



Modernizing Medicaid Eligibility: How to Reduce Hidden Friction in County- Administered States

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About the Foundation

The [California Health Care Foundation](#) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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Introduction and Background: The Structure of State-Supervised, County-Administered Eligibility

Medicaid Eligibility Systems and Meeting the Moment

Medicaid eligibility systems are the front door to coverage for millions of Americans. When they work well, people enroll and stay enrolled in the care they need. When they don't, eligible people lose coverage for procedural reasons, and states face growing risks to program integrity and federal compliance.

Recent federal policy changes have raised the stakes for how Medicaid eligibility systems perform. The passage of House Resolution 1 (H.R. 1) reflects a sharper federal focus on program integrity — including stricter documentation and verification requirements, expanded audit activity, and greater transparency into how eligibility determinations are made. At the same time, states are preparing for higher eligibility volume and administrative strain when work and community engagement requirements and six-month redeterminations for the new adult expansion category take effect on January 1, 2027.

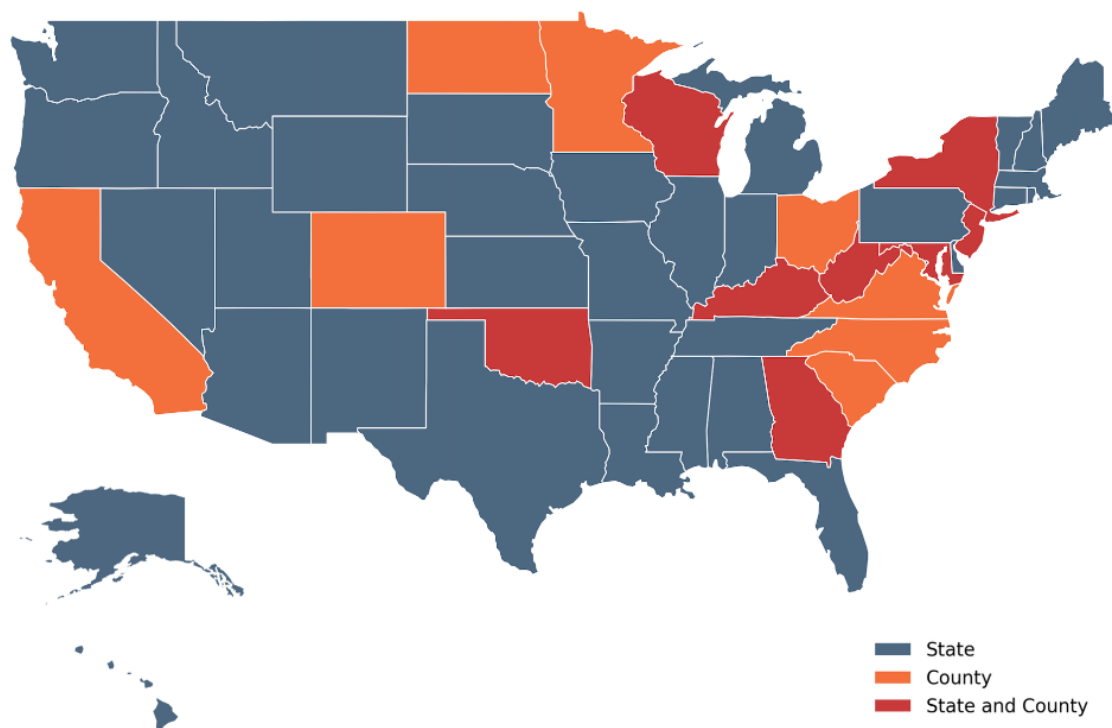
Together, these pressures leave little room for error. Inconsistencies, delays, and mistakes in eligibility administration carry real consequences — for the people who depend on coverage and for states' ability to meet federal compliance standards. That makes it more important than ever for states to strengthen the governance, workforce, and technology systems that keep Medicaid running accurately and equitably.

Medicaid eligibility determination plays a central role in every state's Medicaid program (branded as "NC Medicaid" in North Carolina, "Medi-Cal" in California, and [other names](#) across the nation).¹ Eligibility systems do more than perform an administrative function; they shape who gains and retains coverage and ensure that public dollars are spent appropriately and in compliance with federal requirements.

