

Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19

GAO-24-106883

Q&A Report to Congressional Committees

July 18, 2024

Why This Matters

As in past emergencies, Congress provided additional federal funding to states during the COVID-19 public health emergency (PHE) so Medicaid enrollees could keep their health care coverage. Medicaid is the federal-state program that finances health care for certain low-income and medically needy individuals.

Typically, states must redetermine eligibility for Medicaid enrollees on an annual basis and disenroll those who are no longer eligible. To receive temporary enhanced federal funding during the PHE, Congress required states to keep enrollees continuously enrolled in Medicaid. This contributed to Medicaid growing from approximately 63.8 million enrollees in February 2020 to 86.2 million enrollees in February 2023—an increase of more than 30 percent. Congress ended the continuous enrollment period effective March 2023, and required states to resume full eligibility redeterminations, including disenrollments. This transition from continuous enrollment—a process still ongoing as of May 2024—is known as Medicaid “unwinding.”

During unwinding, millions of people are expected to lose Medicaid coverage. Disenrollments are expected to include people no longer eligible as well as those possibly eligible who would be disenrolled for procedural reasons, such as because they did not submit all the information required to have eligibility redetermined and coverage renewed. When eligible people lose coverage, it can result in “churn” when people move out of and back into Medicaid coverage. Federal research indicates that churn results in worse health outcomes and higher program costs.

The CARES Act includes a provision for us to report on the federal response to the COVID-19 pandemic.¹ This report examines the Centers for Medicare & Medicaid Services’ (CMS) oversight of Medicaid unwinding and the changes states made to their eligibility redetermination processes.

Key Takeaways

- The resumption of Medicaid eligibility redeterminations during unwinding for millions of people has been a complex and unprecedented undertaking for CMS and states.
- As states resumed redetermining eligibility and disenrolling individuals, issues with redetermination processes have emerged across states. This has included identification of noncompliance with long-standing redetermination requirements that had previously gone undetected by CMS. The noncompliance led to eligible individuals losing Medicaid coverage.
- CMS and states have resolved some compliance problems and taken steps to remediate the effects for individuals—by, for example, reinstating eligible

people who were erroneously disenrolled. Other compliance issues require longer-term solutions.

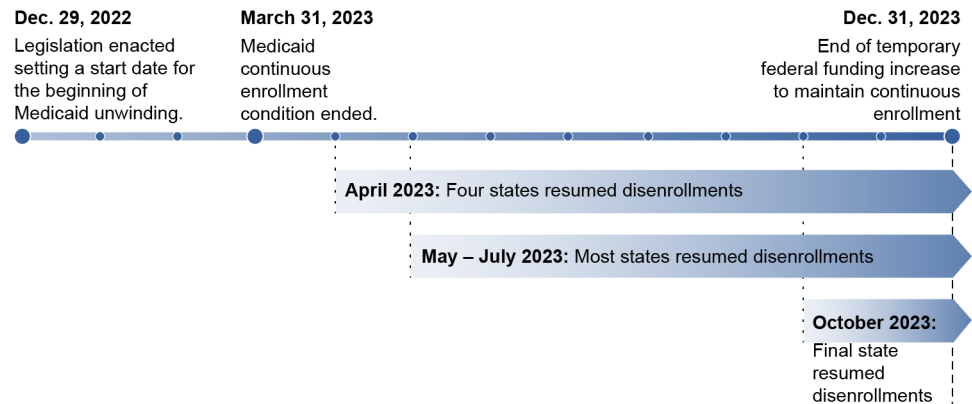
- As of April 2024, CMS officials indicated that the agency’s thinking on future oversight was still evolving but that the agency would likely be making changes that reflect lessons learned, for example, around providing guidance, monitoring data, and engaging states and stakeholders. We recommend that CMS document and implement those changes to its oversight of states’ Medicaid eligibility redeterminations. The agency agreed with the recommendation.
- According to CMS, unwinding has gone on longer than originally expected. It is unclear when all states will have resumed normal operations because CMS has extended temporary flexibilities. Additionally, normal operations will look different, as CMS has recently made permanent some of the temporary flexibilities allowed during the PHE. CMS’s continued efforts to ensure state compliance with redetermination requirements will be important both for preventing erroneous disenrollments and ensuring that only those eligible are enrolled in the program.

What is Medicaid unwinding?

Medicaid unwinding represents the end of the continuous enrollment period in Medicaid. The Consolidated Appropriations Act, 2023, enacted on December 29, 2022, ended the Medicaid continuous enrollment condition on March 31, 2023.² States could resume full eligibility redeterminations, including disenrollments, beginning on April 1, 2023. For some states, that included restarting redeterminations of eligibility that the state opted to pause given the continuous enrollment requirement. For other states that continued to conduct redeterminations but refrained from disenrollments, they could start disenrolling individuals they had redetermined as ineligible. States were also required to submit monthly unwinding data to CMS (e.g., the number of redeterminations conducted and the number of individuals disenrolled) for April 2023 through June 2024.

States had flexibility, within federal parameters, in how quickly they moved to begin unwinding and begin disenrolling individuals after a redetermination. For example, four states—Idaho, New Hampshire, Oklahoma, and South Dakota—began disenrollments in April 2023. In contrast, Oregon began disenrollments in October 2023. (See fig. 1.)

