State-Based Exchanges (SBE) Priority Metrics: Medicaid/Children's Health Insurance Program (CHIP) Continuous Enrollment Condition Unwinding

Overview and Template 1.0 User Guide

Version 1.0

05/19/2023

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Version History

Version	Date	Author	Version Description
1.0	3/27/2023	Cognosante on behalf of CMS State Marketplace and Insurance Programs Group	Initial Medicaid/Children's Health Insurance Program Continuous Enrollment Condition Unwinding Supplemental Metrics Reporting Guide distributed to SBEs to describe reporting requirements.

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Table of Contents

SBE Priority Metrics: Medicaid/ CHIP Continuous Enrollment Condition Unwinding 4

Introduction 4

Enrollment Metrics Points of Contact 5

Submission Timeline and Reporting Periods 6

Metrics and Definitions, Footnotes, and Data Checks 7

Metrics, Definitions and Footnotes 7

Internal Template Logic Checks 15

SBE Reporting Template Technical Specifications and Instructions 16

Template 1.0 Format and Contents 16

Template 1.0 Functionality 16

Single-Value Data Validation Checks 17

Data Validation Explanations 17

Template 1.0 User Instruction 18

Step 1: Open Template 1.0 and Enable Content 18

Step 2: Populate the Title Page by Selecting the Appropriate Inputs 19

Step 3: Input Enrollment Metrics Data in the Metrics Tab 19

Step 4: Input Footnotes in the Metrics Tab 19

Step 5: Review Data and Footnotes for Accuracy and Completion 19

Step 6: Provide General Notes to Reviewers as Needed 20

Step 7: Submit the Data Submission Template to the SMIPG Enrollment Metrics Team 20

Template 1.0 Verification Instructions 20

Reporting Verification Process 20

Step 1: Confirm the Verification Date 20

Step 2: Review Data and Footnotes for Accuracy and Completion 21

Step 3: Review Data Checks 21

Step 4: Address All Follow-up Items 22

Step 5: Mark the Appropriate Verification Status 22

Step 6: Provider General Notes to Reviewers 23

Step 7: Submit the Verified Template to the SMIPG Enrollment Metrics Team 23

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Table of Exhibits

Exhibit 1: CAA Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics. 4
Exhibit 2: SMIPG Enrollment Metrics Points of Contact. 5
Exhibit 3: Submission and Verification Process – Priority Monthly Continuous Enrollment Condition Unwinding Metrics. 6
Exhibit 4: Reporting Timeline – Priority Monthly Continuous Enrollment Condition Unwinding Metrics. 6
Exhibit 5: Priority Metrics: Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics, Definitions, and Footnotes. 8
Exhibit 6: Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics: Internal Logic Checks. 15
Exhibit 7: Template 1.0 Data Collection Tab Descriptions. 16
Exhibit 8: Single Value Data Check. 17
Exhibit 9: Data Validation Explanations. 17
Exhibit 10: Enable Content. 18
Exhibit 11: Enable Excel Macros in Template 1.0. 18
Exhibit 12: Template 1.0 Title Page Inputs. 19
Exhibit 13: General Comments About this Data Submission. 20
Exhibit 14: Sample Report Date. 21
Exhibit 15: Sample Verification Follow-up Question and Response. 22
Exhibit 16: Sample Verification Status. 22
Exhibit 17: Listing Data Changes on the Verification Tab. 23

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SBE Priority Metrics: Medicaid/ CHIP Continuous Enrollment Condition Unwinding

Introduction

The Center for Consumer Information and Insurance Oversight (CCIIO) State Marketplace and Insurance Programs Group (SMIPG) collects, verifies, and reports enrollment metrics data from State-based Exchanges (SBEs) during Open Enrollment (OE) and throughout each health insurance plan year (PY).[1] SBEs will utilize these existing reporting processes during Medicaid and Children's Health Insurance Program (CHIP) Continuous Enrollment Condition Unwinding to provide SBE Priority Metrics of consumer activity as it relates to Qualified Health Plans/Advance Premium Tax Credit (QHP/APTC), and, if applicable, Basic Health Plan (BHP).[2] Data collection will follow a monthly timeline starting in May 2023 and concluding in July 2024.

As detailed in the CMS January 27, 2023 State Health Official (SHO) Letter #23-002, indicators within the SBE Priority Metrics described in this reporting guide will also satisfy the data requirements under section 1902(tt)(1) of the 2023 Consolidated Appropriations Act (CAA), as added by section 5131(b). **Exhibit 1** provides the CAA reporting elements and its corresponding Priority Metrics indicator as described in **Exhibit 5**, as well as the applicable SBE.