States organize Medicaid eligibility administration in near-countless ways. Figure 1 categorizes how states process Medicaid eligibility for applications, illustrating that county-administered structures are relatively uncommon. Thirty-four states and the District of Columbia employ staff directly to process Medicaid eligibility, eight states process with county staff, and eight states use a combination. State-employed eligibility workers are deployed several ways, some at centralized call centers or at regional and local offices. States also vary in which other public benefit programs eligibility workers administer alongside Medicaid. For example, 24 states use their Medicaid eligibility systems to process Supplemental Nutrition Assistance Program (SNAP) benefits, 13 also administer childcare subsidies, and some integrate additional human services programs.

This paper focuses on the limitations of state-supervised, county-administered eligibility systems. It identifies structural and programmatic challenges associated with this governance model and outlines potential policy considerations.

Figure 1. Staff Responsible for Processing Medicaid Applications, by Employer



Source: *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision*, KFF, April 2023.

State-Supervised, County-Administered Systems

State-supervised, county-administered eligibility systems are best understood as a governance model as much as an operational one. The state Medicaid agency — often in coordination with a state human services agency — sets eligibility policy, maintains eligibility technology, and remains accountable for federal compliance. Counties employ the eligibility workforce and manage day-to-day operations, including intake, renewals, case maintenance, and customer assistance. As a result, a single statewide entitlement program is administered through dozens of counties, or “local employers,” each operating within its own management structure and labor market constraints.

This two-level structure creates a persistent tension: Accountability is centralized at the state level, while operational control rests with the counties. County administration introduces meaningful variation across staffing levels, vacancy rates, hiring timelines, supervisory capacity, training infrastructure, and surge ability. Even when counties use the same statewide eligibility system, local practices can diverge over time — such as documentation norms, case routing, and informal workarounds developed in response to operational constraints. As this variation accumulates, technology systems and policy guidance may need to accommodate multiple workflows, increasing complexity and making updates, training, and standardization more difficult.

These structural challenges have long existed, but they have become more consequential in the current policy environment. Heightened federal

Case Study of a County-Administered System Under Stress: North Carolina's Unwinding Experience

North Carolina's Medicaid unwinding period functioned as a real-world stress test of a state-supervised, county-administered eligibility system, and lessons learned can now inform the implementation of work and community engagement requirements and six-month eligibility redeterminations. During unwinding, counties were responsible for processing large volumes of renewals while the state remained accountable for compliance and outcomes. The experience highlighted a core operational reality of this governance model: When demand spikes, workforce capacity — rather than policy design — often becomes the constraint.

North Carolina performed relatively well on several unwinding metrics, aided by policy and process flexibilities that reduced manual workload. Expanded use of data-driven (also known as *ex parte*) renewals and flexibilities such as telephonic signatures helped limit paperwork and allowed eligibility staff to focus on cases requiring individualized review. These tools mitigated, but did not eliminate, the underlying structural strain.

That strain was intensified by the simultaneous implementation of the state's new Medicaid expansion, which significantly increased application volume during the unwinding period. As redeterminations accelerated, performance diverged across the state's 100 counties. Counties with sufficient staffing capacity generally maintained throughput, while counties facing vacancies or high turnover experienced rapid backlog growth. The resulting variation reflected differences in local workforce capacity rather than differences in effort or commitment.

Although capacity existed within the system overall, it could not be flexibly redeployed to where demand was greatest. Counties did not routinely share staff or shift work across jurisdictions, due to liability, supervision, and governance constraints. While the state could observe imbalances, it lacked direct levers to move resources quickly. North Carolina's experience illustrates how, during periods of elevated demand and heightened scrutiny, structural fragmentation can limit system responsiveness — and why targeted forms of centralization, such as statewide call centers or specialized processing, may strengthen performance without requiring full structural redesign. A more detailed operational account of North Carolina's eligibility experience during unwinding is provided in [Appendix A](#).

expectations for eligibility accuracy and program integrity place additional operational demands on states at a time when many eligibility systems are still stabilizing after the COVID-19 pandemic and the unwinding of continuous coverage protections.²

California's Size and Technology Bring Further Complexity

California administers Medi-Cal eligibility through a state-supervised, county-administered model. The California Department of Health Care Services (DHCS) establishes statewide eligibility policy, procedures, and guidance, while California's 58 county health and human services agencies process and determine Medi-Cal eligibility at the local level.