Figure 1: Timeline of State Implementation of Medicaid Unwinding



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-24-106883

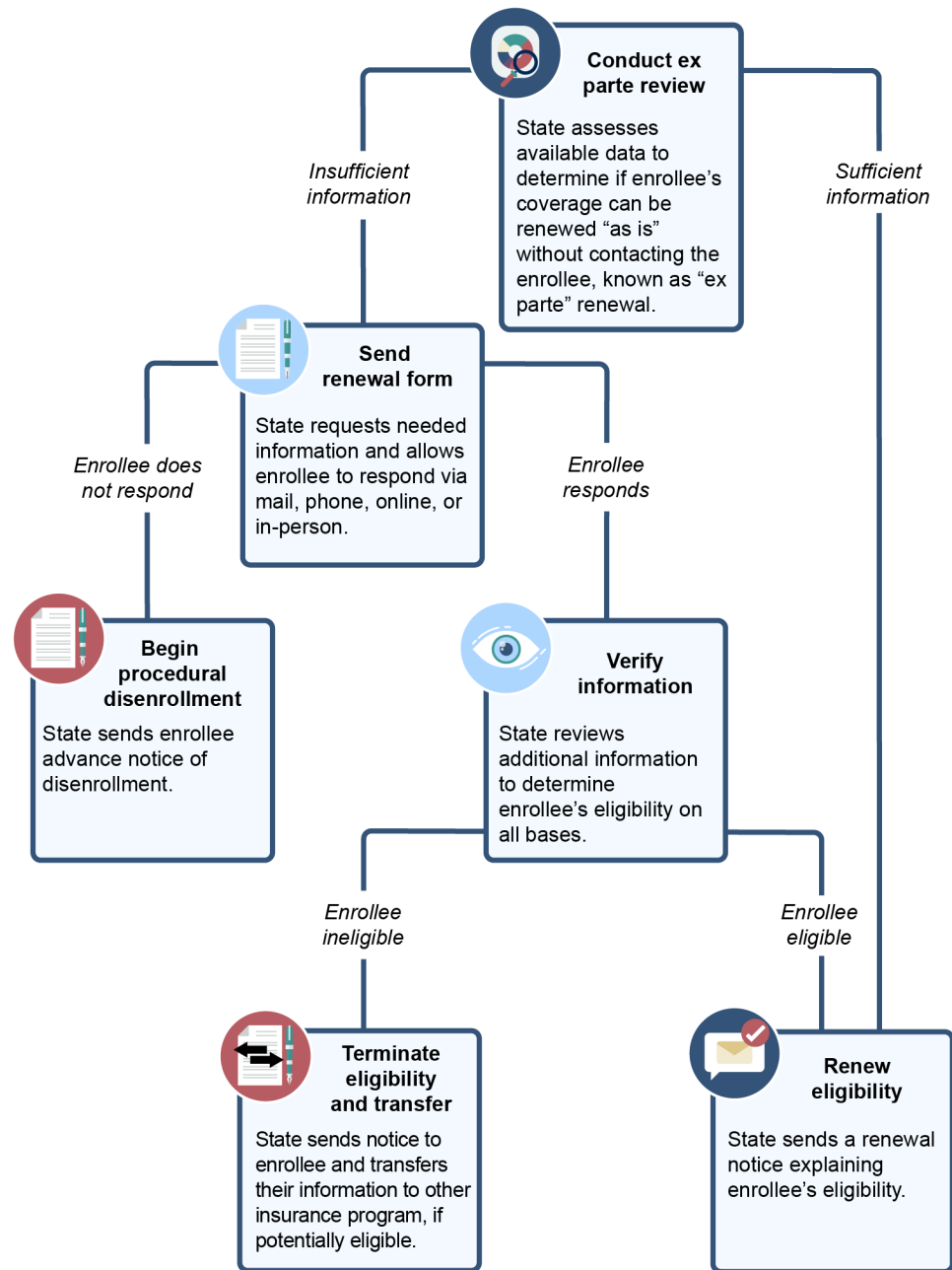
Note: States could resume disenrollments beginning on April 1, 2023, for individuals redetermined as ineligible.

States also had flexibility to prioritize different enrollee populations for redetermination when initiating Medicaid unwinding. For example, 22 states that had been redetermining enrollees' eligibility throughout the PHE—but not terminating enrollment given the continuous enrollment condition—could identify individuals who were likely ineligible and prioritized them for redetermination earlier in unwinding. For example, Arkansas estimated that approximately 422,000 enrollees were likely ineligible on the basis of its redeterminations during the continuous enrollment period and focused its unwinding efforts on this population before redetermining eligibility for other enrollees. Other states moved through their Medicaid populations sequentially according to individuals' annual redetermination date, which is based on the date of enrollment.

What federal requirements do states have to meet when conducting eligibility redeterminations?

Long-standing federal requirements govern how states are to redetermine Medicaid eligibility. According to CMS, the requirements are designed to protect enrollees from, for example, having to provide duplicative information repeatedly, and to streamline state administrative processes, among other things. Federal regulations outline the required steps in the process and timeframes for redetermination. (See fig. 2.)

Figure 2: Medicaid Redetermination Process Requirements



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information (information); toonsteb/stock.adobe.com. | GAO-24-106883

Note: See 42 C.F.R. § 435.916 (2023).

In redetermining Medicaid eligibility, states generally must assess whether enrollees still fall within certain categories (e.g., children, pregnant women, individuals with disabilities, and individuals over 65 years of age) and meet the applicable eligibility criteria. For example, depending on the group, individuals must have an income below specified levels and—for certain individuals who are elderly or have disabilities—meet certain asset and resource tests. Additionally, individuals can have multiple potential bases for eligibility, though they can only be enrolled under one basis. For example, a child who has a disability could meet the eligibility criteria for children as well as an individual with disability. The state must assess whether individuals are eligible on any other bases before determining them ineligible for Medicaid.

As we have noted in our prior work on Medicaid, given differing eligibility requirements for different Medicaid populations, determining eligibility is a complex process that is vulnerable to error.³ Erroneous retention of ineligible individuals can increase program costs. Erroneous termination of eligible individuals can increase churn, resulting in worse health outcomes and higher program costs.⁴ To protect enrollees from erroneous termination and reduce state administrative burdens during periods of transition, such as unwinding, CMS provides states flexibilities. For example, CMS provides temporary waivers authorized under section 1902(e)(14) of the Social Security Act—also referred to as e(14) waivers—of certain eligibility verification and redetermination requirements.⁵

What challenges have selected states experienced in Medicaid unwinding?

Medicaid officials from six states we spoke with told us states faced a variety of challenges in redetermining Medicaid eligibility during unwinding including those related to workload, staffing, and a lack of response from enrollees.⁶

Workload. The volume of redeterminations during unwinding was unprecedented. Officials from all six selected states cited a variety of related changes that increased state program staff workload. For example, officials from one state told us their monthly redetermination caseload was double the pre-PHE caseload. Officials from another three states told us their eligibility and enrollment systems needed significant updates or changes, which resulted in having to conduct manual redeterminations in two of those states. Officials noted that some of the flexibilities they implemented allowed them to protect enrollees' coverage while reducing workload. For example, four selected states received approval from CMS to use income information from an individual's last redetermination to renew eligibility for certain low- and no-income individuals when electronic data sources did not yield data during the current redetermination. This allowed the states to increase the number of individuals whose enrollment could be renewed without additional follow-up.

Staffing. Officials from four states told us they experienced challenges hiring and training sufficient staff, with some citing significant staff turnover during the PHE. Five states invested in increasing staff and contractor resources to staff call centers or conduct redeterminations. Some officials told us that many of the staff who are conducting the redeterminations during this unwinding phase had never performed redeterminations before.

Enrollee response. Officials from two selected states noted that a lack of response from enrollees posed a significant challenge during unwinding, because enrollees may have stopped paying attention to renewals during the continuous enrollment period. To increase enrollee engagement, officials from all six states told us they engaged providers, the state's managed care plans, or community organizations to help conduct outreach to enrollees. Three states expanded outreach by using different modalities such as texts, emails, or automated messages.

During unwinding, to what extent did CMS identify issues with state compliance with federal eligibility redetermination requirements?

During unwinding, CMS had found compliance problems in almost all states as of April 2024. Through systematic compliance reviews in all states, CMS identified a number of common areas of noncompliance with long-standing requirements, which led to eligible individuals losing Medicaid coverage in some cases. (See table 1.) Some states had multiple areas of noncompliance.