Exhibit 1: CAA Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics.

CAA Reporting Element	Priority Metrics	SBE
SBEs with their own platforms that use a Non-Integrated Eligibility System: Number of individuals whose accounts are received by the SBE or BHP	Indicators 7a and 7b, as applicable	CO, ID, ME, NJ, NM, NV, PA
SBEs with their own platforms that use a Non-Integrated Eligibility System: Number of individuals whose accounts are received by the SBE or BHP and are determined eligible for a QHP or BHP	Indicators 9a and 172a, as applicable	CO, ID, ME, NJ, NM, NV, PA
SBEs with their own platforms that use a Non-Integrated Eligibility System: Number of individuals whose accounts are received by the SBE or BHP and are determined eligible for a QHP or a BHP who make a QHP plan selection or are enrolled in a BHP	Indicators 1a and 169a, as applicable	CO, ID, ME, NJ, NM, NV, PA

[1] Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges, OMB #0938-1119, approved May 16, 2022.

[2] The 2023 Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA), ends the continuous enrollment condition established under section 6008 of the Families First Coronavirus Response Act on March 31, 2023, enabling states to terminate Medicaid enrollments for individuals who no longer meet Medicaid eligibility requirements on or after April 1, 2023.

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CAA Reporting Element	Priority Metrics	SBE
SBEs with Integrated Eligibility System: Number of individuals who are determined eligible for a QHP or a BHP	Indicators 9a and 172a, as applicable	CA, CT, DC, KY, MA, MD, MN, NY, RI, VT, WA
SBEs with Integrated Eligibility System: Number of individuals who are determined eligible for a QHP or BHP and make a QHP plan selection or are enrolled in a BHP	Indicators 1a and 169a, as applicable	CA, CT, DC, ID, KY, MA, MD, MN, RI, NY, VT, WA

This reporting guide summarizes the enrollment reporting metrics and definitions included in the reporting template used to collect the Continuous Enrollment Condition Unwinding metrics. It also includes information on the submission and verification process and user instructions.

Enrollment Metrics Points of Contact

Exhibit 2 lists the SMIPG Enrollment Metrics points of contact (POCs).

Exhibit 2: SMIPG Enrollment Metrics Points of Contact.

Name	Organization	Email	Phone
Enrollment Metrics Team	CCIIO and Cognosante	SBE_Enrollment_Metrics@cms.hhs.gov	(301) 492-4353
Enrollment Metrics Team	Cognosante	SBE.Enrollment.Metrics@cognosante.com	N/A

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Submission Timeline and Reporting Periods

Exhibit 3 details the sequence and processing of a priority metrics data submission during a typical reporting month. Data collection and verification will follow a monthly timeline starting May 8, 2023 and concluding July 8, 2024.

Exhibit 3: Submission and Verification Process – Priority Monthly Continuous Enrollment Condition Unwinding Metrics.

Metrics Submission	Metrics Analysis	SBE Data Verification
The 8th of the month by 12 p.m. local	**One week after metric submission**	**Three business days after verification**
• SBEs submit enrollment metrics to the SMIPG Enrollment Metrics Team via email to the email addresses identified in **Exhibit 2**.	• The SMIPG Enrollment Metrics Team reviews submissions. • If the SMIPG Enrollment Metrics Team identifies any follow-up items or discrepancies in the SBEs' submissions, the Team emails those SBEs only. • If the SMIPG Enrollment Metrics Team does not identify any follow-up items in the SBEs' submissions, the Team sends confirmation emails to those SBEs.	• SBEs that receive follow-up emails verify data and address all items included in the verification request. • The SMIPG Enrollment Metrics Team reviews the updated submission and follows up with the SBE to inform the SBE that further information is needed or the response is sufficient.

Exhibit 4 provides submission timelines for all Continuous Enrollment Condition Unwinding reporting periods from May 8, 2023 to July 8, 2024. To meet the CAA requirement, SBEs will submit the metrics for all months by the submission date, even if it has not received or processed any Medicaid/CHIP Continuous Enrollment Condition Unwinding applications or consumers during the reporting period. In those cases, the SBE should report the metric as zero and include a footnote.