California's scale further shapes how this model operates in practice. As the most populous state in the country, California's counties vary dramatically in size, geography, and administrative capacity. Large urban counties process extremely high volumes of applications and renewals and manage complex call center and in-person service operations — sometimes at a scale comparable to, or larger than, many US states. Smaller rural counties, by contrast, often have more limited hiring pipelines, fewer specialized staff, and less ability to surge during periods of increased demand. As a result, resident experience and process times can vary meaningfully across the state, even within a single statewide entitlement program.

California's Medi-Cal eligibility rules are implemented across two primary technology systems: the Statewide Automated Welfare System (CalSAWS) and the California Health Eligibility and Enrollment System (CalHEERS). CalSAWS also supports eligibility for SNAP and Temporary Assistance for Needy Families (TANF), while CalHEERS includes eligibility for Covered California, the state's Affordable Care Act insurance marketplace. This architecture enables relatively consistent statewide policy implementation, but it also requires close coordination across multiple systems and 58 different local county eligibility departments, making training, change management, and operational consistency especially complex.³

This structure makes visible the core dynamic of county-administered eligibility: Counties execute determinations, while the state remains accountable for statewide performance and federal compliance. As federal expectations around eligibility accuracy and program integrity intensify, the central question for California is what governance, technology, and support structures are necessary to ensure that a county-based model delivers consistent, reliable access for residents and a compliant, auditable system for the state — particularly during periods of rapid policy change and heightened scrutiny, like the one currently approaching.

The Challenge of Accountability and Alignment

The structural challenges of county-administered eligibility systems exist within a broader reality: Medicaid eligibility is difficult to administer accurately even in fully centralized models. National assessments consistently show that eligibility systems — combining complex rules, frequent changes in income and household circumstances,

and high-volume workflows — are vulnerable to two simultaneous failures: eligible people losing coverage for procedural reasons and ineligible people remaining enrolled.

Federal oversight mechanisms generally hold states accountable for these outcomes even when counties execute the work. When performance slips — due to backlogs, inconsistent documentation, or uneven adoption of new requirements — the state is responsible for remediation. In county-administered systems, however, the operational fixes must be implemented across multiple county employers, each operating on different timelines and under different workforce and management constraints. The central challenge is how to deliver consistent performance when accountability is centralized but execution is distributed.

These governance challenges are compounded by operational and technological realities. Eligibility systems are often built on aging or highly customized technology and rely on people-intensive workflows, making it difficult for eligible people to enroll and remain enrolled. At the same time, unclear lines of authority and fragmented responsibility increase the risk of human error, including improper enrollment.

Technology investment alone has not resolved these issues. Eligibility systems are expensive and typically developed through large, multiyear procurements requiring ongoing customization. Collectively, states have invested billions of dollars in eligibility and enrollment systems, yet recent congressional inquiries have found that some widely used platforms still produce serious errors — including erroneous coverage losses — and can take years and additional resources to correct. Because many states (and, in some cases, multiple agencies within a state) perform the same core functions such as intake, verification, determinations, renewals, and investments can also be duplicative even as performance remains uneven.⁴

Reviews by the Government Accountability Office, Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission (MACPAC), and academic researchers consistently find that eligibility outcomes are shaped by operational design choices — such as workflow configuration, automation, and workforce execution — even under shared federal rules. The Medicaid unwinding period further demonstrated how administrative processes and capacity constraints can drive large-scale coverage movement, reinforcing that governance, technology, and operational alignment matter as much as policy intent. See [Appendix B](#) for a summary of national evidence on eligibility operations, administrative burden, and coverage outcomes.

Key areas of opportunity:

- ▶ **Workforce fragmentation and uneven capacity.** Counties hire, train, supervise, and retain eligibility staff under local budget constraints and labor market conditions. This produces variation in staffing levels, turnover, supervisory capacity, and the ability to surge during enrollment volume spikes. Over time, these differences translate into uneven processing timelines and inconsistent experience for residents.
- ▶ **Technology misalignment and “one system, many workflows.”** States are typically responsible for eligibility technology and policy guidance, while execution occurs locally. As a result, a single statewide system must support many local workflows. Local workarounds and differing routing practices increase complexity for training and change management and can slow implementation of statewide updates.
- ▶ **Policy interpretation drift and inconsistent implementation.** State policy guidance must be translated into day-to-day execution across many county offices. Over time, small differences in interpretation can compound across training,

supervision, and frontline practice, particularly in areas that require judgment such as documentation adequacy, discrepancy resolution, and renewal workflows.