Table 1: Examples of State Noncompliance with Federal Eligibility Redetermination Requirements Identified by CMS during Medicaid Unwinding

Compliance issue	Description and prevalence
Not conducting ex parte reviews at the individual level	<p>Redetermination requirement: States must conduct ex parte reviews for each individual in a household to determine if they are still eligible for Medicaid, independent of the eligibility of other household members. (Ex parte reviews allow states to renew eligibility based on available reliable data, without contacting enrollees for information.)</p> <p>Number of states determined noncompliant: 29</p> <p>Implication of noncompliance: CMS found in September 2023 that noncompliance with this requirement had led to states disenrolling eligible individuals during unwinding. This was a particular concern for children, who may be Medicaid-eligible even when the adults they live with are not. According to CMS, about 420,000 eligible individuals, including children, lost Medicaid coverage temporarily due to this problem.</p>
Not conducting ex parte reviews for certain populations	<p>Redetermination requirement: States must conduct ex parte reviews first when redetermining eligibility for every group covered under Medicaid.</p> <p>Number of states determined noncompliant: 26</p> <p>Implication of noncompliance: CMS found in early 2023 that states were not prepared to conduct ex parte reviews for certain groups, such as individuals with disabilities or over age 65. Not conducting ex parte reviews can lead to unduly burdensome requests for information from enrollees who may face additional challenges in responding. It can also lead to disenrollment if eligible individuals do not provide information that was already available to the state from other data sources.</p>
Not allowing enrollees to submit renewal forms through all modalities	<p>Redetermination requirement: States must permit enrollees to submit renewal forms by mail, phone, online, or in-person.</p> <p>Number of states determined noncompliant: 19</p> <p>Implication of noncompliance: CMS found in early 2023 that states were not always prepared to let enrollees submit renewal forms through all modalities. This could have made it harder for eligible individuals to respond to states' requests for information if they, for example, lacked access to the internet and needed to respond in other ways.</p>

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) and state information. | GAO-24-106883

In addition to these common areas of noncompliance, CMS identified a range of issues in individual states as a result of reviewing state-reported data, communicating regularly with states, and reviewing information from stakeholders, such as beneficiary advocates. CMS officials described the following examples of noncompliance, which they said have been resolved, with erroneously disenrolled individuals reinstated:

- Erroneous disenrollments due to systems errors.** After stakeholders notified CMS of potentially erroneous disenrollments in Texas, CMS told us they found that about 100,000 eligible individuals had been disenrolled due to eligibility system errors. For example, the system had disenrolled some individuals without processing their returned renewal forms, and disenrolled some women after miscalculating the length of their postpartum Medicaid coverage.
- Not determining eligibility on all bases.** After hearing concerns from stakeholders, CMS officials said they found that Arkansas was not determining eligibility on all bases, when certain enrollees had a change of circumstance that affected eligibility.⁷ The state had not been requesting additional information from these enrollees to determine their eligibility on other bases before disenrolling them.

- **Erroneously maintaining coverage for individuals.** CMS found that a system defect in California prevented the timely disenrollment of approximately 175,000 individuals who should have been disenrolled.
- **Cases not resolved within 90 days via state fair hearings.** CMS officials told us that state data from Ohio showed that a growing number of fair hearings were not resolved within 90 days as generally required.⁸ (When a state determines an individual is not eligible for Medicaid, that person can request a fair hearing where the state will review the eligibility decision.) CMS officials told us the state found this issue was primarily driven by problems in one county and addressed those county-specific issues.

There were a number of reasons for states' noncompliance with federal redetermination requirements, according to CMS officials and state officials we spoke with from selected states.

- **Eligibility systems limitations that preceded the PHE.** Most of the compliance problems CMS identified in early 2023 preceded the PHE and were driven largely by pre-existing eligibility systems issues, CMS officials said. For example, some states did not previously conduct ex parte renewals for enrollees with disabilities or over age 65, because those enrollees' eligibility files were housed in older legacy systems.⁹ Those systems did not support or permit ex parte renewals due, for example, to a lack of connectivity with other systems housing information needed to determine eligibility. Ex parte renewals for these groups may require states to access financial or medical information not needed for other Medicaid-eligible groups.
- **States not aware of noncompliance.** After identifying problems with some states' ex parte review processes, CMS directed all states in August 2023 to assess their compliance with the requirement to use ex parte reviews to determine eligibility for each individual in a household. CMS officials told us the agency found that some states mistakenly thought their eligibility systems and processes complied with ex parte review requirements. For example, Illinois officials told us the state had not interpreted federal guidance to mean that ex parte reviews must be done for each individual; instead, Illinois' eligibility systems had been programmed to do ex parte reviews at the household level.
- **Problems stemming from the PHE and unwinding.** CMS officials said there were a few cases where states made rapid systems changes in early 2020 to prevent people from being disenrolled during the PHE, and those changes later caused problems during unwinding. For example, CMS officials told us that some states implemented manual overrides to prevent disenrollment during the PHE and found that those overrides later resulted in systems failing to conduct ex parte reviews for some enrollees after unwinding began.

What is the status of CMS and states' efforts to address noncompliance with federal redetermination requirements?

As of April 2024, CMS and states had resolved some compliance problems. In other cases, states had implemented mitigation measures while working on longer-term solutions.

For the three common compliance issues described in table 1, CMS officials noted the following progress in reaching compliance:

- **Not conducting ex parte reviews at the individual level.** CMS officials told us that all noncompliant states that had been conducting ex parte reviews at the household level instead of the individual level had mitigated the issue. As of April 2024, some states had made permanent fixes while others had temporary strategies in place. For example, some states were conducting ex

parte renewals at the individual level manually with plans to automate the process. CMS officials said they met with state eligibility systems vendors as part of their work with states to address this area of noncompliance.

- **Not conducting ex parte reviews for certain populations.** CMS officials told us that some noncompliant states had implemented permanent changes to be able to conduct ex parte renewals for certain populations, such as individuals with disabilities, but other states still had temporary mitigation measures in place as of April 2024. Arkansas officials, for example, told us they resolved this issue by updating their eligibility processes and systems to allow ex parte reviews for enrollees with disabilities or over age 65. New York officials said they made temporary changes to redetermination processes for certain populations because they were unable to make larger systems changes in the short term.
- **Not allowing enrollees to submit renewal forms through all modalities.** CMS officials told us that some states had implemented permanent changes to reach compliance, but others had mitigation measures in place as of April 2024. Arizona officials, for example, told us they were addressing noncompliance by creating an online portal to allow enrollees receiving nursing home or other long-term care services to submit renewal forms online. The officials said they expected to implement that change by September 2024; in the interim, dedicated call center staff were helping this population with the renewal process.