SBEs will submit their data on the eighth calendar day of the month for the reporting period ending on the last day of the month prior. Should the eighth calendar day fall on a weekend or federal holiday, data are due on the next business day.

Exhibit 4: Reporting Timeline – Priority Monthly Continuous Enrollment Condition Unwinding Metrics.

Number	Submission Date (By 12 p.m. local time, unless otherwise noted)	Reporting Period
1	May 8, 2023	April 1, 2023–April 30, 2023
2	June 8, 2023	May 1, 2023–May 31, 2023
3	July 10, 2023	June 1, 2023–June 30, 2023
4	August 8, 2023	July 1, 2023–July 31, 2023
5	September 8, 2023	August 1, 2023–August 31, 2023
6	October 9, 2023	September 1, 2023–September 30, 2023
7	November 8, 2023	October 1, 2023–October 31, 2023
8	December 8, 2023	November 1, 2023–November 30, 2023

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Number	Submission Date (By 12 p.m. local time, unless otherwise noted)	Reporting Period
9	January 8, 2024	December 1, 2023–December 31, 2023
10	February 8, 2024	January 1, 2023–January 31, 2024
11	March 8, 2024	February 1, 2023–February 29, 2024
12	April 8, 2024	March 1, 2023–March 31, 2024
13	May 8, 2024	April 1, 2023–April 30, 2024
14	June 10, 2024	May 1, 2023–May 31, 2024
15	July 8, 2024	June 1, 2023–June 30, 2024

Metrics and Definitions, Footnotes, and Data Checks

The following describes and defines the enrollment reporting metrics and definitions that are included within Template 1.0, which SBEs will submit during the Medicaid/CHIP Continuous Enrollment Condition Unwinding period.

Metrics, Definitions and Footnotes

Exhibit 5 lists the priority metrics collected in Template 1.0. The exhibit also includes the footnotes that have been pre-populated in the template from which SBEs can select. For each footnote selected, SBEs are asked to provide further explanation in the Expanded Footnotes column. SBEs should select one or more pre-populated footnotes for each metric to designate when it is unavailable for reporting and should add any extra state-specific footnotes in the Expanded Footnotes column to clarify their data.

The priority metrics include indicators that are specific to Medicaid/CHIP continuous enrollment unwinding activities. For those metrics, SBEs should count activities that were initiated through the Medicaid/CHIP agency's renewal process, in which a consumer was determined ineligible for limited or full benefit Medicaid or CHIP. Cases/applications can be received through an SBE's integrated system, an account transfer, or directly from a consumer. Generally, applications/consumers terminated from Medicaid/CHIP due to procedural or administrative reasons (e.g., failed to respond to a request for information) that are received by an SBE via its integrated system or account transfer process should not be included. However, a consumer terminated from Medicaid/CHIP due to a procedural reason who subsequently applies independently to the SBE should be included if the SBE is able to identify those cases. SBEs should include footnotes in the Expanded footnotes column with any deviations from this definition.

Please note that all metrics should be reported during the reporting period month in which the relevant Marketplace activity occurs. For example, SBEs should count applications, for which a QHP eligibility determination can be made, at the time that the application is received by the Marketplace in the applicable metric breakouts. Furthermore, SBEs should count plan selections on these received applications during the reporting month in which the plan selection is made.

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Exhibit 5: Priority Metrics: Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics, Definitions, and Footnotes.

Measure Title	Definition	Pre-populated Footnotes	Additional Notes
1. Total Plan Selections	Count of unique individuals who have selected or automatically enrolled in a Marketplace medical plan. Count includes all new and re-enrolling consumers regardless of whether the consumer has paid the first month premium.	N/A	Count does not include plans that were selected but then canceled during the reporting month.
1a. Plan Selections, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by a Marketplace due to Medicaid/CHIP denial or termination determined eligible for a QHP (Indicator 9a), who have selected or were automatically enrolled in a Marketplace medical plan. This count is a subset of Total Plan Selections (Indicator 1).	• The breakouts of active and automatic plan selections, Medicaid/CHIP renewal do not sum to the total.	Count does not include plans that were selected but then canceled during the reporting month.
1a.1. Active Plan Selections, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by a Marketplace due to Medicaid/CHIP denial or termination determined eligible for a QHP (Indicator 9a), who have actively selected a Marketplace medical plan. This count is a subset of Plan Selections, Medicaid/CHIP Renewal (Indicator 1a).	N/A	For SBEs that make automatic plan assignments for individuals requesting coverage on applications, this metric may include plan selections from individuals who opt out of an automatic plan assignment and actively select their own plan.