- ▶ **Accountability without authority.** States are accountable to the US Centers for Medicare & Medicaid Services for eligibility accuracy, timeliness, and improper payment risk but often do not control county hiring, supervision, or daily work management. When performance problems arise, states must solve problems they do not fully control, often through indirect levers such as guidance, training, performance dashboards, and corrective action processes.
- ▶ **Variation in resident experience and access.** Residents experience eligibility through practical touchpoints: whether calls are answered, documents can be submitted easily, notices are understandable, and problems can be resolved without loss of coverage. County-administered structures can create meaningful geographic variation in these touchpoints, creating risk that a statewide entitlement program delivers a different experience depending on where a person lives.
- ▶ **Rising program integrity expectations heighten the stakes of inconsistency.** As federal and state program integrity expectations intensify, variability in training, workflow, and documentation practices carries greater risk in both directions. Eligible people may lose coverage for procedural reasons, while ineligible people may remain enrolled due to errors or delays.

Policy Recommendations to Improve State-Supervised, County-Administered Eligibility

County-administered eligibility systems can achieve strong performance, but they require deliberate design to manage the inherent misalignment between centralized accountability and local operational control. The recommendations below focus on practical levers states can use to strengthen consistency, resilience, and auditability without assuming a single structural solution for every state.

Standardize Statewide Eligibility Workforce Training and Competency Expectations

States should establish uniform expectations for eligibility training, competency, and ongoing refresher education. This includes a consistent statewide curriculum, standardized job aids, and clear escalation pathways for policy questions. Training should address both technical eligibility rules and operational execution such as documentation handling, discrepancy resolution, renewal workflows, and customer assistance practices.

Centralize High-Value Functions That Benefit from Scale and Specialization

States can improve consistency and throughput by centralizing a limited set of functions that benefit most from scale, specialization, and standardization — especially those that reduce frontline workload and improve resident access. High-value opportunities include statewide Medicaid call centers and centralized or regional processing for long-term services and supports eligibility. States may also consider shared-service models for document processing, case routing, and surge support.

Modernize Eligibility Technology Around Unified Business Rules and Data-Driven Renewal

Technology modernization should focus on measurable operational outcomes including increased reliable automation, fewer manual touchpoints, and clearer business rules applied consistently statewide. States should focus on unified rules engines, stronger data-driven renewals and verification pathways, and workflow designs that reduce local workarounds, paired with strong change management and training.

Build Statewide Transparency, Performance Monitoring, and Escalation Pathways

States should maintain transparent, county-level performance dashboards that track timeliness, backlog volume and age, renewal outcomes, and quality measures. These tools should be paired with clear escalation pathways, technical assistance, and corrective action processes to support rapid stabilization and shared accountability for performance. States can also give legal authority to overrule determination decisions made at the county level as a further lever of oversight.

Create Surge Capacity for High-Volume Events and Rapid Policy Change

States should plan for volume spikes driven by economic downturns, policy expansions, and federal changes by developing deployable surge capacity. Options may include state-based teams, regional hubs, shared services, or temporary staffing resources tied to clear triggers, governance frameworks, and quality controls.

Case Study of a Centralized System: Utah's Approach

Utah offers a useful contrast to county-administered eligibility systems. While the Utah Department of Health and Human Services administered Medicaid, eligibility is state-run and centralized within the Utah Department of Workforce Services. This organizational choice does not eliminate eligibility risk, but it materially changes how authority, workforce management, and accountability align in day-to-day operations. Utah illustrates what becomes easier when responsibility for compliance is paired with direct operational control: more consistent training and supervision, clearer management of workflow and quality, and greater ability to deploy staff during periods of elevated demand.

Utah's model is also notable for where eligibility administration is located: Medicaid eligibility is housed within a workforce agency that administers unemployment insurance, SNAP, TANF, and workforce development programs aligned with the Workforce Innovation and Opportunity Act — creating a broader “no wrong door” approach for residents. In many states, workforce programs operate outside the traditional health and human services portfolio, making cross-program coordination more difficult. Utah's structure brings health coverage eligibility into closer operational alignment with workforce and income-support programs, with implications for administrative efficiency and for residents who interact with multiple systems simultaneously.

Operationally, Utah relies on a single statewide eligibility workforce rather than dozens of counties as eligibility workforce employers. This structure enables more uniform training, supervision, and workflow execution and provides state leadership with clearer levers to manage throughput, quality, and surge capacity. When policy or system changes occur, the same entity accountable for compliance generally controls the workforce and operational processes needed to implement the changes.

