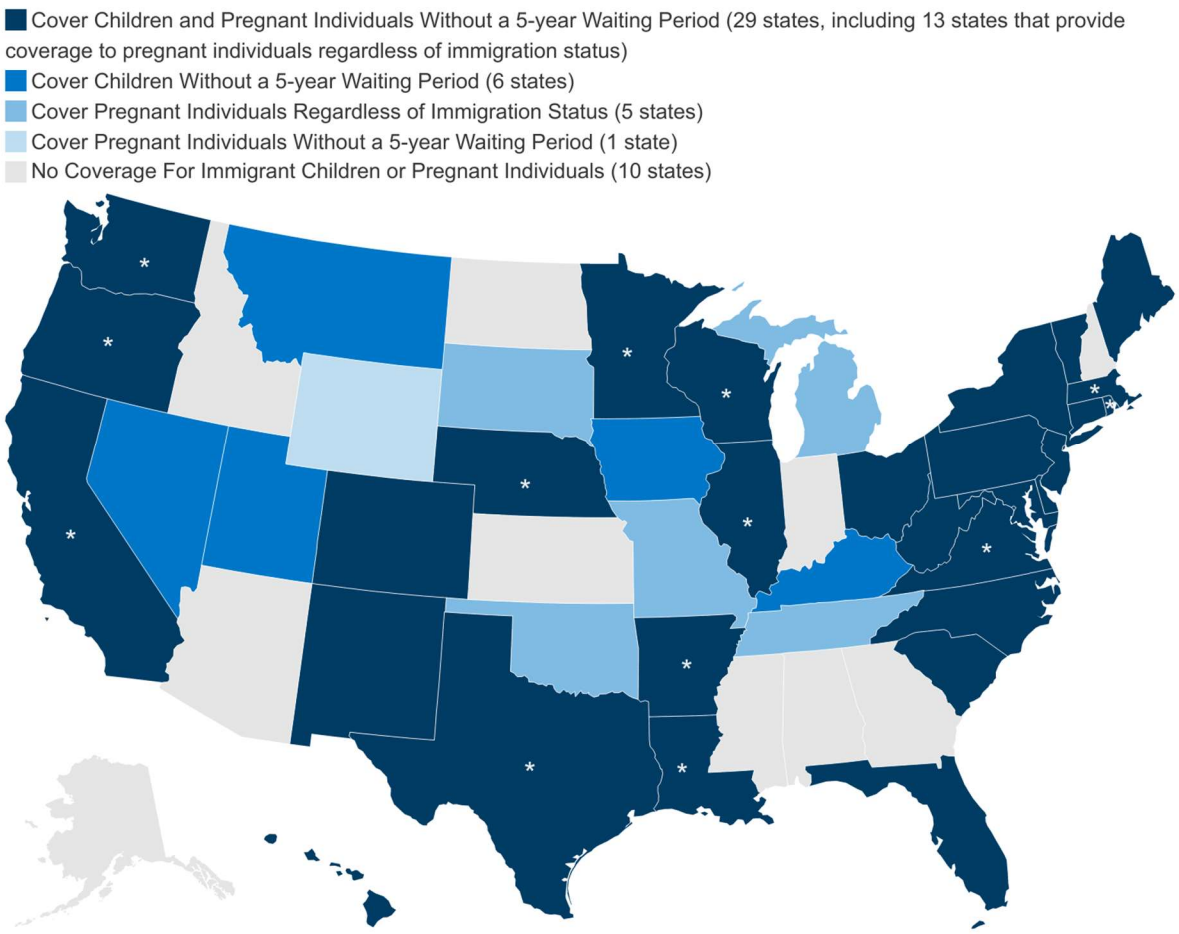
As of January 2022, 41 states have adopted federal options to extend coverage to immigrant children and pregnant women; eight of these states use state funds to extend coverage or limited benefits to some adults and children who do not qualify for federal funding. States have several options to use federal funding to cover children or pregnant people without the five-year waiting period in Medicaid and CHIP. Dating back to the enactment of CHIP, states have had the option to provide coverage in CHIP from conception to birth, known as the unborn child option, which effectively extends coverage to pregnant people without regard to immigration status. In 2021, Virginia became the 18th state to adopt this option. The 2009 CHIP Reauthorization Act (CHIPRA) also provided states another option to waive the five-year waiting period before covering lawfully-residing children and pregnant people. As of January 2022, two-thirds of states (35) have implemented the CHIPRA option for children in Medicaid and all of those states with separate CHIP programs (24 states) cover lawfully-residing children in CHIP.

Twenty-five states have adopted the CHIPRA option to cover lawfully-residing pregnant people (Figure 18).

Figure 18

Federally Funded Medicaid/CHIP Coverage For Immigrant Children And Immigrant Pregnant Individuals, January 2022



NOTE: * State also covers pregnant individuals regardless of immigration status through the Unborn Child Option. Unborn Child Options: Permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

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States also use state-only funds to extend coverage to immigrant groups who are not eligible for federal funding. As of January 2022, seven states cover all children regardless of immigration status, while Iowa covers some immigrant children who do not qualify for federal funding. California began covering young adults ages 19-26 regardless of immigration status in January 2020 and starting in May 2022, will extend coverage to adults ages 50 and older regardless of immigration status. There is growing interest in filling coverage gaps, particularly for children and pregnant women. Maine, New Jersey, and

Vermont will extend coverage to all children regardless of immigration status in July 2022 and Connecticut will cover all children under age nine starting in January 2023. Vermont will also extend state-funded coverage to pregnant people who do not qualify for federal funding in mdi-2022 and the District of Columbia and Maine are planning to adopt the CHIP unborn child option for pregnant people in April and July 2022, respectively.

The median eligibility level for family planning services was 206% FPL, but eligibility levels range from 138% FPL in Louisiana and Oklahoma to a high of 306% FPL in Wisconsin. All states must cover family planning services in Medicaid and 30 states use federal funds, through a state plan option or waiver, to provide family planning only services to people who do not qualify for full Medicaid through another pathway.

Looking Ahead

States are preparing now for the end of the PHE, but they will still need lead time to finalize their plans. Anticipating the end of the PHE in the coming months, states have begun making decisions around actions they will take to resume normal operations. However, some states have yet to adopt key strategies related to how they will approach processing redeterminations and other pending actions that will inform their overall operational plans. These plans are necessary to begin taking steps to update policies and procedures, make any needed systems changes, and engage with stakeholders around the details. Providing adequate lead time to states before ending the PHE will enable states to finalize their operational plans. The Biden administration has promised to provide at least 60 days' notice, but signaling even earlier when the PHE will end, if possible, would enable states and other key stakeholders, including MCOs, to ensure policies and processes are in place and ready to implement.

CMS guidance on resuming normal operations focuses on prioritizing continuity of coverage. CMS has released several rounds of guidance during the PHE, initially in December 2020, in August 2021 and most recently in March 2022 (the latest guidance was released after the survey was fielded). Guidance issued under the Biden administration has consistently emphasized strategies to promote continuity of coverage and avoid inappropriate terminations among people who remain eligible for coverage. The most recent guidance reiterates that all states must complete a full redetermination before an enrollee's coverage can be terminated. It also gives states an additional two months to complete processing renewals, but all renewals must still be initiated in the 12-month unwinding period. The guidance strongly encourages states to initiate no more than 1/9th of total caseloads each month to reduce the risk that a compressed renewal workload will result in individuals being erroneously determined ineligible and to distribute renewals more evenly in future years. It also provides states with additional flexibilities to align work on pending actions, including aligning Medicaid renewals with SNAP recertifications or coordinating renewals for all household members.

The PHE has demonstrated how continuous enrollment can eliminate churn in Medicaid; going forward states can adopt existing options and strategies to promote coverage. Such options include adopting 12-month continuous coverage for children (also for adults through an 1115 waiver), extending

postpartum coverage for 12-months, and increasing the effectiveness of data-driven determinations and renewals by using information from other programs and expanding data sources used to verify income and other information. Many states have adopted these options, including 32 states that provide 12-month continuous eligibility for children and 21 states that have or plan to extend postpartum coverage from 60 days to 12 months to all pregnant individuals. Adopting the Medicaid expansion in the 12 states that have not yet done so can also ensure continuity of coverage for parents in those states who may have experienced a small increase in income during the pandemic and may no longer be eligible under current rules. It would also provide coverage to the two million people in the coverage gap who do not currently have an affordable coverage option. The American Rescue Plan Act (ARPA) provides temporary financial incentives for states that newly adopt the Medicaid expansion. States that have not yet done so can protect ongoing coverage by adopting these options or otherwise streamlining automated renewal processes.

State actions and decisions around the unwinding will affect Medicaid enrollment and transitions to other coverage. How states approach the unwinding of the continuous enrollment requirement will affect the extent to which eligible individuals retain coverage and those who are no longer eligible are able to transition to other coverage. Outcomes will differ across states as they make different choices and face challenges balancing workforce capacity, fiscal pressures, and the volume of work. Careful monitoring of state progress throughout the unwinding period can provide information to assess fiscal effects and state efforts to promote continuity of coverage. CMS has indicated states will be required to submit baseline and monthly data for a minimum of 14 months that it will use to monitor the unwinding to ensure compliance with timelines and to prevent erroneous disenrollment of eligible individuals. CMS has not yet specified what data elements states will need to report nor does it indicate whether the data will be made publicly available. If the data are not released publicly, it will be more difficult for entities other than CMS to monitor state actions.

The fate of the Build Back Better Act (BBBA) will have implications for overall coverage. The BBBA includes several provisions related to the unwinding of the continuous enrollment requirement, some of which CMS has incorporated in the most recent guidance. BBBA also includes provisions to close the Medicaid coverage gap in the dozen states that have not expanded eligibility under the ACA and to extend the enhanced Marketplace premium subsidies initially made available by ARPA that have made coverage more affordable for millions of people. The number of people who are uninsured has not increased during the PHE as many had predicted. However, the end of the PHE poses risks to that coverage stability. Millions of people could lose coverage if those who continue to be eligible for Medicaid are not able to retain coverage and if the provisions in the BBBA that close the coverage gap and make Marketplace coverage more affordable are not enacted.

