Tips for Interpreting Unwinding Data

In March 2022, The Centers for Medicare & Medicaid Services (CMS) released a **template** of data metrics that states would be required to report monthly throughout the unwinding to CMS for monitoring and oversight. The **Consolidated Appropriations Act of 2023** codified many of these data reporting requirements into law. Additionally, the legislation established monetary penalties for states' failure to report required metrics from July 2023 through June 2024. The CAA requires CMS to publicly post states' data; however, many states are also posting or sharing monthly reports themselves.

States have been instructed to report data on renewal outcomes in monthly cohorts based on the month the renewals are due. The monthly unwinding report data metrics are separate from other required performance indicators that are already reported to CMS that date back to the ACA, which include call center statistics, enrollment, and application volume. The data metrics in each monthly report are detailed below. These data provide insight into how states are doing in their return to routine operations.

Monthly Unwinding Data Metrics

Application Processing

This set of metrics indicates the extent to which the state has unprocessed applications, which could mean that the state has a backlog. Guidance issued in March 2022 stated that states are expected to catch up on application processing for MAGI groups in two months, and all applications within four months after the start of the state's unwinding period.

- <u>Measure 1</u> - shows how many applications the state had not processed while the continuous enrollment condition was in place.
- <u>Measure 2</u> - reports how many pending applications from measure 1 the state completed in the reporting month.
- <u>Measure 3</u> - shows how many of the applications in measure 1 remain pending. These measures are cumulative for applications in current and prior reporting periods. We would expect to see measure 3 declining each month if the state is working through any existing backlog.

Renewals Initiated

60 to 90 days before an enrollee is due for renewal, the state initiates a renewal by starting the ex parte process. States are required to attempt an ex parte renewal, where the state checks available data sources for ongoing Medicaid eligibility, before requesting information from enrollees to verify ongoing eligibility. Outcomes for renewals initiated in the reporting period will be reported two or three months following the initiation month depending on the state's renewal cycle.

Renewals & Outcomes

This section of the monthly reports provides the most critical information for understanding what is occurring to enrollees during the unwinding. It documents how many individuals maintained Medicaid coverage, how many were disenrolled, and how many renewals are pending.

- <u>Number of individuals due for renewal (5)</u> - This metric indicates how many individuals were due for a renewal in the reporting month.CMS has instructed states to report only on individuals due for the given month in the monthly report. Submetrics 5a through 5d should equal the total for measure 5 when summed.

- <u>Number of individuals who remained enrolled (5a)</u> - The number of individuals who remained enrolled are those who went through the renewal process and were found eligible to maintain Medicaid coverage. Individuals can be renewed via ex parte (measure 5a(1)), which means the state was able to verify ongoing eligibility through available data sources without requiring the individual to complete a form or submit information to the state.

  If the state is unable to determine ongoing eligibility through ex parte, the state sends an individual a prepopulated renewal form or notice. Individuals who return their renewal form and remain Medicaid eligible are captured in measure 5a(2).

  Importance of measure: Individuals who remain eligible and enrolled in Medicaid have not experienced a gap in coverage and can more easily access necessary care.

- <u>Number of individuals disenrolled for ineligibility (5b)</u> - Coverage for individuals who return their renewal form to the state but are found to be no longer eligible for Medicaid is terminated. For those determined ineligible, states are required to transfer the accounts to the Marketplace where they can apply for financial assistance and complete the steps to enroll in a plan.

Renewals & Outcomes (cont.)

States have indicated that individuals terminated for non-procedural reasons (who are found to have died, moved out of state, or voluntarily requested disenrollment) are also captured in this metric even if those individuals are not transferred to the Marketplace.

Importance of measure: Individuals who are found ineligible for Medicaid may be eligible for affordable plan options through the marketplace. However, transitions to the marketplace are not always smooth and assistance may be needed for the individual to actually get enrolled in a plan.

- <u>Number of individuals disenrolled for procedural reasons (5c)</u> - Procedural disenrollments occur when an individual does not return the renewal form or provide information needed to determine eligibility. This can happen for a variety of reasons including not receiving the form in the mail, difficulty providing the requested information, or inability to get through to the call center or otherwise get assistance to complete the form.

  Importance of measure: Individuals disenrolled for procedural reasons may not realize their coverage has been terminated until they seek medical care or fill needed prescriptions. Many are likely still eligible for coverage, especially in non-expansion states where the majority of individuals enrolled on Medicaid are children. Gaps in coverage can result in delays in necessary care, missed well-child visits, and increased financial risks for families.

- <u>Number of individuals with pending renewals (5d)</u> – Typically pending renewals would indicate that the state is not able to process all renewals received by the end of the month. However, there are other reasons a renewal may be pended, including the state holding back action on a group of renewals due to some issue. Additionally, states have the option to delay procedural disenrollments 30 days to do targeted outreach. Individuals who would have otherwise been terminated for procedural reasons absent that flexibility are captured in the number of pending renewals as well.

  Importance of measure: High numbers of pending cases may indicate a backlog or system issue, especially in states that have not taken up the 30-day procedural disenrollment delay. Since monthly reports are based on renewals due in a given month, we are currently unable to see the outcomes of renewals reported in the pending category once they are completed.

Renewals & Outcomes (cont.)

- <u>Month renewals were initiated (6)</u> - Renewals are initiated 60 to 90 days prior to eligibility end date. The month renewals are initiated indicates when the state first began the renewal process by attempting an ex parte renewal.

- <u>Total pending renewals (7)</u> - Total pending renewals provides a cumulative total of pending renewals the state has not completed yet. The total is cumulative for renewals due from the beginning of the unwinding period through the given reporting month.

  Importance of measure: Like measure 5, large numbers of total pending renewals may indicate an unmanageable workload for state agency staff or system issues. However, in states that also delay procedural disenrollments for a month, this data metric will be less useful in assessing a state's potential backlog.

Medicaid Fair Hearings

Medicaid rules stipulate that individuals can appeal an eligibility decision by requesting a fair hearing if they believe the state has made an error and they remain eligible for coverage. Significant numbers of pending fair hearings may indicate a workload issue or could signal a larger systems issue that is resulting in individuals being terminated from coverage inappropriately within the state.

Where to Find State Monthly Reports

CMS Unwinding Data Reporting

CMS **began posting** CAA-required metrics as well as other unwinding-related data at the end of July. **Monthly unwinding report data** was released for the 18 states who terminated individuals as of the end of March or April. In many, if not most states particularly those using managed care, coverage ends the last day of a month with disenrollments effective the first day of the following month, so states that were indicated to begin terminations in April, for example, may have disenrollment data reported for March). There is lag of several months for most data posted by CMS.

CCF 50-State Tracker

Some states have been publishing monthly report data themselves or the data has been made available through public records requests. Data released through these pathways are often available shortly after state submission of the report to CMS on the 8th of each month. All available monthly reports are available on **CCF's 50-state tracker**. For analysis of the renewal outcome metrics for states with public data, see our "**State Unwinding Renewal Data**" tracker.