CMS officials said states were working toward full compliance with all federal redetermination requirements. However, officials noted that a number of changes needed to reach compliance would require significant state investment and work—and could introduce risk if made during unwinding. For example, information technology systems changes can be difficult, time-intensive, and require procurement efforts, officials said. CMS officials also told us that making system changes can have unintended consequences for enrollees and that large-scale systems changes could divert limited state resources from unwinding efforts. These officials said that in addition to unwinding, states were working on other changes to their eligibility systems that also required state attention.¹⁰

To resolve or prevent disenrollment due to compliance problems, CMS had also worked with states to reinstate coverage and pause disenrollments.

- **Reinstating Medicaid coverage.** At least 35 states have reinstated coverage for enrollees who were disenrolled erroneously during unwinding, according to CMS. For example, CMS data indicate that in 28 of the 29 states that did not always conduct ex parte reviews for each individual in a household, roughly 420,000 children and adults lost Medicaid coverage due to this problem; as of January 2024, all of these individuals had been reinstated, CMS officials told us. This ranged from fewer than 5,000 individuals reinstated in 15 states to more than 50,000 reinstated in two states. The remaining state corrected the problem before anyone had been disenrolled, according to CMS officials.
- **Pausing procedural disenrollments.** At least 23 states temporarily paused some or all disenrollments for procedural reasons, such as an individual not submitting the information needed to have their eligibility redetermined and coverage renewed.¹¹ For example, CMS officials said they required pauses in procedural disenrollments in 15 of the states that did not always conduct ex parte reviews for each individual in a household. These pauses allowed states to assess and address this problem.

During unwinding, CMS officials told us that the agency and states have largely worked in partnership to resolve compliance issues and CMS has generally not

required states to provide formal corrective action plans. As of April 2024, CMS had taken formal action to recoup federal funds for one state's noncompliance with unwinding data reporting requirements, using enforcement authority established in the Consolidated Appropriations Act, 2023.¹²

As states complete unwinding, CMS officials told us the agency continues to work with states to identify potential compliance issues. They said the agency has been conducting unwinding audits to help identify areas of concern and work with states to reach compliance.¹³ CMS officials also told us the agency plans to require all states to submit compliance plans that describe areas of noncompliance already identified, actions needed to reach compliance, and the time frames for doing so. As part of this effort, CMS issued guidance on prohibited practices in March 2024.¹⁴

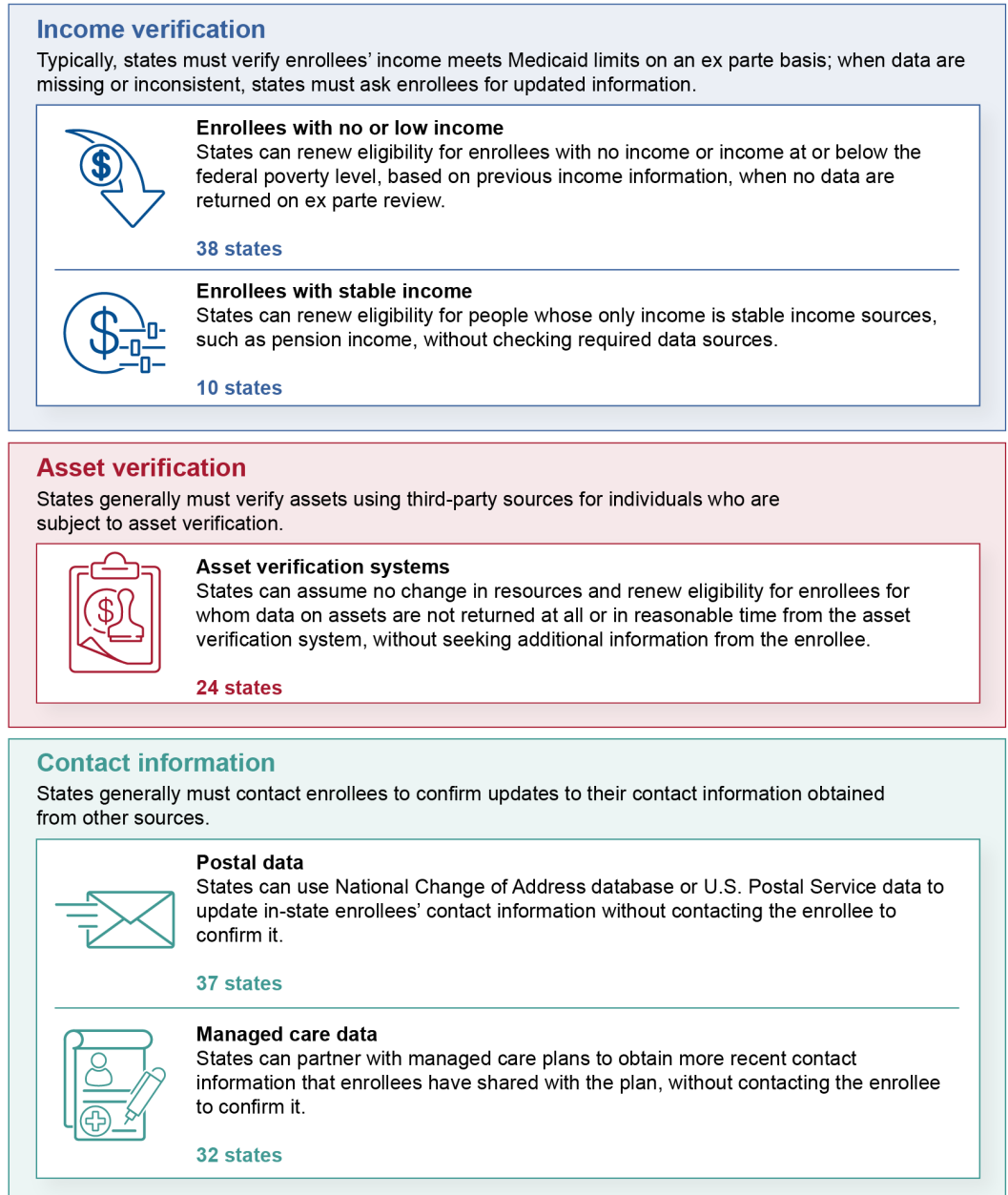
What flexibilities has CMS given states during Medicaid unwinding to prevent eligible enrollees from losing coverage?

CMS has approved flexibilities for nearly all states and across a range of redetermination requirements with the goal of helping protect eligible enrollees from being disenrolled from Medicaid and easing administrative burden for states during unwinding. CMS can grant states flexibilities by temporarily waiving certain federal requirements—such as modifying requirements for verifying enrollees' income—under waivers known as e(14) waivers.¹⁵ For example, CMS has allowed states to use alternative methods for determining eligibility when doing so would help prevent eligible enrollees from losing coverage.

CMS-approved flexibilities can also help states mitigate the effect on enrollees of noncompliance. For example, officials from New York—a state that had not been conducting ex parte renewals for certain populations as required—said that flexibility when verifying enrollees' income and assets allowed the state to renew more enrollees without requiring them to provide more information.

