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Unwinding Medicaid Data

A Real-Time 50-State Assessment as Redeterminations Approach the Midpoint

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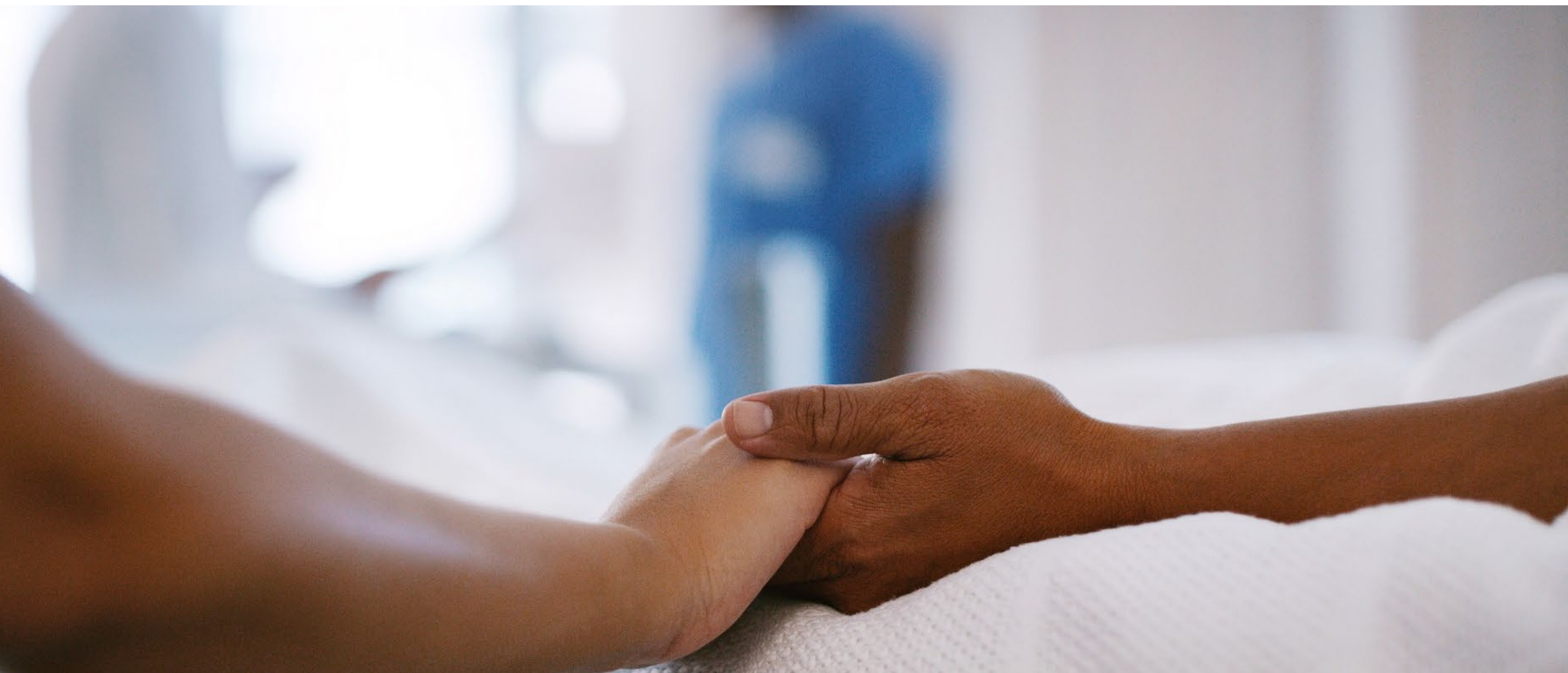


Table of Contents

Unwinding Medicaid Data: A Real-Time, 50-State Assessment as Redeterminations Approach the Midpoint 3
As Midpoint Approaches, Data Suggest that Medicaid Disenrollments Are Consistent with Projections 5
Two Observations to Consider When Interpreting Disenrollment Data 6
Full Unwind Data Better Contextualizes that the Medicaid Unwinding Is in Its Earlier Stages 7
Lessons for the Future 7
HMA Can Help 8