Trend and State-by-State Tables

Table A: Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies, July 2005-January 2022 [1]																	
	Program	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013	January 2015	January 2016	January 2017	January 2018	January 2019	January 2020	January 2021	January 2022
ELIGIBILITY																	
Cover children ≥200% FPL	**N/A**	41	41	45	44	47	47	47	47	48	48	49	49	49	49	49	49
Cover children ≥300% FPL	**N/A**	6	8	9	10	16	16	17	17	19	19	19	19	19	19	19	19
Cover lawfully-residing immigrant children without five-year wait	**Medicaid**	Option Not Available									29	31	33	34	35	35	35
	CHIP					17	21	24	25	28	19	21	22	23	24	24	24
Cover pregnant individuals ≥200% FPL	**N/A**	17	17	20	21	24	25	25	25	33	33	34	34	34	35	35	35
Cover lawfully-residing immigrant pregnant individuals without five-year wait	**Medicaid**	Option Not Available									23	23	25	25	25	25	25
	CHIP					14	17	18	20	23	4	3	3	3	4	4	4
Cover parents ≥100% FPL [2]	**N/A**	17	16	18	18	17	18	18	18	31	34	35	34	35	37	38	40
Cover other adults [2 3]	**N/A**	NC					7	8	25	29	32	33	33	35	37	37	40
Asset test not required [4]	**Medicaid Children**	47	47	47	47	48	48	48	48								
	CHIP	33	34	35	36	37	36	37	36								
	Parents	22	21	22	23	24	24	24	24	51	51	51	51	51	51	NC	NC
STREAMLINED ENROLLMENT PROCESSES																	
Real-time eligibility determinations	**N/A**	NC									37	39	40	46	47	NC	43
Online Medicaid application [4]	**Medicaid**	NC					32	34	36	50	50	50	50	51	51	NC	51
Telephone Medicaid application [4]	**Medicaid**	NC							17	47	49	49	49	47	45	NC	49
Presumptive eligibility for children	**Medicaid**	9	9	14	14	14	16	16	17	15	18	20	20	20	19	NC	NC
	CHIP	6	6	9	9	9	10	11	12	9	10	11	11	11	10	NC	NC
Presumptive eligibility for pregnant individuals	**Medicaid**										29	30	30	30	30	NC	NC
	CHIP	30	31	30	30	30	31	31	32	27	2	3	3	3	3	NC	NC
No face-to-face interview at enrollment [4]	**Medicaid Children**	45	46	46	48	48	49	49	49								
	CHIP	33	33	34	38	38	37	38	37								
	Parents	36	39	40	41	41	44	45	45	51	51	51	51	51	51	NC	NC
STREAMLINED RENEWAL PROCESSES																	
Processing automated renewals	**N/A**	NC									34	42	46	46	47	NC	42
Telephone Medicaid renewal	**N/A**	NC									41	41	41	41	41	NC	39
No face-to-face interview at renewal [4]	**Medicaid Children**	48	48	48	49	50	50	50	50								
	CHIP	35	35	36	38	38	37	38	37								
	Parents	43	45	46	46	46	46	48	48	51	51	51	51	51	51	NC	NC
12-month eligibility period [4]	**Medicaid Children**	42	44	45	44	47	49	49	49								
	CHIP	34	34	37	39	39	38	28	38								
	Parents	36	39	40	40	43	45	46	46	51	51	51	51	51	51	NC	NC
12-month continuous eligibility for children	**Medicaid**	17	16	16	18	22	23	23	23	21	24	24	24	24	23	NC	27
	CHIP	24	25	27	30	30	28	28	27	25	26	26	26	26	25	NC	25

NOTE: NC indicates that data were not collected for the period. 1. The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year. 2. These counts do not include states that may have provided coverage above the levels shown using state-only funding or provide a more limited benefit package. 3. This count includes Wisconsin's coverage of adults to 100% FPL. 4. Required across all states under the Affordable Care Act (ACA). See S. Artiga, M. Musumeci, and R. Rudowitz, "Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule," December 2012. Mitigation strategies are in place in cases in which requirements have not yet been met.

SOURCE: Based on a national survey conducted by the KFF with the Center on Budget and Policy Priorities, 2005-2009; and with the Georgetown University Center for Children and Families, 2011-2022.

Table 1: Income Eligibility Limits for Children's Health Coverage as a Percent Of The Federal Poverty Level, January 2022 [1]								
State	Upper Income Limit	Medicaid Coverage for Infants Ages 0-1 [2]		Medicaid Coverage for Children Ages 1-5 [2]		Medicaid Coverage for Children Ages 6-18 [2]		Separate CHIP for Uninsured Children Ages 0-18 [3]
		Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	
Median [4]	**255%**	**195%**	**217%**	**148%**	**216%**	**138%**	**156%**	**255%**
Alabama [5]	317%	146%		146%		146%	107%-146%	317%
Alaska	208%	177%	159%-208%	177%	159%-208%	177%	124%-208%	
Arizona	205%	152%		146%		138%	104%-138%	205%
Arkansas	216%	147%		147%		147%	107%-147%	216%
California [6]	266%	208%	208%-266%	142%	142%-266%	133%	108%-266%	
Colorado	265%	147%		147%		147%	108%-147%	265%
Connecticut	323%	201%		201%		201%		323%
Delaware	217%	217%	194%-217%	142%	143%-217%	138%	110%-138%	217%
District of Columbia [5]	324%	324%	206%-324%	324%	146%-324%	324%	112%-324%	
Florida [7]	215%	211%	192%-211%	145%		138%	112%-138%	215%
Georgia	252%	210%		154%		138%	113%-138%	252%
Hawaii	313%	191%	191%-313%	139%	139%-313%	133%	105%-313%	
Idaho	190%	147%		147%		138%	107%-138%	190%
Illinois	318%	147%		147%		147%	108%-147%	318%
Indiana	255%	213%	158%-213%	163%	141%-163%	163%	106%-163%	255%
Iowa	380%	380%	240%-380%	172%		172%	122%-172%	307%
Kansas [8]	230%	171%		154%		138%	113%-138%	230%
Kentucky	218%	200%		142%	142%-164%	133%	109%-164%	218%
Louisiana	255%	142%	142%-217%	142%	142%-217%	142%	108%-217%	255%
Maine	213%	196%		162%	140%-162%	162%	132%-162%	213%
Maryland	322%	194%	194%-322%	138%	138%-322%	133%	109%-322%	
Massachusetts	305%	205%	185%-205%	155%	133%-155%	155%	114%-155%	305%
Michigan [9]	217%	195%	195%-217%	160%	143%-217%	160%	109%-217%	
Minnesota [10]	288%	275%	275%-288%	280%		280%		
Mississippi	214%	199%		148%		138%	107%-138%	214%
Missouri	305%	201%		148%	148%-155%	148%	110%-155%	305%
Montana	266%	148%		148%		133%	109%-148%	266%
Nebraska	218%	162%	162%-218%	145%	145%-218%	133%	109%-218%	
Nevada	205%	165%		165%		138%	122%-138%	205%
New Hampshire	323%	196%	196%-323%	196%	196%-323%	196%	196%-323%	
New Jersey	355%	199%		147%		147%	107%-147%	355%
New Mexico	305%	240%	200%-305%	240%	200%-305%	190%	138%-245%	
New York	405%	223%		154%		154%	110%-154%	405%
North Carolina [11]	216%	215%	194%-215%	215%	141%-215%	138%	107%-138%	216%
North Dakota	175%	147%	147%-175%	147%	147%-175%	133%	111%-175%	
Ohio	211%	156%	141%-211%	156%	141%-211%	156%	107%-211%	
Oklahoma [5] [12]	210%	210%	169%-210%	210%	151%-210%	210%	115%-210%	
Oregon	305%	190%	133%-190%	138%		138%	100%-138%	305%
Pennsylvania	319%	220%		162%		138%	119%-138%	319%
Rhode Island	266%	190%	190%-266%	142%	142%-266%	133%	109%-266%	
South Carolina	213%	194%	194%-213%	143%	143%-213%	133%	107%-213%	
South Dakota	209%	187%	147%-187%	187%	147%-187%	187%	111%-187%	209%
Tennessee [5] [13]	255%	195%	195%-216%	142%	142%-216%	133%	109%-216%	255%
Texas	206%	203%		149%		138%	109%-138%	206%
Utah	205%	144%		144%		138%	105%-138%	205%
Vermont	317%	317%	237%-317%	317%	237%-317%	317%	237%-317%	
Virginia	205%	148%		148%		148%	109%-148%	205%
Washington	317%	215%		215%		215%		317%
West Virginia	305%	163%		146%		138%	108%-138%	305%
Wisconsin [14]	306%	306%		191%		133%	101%-156%	306%
Wyoming [15]	205%	154%	155%-205%	154%	155%-205%	133%	119%-205%	

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 1 Notes

1. January 2022 income limits are reported as a percentage of the federal poverty level (FPL). The 2022 FPL for a family of three is $23,030. The reported levels reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the FPL applied at the highest income level for Medicaid and separate CHIP coverage. In states without a separate CHIP program, the disregard is added to the highest Medicaid or the CHIP-funded Medicaid expansion limit. In states with a separate CHIP program, the disregard is applied to the highest Medicaid or CHIP-funded Medicaid expansion limit (M-CHIP) as well as to the upper eligibility limit of the separate CHIP program. Because CHIP funding is limited to uninsured children, in states that have a higher eligibility limit for their CHIP-funded Medicaid expansion than regular Medicaid, there may be a small number of children who have another source of coverage that would be eligible for Medicaid when the 5-percentage point disregard is applied, which is not reflected in the table.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs (M-CHIP) and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more limited benefit package. They also may impose premiums or other cost sharing obligations on some or all families with eligible children. Unlike Medicaid, which gives states the option to cover 19 and 20 years as children, CHIP coverage is limited to uninsured children under the age of 19.
4. Medians for children are based on the upper income limit for Medicaid and CHIP combined.
5. Alabama, the District of Columbia, Oklahoma, and Tennessee have different lower bounds for adolescents in Title XXI funded Medicaid expansions depending on age. The lower bound for Title XXI funded Medicaid is 18% for children ages 14 through 18 in Alabama, 63% for children ages 15 through 18 in the District of Columbia, 69% for children ages 14 through 18 in Oklahoma, and 29% for children ages 14 through 18 in Tennessee.
6. In California, children with higher incomes are eligible for separate CHIP coverage in certain counties.
7. In Florida, all infants ages 0 to 1 are covered in Medicaid. Florida operates three separate CHIP programs: MediKids covers children ages 1 through 4; Healthy Kids covers children ages 5 through 18; and the Children's Medical Services Managed Care Plan serves children with special health care needs from birth through age 21. In Florida, families can buy in to Healthy Kids for children ages 5-19 and to MediKids children ages 1 to 4.

