Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

NATIONAL ASSOCIATION OF Community Health Centers®

SUMMARY OF DATA METRICS IN STATE MONTHLY REPORTS TO CMS

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 (CAA, 2023) codified many of these data reporting requirements into law. The legislation established monetary penalties for states' failure to report required metrics from July 2023 through June 2024. CMS is required to publicly post states' data, which many states are additionally posting or sharing monthly reports themselves. States have been instructed to report data on renewal outcomes in monthly cohorts. These cohorts are based on the month the renewals are due.

This summary was developed to help health centers understand the reported metrics and their significance. The data metrics in each monthly report are detailed below. Please note these data are separate from other required performance indicators that are already reported to CMS that date back to the ACA, including enrollment and application statistics. These data provide insight into how states are doing in their return to routine operations.

DATA REPORTING 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.

- **MEASURE 1** shows how many applications the state had not processed while the continuous enrollment condition was in place.
- **MEASURE 2** reports how many pending applications from measure 1 the state completed in the reporting month.
- **MEASURE 3** 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 confirm 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 AND 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 whether there is a potential backlog processing renewals.

REPORTING METRIC	DESCRIPTION:	WHY IS IT IMPORTANT:
5. Number of Individuals Due for Renewal	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.
5a. Number of individuals who remained enrolled	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 that return their renewal form and remain Medicaid eligible are captured in measure 5a(2).	Individuals who remain eligible and enrolled in Medicaid have not experienced a gap in coverage and can more easily access necessary care.
5b. Number of individuals disenrolled for ineligibility	Coverage for individuals who return their renewal form to the state but are found to be no longer eligible and have their Medicaid coverage 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. 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.	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.
5c. Number of individuals disenrolled for procedural reasons	Procedural disenrollments occur when an individual does not complete their renewal form; 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.	Many individuals disenrolled for procedural reasons may still be eligible for coverage, especially in non-expansion states where the majority of individuals enrolled on Medicaid are children.

REPORTING METRIC	DESCRIPTION:	WHY IS IT IMPORTANT:
5d. Number of individuals with pending renewals	States may not be able to process all renewals received by the end of the month, resulting in pending renewals. Some states have also chosen to take up an 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.	High numbers of pending cases may indicate a backlog, 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.
6. Month renewals were initiated	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.
7. Total pending renewals	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.	Large numbers of total pending renewals may indicate a backlog or unmanageable workload for state agency staff. 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.

ADDITIONAL UNWINDING METRICS TO WATCH:

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.