UNWINDING MEDICAID DATA: A REAL-TIME, 50-STATE ASSESSMENT AS REDETERMINATIONS APPROACH THE MIDPOINT

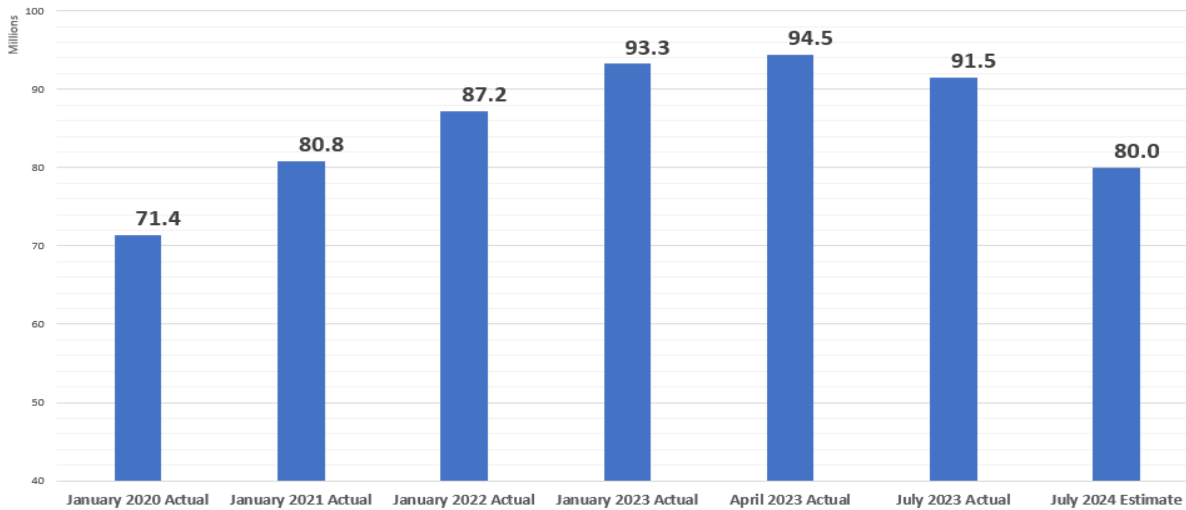
The Medicaid program is undergoing the most significant change in enrollment since its inception in 1965. With millions of individuals transitioning out of the program, a key issue is assessing how redeterminations are going relative to expectations in real time. An assessment is especially relevant given that timely and systematic tracking is cumbersome and state approaches vary greatly. In this piece, we review why the current changes to Medicaid are so unprecedented, how enrollment changes compare with prospects at the state level, and what lessons policymakers can learn from this experience to improve coverage for eligible individuals in the future.

During the public health emergency, Congress provided additional support and flexibilities for the Medicaid program and its beneficiaries, including a provision in the Families First Coronavirus Response Act, which increased federal funding to states that elected to provide continuous enrollment in Medicaid beginning in February 2020. This provision froze Medicaid disenrollments and stopped individuals from "churning" on and off the Medicaid rolls.

In December 2022, as part of the Consolidated Appropriations Act of 2023, Congress agreed to end the continuous enrollment policy starting March 31, 2023, creating major operational undertakings for state and federal agencies and their community partners. During the three years that the continuous enrollment policy was in effect, Medicaid and CHIP (Children's Health Insurance Program) enrollment experienced historic growth. The programs are now poised for historic declines as states "unwind" the continuous enrollment policy and review eligibility criteria for their Medicaid populations.