8. In Kansas, eligibility for children in the separate CHIP program is a dollar-based income level equal to 250% FPL in 2008. As a fixed dollar amount, the equivalent FPL level may erode over time.
9. Michigan provides CHIP-funded Medicaid expansion coverage to children with incomes between 212% FPL to 400% FPL affected by the Flint water crisis.
10. In Minnesota, the infant category under Title XIX-funded Medicaid includes insured and uninsured children up to age two with incomes up to 275% FPL, and insured children up to age 2 from 275-288% FPL.
11. In North Carolina, all children ages 0 through 5 are covered in Medicaid up to 215% FPL while the separate CHIP program covers children ages 6 through 18 with incomes above Medicaid limits up to 216% FPL.
12. Oklahoma offers a premium assistance program through its Insure Oklahoma program to children ages 0 through 18 with income up to 222% FPL with access to employer sponsored insurance.
13. In Tennessee, Title XXI funds are used for two programs, TennCare Standard (a Medicaid expansion program) and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 216% FPL or are medically eligible.
14. In Wisconsin, children are not eligible for its separate CHIP program if they have access to job-based health insurance coverage where the employer covers at least 80% of the cost.
15. In May 2021, Wyoming received approval to transition its separate CHIP program into a CHIP-funded Medicaid expansion effective retroactively to October 2020.

Table 2: Medicaid and CHIP Coverage for Pregnant Individuals and Medicaid Family Planning Expansion, January 2022					
State	Income Eligibility Limits for Pregnant Individuals (% of the FPL)				Income Eligibility Limit for Family Planning Expansion Program [1] [4]
	Medicaid [1]	CHIP [1] [3] (Total = 6)	Unborn Child Option [1] [2] [3] (CHIP Funded) (Total = 18)	Upper Income Limit [1]	
Median	**200%**	**262%**	**212%**	**205%**	**206%**
Alabama [5]	146%			146%	146%
Alaska	205%			205%	N/A
Arizona	161%			161%	N/A
Arkansas	214%		214%	214%	N/A
California	213%		322%	322%	205%
Colorado	200%	265%		265%	N/A
Connecticut	263%			263%	263%
Delaware	217%			217%	N/A
District of Columbia	324%			324%	N/A
Florida	196%			196%	190%
Georgia	225%			225%	216%
Hawaii	196%			196%	N/A
Idaho	138%			138%	N/A
Illinois	213%		213%	213%	N/A
Indiana	213%			213%	146%
Iowa [6]	380%			380%	N/A
Kansas	171%			171%	N/A
Kentucky	200%			200%	218%
Louisiana	138%		214%	214%	138%
Maine	214%			214%	214%
Maryland	264%			264%	264%
Massachusetts	205%		205%	205%	N/A
Michigan [7]	200%		200%	200%	N/A
Minnesota	283%		283%	283%	205%
Mississippi	199%			199%	199%
Missouri	201%	305%	305%	305%	206%
Montana	162%			162%	216%
Nebraska	199%		202%	202%	N/A
Nevada	165%			165%	N/A
New Hampshire	201%			201%	201%
New Jersey	199%	205%		205%	205%
New Mexico [8]	255%			255%	255%
New York	223%			223%	223%
North Carolina	201%			201%	200%
North Dakota	162%			162%	N/A
Ohio	205%			205%	N/A
Oklahoma [9]	138%		210%	210%	138%
Oregon	190%		190%	190%	255%
Pennsylvania	220%			220%	220%
Rhode Island	195%	258%	258%	258%	258%
South Carolina	199%			199%	199%
South Dakota	138%		138%	138%	N/A
Tennessee	200%		255%	255%	N/A
Texas	203%		207%	207%	209%
Utah	144%			144%	N/A
Vermont	213%			213%	205%
Virginia [10]	148%	205%	205%	205%	205%
Washington	198%		198%	198%	265%
West Virginia	190%	305%		305%	N/A
Wisconsin	306%		306%	306%	306%
Wyoming	159%			159%	159%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 2 Notes

1. January 2022 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the federal poverty level (FPL). The FPL for a family of three is $23,030 as of 2022.
2. This column indicates whether the state has adopted the unborn child option in CHIP. The unborn child option permits states to cover “targeted low-income children” from conception to birth in CHIP, regardless of the pregnant person’s immigration status.
3. The totals in column headers indicate that the option only applies to the limited number of states that have adopted the coverage pathway. As of January 2022, 6 states use CHIP funding to cover pregnant individuals and 18 states provide coverage through the unborn child option.
4. This column lists income eligibility limits for programs in states that use federal funds under a state option or waiver to provide family planning services to individuals who do not qualify for full Medicaid benefits. January 2022 income limits include a disregard equal to five percentage points of the FPL.
5. Alabama has a pilot program for the unborn child option, providing coverage up to 317% FPL in three counties.
6. Iowa has a state-funded family planning program for individuals with incomes up to 300% FPL who lose Medicaid at the end of the postpartum period.
7. Michigan provides coverage to pregnant individuals with incomes up to 400% FPL affected by the Flint water crisis.
8. In New Mexico, family planning coverage is limited to individuals age 50 and under without health insurance.
9. Oklahoma offers a premium assistance program through its Insure Oklahoma program to pregnant individuals with incomes up to 205% FPL who have access to employer sponsored insurance.
10. Virginia adopted the unborn child option, effective July 2021.

Table 3: State Adoption of Options to Cover Immigrant Populations, January 2022							
State	Lawfully-Residing Immigrant Children Covered Without Five-Year Wait [1]		Lawfully-Residing Immigrant Pregnant Women Covered Without Five-Year Wait [1]		Unborn Child Option [3]	Coverage with State-Only Funds [4]	
	Medicaid	CHIP [2]	Medicaid	CHIP		Immigrant Children	Immigrant Parents or Other Adults
Median	**35**	**24**	**25**	**4**	**18**	**8**	**8**
Alabama				N/A			
Alaska		N/A (M-CHIP)		N/A			
Arizona				N/A			
Arkansas	Y	Y	Y	N/A	Y		
California [5] [6]	Y	N/A (M-CHIP)	Y	N/A	Y	Y	Y
Colorado	Y	Y	Y	Y			
Connecticut	Y	Y	Y	N/A			
Delaware	Y	Y	Y	N/A			
District of Columbia [5] [6]	Y	N/A (M-CHIP)	Y	N/A		Y	Y
Florida	Y	Y		N/A			
Georgia				N/A			
Hawaii [6]	Y	N/A (M-CHIP)	Y	N/A			Y
Idaho				N/A			
Illinois [5] [6]	Y	Y		N/A	Y	Y	Y
Indiana				N/A			
Iowa [7]	Y	Y		N/A		Y	
Kansas				N/A			
Kentucky	Y	Y		N/A			
Louisiana	Y	Y		N/A	Y		
Maine	Y	Y	Y				
Maryland	Y	N/A (M-CHIP)	Y	N/A			
Massachusetts [6] [8]	Y	Y	Y	N/A	Y	Y	Y
Michigan		N/A (M-CHIP)		N/A	Y		
Minnesota	Y	N/A (M-CHIP)	Y	N/A	Y		
Mississippi				N/A			
Missouri					Y		
Montana	Y	Y		N/A			
Nebraska	Y	N/A (M-CHIP)	Y	N/A	Y		
Nevada	Y	Y		N/A			
New Hampshire		N/A (M-CHIP)		N/A			
New Jersey	Y	Y	Y	Y			
New Mexico [6]	Y	N/A (M-CHIP)	Y	N/A			Y
New York [5] [6]	Y	Y	Y	N/A		Y	Y
North Carolina	Y	Y	Y	N/A			
North Dakota		N/A (M-CHIP)		N/A			
Ohio	Y	N/A (M-CHIP)	Y	N/A			
Oklahoma		N/A (M-CHIP)		N/A	Y		
Oregon [5]	Y	Y		N/A	Y	Y	
Pennsylvania [6]	Y	Y	Y	N/A			Y
Rhode Island	Y	N/A (M-CHIP)			Y		
South Carolina	Y	N/A (M-CHIP)	Y	N/A			
South Dakota				N/A	Y		
Tennessee				N/A	Y		
Texas	Y	Y		N/A	Y		
Utah	Y	Y		N/A			
Vermont [9]	Y	N/A (M-CHIP)	Y	N/A			
Virginia [10]	Y	Y	Y	Y	Y		
Washington [5]	Y	Y	Y	N/A	Y	Y	
West Virginia	Y	Y	Y	Y			
Wisconsin	Y	Y	Y	N/A	Y		
Wyoming			Y	N/A			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 3 Notes

1. These columns indicate whether the state has adopted the option to provide coverage for immigrant children and pregnant women who have been lawfully residing in the U.S. for less than five years, otherwise known as the Immigrant Children's Health Improvement Act (ICHIA) option.
2. N/A (M-CHIP) responses indicate that the state does not operate a separate CHIP program for uninsured children.
3. This column indicates whether the state has adopted the unborn child option in CHIP. The unborn child option permits states to cover "targeted low-income children" from conception to birth in CHIP, regardless of the pregnant person's immigration status.
4. These columns indicate if the state uses state-only funds to provide coverage for immigrant children or adults. In some cases, coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or the coverage provides more limited benefits than Medicaid.
5. California, the District of Columbia, Illinois, New York, Oregon, and Washington cover all income-eligible children, regardless of immigration status using state-only funds.
6. California, the District of Columbia, Hawaii, Illinois, Massachusetts, New Mexico, New York, and Pennsylvania cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds. In some cases, the coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or the coverage provides more limited benefits than Medicaid.
7. Iowa covers immigrant children in foster care or with a subsidized adoption or guardianship agreement with state-only funds.
8. Massachusetts covers certain children using state-only funds under the Children's Medical Security Program and other programs. The Children's Medical Security plan provides preventive and primary medical and dental services to uninsured children who do not qualify for other MassHealth coverage (other than MassHealth Limited) because of immigration status..
9. In January 2022, Vermont began providing state-only grant funding to providers who serve children and pregnant women who are not otherwise eligible due to immigration status. A more formal coverage program will begin in July 2022 using state-only funds.
10. Virginia adopted the unborn child option, effective July 2021.