Some of the most common flexibilities CMS approved for Medicaid unwinding related to how states verify enrollees' income and assets and how states update enrollees' contact information. (See fig. 3.)

Figure 3: Examples of Temporary Flexibilities CMS Approved for Medicaid Unwinding



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information (information); Vektor67/stock.adobe.com (icons). | GAO-24-106883

Notes: Under certain circumstances, CMS can temporarily waive certain federal requirements—such as requirements for verifying enrollees' income—under section 1902(e)(14) of the Social Security Act. Using these flexibilities, known as e(14) waivers, CMS has allowed states to use alternative approaches for determining eligibility when doing so would help prevent eligible enrollees from losing their Medicaid coverage. State counts reflect CMS information on waivers as of May 2024.

An asset verification system provides a portal between state eligibility systems and banks or other third-party systems with electronic access to financial information.

CMS also approved a range of other temporary flexibilities, such as allowing states to renew eligibility based on financial findings from the Supplemental Nutrition Assistance Program or the Temporary Assistance for Needy Families program; permitting states' managed care plans to help enrollees complete and submit renewal forms; and extending the time frame for states to take final administrative action on certain fair hearing requests.

When approving these flexibilities for unwinding, CMS sought to balance protecting enrollees' access to care with program integrity concerns, agency officials said. CMS officials said they wanted to ensure these flexibilities would

not result in large numbers of ineligible individuals remaining in Medicaid and worked with Department of Health and Human Services (HHS) staff to assess risks. For example, when assessing the potential effect of allowing states to use older data when verifying income for enrollees with low income as part of ex parte reviews, CMS used historical data to estimate how many enrollees who would be renewed due to that flexibility would not have been eligible for Medicaid.

Looking ahead, CMS plans to examine the effect of these flexibilities and decide how long states can use them. In April 2024, CMS issued a final rule that made permanent some flexibilities, such as states' ability to obtain updated enrollee contact information from reliable sources, including managed care plans or the U.S. Postal Service, without independently confirming that information with enrollees.¹⁶ In a May 2024 letter to states, CMS announced that states could use the remaining flexibilities through June 2025.¹⁷ In extending the flexibilities beyond 2024, CMS noted that unwinding was taking longer than expected in many states, that the flexibilities were still needed to protect enrollees while states address areas of noncompliance, and that the extension would allow states to shift their limited resources to reduce application processing times. CMS's letter also stated that the agency was reviewing the flexibilities to determine which could be implemented on a long-standing basis under other authorities.

How does CMS plan to ensure state compliance with redetermination requirements in the post-unwinding future?

CMS officials told us that their plans for the agency's oversight approach going forward were still evolving as of April 2024. However, officials told us that future oversight will entail a multipronged approach that reflects lessons learned from unwinding.

Unwinding provided CMS an opportunity to assess CMS's framework for overseeing state compliance with federal requirements. Officials told us CMS identified key lessons learned about agency oversight as it worked with states to address compliance issues, some of which were previously undetected. According to officials, key lessons learned related to the need for ongoing guidance and better identification of emerging issues through monitoring and engaging states and stakeholders. Accordingly, officials indicated that future oversight will likely include

- **Issuing guidance on an ongoing basis.** CMS officials told us that the agency plans to issue additional guidance to further clarify the requirements on an ongoing basis as state systems evolve. Officials told us that they realized that with turnover in staff at the state level, states often did not know that their systems were out of compliance and additional guidance could help new state staff better understand the requirements. CMS officials said they envision a series of guidance issued over time paired with technical assistance to states.
- **Monitoring redetermination data.** CMS officials indicated that the agency was exploring its authorities to continue collecting data on disenrollments that states were required to report during unwinding and how to leverage the data infrastructure built during unwinding that drew together data across various sources. CMS officials said their oversight approach during unwinding—which involved monitoring a wider range of state data—had proven beneficial in identifying potential compliance issues.
- **Engaging states and stakeholders.** CMS officials told us that they plan to continue engaging with states and stakeholders to identify and address compliance issues. Officials also noted that working more closely with states and stakeholders, such as advocates and state eligibility systems vendors,

has been beneficial in identifying and addressing issues. For example, officials told us they are working with a number of states' systems vendors to provide guidance on ex parte determinations at the individual level and coordinated internally to better align systems reviews with eligibility requirements.

It is positive that CMS has identified lessons learned from unwinding. CMS officials also indicated they were seeking dedicated staff resources to continue to build lessons learned into oversight going forward. However, as of April 2024, CMS had not documented the oversight practices that reflect lessons learned during unwinding or developed plans for how or when the agency would implement them. CMS officials said they had not progressed further in their planning and implementation because unwinding was still ongoing and they were focused on supporting states' redetermination efforts, including preventing erroneous disenrollments. Without documentation of the oversight practices the agency learned were needed to better ensure compliance, it is unclear how or when these practices would be implemented.

Federal Medicaid eligibility redetermination requirements are designed to ensure that only eligible individuals remain enrolled and to minimize the churn of eligible individuals out of and back into the program. CMS's oversight of state compliance with federal redetermination requirements is critical for meeting those goals. Documenting and implementing oversight practices that reflect lessons learned during unwinding could help the agency prevent or more quickly identify and mitigate compliance problems, including those that can lead to erroneous disenrollment and program churn.

What is CMS doing to identify and share state lessons learned from unwinding?

CMS officials told us they have been gathering and sharing state lessons learned throughout unwinding. They told us they have facilitated the informal sharing of lessons learned in weekly meetings with states and incorporated some state best practices as clarifying examples in guidance. In addition, state lessons learned have informed CMS policy changes such as making permanent certain temporary flexibilities in an April 2024 final rule on Medicaid eligibility. For example, according to CMS, having determined that there was no harm to enrollees and efficiencies to be gained, the agency will generally allow states to obtain updated enrollee contact information from managed care plans without independently verifying the information with enrollees beginning on June 3, 2024.

In our work throughout the PHE, our recommendations have highlighted the importance of gathering and incorporating lessons learned to inform and improve planning and response for future public health emergencies.¹⁸ CMS's efforts to gather and share state lessons learned are consistent with our prior recommendations.

Conclusions

Determining whether individuals are eligible for Medicaid is a complex process for states that is vulnerable to error. The resumption of Medicaid eligibility redeterminations on such a large scale further compounded this complexity. Federal redetermination requirements are designed to limit those errors, thereby minimizing ineligible people staying enrolled and eligible people churning out of and back into the program. The widespread noncompliance with those requirements found during unwinding—some of which had been long-standing and had gone undetected by CMS—has highlighted the need to improve federal oversight. CMS has learned that providing clear guidance on an ongoing basis, monitoring data, and engaging with states and stakeholders are needed to ensure state compliance. As CMS's work with states to resolve current compliance issues continues, documenting and implementing the oversight practices that CMS has learned during unwinding are needed could help CMS

prevent or more effectively identify and address compliance issues going forward.