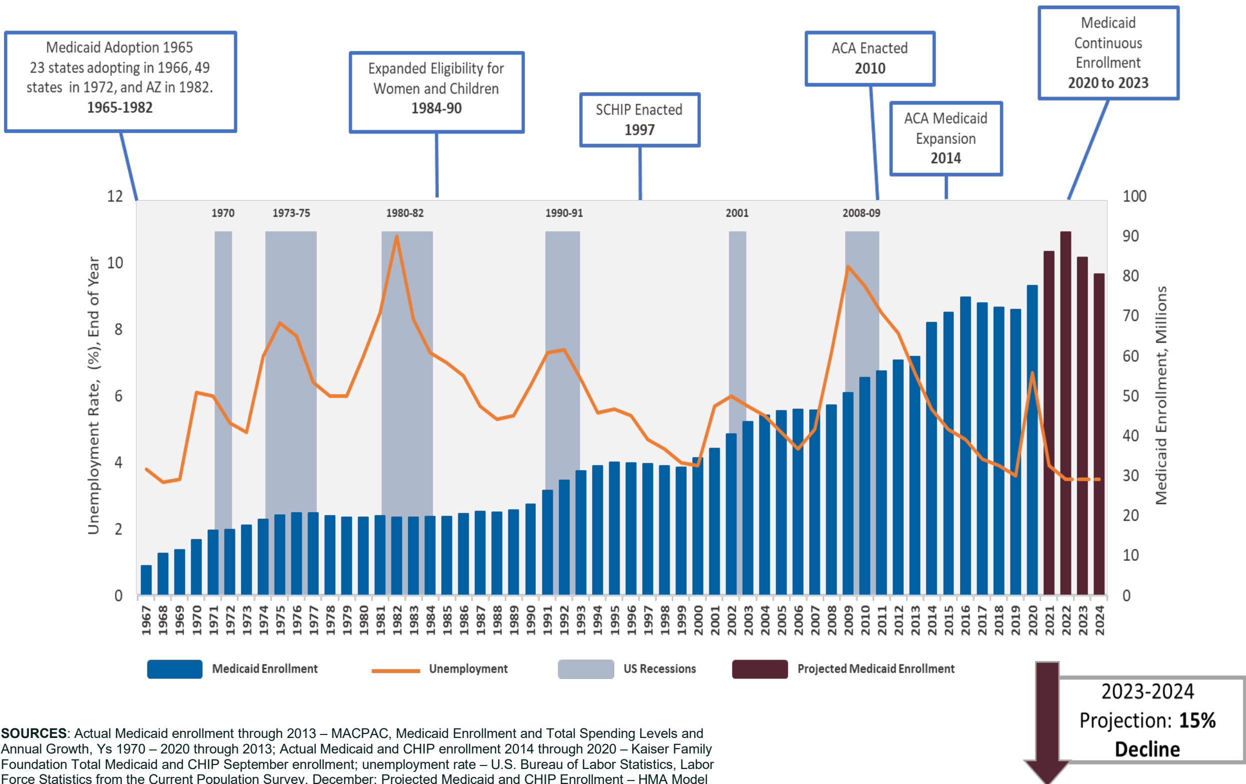
A number of models have projected the coverage changes that will occur with the unwinding process. Most of these projections suggest a significant reduction in Medicaid enrollment. Both the Urban Institute and Congressional Budget Office (CBO) project that approximately 15 million people will lose their eligibility for Medicaid, with differing assumptions about the number of individuals who will become uninsured. The Health Management Associates (HMA) model makes a similar overall estimate (see Figure 1). Notably, it also shows that despite a projected 15 percent decline in enrollment during the 14-month unwinding period, projected enrollment in July 2024 will be about 10 million enrollees (about 13%) higher than the pre-pandemic month of January 2020.

Figure 1. Medicaid and CHIP Enrollment: Actual Growth and HMA's End of Unwind Projection



Medicaid spending in 2022 totaled approximately $800 billion, with 30 percent of funding coming from state/local governments and 70 percent from federal funds. Medicaid is the largest public healthcare insurance program in terms of enrollment and one of the largest in total spending. Figure 2 illustrates critical policy changes since the Medicaid program was enacted in July 1965 and the associated impact on enrollment. Despite a long history of enrollment and eligibility changes, the effects of the unwinding are unprecedented.

Figure 2. Medicaid Enrollments Since Program Inception, with Key Changes



SOURCES: Actual Medicaid enrollment through 2013 – MACPAC, Medicaid Enrollment and Total Spending Levels and Annual Growth, Ys 1970 – 2020 through 2013; Actual Medicaid and CHIP enrollment 2014 through 2020 – Kaiser Family Foundation Total Medicaid and CHIP September enrollment; unemployment rate – U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, December; Projected Medicaid and CHIP Enrollment – HMA Model