Table 4: Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 2022 [1]			
State	Parents (In a Family of Three)		Other Adults (For an Individual)
	Section 1931 Limit	Upper Limit	
Expansion States			
Group Median [2]	**45%**	**138%**	**138%**
Alaska [3]	122%	138%	138%
Arizona	106%	138%	138%
Arkansas	14%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut	160%	160%	138%
Delaware	87%	138%	138%
District of Columbia	221%	221%	215%
Hawaii	100%	138%	138%
Idaho	19%	138%	138%
Illinois [4]	28%	138%	138%
Indiana	16%	138%	138%
Iowa	45%	138%	138%
Kentucky	17%	138%	138%
Louisiana	19%	138%	138%
Maine	100%	138%	138%
Maryland	123%	138%	138%
Massachusetts [5]	138%	138%	138%
Michigan	54%	138%	138%
Minnesota [6]	138%	138%	138%
Missouri [7]	15%	138%	138%
Montana	24%	138%	138%
Nebraska	58%	138%	138%
Nevada	25%	138%	138%
New Hampshire	50%	138%	138%
New Jersey	26%	138%	138%
New Mexico	39%	138%	138%
New York [6]	90%	138%	138%
North Dakota	45%	138%	138%
Ohio	90%	138%	138%
Oklahoma [7] [8]	34%	138%	138%
Oregon	31%	138%	138%
Pennsylvania	33%	138%	138%
Rhode Island	116%	138%	138%
Utah	35%	138%	138%
Vermont	39%	138%	138%
Virginia [9]	32%	138%	138%
Washington	42%	138%	138%
West Virginia	16%	138%	138%
Non-Expansion States			
Group Median [2]	**39%**	**39%**	**0%**
Alabama	18%	18%	0%
Florida	30%	30%	0%
Georgia	33%	33%	0%
Kansas	38%	38%	0%
Mississippi	25%	25%	0%
North Carolina	39%	39%	0%
South Carolina	67%	67%	0%
South Dakota	46%	46%	0%
Tennessee	88%	88%	0%
Texas [10]	16%	16%	0%
Wisconsin [11]	100%	100%	100%
Wyoming	50%	50%	0%
All States Median [2]	**42%**	**138%**	**138%**

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 4 Notes

1. January 2022 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the Federal Poverty Level (FPL) applied to the highest eligibility limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2022 FPL for a family of three, which is $23,030. Eligibility limits for other adults are presented as a percentage of the 2022 FPL for an individual, which is $13,590.
2. Group and all state median values are rounded.
3. In Alaska, the dollar threshold is updated every January 1 based on the CPI-U plus an adjustment for annual dividend payments to Alaska residents.
4. In Illinois, traditional 1931 Medicaid coverage is based on a dollar threshold tied to TANF levels. Parents are also covered up to 133% FPL based on prior waiver eligibility and are not considered Section VIII expansion adults.
5. In Massachusetts, the state's Section 1115 waiver authorizes MassHealth coverage for HIV-positive individuals with incomes up to 200% FPL and for adults with disabilities with no income limit, provided that they have either met a one-time deductible or are working disabled adults.
6. Minnesota and New York have implemented Basic Health Programs (BHPs) established by the Affordable Care Act (ACA) for adults with incomes between 138%-200% FPL.
7. Missouri and Oklahoma implemented the Affordable Care Act Medicaid expansion for adults in July 2021.
8. In Oklahoma, individuals working for certain qualified employers with incomes at or below 222% FPL are eligible for premium assistance for employer-sponsored insurance.
9. In Virginia, eligibility levels for 1931 parents vary by region. The value shown is the eligibility level for region 2, the most populous region.
10. In Texas, the income limit for parents and other caretaker relatives is based on monthly dollar amounts which differ depending on family size and whether there is one or two parents in the family. The eligibility level shown is for a single parent household and a family size of three.
11. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 5: Integration of MAGI-Medicaid Eligibility Systems with Marketplace Systems, Non-MAGI Medicaid, and Non-Health Programs, January 2022 [1]						
MAGI-Medicaid Eligibility System Integrated with Marketplace Eligibility System						
State	**Marketplace Structure [2]**	**Marketplace System Determines Eligibility For:**				
		MAGI-Medicaid and CHIP [3]	**Non-MAGI Medicaid [4]**	**SNAP [4]**	**TANF [4]**	**Child Care Subsidy [4]**
Group Total	See Grand Total	**10**	**2**	**2**	**2**	**2**
California	SBM	Y				
Connecticut	SBM	Y				
Kentucky	SBM	Y	Y	Y	Y	Y
Maryland	SBM	Y				
Massachusetts	SBM	Y				
Minnesota	SBM	Y				
New York	SBM	Y				
Rhode Island	SBM	Y	Y	Y	Y	Y
Vermont	SBM	Y				
Washington	SBM	Y				
MAGI-Medicaid Eligibility System Not Integrated with Marketplace Eligibility System						
State	**Marketplace Structure**	**MAGI-Medicaid System Determines Eligibility For: [5]**				
		CHIP	**Non-MAGI Medicaid**	**SNAP**	**TANF**	**Child Care Subsidy**
Group Total	See Grand Total	**41**	**34**	**26**	**26**	**13**
Alabama	FFM	Y	Y			
Alaska	FFM	Y				
Arizona [6]	FFM	Y	Y	Y	Y	
Arkansas	SBM-FP	Y				
Colorado [7]	SBM	Y	Y	Y	Y	
Delaware	FFM-Partnership	Y	Y	Y	Y	Y
District of Columbia	SBM	Y	Y	Y	Y	
Florida	FFM	Y	Y	Y	Y	Y
Georgia	FFM	Y	Y	Y	Y	Y
Hawaii	FFM	Y	Y			
Idaho	SBM	Y	Y	Y	Y	Y
Illinois	FFM-Partnership	Y	Y	Y	Y	
Indiana	FFM	Y	Y	Y	Y	
Iowa	FFM-Partnership	Y	Y			
Kansas	FFM	Y	Y	Y	Y	Y
Louisiana	FFM	Y	Y			
Maine	SBM	Y	Y	Y	Y	
Michigan	FFM-Partnership	Y				
Mississippi	FFM	Y	Y			
Missouri	FFM	Y				
Montana	FFM	Y	Y	Y	Y	
Nebraska	FFM	Y	Y	Y	Y	Y
Nevada	SBM	Y	Y	Y	Y	
New Hampshire	FFM-Partnership	Y	Y	Y	Y	Y
New Jersey	SBM	Y	Y			
New Mexico	SBM	Y	Y	Y	Y	
North Carolina	FFM	Y	Y	Y	Y	Y
North Dakota	FFM	Y	Y	Y	Y	Y
Ohio	FFM	Y	Y	Y	Y	
Oklahoma	FFM	Y				
Oregon	SBM-FP	Y	Y	Y	Y	Y
Pennsylvania	SBM	Y	Y	Y	Y	
South Carolina	FFM	Y				
South Dakota	FFM	Y				
Tennessee	FFM	Y	Y			
Texas	FFM	Y	Y	Y	Y	
Utah	FFM	Y	Y	Y	Y	Y
Virginia	SBM-FP	Y	Y	Y	Y	Y
West Virginia	FFM-Partnership	Y	Y	Y	Y	
Wisconsin	FFM	Y	Y	Y	Y	Y
Wyoming	FFM	Y	Y			
Grand Total	**SBM: 18 SBM-FP: 3 FFM: 24 FFM-Partnership: 6**	**51**	**36**	**28**	**28**	**15**

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 5 Notes

1. The table is first grouped by SBMs with MAGI-Medicaid and CHIP integrated into the Marketplace eligibility system, and then by all other states with Medicaid eligibility systems that are not integrated with the Marketplace, regardless of Marketplace structure.
2. This column indicates whether a state has elected to use the Federally-facilitated Marketplace (FFM), establish a Marketplace in partnership with the federal government (FFM-Partnership), establish a State-based Marketplace that uses Healthcare.gov, the federal eligibility and enrollment platform, (SBM-FP), or establish and operate its own State-based Marketplace (SBM). In an FFM state, the US Department of Health and Human Services (HHS) conducts all Marketplace functions. States with a Partnership Marketplace may administer plan management functions, in-person consumer assistance functions, or both, and HHS is responsible for the remaining Marketplace functions. States running a SBM are responsible for performing all Marketplace functions, except for SBM-FP states that rely on the Healthcare.gov for application processing and certain eligibility and enrollment activities.
3. This column indicates whether the eligibility system for the State-based Marketplace determines eligibility for MAGI-based Medicaid groups (children, pregnant women, parents, and expansion adults) and CHIP.
4. These columns indicate whether the eligibility system for the State-based Marketplace determines eligibility for non-MAGI Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and/or Child Care Subsidy
5. In the second group, these columns indicate if the MAGI-Medicaid system determines eligibility for CHIP, non-MAGI Medicaid, SNAP, TANF, and/or Child Care Subsidy.
6. Arizona uses its Medicaid eligibility system to collect application data for SNAP and TANF but refers the information to a legacy eligibility system for those programs.
7. In Colorado the Marketplace eligibility system does a prescreening to determine if an applicant is potentially eligible for a Medicaid and/or CHP+ program.