Recommendation for Executive Action

The Administrator of CMS should document and implement the oversight practices the agency learned during unwinding were needed for preventing and detecting state compliance issues with redetermination requirements. (Recommendation 1)

Agency Comments

We provided a draft of this report to HHS for review and comment. In its written responses, which are reproduced in appendix I, HHS concurred with our recommendation. HHS noted that the agency plans to integrate oversight strategies into ongoing operations as the unwinding process concludes and states resume their routine eligibility and enrollment operations. For example, HHS cited guidance issued in May 2024 requiring states to continue reporting redetermination data beyond unwinding, which HHS said indicates the value of those data for ongoing monitoring and oversight.

HHS also provided technical comments, which we incorporated as appropriate.

How GAO Did This Study

We reviewed relevant federal laws, regulations, and CMS guidance related to Medicaid unwinding, including relevant redetermination requirements. We reviewed documentation of CMS's efforts to assess state compliance with those requirements and resolve any noncompliance from March 2023 through April 2024. This included reviewing state compliance attestations and mitigation plans, as well as CMS trackers of identified compliance issues and resolutions. We compared CMS's plans for future oversight to the goals of federal redetermination regulations and requirements. We interviewed CMS officials about their current oversight practices and plans for future oversight. We also interviewed Medicaid officials and reviewed documents from six states—Arizona, Arkansas, Florida, Illinois, New Hampshire, and New York—selected to capture a mix of program size, geographic diversity, and length of experience with unwinding.

We conducted this performance audit from June 2023 to July 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

List of Addressees

The Honorable Patty Murray
Chair
The Honorable Susan Collins
Vice Chair
Committee on Appropriations
United States Senate

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Bernard Sanders
Chair

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Gary C. Peters
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The Honorable Rand Paul, M.D.
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Committee on Homeland Security and Governmental Affairs
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The Honorable James Comer
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House of Representatives

The Honorable Jason Smith
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The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <https://www.gao.gov>.

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**Appendix 1: Comments
from the Department of
Health and Human
Services**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

July 1, 2024

Catina B. Latham
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Latham:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MEDICAID: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned After COVID-19" (GAO-24-106883)**.

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE’S DRAFT REPORT TITLED: MEDICAID: FEDERAL OVERSIGHT OF STATE ELIGIBILITY REDETERMINATIONS SHOULD REFLECT LESSONS LEARNED AFTER COVID-19 (GAO-24-106883)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office’s (GAO) draft report. HHS is committed to ensuring that renewals of Medicaid eligibility, transitions between coverage programs, and terminations of coverage are conducted efficiently, comply with federal requirements, and minimize administrative burden while promoting continuity of coverage.

Background

As noted in the GAO’s report, in order to receive the temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase authorized under the Families First Coronavirus Response Act (P.L. 116-127) (FFCRA), states were required to maintain the enrollment of nearly all Medicaid enrollees for most of the duration of the COVID-19 Public Health Emergency (PHE). As a result of this legislation, and other temporary flexibilities adopted by states, Medicaid and Children’s Health Insurance Program (CHIP) enrollment grew to 94 million individuals in March 2023, representing an increase of over 22 million individuals, or 32.5 percent, since February 2020. The Consolidated Appropriations Act, 2023, (P.L. 117-328) (CAA, 2023) subsequently delinked the end of the Medicaid continuous enrollment condition from the end of the COVID-19 PHE, and beginning on April 1, 2023, states were able to begin terminating the enrollment of ineligible individuals following a full eligibility redetermination. This process is often referred to as “unwinding” and represents the single largest health coverage transition event since the first open enrollment period for the Health Insurance Marketplaces authorized under the Affordable Care Act. HHS is committed to providing states with guidance, resources, and technical assistance to ensure continuity of coverage for Medicaid and CHIP eligible individuals throughout the unwinding process.

The CAA, 2023 amended the FFCRA to establish new conditions for states to continue to claim the temporary FFCRA FMAP increase after March 31, 2023, including the condition that states conduct redeterminations of eligibility under title XIX of the Social Security Act (the Act) consistent with all applicable federal requirements, including any renewal strategy approved under section 1902(e)(14)(A) of the Act or other processes and procedures authorized by HHS. Following the enactment of the CAA, 2023, HHS promptly issued guidance to states about the changes included in the legislation and expectations for compliance with federal requirements related to redeterminations of eligibility outlined in 42 CFR § 435.916.¹ HHS worked with all states and territories prior to the end of the continuous enrollment condition to assess their compliance with Medicaid and CHIP renewal requirements and to assist with the implementation of strategies and mitigation measures, as appropriate, to address areas of non-compliance.

Temporary Waivers and Flexibilities

HHS implemented a multi-pronged “whole-of-government” approach to support individuals with Medicaid and CHIP, states, and other stakeholders and partners through the unwinding process. These efforts included the development of policy guidance and tools, intensive technical assistance to states, a

¹CMS, Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023. 2023. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf>

robust federal and multi-state communications approach, and system and policy changes to support transitions to other coverage programs.

In order to further support states, HHS has approved waivers under Section 1902(e)(14)(A) of the Act, which are intended to streamline renewal processes and protect otherwise eligible individuals who may be at risk of inappropriately losing coverage. As of May 2024, HHS has approved almost 400 1902(e)(14)(A) waivers intended to address unwinding-related challenges experienced by states, including, strategies to support individuals with the submission or completion of their renewal forms, as well as strategies to obtain updated contact information for individuals.² In addition to the 1902(e)(14)(A) waiver strategies, states that meet certain conditions may use a regulatory exception to the requirement for timely determinations of eligibility laid out in 42 CFR 435.912(e)(2) to delay procedural disenrollments for one or more months while the state conducts targeted outreach, allowing individuals who would otherwise lose coverage for procedural reasons additional time to complete their renewal form or provide other necessary information. States that meet the applicable conditions are strongly encouraged to seek HHS concurrence to use the exception.

In May 2024, HHS notified states that unwinding-related section 1902(e)(14)(A) waivers, and certain other temporary flexibilities, are extended through June 30, 2025.³ While all states were initially expected to complete unwinding-related renewals by June 2024, due to state adoption of strategies to prevent inappropriate disenrollments and other approved unwinding-related strategies and mitigation measures, many states will continue conducting unwinding-related renewals beyond June 2024 for some populations.⁴ States can continue to utilize previously approved unwinding-related section 1902(e)(14)(A) waivers provided that the terms and conditions of the original waiver continue to be met. States can also request approval for new section 1902(e)(14)(A) waivers.