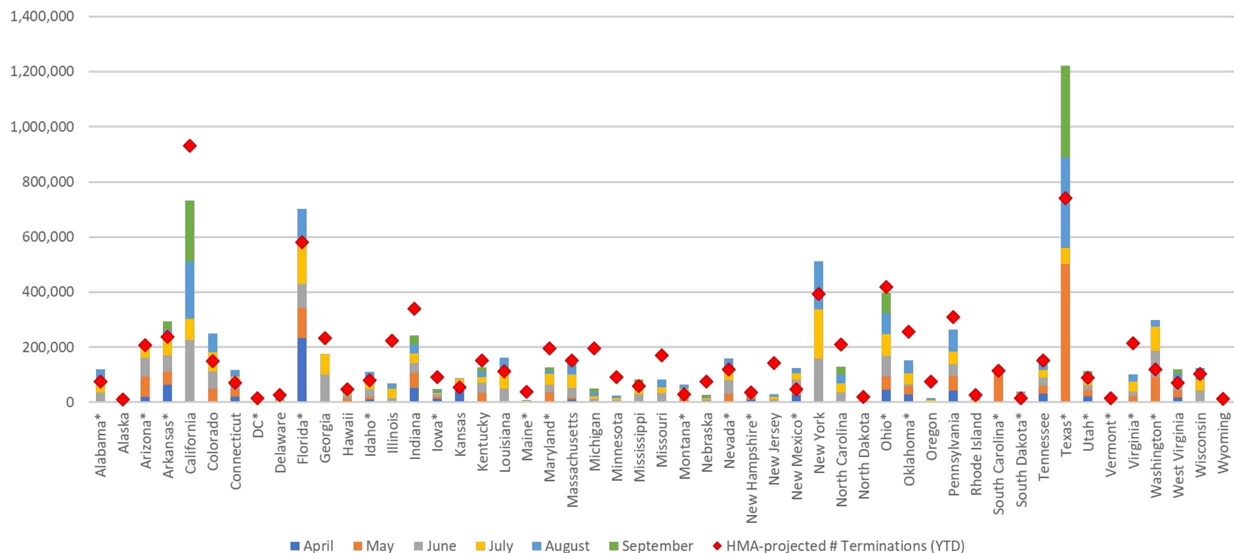
Federal and state agencies have been collaborating over the last few years in preparation for the Medicaid unwinding initiative. These entities, as well as health plans, providers, and advocacy organizations, have directed considerable resources toward informing members that redeterminations would be resuming. Yet given the enormity of the operational challenges that the unwinding poses, concerns remain that a significant number of enrollees might be incorrectly terminated from the program for reasons unrelated to their eligibility, resulting in an amplified version of the normal amount of churn in the Medicaid program. These apprehensions have grown in response to data that often show higher than anticipated numbers of total terminations and a large share of procedural terminations that occur when enrollees are nonresponsive to requests for information.

AS MIDPOINT APPROACHES, DATA SUGGEST THAT MEDICAID DISENROLLMENTS ARE CONSISTENT WITH PROJECTIONS

The HMA model combines a variety of resources to estimate Medicaid disenrollments (see Figure 3). Data from published monthly state enrollment and termination reports are compared with a by-month, by-state model that incorporates factors such as state population, employment rates, and state economic/fiscal conditions. This approach allows for monitoring and contextualizing early unwinding data while observing and

projecting state-specific trends. The model also can account for certain complexities, including the fact that enrollment data are often lagged and revised over time to account for individuals who are reinstated into the program.

Figure 3. State-Reported Disenrollments by Month Compared to HMA Disenrollment Projection



*State indicated that it is prioritizing likely ineligible populations.
Source: State-published CMS Unwinding Monthly Reports; last updated 11/1/2023

TWO OBSERVATIONS TO CONSIDER WHEN INTERPRETING DISENROLLMENT DATA

Comparing the model projections to state data reveals two key findings.

- **Most State Disenrollments Are Tracking Near Projections.** Through October, Figure 3 indicates that roughly half of the states are tracking below the level of net disenrollment that HMA projected (represented by the red diamond above the bar), whereas about half of the states have disenrolled more Medicaid beneficiaries than we projected through October (represented by the red diamond inside the bar). Although subject to change in the future, the results seem to be on target with HMA projections. It’s not a stretch to hypothesize that disenrollments are slower overall than projected given state choices to prioritize different groups of beneficiaries.