Utah's centralized model does not suggest that centralization is appropriate or feasible for every state. It does, however, highlight how governance alignment expands the operational tools available to state leaders seeking to stabilize eligibility performance and respond to heightened scrutiny or rapid changes.

Sources: “[Medicaid/Medical Assistance](#),” Utah Department of Workforce Services, accessed January 19, 2026; and “[Apply for Assistance](#),” Utah Department of Workforce Services, accessed January 19, 2026.

Conclusion

Medicaid eligibility administration sits at the intersection of access, accountability, and sustainability. As federal expectations around program integrity, transparency, and compliance intensify — particularly following the passage of H.R. 1 — long-standing structural features of eligibility systems have become more consequential. For states that rely on county-administered models, the challenge is not whether these systems can function, but whether existing governance, workforce, and technology arrangements are sufficient to deliver consistent performance under heightened scrutiny and changing conditions.

The experiences of states highlighted in this paper illustrate that no single administrative structure eliminates eligibility risk. Centralized systems face their own operational challenges, while county-administered models offer strengths in local knowledge and service integration but require additional coordination and support to manage variation and surge demands. What matters most is not the formal structure alone, but the alignment between accountability, operational authority, and the tools available to manage performance.

As states continue to navigate post-unwinding eligibility workloads and respond to evolving federal requirements, deliberate governance choices and

investments in training, technology, performance monitoring, and surge capacity can strengthen both access and compliance. These choices do not require wholesale system redesign, but they do require clarity about where consistency matters most and where flexibility can be preserved.

For North Carolina, California, and other states with county-administered models — eligibility administration is not a peripheral operational issue. It is a core determinant of whether Medicaid reliably reaches eligible people, protects public resources, and remains resilient in the face of policy change. Decisions about eligibility governance will shape not only compliance outcomes, but also the lived experience of coverage for millions of residents in the years ahead.

Appendix A. Eligibility Administration in Practice — North Carolina’s Unwinding Experience

The Medicaid unwinding period functioned, in practice, as a statewide stress test of eligibility operations. In North Carolina, the experience underscored a core dynamic of state-supervised, county-administered eligibility systems often underappreciated in policy debates: During periods of elevated demand, the limiting factor is frequently not policy design but the operational capacity of the local workforce and the state’s ability to deploy that capacity consistently and quickly across jurisdictions.

Overall, North Carolina performed relatively well on several unwinding metrics. A key factor was the use of policy and process flexibilities that reduced paperwork and manual workload, including expanded use of data-driven (*ex parte*) renewals and flexibilities that made renewals less paper-dependent, such as telephonic (verbal) signatures. These approaches helped reduce procedural burden and allowed eligibility staff to focus on cases requiring individualized review.⁵

The unwinding stress test was further intensified by a major, simultaneous operational reality: In the midst of unwinding, North Carolina implemented Medicaid expansion. Expansion represented a historic coverage achievement, but it also substantially increased application volume at the same time counties were processing large numbers of renewals. Eligibility workers were therefore managing rising workloads while adapting to shifting policy guidance and eligibility rules during an already demanding period.

As redeterminations ramped up, system performance diverged across North Carolina’s 100

counties. In some counties, throughput largely held — renewals were processed, documentation issues were resolved, and case flow remained relatively stable. In others, throughput slowed and backlogs accumulated rapidly. These differences were not attributable to variation in effort or commitment but to differences in baseline workforce capacity.

Counties entered the unwinding period with varying staffing levels, turnover rates, pay scales, and local labor market conditions. In counties able to recruit and retain eligibility workers, throughput generally remained stable even as demand increased. In counties facing persistent vacancies or elevated turnover, work accumulated quickly. Backlogs, in turn, created reinforcing pressures: Overtime increased, training time compressed, quality assurance became more difficult, and worker fatigue intensified.

Federal policy flexibilities helped counterbalance — but did not eliminate — these structural stresses. The expanded use of *ex parte* renewals illustrates the operational value of leveraging existing data to confirm ongoing eligibility without requiring enrollees to resubmit documentation. In practice, this approach reduced churn driven by paperwork, limited procedural disenrollments, and allowed staff to concentrate on cases that required manual intervention. More broadly, these flexibilities highlighted the potential for eligibility process reforms to improve system performance by reducing reliance on people-intensive workflows.

Despite variation in capacity across counties, the system as a whole had limited ability to redeploy

resources to where demand was greatest. Counties with relatively stable staffing did not routinely “lend” workers to counties facing significant backlogs. The reasons were predictable and often rational, including concerns about accountability and liability, supervision and quality control, and unclear authority for moving work across county lines.