HHS has been exploring ways to make some of these waiver strategies which support continuity of coverage for eligible individuals available to states on a more longstanding basis under other authorities and has already taken steps toward this effort. The recently finalized Eligibility and Enrollment rule makes changes to 42 CFR § 435.608, 435.919, 436.608 and 457.344 to make permanent three such strategies upon the rule's effective date of June 3, 2024.⁵ These strategies include waiving the requirement that individuals must apply for other benefits to qualify for Medicaid, as well as allowing states to update individuals' contact information with information from managed care plans and the U.S. Postal Service National Change of Address database and mail forwarding service. HHS expects to

² CMS, COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals. 2024. Accessed at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html#:~:text=As%20of%20May%202024,Completion%20to%20Reduce%20Procedural%20Terminations>

³ CMS, Extension of Temporary Unwinding-Related Flexibilities. 2024. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf>

⁴ CMS, Scheduled State Timelines for Completing Unwinding-Related Renewals. 2024. Accessed at <https://www.medicaid.gov/resources-for-states/downloads/sst-cmpltng-unwldng-rmwls-prlmyr-anlys-05312024.pdf>

⁵ *Federal Register*: Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes; Final Rule (89 FR 22780) (May 2, 2024)

release further guidance in 2024 addressing which additional strategies may be made available to states on a permanent basis.

Data Reporting and Monitoring

The CAA, 2023 also added section 1902(tt) to the Act, which requires that, for each month occurring during the period beginning on April 1, 2023 and ending on June 30, 2024, states must submit to HHS, and HHS must make public, certain monthly data about activities conducted during that same period related to eligibility renewals, CHIP enrollment, call center operations, and enrollment in Marketplace coverage. All the data states must report under these reporting requirements are included in data sets that predated the enactment of section 1902(tt)(1). HHS issued an Interim Final Rule that implemented section 1902(tt) of the Act.⁶ HHS also released guidance,⁷ technical specifications,⁸ reporting templates,⁹ and Frequently Asked Questions to support states' reporting on renewal outcomes, and to monitor states' progress through unwinding.¹⁰ As required by section 1902(tt)(1) of the Act, HHS has been publicly reporting the data provided by states pursuant to section 1902(tt)(1) of the Act, and most recently has published data covering renewals conducted in February 2024.¹¹ In addition to the reporting required by section 1902(tt)(1) of the Act, HHS has been collecting, and publicly reporting on, information from states on changes in Medicaid, CHIP, and Marketplace enrollment, state operations, and, on an ad hoc basis, additional data on transitions to other forms of coverage beyond the Marketplace.^{12,13}

Collecting these data has provided states, the public, and HHS with unprecedented transparency into, and operational understanding of, Medicaid and CHIP eligibility and enrollment processes. In May 2024, HHS issued guidance to inform states that they should continue to submit certain renewal and fair hearing metrics, referred to as the "Eligibility Processing Data Report," beyond the reporting period

⁶ *Federal Register*. Medicaid Program; CMS Enforcement of State Compliance With Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act; Interim Final Rule (88 FR 84713) (December 6, 2023)

⁷ CMS, Medicaid and CHIP Unwinding: Data Sources and Metrics Definitions Overview. 2024. Accessed at <https://www.medicaid.gov/media/160271>

⁸ CMS, Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding. 2023. Accessed at <https://www.medicaid.gov/media/136536>

⁹ CMS, Data Reporting Tools. Accessed at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/data-reporting-tools/index.html>

¹⁰ CMS, Consolidated Appropriations Act, 2023: FMAP Reduction for Failure to Meet Reporting Requirements under Section 1902(tt)(1) of the Social Security Act. Frequently Asked Questions for State Medicaid and CHIP Agencies. 2023. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/fmap-rdctn-repot-medicid-chip-agncs-06302023.pdf>

¹¹ CMS, Monthly Data Reports. Accessed at: <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/monthly-data-reports/index.html>

¹² CMS, Medicaid and CHIP Enrollment; Child and Youth Data Snapshot. 2023. Accessed at <https://www.medicaid.gov/resources-for-states/downloads/medicaid-unwinding-child-data-snapshot.pdf>

¹³ CMS, Medicaid, CHIP, and Marketplace Enrollments: Enrollment Trends Update. 2023. Accessed at <https://www.medicaid.gov/resources-for-states/downloads/medicaid-unwinding-enroll-trends-snapshot-sep2023.pdf>

ending June 30, 2024, when the reporting requirements in section 1902(tt)(1) of the Act no longer apply.¹⁴

Renewal Compliance and Oversight

HHS is using a multi-pronged data monitoring strategy that uses these state-reported data, as well as information received from advocates, providers, and other stakeholders, to track and support the early identification of renewal, eligibility, and transition issues. When potential issues are identified, HHS conducts outreach to assess the accuracy of the data being reported, troubleshoot the root cause of issues, and provide states with immediate and intensive technical assistance. In August 2023, HHS sent letters to 37 states whose May 2023 data submissions indicated potential issues related to call center operations, renewal outcomes, and application processing timelines, as these areas could indicate a potential system or operational issue.¹⁵ HHS reiterated that states are expected to continually review call center data, renewals outcome metrics, and application determination processing timeliness data and adjust their operations as necessary.

If HHS determines that a state is not complying, or is not able to comply, with federal requirements, HHS can take action to prevent eligible people from losing coverage. For example, HHS has taken action to require states to pause terminations, reinstate coverage, adopt strategies to support individuals through the renewal process, and address systems issues. In summer 2023, HHS' multi-pronged data monitoring strategy led to the identification of systems and operational issues affecting multiple states in which *ex parte* renewals were being conducted at the household level, without regard to differing eligibility statuses and income thresholds for individuals within the household. As a result, some states were requesting additional information to redetermine eligibility and disenrolling some individuals from Medicaid or CHIP if the renewal form was not returned to renew coverage for another household member, a practice that violates federal renewal requirements. Upon identification of this issue, HHS provided individualized technical assistance, issued guidance to states,¹⁶ and published a template that states could use to request approval for strategies that would prevent inappropriate terminations of eligibility until the state could achieve full compliance with federal requirements.¹⁷ HHS also required that states pause disenrollments for impacted individuals and reinstate coverage for all individuals who were inappropriately disenrolled to avoid HHS taking further action. A preliminary summary of state

¹⁴ CMS, Continuation of Certain Medicaid and CHIP Eligibility Processing Data Reporting, 2024. Accessed at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24002.pdf>

¹⁵ CMS, Unwinding Documents. Accessed at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/state-letters/index.html>

¹⁶ CMS, Requirements to Conduct Medicaid and CHIP Renewal at the Individual Level. 2023. Accessed at <https://www.medicaid.gov/media/162301>; CMS, Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Processes. 2023. Accessed at <https://www.medicaid.gov/media/164691>; CMS, Notice Considerations for Conducting Medicaid and Children's Health Insurance Program (CHIP) Renewals at the Individual Level. 2023. Accessed at <https://www.medicaid.gov/media/165686>

¹⁷ CMS, Mitigation Plan Template for Ex Parte Renewal Compliance Issues. 2023. Accessed at <https://www.medicaid.gov/media/162306>

compliance with requirements to conduct renewals at the individual level was published in September 2023, and HHS continues to work closely with states as they work towards achieving full compliance.¹⁸