Table 6: Modes For Submitting Medicaid Applications and Features of Online Applications, January 2022									
State	Applications Can Be Submitted (At State Level): [1]				Mobile Friendly Formatting for Online Application [2]	Online Electronically-Submitted Multi-Benefit Application Available for: [3]			
	Online	In Person	By Mail	By Telephone		Non-MAGI Medicaid	SNAP	TANF	Child Care Subsidy
Total	**51**	**51**	**50**	**49**	**32**	**39**	**29**	**27**	**17**
Alabama	Y	Y	Y	Y	Y				
Alaska	Y	Y	Y	Y	Y	Y			
Arizona	Y	Y	Y	Y	Y	Y	Y	Y	
Arkansas	Y	Y	Y	Y	Y	Y	Y	Y	
California	Y	Y	Y	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y				
Delaware	Y	Y	Y	Y		Y	Y	Y	Y
District of Columbia	Y	Y	Y	Y	Y	Y	Y	Y	
Florida	Y	Y	Y	Y		Y	Y	Y	
Georgia	Y	Y	Y	Y		Y	Y	Y	Y
Hawaii	Y	Y	Y	Y					
Idaho	Y	Y	Y	Y		Y			
Illinois	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indiana	Y	Y	Y	Y	Y	Y			
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	
Kansas	Y	Y	Y	Y	Y	Y			
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y	Y	Y			
Maine	Y	Y	Y	Y		Y	Y	Y	
Maryland	Y	Y	Y	Y	Y				
Massachusetts	Y	Y	Y	Y	Y				
Michigan	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota	Y	Y	Y						
Mississippi	Y	Y	Y	Y	Y	Y	Y	Y	
Missouri	Y	Y	Y	Y	Y	Y			
Montana	Y	Y	Y	Y	Y	Y	Y	Y	
Nebraska	Y	Y	Y	Y		Y			
Nevada	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey	Y	Y	Y	Y		Y			
New Mexico	Y	Y	Y	Y	Y	Y	Y	Y	
New York	Y	Y	Y	Y					
North Carolina [4]	Y	Y	Y		Y	Y			
North Dakota	Y	Y	Y	Y		Y	Y	Y	Y
Ohio	Y	Y	Y	Y	Y	Y	Y	Y	
Oklahoma	Y	Y		Y	Y				
Oregon	Y	Y	Y	Y		Y	Y	Y	Y
Pennsylvania	Y	Y	Y	Y		Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y		Y	Y	Y	Y
South Carolina	Y	Y	Y	Y		Y			
South Dakota	Y	Y	Y	Y			Y		
Tennessee	Y	Y	Y	Y	Y	Y			
Texas	Y	Y	Y	Y	Y	Y	Y	Y	
Utah	Y	Y	Y	Y		Y	Y	Y	Y
Vermont	Y	Y	Y	Y					
Virginia	Y	Y	Y	Y		Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y				
West Virginia	Y	Y	Y	Y	Y		Y		Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y	Y	Y	Y	Y			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 6 Notes

1. These columns indicate whether individuals can submit Medicaid applications online at the state level, in person, by mail, and over the telephone at the state level, either through the Medicaid agency or the State-based Marketplace without being required to send a follow-up paper form or written signature to complete the application.
2. This column indicates if the state has taken steps to ensure that online applications are accessible through different devices, including smart phones and tablets.
3. These columns indicate if the state has a combined online multi-benefit application available that allows applicants to apply for Medicaid, including non-MAGI Medicaid for seniors and individuals eligible based on disability, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Child Care Subsidy. Some states include other programs, such as fuel assistance, in their multi-benefit applications.
4. In North Carolina, a follow-up signature form is required to complete a telephonic application. The state is in the process of developing a method for accepting a telephonic signature.

Table 7: Features of Online Medicaid Accounts, January 2022									
State	Online Medicaid Account [1]	Mobile-Friendly Formatting for Smartphone/ Tablet [2]	Online Account Allows Individuals to: [3]						
			Review Application Status	Report Changes	View Notices	Renew Coverage	Upload Verification Documents	Go Paperless and Receive Electronic Notices	Authorize Third Party Access
Total	**48**	**35**	**46**	**45**	**46**	**41**	**41**	**41**	**30**
Alabama	Y	Y	Y	Y	Y	Y			
Alaska									
Arizona	Y	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas	Y	Y	Y	Y	Y	Y	Y	Y	Y
California	Y	Y	Y	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y	
Delaware	Y		Y	Y	Y	Y	Y	Y	Y
District of Columbia	Y	Y	Y	Y	Y	Y	Y	Y	Y
Florida	Y		Y	Y	Y	Y	Y	Y	
Georgia	Y		Y	Y	Y	Y	Y	Y	Y
Hawaii	Y		Y	Y	Y		Y	Y	
Idaho	Y		Y	Y	Y	Y	Y	Y	Y
Illinois	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indiana	Y	Y	Y	Y	Y			Y	
Iowa	Y	Y	Y		Y		Y	Y	
Kansas	Y	Y	Y	Y	Y	Y	Y	Y	
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y	Y	Y	Y	Y	
Maine	Y		Y	Y	Y	Y		Y	
Maryland	Y	Y	Y	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y		Y	Y		
Michigan	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota	Y				Y				
Mississippi									
Missouri	Y	Y	Y	Y					
Montana	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y		Y	Y	Y	Y	Y	Y	Y
Nevada	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey	Y	Y	Y		Y		Y	Y	
New Mexico	Y	Y	Y	Y	Y	Y	Y		
New York	Y		Y	Y	Y	Y	Y	Y	Y
North Carolina	Y	Y	Y	Y	Y	Y	Y	Y	
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ohio	Y	Y	Y	Y	Y	Y	Y		Y
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y	Y
Oregon	Y		Y	Y	Y	Y	Y	Y	Y
Pennsylvania	Y	Y	Y	Y	Y	Y	Y	Y	
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y	Y
South Carolina	Y		Y	Y	Y			Y	
South Dakota									
Tennessee	Y	Y	Y	Y	Y	Y	Y	Y	Y
Texas	Y	Y	Y	Y	Y	Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y		Y	Y	Y	Y	Y		
Virginia	Y		Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y	Y		Y	Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y		Y	Y	Y	Y	Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 7 Notes

1. This column indicates whether individuals can create an online account to review, update, or submit information at the state level, either through Medicaid or the State-Based Marketplace (SBM) system.
2. This column indicates if the state has taken steps to ensure that online accounts are accessible through different devices, including smart phones and tablets.
3. These columns indicate the features that are available in the state's online account. Account functionality varies by state and feature. For example, while states may allow an account holder to go paperless and receive electronic notices, some notices may not be posted and others are also sent by mail.

Table 8: Income Verification and Real-Time Eligibility Determinations, January 2022							
State	Able to Make Real-Time Determinations (<24 Hours) [1]	Databases Used to Verify Income (in addition to the Social Security Administration): [2]					
		Federal Data Services Hub	State Wage Data Base (SWICA)	State Unemployment Database	State Tax Department	Commercial Databases	Supplemental Nutrition Assistance Program (SNAP)
Total	**43**	**43**	**43**	**45**	**9**	**34**	**30**
Alabama	Y	Y					Y
Alaska		Y	Y	Y		Y	Y
Arizona	Y	Y	Y	Y	Y	Y	
Arkansas	Y	Y	Y	Y		Y	Y
California	Y	Y	Y	Y	Y		Y
Colorado	Y	Y		Y		Y	Y
Connecticut	Y	Y	Y	Y		Y	
Delaware	Y	Y	Y	Y	Y	Y	Y
District of Columbia	Y	Y			Y		Y
Florida	Y	Y	Y	Y		Y	
Georgia	Y	Y	Y	Y		Y	Y
Hawaii	Y	Y	Y	Y			
Idaho	Y	Y	Y	Y		Y	Y
Illinois		Y	Y	Y	Y	Y	Y
Indiana	Y	Y	Y	Y		Y	Y
Iowa	Y	Y	Y	Y	Y	Y	Y
Kansas	Y		Y	Y		Y	Y
Kentucky	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y		Y	Y
Maine	Y		Y	Y		Y	Y
Maryland	Y	Y	Y	Y			
Massachusetts	Y	Y	Y		Y		
Michigan	Y	Y					
Minnesota	Y	Y	Y	Y			
Mississippi	Y	Y	Y	Y		Y	
Missouri		Y	Y	Y		Y	Y
Montana			Y	Y	Y	Y	Y
Nebraska		Y	Y	Y		Y	Y
Nevada		Y		Y			Y
New Hampshire	Y	Y	Y	Y		Y	Y
New Jersey	Y	Y	Y	Y		Y	
New Mexico	Y		Y	Y		Y	
New York	Y	Y	Y	Y			
North Carolina	Y		Y	Y		Y	Y
North Dakota	Y	Y	Y	Y		Y	Y
Ohio	Y	Y	Y	Y		Y	
Oklahoma	Y		Y	Y			
Oregon	Y	Y		Y			
Pennsylvania	Y	Y	Y	Y		Y	Y
Rhode Island	Y	Y	Y	Y			
South Carolina	Y	Y	Y	Y			
South Dakota		Y	Y	Y		Y	Y
Tennessee	Y	Y	Y	Y		Y	
Texas			Y	Y			Y
Utah	Y		Y	Y		Y	
Vermont	Y	Y	Y				
Virginia	Y	Y		Y		Y	Y
Washington	Y	Y	Y	Y		Y	Y
West Virginia	Y	Y	Y	Y		Y	Y
Wisconsin	Y	Y	Y	Y		Y	Y
Wyoming	Y	Y					

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 8 Notes

1. This column reflects whether the state Medicaid system is able to make real-time eligibility determinations, defined as within 24 hours. Not all states have programmed their eligibility systems to make real-time determinations without worker action. In some states, only a small share of applications completed in person or over the phone that can be verified by an eligibility worker immediately are processed in real time.
2. Under the Affordable Care Act (ACA), states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. These columns indicate databases the state uses as primary sources to verify income eligibility for MAGI-based groups (children, pregnant women, parents, and expansion adults), in addition to the Social Security Administration.