As a result, while the state could observe imbalances across the system — capacity in some locations and bottlenecks in others — it lacked practical levers to move resources quickly to stabilize performance. This dynamic illustrates the “accountability without authority” challenge in county-administered eligibility systems.

North Carolina’s unwinding experience also revealed targeted opportunities to strengthen a county-based model without requiring wholesale

structural redesign. Two areas emerged as particularly promising: development of a statewide Medicaid call center to absorb routine inquiries and reduce geographic disparities in access to assistance, and centralized or regional processing for long-term services and supports eligibility, where specialization and standardization can reduce error risk in one of the most complex eligibility pathways.

Taken together, North Carolina’s experience does not suggest that county-administered eligibility systems cannot perform well. Rather, it illustrates how, during periods of elevated demand and heightened scrutiny — especially when major coverage expansions are layered into the same operational window — structural fragmentation can become a limiting factor. In these contexts, targeted centralization and deliberate operational design choices can play an important role in improving consistency, resilience, and program integrity.

Appendix B. National Evidence on Medicaid Eligibility Operations

This appendix summarizes national evidence on Medicaid eligibility administration to complement the analysis in the main body of the paper. Across multiple sources — including federal oversight agencies, independent policy commissions, and academic research — eligibility outcomes are shown to be shaped not only by statutory rules, but by operational design choices such as workflow configuration, automation, and workforce execution. The evidence below is intended to ground the paper’s discussion of governance, capacity, and system design without replicating a full literature review.

GAO: Recurring Eligibility Errors Are Operational

In 2020, the US Government Accountability Office (GAO) reviewed 47 state and federal audits of Medicaid eligibility determinations across 21 states and identified recurring weaknesses in how eligibility rules were executed in practice. Common findings included failure to complete redeterminations, unresolved discrepancies, and delays in terminating coverage when people became ineligible. GAO’s synthesis emphasizes that these issues are largely operational — driven by workflow execution, documentation handling, and capacity constraints — rather than by policy design alone.⁶

MACPAC and SHADAC: Variation Persists Under Shared Federal Rules

A 2018 MACPAC assessment conducted by the State Health Access Data Assistance Center (SHADAC) examined eligibility, enrollment, and renewal processes for modified adjusted gross income-based Medicaid populations in six states.

The study documented substantial variation in workflow design, automation levels, and use of electronic data sources, even under shared federal eligibility rules. A key finding was that eligibility outcomes are shaped by how states integrate data, resolve discrepancies, and train and supervise staff over time, reinforcing the role of operational choices in driving consistency and accuracy.⁷

Unwinding as a Stress Test of Eligibility Operations

The unwinding of the federal continuous coverage requirement provided a large-scale stress test of eligibility and renewal systems. Academic analyses estimate that more than 25 million people were disenrolled nationally during the unwinding period and note that differences between total disenrollments and net coverage losses reflect substantial churn and coverage transitions. These patterns highlight how administrative processes and capacity constraints — rather than eligibility changes alone — can drive large-scale movement in and out of coverage.⁸

KFF’s Medicaid Enrollment and Unwinding Tracker further illustrates how eligibility performance varied across states. Using US Centers for Medicare & Medicaid Services and state-reported data, KFF documents differences in renewal timelines, disenrollment rates, and enrollment changes, and shows how procedural disenrollment and ex parte renewal rates evolved as states adjusted systems and workflows over time.⁹

Administrative Burden, Automation, and Churn

A consistent theme across the academic literature is that administrative burden is measurable in coverage stability and participation. Goldman and Sommers find that churn among low-income adults declined after the Affordable Care Act, particularly in expansion states, suggesting that eligibility stability responds to system design choices.¹⁰ Nelson and colleagues link renewal outcomes to variation in state administrative burden and implementation approaches for automated renewals.¹¹ Herd and colleagues evaluate a federal initiative to increase

automated ex parte renewals and find that these interventions increased automation and were associated with reductions in procedural denials and improved coverage continuity.¹²

Recent unwinding analyses by McIntyre and colleagues reinforce the importance of these findings at scale.¹³ Large disenrollment volumes and persistent gaps between disenrollments and net coverage losses underscore how administrative processes — and the capacity to execute them reliably — remain defining features of eligibility performance during periods of heightened demand.

Endnotes

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