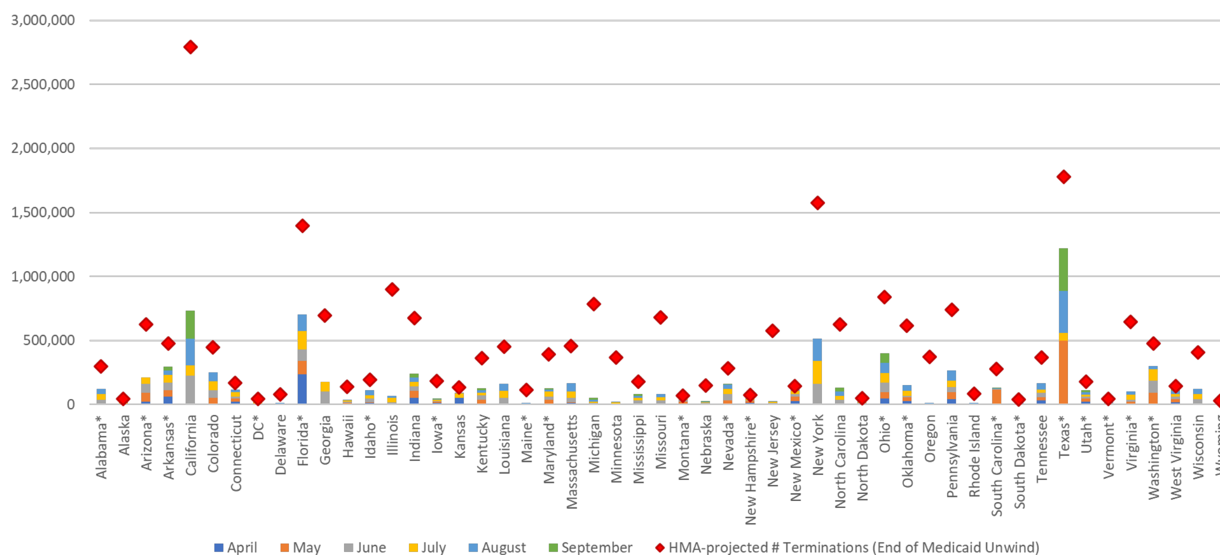
- **States That Prioritized Redeterminations for Certain Populations Have Reported More Disenrollments.** A number of states chose to prioritize eligibility reviews for the “likely ineligible” populations. Some of these states, such as Texas and Florida, have a higher than anticipated number of projected disenrollments. This outcome was anticipated because the HMA model spreads disenrollments across the duration of the unwinding period. States that have prioritized redeterminations by eligibility category (e.g., adult without children), non-utilizers, or other factors

rather than eligibility renewal dates are more likely to have early-month disenrollments greater than the even distribution of disenrollments in the model. Yet this is not the case for all states that have prioritized “likely ineligible” enrollees. Arizona and Arkansas, for example, have reported a number of disenrollments that align with projections.

FULL UNWIND DATA BETTER CONTEXTUALIZES THAT THE MEDICAID UNWINDING IS IN ITS EARLIER STAGES

Figure 4 compares the earlier months of the disenrollments with each state’s total projected disenrollment endpoint. At this point, the gap between the projected disenrollment endpoints and the monthly disenrollments is quite large in most states.

Figure 4. Still Relatively Early in the Medicaid Redetermination Process



*State indicated that it is prioritizing likely ineligible populations.
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LESSONS FOR THE FUTURE

Given the magnitude of this projected enrollment decline, compounded by the health and economic consequences of losing coverage, the immediate priorities are to minimize unnecessary coverage loss and help to transition those losing eligibility to other sources of coverage. Looking ahead, the Medicaid unwinding will hopefully help strengthen multiple aspects of public coverage programs, including eligibility policies, systems, and outreach and engagement tools. Eligibility policy has always been complex, and the unwinding experience has provided more transparency about the process, demonstrating how advocates, health plans and providers may be able to play significant roles in outreach and assistance. Better understanding of the

factors that contribute to shortcomings and successes in the unwinding process can inform longer-term reforms.

Continued comparison of monthly data with model projections will provide context and perspective. These data should also help to inform federal and state policy and programmatic decisions about managing the current enrollment and making investments in infrastructure. The HMA model has certain limitations. Currently, the model includes the different state start dates, recent Medicaid expansion additions (e.g., South Dakota), and economic and geographic factors. The model does not yet incorporate factors like redetermination policy or process revisions affected by disenrollment reports and changes to Centers for Medicare & Medicaid Services and state policy and approaches. The model was last updated early in the summer of 2023. The assumptions to that model can be accessed here. The next iteration of the model will incorporate new data and multiple new factors; it will be available in December 2023.

HMA CAN HELP

Please contact HMA experts with questions and for more information about our work with clients to address these issues. We support payers, stakeholders, states, and communities using these models to develop strategies for Medicaid redeterminations, enrollment, and coverage.

For more information, contact Matt Powers, Managing Director, mpowers@healthmanagement.com.