Table 9: Medicaid Ex Parte Renewals for Children, Pregnant Women, Parents, and Expansion Adults, January 2022 [1]						
State	Processing Ex Parte Renewals [2]	Percentage of Renewals Conducted Using Ex Parte Processes: [3]				Renewal Form Sent if Unable to Process Ex Parte Renewal While Continuous Enrollment Requirement in Effect [4]
		<25%	25%-50%	50%-75%	>75%	
Total	**42**	**11**	**11**	**4**	**7**	**30**
Alabama	Y	NR	NR	NR	NR	Y
Alaska						
Arizona	Y				Y	Y
Arkansas	Y				Y	Y
California	Y		Y			Y
Colorado	Y				Y	Y
Connecticut	Y			Y		Y
Delaware	Y	Y				
District of Columbia						
Florida	Y	Y				Y
Georgia						
Hawaii	Y	NR	NR	NR	NR	
Idaho	Y		Y			Y
Illinois	Y		Y			
Indiana	Y			Y		Y
Iowa	Y		Y			Y
Kansas	Y	Y				
Kentucky	Y	NR	NR	NR	NR	Y
Louisiana	Y	NR	NR	NR	NR	
Maine						Y
Maryland	Y			Y		Y
Massachusetts	Y			Y		Y
Michigan	Y	Y				
Minnesota	Y	Y				
Mississippi	Y		Y			Y
Missouri						
Montana						
Nebraska	Y					Y
Nevada						Y
New Hampshire	Y		Y			Y
New Jersey	Y	Y				Y
New Mexico	Y		Y			Y
New York						
North Carolina	Y					Y
North Dakota	Y	NR	NR	NR	NR	Y
Ohio	Y		Y			Y
Oklahoma	Y	Y				
Oregon	Y				Y	Y
Pennsylvania	Y	Y				Y
Rhode Island	Y				Y	
South Carolina	Y					
South Dakota	Y	NR	NR	NR	NR	Y
Tennessee	Y		Y			
Texas	Y	Y				Y
Utah	Y		Y			Y
Vermont	Y		Y			
Virginia	Y				Y	
Washington	Y				Y	Y
West Virginia	Y	Y				Y
Wisconsin	Y	Y				
Wyoming						

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 9 Notes

1. Under the Affordable Care Act (ACA), states must seek to re-determine eligibility at renewal using electronic data matches with reliable sources of data prior to requiring enrollees to complete a renewal form or submit documentation. This process is technically called ex parte but is often referred to as administrative renewal. Although ex parte renewals are also known as automated renewals, not all state systems are programmed to process ex parte renewals without worker action. Any process that allows renewal of coverage without the individual completing a form or providing documentation, including express lane eligibility and using SNAP information to verify Medicaid eligibility, are included as types of ex parte renewals.

2. This column indicates whether the state system is processing ex parte renewals as of January 2022. Some states have suspended ex parte renewals during the public health emergency.

3. These columns indicate the approximate share of renewals for MAGI-based groups that are successfully completed via automated processes. NR indicates a state was not able to report the share of renewals conducted on an ex parte basis.

4. Under the ACA, when a state is unable to process an automated renewal, it is expected to send the enrollee a renewal notice or form pre-populated with data on file. Although states may be conducting ex parte renewals during the public health emergency, some have chosen not to follow-up with a renewal form if the renewal cannot be completed via ex parte. This column indicates if a state was continuing to send pre-populated renewal forms as of January 2022.

Table 10: Modes For Submitting Medicaid Renewals, January 2022 [1]					
State	Through a Feature in Online Account	Telephone	In Person	Mail	Fax
Total	**41**	**39**	**50**	**50**	**49**
Alabama	Y	Y	Y	Y	Y
Alaska		Y	Y	Y	Y
Arizona	Y	Y	Y	Y	Y
Arkansas	Y		Y	Y	Y
California	Y	Y	Y	Y	Y
Colorado	Y		Y	Y	Y
Connecticut	Y	Y	Y	Y	
Delaware	Y	Y	Y	Y	Y
District of Columbia	Y	Y	Y	Y	Y
Florida	Y	Y	Y	Y	Y
Georgia	Y	Y	Y	Y	Y
Hawaii		Y	Y	Y	Y
Idaho	Y	Y	Y	Y	Y
Illinois	Y	Y	Y	Y	Y
Indiana		Y	Y	Y	Y
Iowa			Y	Y	Y
Kansas	Y	Y	Y	Y	Y
Kentucky	Y	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y	Y
Maine	Y	Y	Y	Y	Y
Maryland	Y	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y	Y
Michigan	Y	Y	Y	Y	Y
Minnesota			Y	Y	Y
Mississippi		Y	Y	Y	Y
Missouri		Y	Y	Y	Y
Montana	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y
Nevada	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y
New Jersey				Y	Y
New Mexico	Y	Y	Y	Y	Y
New York	Y	Y	Y	Y	Y
North Carolina	Y		Y	Y	Y
North Dakota	Y		Y	Y	Y
Ohio	Y	Y	Y	Y	Y
Oklahoma	Y	Y	Y		
Oregon	Y	Y	Y	Y	Y
Pennsylvania	Y	Y	Y	Y	Y
Rhode Island	Y		Y	Y	Y
South Carolina			Y	Y	Y
South Dakota			Y	Y	Y
Tennessee	Y	Y	Y	Y	Y
Texas	Y	Y	Y	Y	Y
Utah	Y		Y	Y	Y
Vermont	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y
West Virginia	Y		Y	Y	Y
Wisconsin	Y	Y	Y	Y	Y
Wyoming	Y	Y	Y	Y	Y
SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.					

Table 10 Notes

1. Under the ACA, states are required to provide options for individuals to renew coverage through four modes: online, over the telephone, in person or through the mail. This table indicates the modes that states report are available for renewal.

Table 11: State Adoption of 12-Month Continuous Eligibility for Selected Populations, January 2022 [1]			
State	12-Month Continuous Eligibility for:		
	Children's Medicaid	CHIP	Other MAGI Group(s) [2]
Total	**Y: 24 Limited Group: 3**	**Y: 24 Limited Group: 1**	**Y: 4**
Alabama	Y	Y	
Alaska	Y	N/A (M-CHIP)	
Arizona			
Arkansas		Y	
California	Y	N/A (M-CHIP)	
Colorado	Y	Y	
Connecticut			
Delaware		Y	
District of Columbia			
Florida [3]	Limited Group	Y	
Georgia			
Hawaii			
Idaho	Y	Y	
Illinois	Y	Y	
Indiana [4]	Limited Group	Limited Group	
Iowa	Y	Y	
Kansas [5]	Y	Y	Y
Kentucky			
Louisiana	Y	Y	
Maine	Y	Y	
Maryland			
Massachusetts			
Michigan	Y	N/A (M-CHIP)	
Minnesota			
Mississippi	Y	Y	
Missouri			
Montana [6]	Y	Y	Y
Nebraska			
Nevada		Y	
New Hampshire			
New Jersey	Y	Y	
New Mexico	Y	N/A (M-CHIP)	
New York [7]	Y	Y	Y
North Carolina	Y	Y	
North Dakota	Y	N/A (M-CHIP)	
Ohio	Y	N/A (M-CHIP)	
Oklahoma			
Oregon	Y	Y	
Pennsylvania [8]	Limited Group	Y	
Rhode Island			
South Carolina	Y	N/A (M-CHIP)	
South Dakota			
Tennessee		Y	
Texas [9]		Y	
Utah [10]		Y	Y
Vermont			
Virginia			
Washington	Y	Y	
West Virginia	Y	Y	
Wisconsin			
Wyoming	Y	N/A (M-CHIP)	

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 11 Notes

1. All states are required to maintain continuous enrollment in Medicaid during the COVID-19 public health emergency with few exceptions. However, under normal operations states have the option to provide 12-month continuous eligibility to children in Medicaid and/or CHIP through a state plan amendment. Continuous eligibility provides coverage to children in Medicaid and/or CHIP for a full twelve months unless the child ages out, moves out of state, voluntarily withdraws, or does not make premium payments. States may adopt 12-month continuous eligibility for all children under age 19 or a younger age specified by the state.
2. 12-month continuous eligibility for other MAGI groups (e.g., parents, adults) or targeted adults may be approved through a Section 1115 waiver. This column indicates whether states have adopted continuous eligibility for any adults through a section 1115 waiver.
3. In Florida, children in Medicaid under the age of 5 receive 12-month continuous eligibility while children ages five and older receive six months of continuous eligibility.
4. Indiana provides 12-month continuous eligibility in Medicaid and CHIP to children under age 3.
5. Kansas provides 12-month continuous eligibility to parents and caretaker relatives through a Section 1115 waiver.
6. Montana eliminated 12-month continuous eligibility for expansion adults in December 2021. However, CMS has not acted on the state's request to eliminate 12-month continuous eligibility for Section 1931 parents. The state is continuing to provide continuous enrollment to all individuals as required until the end of the public health emergency.
7. New York provides 12-month continuous eligibility to adults in Medicaid via a Section 1115 waiver.
8. Pennsylvania provides continuous eligibility for children in Medicaid under age 4.
9. Texas provides 12-month continuous eligibility to children in CHIP with income up to 185% FPL.
10. Utah has adopted continuous eligibility for a targeted group of adults with incomes between 0-5% FPL.

Table 12: State Plans For Unwinding the Continuous Enrollment Requirement, January 2022 [1]				
State	Resuming Disenrollments Before the Continuous Enrollment Is Lifted [2]	Estimated Time to Process Redeterminations and Return to Normal Operations [3]	Conduct Electronic Data Matches to Identify and Target Enrollees Who May No Longer Be Eligible [4]	Strategy for Prioritizing Redeterminations [5]
Total	**Y: 0 N: 47 Undetermined: 3**	**3 to 6 months: 3 6 to 9 months: 4 9 to 12 months: 41**	**Y: 15 N: 19 Undetermined: 16**	**Population-Based: 11 Time-Based: 8 Hybrid: 8 Undetermined: 16**
Alabama	N	9 to 12 months	Undetermined	
Alaska	N	9 to 12 months	N	NR
Arizona	N	9 to 12 months	N	Population-Based
Arkansas	N	3 to 6 months	N	NR
California	N	9 to 12 months	Undetermined	Hybrid
Colorado	N	9 to 12 months	N	Time-Based
Connecticut	N	9 to 12 months	Undetermined	Undetermined
Delaware	N	9 to 12 months	Undetermined	Undetermined
District of Columbia	N	9 to 12 months	N	Undetermined
Florida	Undetermined	9 to 12 months	Undetermined	Time-Based
Georgia	N	9 to 12 months	N	Time-Based
Hawaii	N	9 to 12 months	Y	Undetermined
Idaho	N	3 to 6 months	Y	NR
Illinois	N	9 to 12 months	Undetermined	Undetermined
Indiana	N	6 to 9 months	N	Population-Based
Iowa	N	9 to 12 months	N	Hybrid
Kansas	N	9 to 12 months	N	Hybrid
Kentucky	N	9 to 12 months	N	Population-Based
Louisiana [6]	N	9 to 12 months	N	Hybrid
Maine	N	9 to 12 months	N	Undetermined
Maryland	N	9 to 12 months	Y	Undetermined
Massachusetts	N	9 to 12 months	N	Population-Based
Michigan	N	9 to 12 months	N	Undetermined
Minnesota	N	9 to 12 months	Undetermined	Time-Based
Mississippi	N	9 to 12 months	Undetermined	Hybrid
Missouri	N	6 to 9 months	Y	Undetermined
Montana	N	9 to 12 months	Y	Population-Based
Nebraska	N	9 to 12 months	Y	Hybrid
Nevada	N	6 to 9 months	Undetermined	Population-Based
New Hampshire	N	3 to 6 months	Y	Undetermined
New Jersey	N	9 to 12 months	Undetermined	Undetermined
New Mexico	N	6 to 9 months	N	Population-Based
New York [6]	N	9 to 12 months	N	Time-Based
North Carolina	N	9 to 12 months	Y	Undetermined
North Dakota	N	9 to 12 months	N	Time-Based
Ohio	N	NR	Y	Hybrid
Oklahoma	Undetermined	9 to 12 months	Y	Population-Based
Oregon	N	9 to 12 months	Undetermined	Undetermined
Pennsylvania	Undetermined	NR	Undetermined	Undetermined
Rhode Island	N	9 to 12 months	Y	Population-Based
South Carolina	N	9 to 12 months	Y	Population-Based
South Dakota	N	9 to 12 months	Undetermined	
Tennessee	N	9 to 12 months	Undetermined	NR
Texas	NR	NR	NR	NR
Utah	N	9 to 12 months	Undetermined	Population-Based
Vermont	N	9 to 12 months	N	Hybrid
Virginia	N	9 to 12 months	Undetermined	NR
Washington	N	9 to 12 months	Y	Time-Based
West Virginia	N	9 to 12 months	Y	Undetermined
Wisconsin	N	9 to 12 months	N	Time-Based
Wyoming	N	9 to 12 months	Y	Undetermined