In preparation for, and during unwinding, intensive state engagement and technical assistance has been a critical component of HHS' efforts to identify and address the root causes of states' policy and operational deficiencies, and to support states in achieving compliance with renewal requirements. This work has included one-on-one technical assistance with states, weekly workgroup meetings between HHS and state Medicaid directors and staff, as well as the release of a vast array of policy and operational resources. As states complete unwinding-related renewals and return to normal eligibility operations, HHS intends to continue its efforts to ensure state compliance with renewal requirements through continued state engagement, technical assistance, workgroup meetings, and the publication of guidance and tools. For example, to explain what is permitted under federal renewal requirements, both during and beyond unwinding, HHS recently provided guidance to states outlining several practices that are not permitted under existing federal regulations.¹⁹ HHS has strongly encouraged all states to review their renewal processes and procedures, renewal forms and notices, and the renewal logic in eligibility systems to confirm that their processes and systems are compliant with federal requirements. States that are determined to be relying on any prohibited processes must work with HHS to change their practices as quickly as possible.

As states resume routine eligibility and enrollment operations, HHS shares states' goals of ensuring that eligible individuals remain enrolled in Medicaid or CHIP and that individuals who are no longer eligible transition seamlessly to other coverage options. HHS is committed to providing states with updated guidance and resources, as appropriate, as well as ongoing technical assistance, to better enable states to ensure continuity of coverage.

GAO's recommendation and HHS' responses are below.

GAO Recommendation

The Administrator of CMS should document and implement the oversight practices the agency learned during unwinding were needed for preventing and detecting state compliance issues with redetermination.

HHS Response

HHS concurs with this recommendation. States' experiences throughout the unwinding process have made clear the importance of continuing to provide clear guidance, collect data for monitoring, and engage with states. HHS has already shown its commitment to continued oversight based on lessons learned from unwinding. For example, HHS' May 2024 release of guidance to states on continued reporting of certain Medicaid and CHIP eligibility processing data highlights the valuable role of state-

¹⁸ CMS, Preliminary Overview of State Assessments Regarding Compliance with Medicaid and CHIP Automatic Renewal Requirements at the Individual Level. 2023. Accessed at <https://www.medicaid.gov/media/163401>

¹⁹ CMS, Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders. 2024. Accessed at <https://www.medicaid.gov/media/173651>

reported data in supporting ongoing monitoring and oversight.²⁰ HHS plans to appropriately integrate these strategies into ongoing operations as the unwinding process concludes and states resume their routine eligibility and enrollment operations.

²⁰ CMS, SHO: Continuation of Certain Medicaid and CHIP Eligibility Processing Data Reporting. 2024. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24002.pdf>

Endnotes

¹Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). All of GAO's reports related to the COVID-19 pandemic are available on GAO's website at <https://www.gao.gov/coronavirus>.

²Pub. L. No. 117-328, div. FF, tit. V, subtit. D, § 5131, 136 Stat. 4459, 5949 (2022).

³See GAO, *Medicaid Eligibility: Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors*, [GAO-20-157](#) (Washington, D.C.: Jan. 13, 2020).

⁴See Department of Health and Human Services. Assistant Secretary for Planning and Evaluation, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, HP-2021-10 (Washington, D.C.: Apr. 21, 2021).

⁵42 U.S.C. § 1396a(e)(14)(A).

⁶We spoke with officials from Arkansas, Arizona, Florida, Illinois, New Hampshire, and New York.

⁷Because individuals can have multiple potential bases for eligibility, if a Medicaid enrollee is found to no longer be eligible for the eligibility group under which they are receiving coverage, the state must determine if they are eligible under any other eligibility groups offered by the state. See 42 C.F.R. § 435.916(f) (2023). Arkansas was not determining eligibility on all bases for enrollees who were Medicaid-eligible due to receiving Supplemental Security Income benefits and experienced a change in circumstance that affected their Medicaid eligibility, according to CMS officials. CMS and Arkansas officials told us the state revised its processes to assess Medicaid eligibility on other bases for individuals who lost their Supplemental Security Income benefits.

⁸States typically must take final administrative action within 90 days of the date of a request for a state fair hearing and no later than 7 working days after the agency receives a request for an expedited hearing for a claim related to eligibility. See 42 C.F.R. § 431.244(f) (2023).

⁹Some states use their legacy Medicaid eligibility systems for some categories of low-income individuals who were eligible for Medicaid before the 2010 enactment of the Patient Protection and Affordable Care Act (PPACA), such as individuals with disabilities or over age 65. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). PPACA gave states the option to expand Medicaid eligibility to certain nonelderly individuals. See Medicaid and CHIP Payment and Access Commission, *Issue Brief: Increasing the Rate of Ex Parte Renewals*, (Washington, D.C.: Sept. 2023).

¹⁰For example, some states were making changes to implement new requirements under the Consolidated Appropriations Act, 2023. One new requirement is that states must keep children continuously enrolled in Medicaid for 12 months beginning January 1, 2024, even if the family experiences a change in circumstances during the year that would otherwise affect the child's eligibility, such as a change in income or household size. See Pub. L. No. 117-328, div. FF, tit. V, subtit. B, § 5112, 136 Stat. 4459, 5940.

¹¹In addition, 15 states opted to delay procedural disenrollments for 1 or 2 months to conduct targeted renewal outreach to enrollees.

¹²See Pub. L. No. 117-328, div. FF, tit. V, subtit. D, § 5131(b), 136 Stat. 4459, 5950 (codified as amended at 42 U.S.C. § 1396a(tt)). In March 2024, CMS enforced a required reduction in federal matching funds for Nevada because the state did not report complete call center data required by that law. CMS also required the state to implement a corrective action plan to help ensure the problem was resolved.

¹³CMS officials told us that in late 2023, CMS began audits examining disenrollments of infants and children in 10 states. CMS plans to conduct 10 additional audits in 2024, focusing on disenrollments of a broader population of enrollees, including adults.

¹⁴Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services. *CMCS Informational Bulletin: Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders*, (Baltimore, Md.: March 15, 2024).

¹⁵These waivers are authorized under section 1902(e)(14) of the Social Security Act. See 42 U.S.C. § 1396a(e)(14)(A).

¹⁶See 89 Fed. Reg. 22,780 (April 2, 2024). The final rule also aligns redetermination process requirements for different groups of Medicaid enrollees starting on June 3, 2024.

¹⁷The letter noted that states can use the flexibilities more than once for the same enrollee, in certain circumstances. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *CMCS Informational Bulletin: Extension of Temporary Unwinding-Related Flexibilities* (Baltimore, Md.: May 9, 2024).

¹⁸See GAO, *COVID-19: Pandemic Lessons Highlight Need for Public Health Situational Awareness Network*. [GAO-22-104600](#) (Washington, D.C.: June 23, 2022). HHS concurred with these recommendations, but as of February 2024, they remained open.