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents state plans in effect as of January 1, 2022.

Table 12 Notes

1. The Families First Coronavirus Response Act requires states to maintain continuous enrollment for Medicaid enrollees during the public health emergency (PHE). This table indicates various aspects of states' plans for unwinding this requirement. Some states indicated they were waiting for additional guidance from CMS or considering approaches before finalizing their plans.
2. This column indicates if the state is considering forgoing the enhanced federal Medicaid matching payments and resuming disenrollments before the end of the PHE. Undetermined indicates the state has not yet made a final decision.
3. This column indicates how long the state plans to take to act on delayed renewals and other pending actions. CMS guidance gives states up to 12 months to initiate all renewals and pending actions and 14 months to complete all pending actions, though states can choose to complete pending actions more quickly.
4. This column indicates if the state plans to conduct data searches to identify enrollees who may no longer be eligible as a way to prioritize redeterminations when the PHE ends. Undetermined indicates the state has not made a final decision.
5. This column indicates the strategy the state plans to adopt in prioritizing redeterminations when the PHE ends. CMS guidance requires states to adopt one of four risk-based approaches for prioritizing pending eligibility and enrollment actions. Under a population-based approach, states would prioritize populations who are likely to no longer be eligible (e.g., individuals aging out of coverage). Under a time-based approach, states would prioritize actions based on the length of time the renewal or change in circumstances has been pending. In a hybrid scenario, a state would combine population and time-based approaches. States may also develop a state-specific approach if it meets the goal of keeping eligible individuals enrolled, minimizes the extent to which ineligible individuals remain enrolled, and achieves a sustainable renewal schedule. States were asked to describe their approach to prioritizing action on outstanding renewals and changes in circumstances in an open-ended question. Where possible, their responses were categorized into one of the four risk-based approaches described in CMS guidance. Undetermined indicates that the state has not yet determined its approach. NR indicates the state did not provide a response. A blank response indicates the state's answer to the open-ended survey question could not be categorized into one of the four risk-based approaches.
6. Louisiana and New York reported that they plan to take up to 14 months to complete all redeterminations; these states are categorized as taking 9 to 12 months since current CMS guidance requires states to initiate all redeterminations within 12 months.

Table 13: Medicaid Renewal Communications When Continuous Enrollment Requirement Ends, January 2022						
State	State Plans to Follow up with Enrollees When Action Must be Taken to Maintain Coverage [1]	Methods to Contact Enrollees When They Need to Respond to a Request for Information to Retain Coverage: [2] [3]				
		Mail	Individual Phone Call	Automated Phone Call	Text	Email
Total	**41**	**33**	**17**	**11**	**11**	**18**
Alabama	Y	Y	Y			Y
Alaska	Y	Y				
Arizona						
Arkansas	Y	Y				Y
California	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y			
Connecticut	Y	Y			Y	Y
Delaware						
District of Columbia	Y	Y	Y	Y		Y
Florida	Y	Y				Y
Georgia	Y	Y	Y	Y		Y
Hawaii	Y	Y	Y			Y
Idaho	Y	Y	Y	Y	Y	Y
Illinois	Y				Y	
Indiana	Y	Y	Y	Y		
Iowa						
Kansas	Y	Y	Y			
Kentucky	Y	Y	Y	Y	Y	Y
Louisiana						
Maine	TBD	TBD	TBD	TBD	TBD	TBD
Maryland	Y	Y	Y		Y	Y
Massachusetts	Y	Y				
Michigan	Y	Y				
Minnesota	Y	TBD	TBD	TBD	TBD	TBD
Mississippi	Y		Y			
Missouri	Y	Y		Y	Y	
Montana	Y	Y				Y
Nebraska	Y	NR	NR	NR	NR	NR
Nevada	Y	Y			Y	Y
New Hampshire	Y	TBD	TBD	TBD	TBD	TBD
New Jersey	Y	Y				
New Mexico	Y	Y				
New York						
North Carolina						
North Dakota	Y	Y	Y			
Ohio	Y	Y				
Oklahoma	Y	Y		Y		Y
Oregon	Y	TBD	TBD	TBD	TBD	TBD
Pennsylvania	Y	TBD	TBD	TBD	TBD	TBD
Rhode Island	Y	Y		Y	Y	Y
South Carolina	Y	Y	Y	Y	Y	
South Dakota	Y	Y	Y			
Tennessee	Y	Y	Y	Y	Y	Y
Texas						
Utah	Y	Y				
Vermont	TBD	TBD	TBD	TBD	TBD	TBD
Virginia	Y	Y				Y
Washington	Y	Y	Y			
West Virginia	Y	Y				Y
Wisconsin	Y	TBD	TBD	TBD	TBD	TBD
Wyoming						

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents state plans in effect as of January 1, 2022.

Table 13 Notes

1. This column indicates whether in cases where the individual must take action at renewal to retain coverage, the state plans to follow-up after sending the renewal form and before terminating coverage. Regulations require a state to send a renewal form requesting additional information if it has been unable to renew coverage via ex parte processes and provide the individual with 30 days to respond. If the individual does not respond, the state is only required to send a termination notice with a 10-day advance notice.
2. These columns indicate which communication methods states will use to follow-up with individuals who must provide information to have eligibility redetermined before terminating coverage. TBD indicates the state has not made a final decision about what method it will use to follow up with enrollees. NR means state did not respond.
3. Several states reported they are considering contacting enrollees using other methods in addition to those reported here.

Table 14: Ongoing or Planned Actions to Update Mailing Address, January 2022							
State	Current or Planned Actions to Update Mailing Addresses Before the End of the Continuous Enrollment Requirement: [1]				State Accepts Updated Addresses on Behalf of Enrollees from: [2]		
	Data Matches with USPS National Change of Address Database	Request MCOs Contact Enrollees	Check for Updated Addresses in SNAP and/or Other Programs	Conduct "Update Your Address" Outreach	MCO	Navigators/ Assisters	Medicaid Providers
Total	**9**	**25**	**27**	**34**	**24**	**20**	**7**
Alabama	Y	Y	Y	Y	Y	Y	Y
Alaska			Y				
Arizona		Y		Y	Y	Y	
Arkansas					Y	Y	Y
California	Y	Y	Y	Y	Y	Y	Y
Colorado [3]		Y		Y			
Connecticut [3]				Y			
Delaware		Y	Y	Y			
District of Columbia [3]		Y		Y			
Florida		Y		Y			
Georgia			Y	Y			
Hawaii [3]	Y	Y			Y	Y	
Idaho	Y		Y				
Illinois				Y			
Indiana		Y	Y	Y	Y		
Iowa		Y		Y	Y		
Kansas		Y	Y	Y	Y		
Kentucky [3]			Y			Y	
Louisiana [3]		Y		Y	Y		
Maine			Y				
Maryland		Y	Y	Y			
Massachusetts	Y	Y	Y	Y	Y	Y	
Michigan [3]							
Minnesota	TBD	TBD	TBD	TBD		Y	
Mississippi				Y	Y	Y	Y
Missouri [3]		Y	Y	Y	Y	Y	Y
Montana [3]			Y				
Nebraska			Y	Y	Y	Y	Y
Nevada [3]		Y	Y		Y		
New Hampshire	Y	Y	Y	Y	Y		
New Jersey	Y						
New Mexico		Y	Y	Y			
New York [3]			Y		Y	Y	
North Carolina			Y				
North Dakota [3]			Y	Y	Y		
Ohio		Y		Y			
Oklahoma				Y		Y	
Oregon [3]			Y			Y	
Pennsylvania	TBD	TBD	TBD	TBD	Y		
Rhode Island		Y		Y	Y	Y	
South Carolina		Y		Y			
South Dakota							
Tennessee	Y	Y		Y	Y	Y	
Texas	NR	NR	NR	NR	Y	Y	Y
Utah [3]			Y	Y	Y	Y	
Vermont			Y	Y			
Virginia	Y	Y	Y	Y	Y		
Washington		Y	Y	Y	Y	Y	
West Virginia			Y	Y		Y	
Wisconsin		Y		Y			
Wyoming				Y			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents state plans in effect as of January 1, 2022.

Table 14 Notes

1. These columns indicate actions a state is taking or plans to take prior to the end of the public health emergency to update mailing addresses and other contact information for enrollees. TBD means the state has not made a final decision on actions to update mailing addresses. Several states indicted they are considering actions in addition to the ones reported here.
2. These columns indicate if the state is working with managed care organizations, navigators and assisters, and Medicaid providers to update mailing addresses, subject to requirements to verify information with enrollees.
3. Several states, including Colorado, Connecticut, District of Columbia, Hawaii, Kentucky, Louisiana, Michigan Missouri, Montana, Nevada, New York, North Dakota, Oregon, and Utah reported taking other actions to update mailing addresses before the end of the continuous enrollment requirement.

Table 15: State Follow-Up on Returned Mail, January 2022				
State	State Takes Steps Beyond Re-Mailing to the Address on File if Mail is Returned with no Forwarding Address	Methods to Contact Enrollees When Mail is Returned:		
		Phone	Text	Email
Total	**35**	**32**	**3**	**12**
Alabama	Y	Y		Y
Alaska	Y	Y		Y
Arizona	Y	Y		
Arkansas				
California	Y	Y	Y	Y
Colorado	Y	Y		Y
Connecticut				
Delaware				
District of Columbia	Y	Y		
Florida	Y			Y
Georgia	Y	Y	Y	
Hawaii	Y	Y		
Idaho	Y	Y		
Illinois				
Indiana	Y	Y		
Iowa	Y			
Kansas	Y	Y		
Kentucky	Y	Y		Y
Louisiana	Y	Y		
Maine	Y	Y		
Maryland	Y	Y	Y	Y
Massachusetts				
Michigan				
Minnesota	Y	Y		
Mississippi	Y	Y		
Missouri	Y			
Montana		Y		
Nebraska	NR			
Nevada	Y	Y		Y
New Hampshire	Y	Y		Y
New Jersey				
New Mexico				
New York	Y			
North Carolina	Y			
North Dakota				
Ohio				
Oklahoma	Y	Y		
Oregon	Y	Y		
Pennsylvania	Y	Y		
Rhode Island	Y	Y		
South Carolina				
South Dakota	Y	Y		
Tennessee				
Texas	Y	Y		
Utah		Y		Y
Vermont	Y	Y		
Virginia				
Washington	Y	Y		
West Virginia	Y	Y		Y
Wisconsin	Y	Y		Y
Wyoming	Y	Y		

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.

Table 16: Planned Actions to Increase Eligibility Staff Capacity for Processing Redeterminations When the Continuous Enrollment Requirement Ends, January 2022						
State	State Plans to Increase Eligibility Staff Capacity [1]	Actions to Increase Eligibility Staff Capacity: [2]				
		Approving Overtime	Bringing Back Retired Workers Temporarily	Hiring New Eligibility Workers	Borrowing Staff From Other Units/Agencies	Hiring Contractors
Total	**30**	**21**	**4**	**15**	**6**	**12**
Alabama	Y					Y
Alaska						
Arizona	TBD	TBD	TBD	TBD	TBD	TBD
Arkansas						
California	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	
Connecticut	Y	Y				
Delaware	Y	Y	Y	Y		
District of Columbia	Y					Y
Florida	Y	Y		Y	Y	Y
Georgia	Y	Y				
Hawaii						
Idaho	NR	NR	NR	NR	NR	NR
Illinois	Y	Y		Y		
Indiana	Y	Y				
Iowa	Y	Y			Y	
Kansas	Y	Y		Y	Y	
Kentucky						
Louisiana	Y	Y				
Maine	Y	Y				
Maryland						
Massachusetts	Y			Y		
Michigan	Y	Y		Y		
Minnesota	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi	TBD	TBD	TBD	TBD	TBD	TBD
Missouri	Y	Y				Y
Montana						
Nebraska	Y	Y	Y	Y	Y	Y
Nevada	Y	Y		Y		
New Hampshire	Y					Y
New Jersey						
New Mexico	Y	Y		Y		
New York	Y	NR	NR	NR	NR	NR
North Carolina	N/A	N/A	N/A	N/A	N/A	N/A
North Dakota	N/A	N/A	N/A	N/A	N/A	N/A
Ohio	Y					
Oklahoma	Y					Y
Oregon	Y	Y		Y		Y
Pennsylvania	TBD	TBD	TBD	TBD	TBD	TBD
Rhode Island	TBD	TBD	TBD	TBD	TBD	TBD
South Carolina	Y	Y		Y		Y
South Dakota						
Tennessee	Y			Y		Y
Texas	NR	NR	NR	NR	NR	NR
Utah	Y	Y		Y		
Vermont	Y	Y				
Virginia	Y					Y
Washington						
West Virginia						
Wisconsin	TBD	TBD	TBD	TBD	TBD	TBD
Wyoming						

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents state plans in effect as of January 1, 2022.

Table 16 Notes

1. This column indicates if the state plans to boost eligibility workforce capacity to assist with the unwinding. TBD indicates the state has not made a final decision on whether it will take action to enhance staff capacity. N/A means that some states with eligibility administered at the county level indicated that decisions related to enhancing eligibility staff capacity will be made at the local level. NR indicates the states did not provide a response.
2. These columns indicate the actions states plan to take to boost eligibility staff capacity. Several states indicated they are considering taking actions in addition to the ones reported here.

Table 17: Call Center and Disenrollment Data Tracking Capabilities, January 2022			
State	Capable of Tracking Call Center Volume, Wait Times, and Abandonment Rates [1]	Capable of Tracking Disenrollment Stratified by "Ineligibility Established" and "Eligibility Could not be Established" [2]	Capable of Tracking Both Call Center Data and Disenrollment by Eligibility Status Data
Total	**50**	**41**	**40**
Alabama	Y	Y	Y
Alaska	Y		
Arizona	Y	Y	Y
Arkansas	Y	Y	Y
California	Y	Y	Y
Colorado	Y	Y	Y
Connecticut	Y	Y	Y
Delaware	Y	Y	Y
District of Columbia	Y	Y	Y
Florida	Y	Y	Y
Georgia	Y	Y	Y
Hawaii	Y	Y	Y
Idaho	Y	Y	Y
Illinois	Y	Y	Y
Indiana	Y	Y	Y
Iowa	Y	Y	Y
Kansas	Y	Y	Y
Kentucky	Y		
Louisiana	Y	Y	Y
Maine	Y	Y	Y
Maryland	Y		
Massachusetts	Y	Y	Y
Michigan	Y		
Minnesota	Y	Y	Y
Mississippi	Y	Y	Y
Missouri	Y	Y	Y
Montana	Y	Y	Y
Nebraska	Y	Y	Y
Nevada	Y		
New Hampshire	Y	Y	Y
New Jersey	Y	Y	Y
New Mexico	Y	Y	Y
New York	Y	Y	Y
North Carolina	Y		
North Dakota	Y	Y	Y
Ohio	Y		
Oklahoma	Y	Y	Y
Oregon	Y	Y	Y
Pennsylvania	Y	Y	Y
Rhode Island	Y	Y	Y
South Carolina	Y	Y	Y
South Dakota		Y	
Tennessee	Y	Y	Y
Texas	Y	Y	Y
Utah	Y	Y	Y
Vermont	Y		
Virginia	Y		
Washington	Y	Y	Y
West Virginia	Y	Y	Y
Wisconsin	Y	Y	Y
Wyoming	Y		
SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents rules in effect as of January 1, 2022.			

Table 17 Notes

1. Timely data reporting will be important to monitoring the unwinding of the continuous enrollment requirement. This column indicates whether the state tracks key call center statistics, including call volume, wait times, and abandonment rates.
2. This column indicates if the state tracks disenrollment stratified by whether the individual was disenrolled because they were no longer eligible due to an increase in income or a change in circumstance (ineligibility established) or whether the individual was disenrolled because the state could not locate the enrollee, the enrollee did not respond to a request for information, or for another procedural reason (eligibility could not be established).

Table 18: State Estimates of the Share of Medicaid Enrollees Who Will Be Determined Ineligible When the Continuous Enrollment Requirement Ends and Primary Reason(s) for Loss of Eligibility, January 2022					
State	Estimated Share of Medicaid Enrollees Who Will Be Determined Ineligible [1] [2]	Anticipated Primary Reason(s) for Eligibility Loss Among People Who Will Likely Be Determined Ineligible: [3]			
		Change in Income	Change in Circumstance	Enrollee Moved	Other Reason
Total	**13%**	**24**	**15**	**3**	**11**
Alabama		Y			
Alaska					
Arizona		Y			
Arkansas		Y	Y	Y	
California	12%	Y			
Colorado	28%	Y	Y		
Connecticut					
Delaware		Y	Y		
District of Columbia					
Florida	13%	Y	Y		Y
Georgia	11%		Y		
Hawaii	31%	Y			
Idaho					
Illinois					
Indiana	10%				Y
Iowa	10%				Y
Kansas			Y	Y	
Kentucky		Y			
Louisiana	10%	Y			
Maine					
Maryland	13%		Y		
Massachusetts					Y
Michigan					
Minnesota		Y	Y		
Mississippi	14%		Y		
Missouri			Y		
Montana		Y	Y		
Nebraska	10%	Y			
Nevada		Y			
New Hampshire		Y			Y
New Jersey					
New Mexico	10%	Y			
New York					
North Carolina					Y
North Dakota		Y	Y	Y	
Ohio					Y
Oklahoma	17%	Y			
Oregon		Y			
Pennsylvania	14%	Y			
Rhode Island	12%		Y		
South Carolina					Y
South Dakota					
Tennessee	15%	Y			
Texas					
Utah	15%				Y
Vermont	17%		Y		
Virginia					Y
Washington		Y			
West Virginia	8%	Y	Y		Y
Wisconsin					
Wyoming	9%	Y			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2022; table presents state plans in effect as of January 1, 2022.

Table 18 Notes

1. States were asked to estimate the number of people who will likely be determined ineligible once redeterminations and disenrollments resume at the end of the PHE. To standardize these numbers and allow for comparisons across states, we calculated the number of people states estimated would be determined ineligible as a percent of the state's total Medicaid enrollment as of July 31, 2021 as reported on *Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports: June 2017 - September 2021 (preliminary)*, as of February 28, 2021, Centers for Medicare and Medicaid Services (CMS). Data can be accessed at https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment/.
2. Many states were unable to estimate the number of people who would will likely be determined ineligible when redeterminations resume or did not respond to the question.
3. States were asked to report whether they expect the primary reason why individuals will be disenrolled from Medicaid at the end of the PHE will be due to changes in income, changes in circumstances (aging out of children's coverage, end of pregnancy, etc.), out-of-state move, or other reason. If a state selected more than one reason, all selections are reported.

KFF

Headquarters and Conference Center
185 Berry Street, Suite 2000
San Francisco, CA 94107
650-854-9400

Washington Offices and Conference Center
1330 G Street, NW
Washington, DC 20005
202-347-5270

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