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
1a.2. Automatic Plan Selections, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by a Marketplace due to Medicaid/CHIP denial or termination determined eligible for a QHP (Indicator 9a), who were automatically enrolled into a Marketplace medical plan. This count is a subset of Plan Selections, Medicaid/CHIP Renewal (Indicator 1a).	N/A	This metric should be noted as N/A if not applicable
6. Number of Submitted Applications	Total count of submitted electronic and paper applications. This metric includes new and renewal applications. Updated applications should not be counted as an additional application.	N/A	A submitted application is one in which a QHP eligibility determination can be made.
6a. Number of Submitted Applications, Medicaid/CHIP Renewal	Total count of submitted applications that were received by the Marketplace due to a Medicaid/CHIP denial or termination. This count is a subset of Number of Submitted Applications (Indicator 6).	• This count does not include applications in which a consumer was terminated from Medicaid/CHIP and subsequently applied independently to the SBE. • This count may include duplicate applications for consumers who were terminated from Medicaid/CHIP and subsequently applied independently to the SBE.	For integrated SBEs, this count should include “in process” applications received by the Marketplace, in which a QHP eligibility determination can be made. For non-integrated SBEs, this should include all applications including those account transfers or referrals (reported in 6b) that become complete applications (i.e., after consumer action is taken).

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
6b. Number of Account Transfers or Referrals, Medicaid/CHIP Renewal This metric only applies to non-integrated SBEs that do not receive complete applications from the Medicaid/CHIP agency: CO, ID, ME, NJ, NM, NV, PA.	Total count of account transfers or referrals (non-applications) that were received by the Marketplace due to a Medicaid/CHIP denial or termination, in which a QHP eligibility determination cannot be made. Account transfers/referrals counted in this metric that subsequently result in a submitted application should also be counted in indicator 6 and 6a. This metric in NOT a subset of Number of Submitted Applications (Indicator 6).	N/A	Account transfers or referrals include all partial applications or other consumer information transferred to the SBE following a Medicaid/CHIP agency's annual renewal process, in which a consumer was determined ineligible for limited-scope or full Medicaid or CHIP. This count includes all account transfers or referrals (partial applications) even those that become complete applications after consumer action is taken and are reported in 6 and 6a during the applicable monthly reporting period. This metric should be noted as N/A if not applicable.
7. Consumers on Applications Submitted	Total count of individuals requesting coverage on submitted applications (Indicator 6).	N/A	
7a. Consumers on Applications Submitted, Medicaid/CHIP Renewal	Total count of individuals requesting coverage on submitted applications (Indicator 6a) that were received by the Marketplace due to a Medicaid/CHIP denial or termination. This count is a subset of Consumers on Applications Submitted (Indicator 7).	• This count does not include consumers who were terminated from Medicaid/CHIP and subsequently applied independently to the SBE. • This count may include duplicate consumers who were terminated from Medicaid/CHIP and subsequently applied independently to the SBE.	

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
7b. Consumers on Transfers or Referrals, Medicaid/CHIP Renewal This metric only applies to non-integrated SBEs that do not receive complete applications from the Medicaid/CHIP agency: CO, ID, ME, NJ, NM, NV, PA.	Total count of individuals on account transfers or referrals (non-applications) that were received by the Marketplace due to a Medicaid/CHIP denial or termination, in which a QHP eligibility determination could not be made. Consumers that subsequently submit a complete application should also be counted in indicators 7 and 7a. This metric in NOT a subset of Consumers on Applications Submitted (Indicator 7).	N/A	This metric should be noted as N/A if not applicable.
9. Consumers Eligible for QHP	Count of individuals on submitted applications who were determined eligible for enrollment in a Marketplace medical plan, regardless of whether they applied for or are eligible for financial assistance. Both new consumers and consumers re-enrolling (automatic and active) in coverage should be counted. This count is a subset of Consumers on Applications Submitted (Indicator 7). Eligibility for Medicaid/CHIP takes precedence over eligibility for a QHP without financial assistance. Individuals determined eligible for both Medicaid/CHIP and a non-financial QHP should not be counted.	N/A	

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
9a. Consumers Eligible for QHP, Medicaid/CHIP Renewal	Count of individuals on submitted applications received by a Marketplace due to a Medicaid/CHIP denial or termination (Indicator 7a), who were determined eligible for enrollment in a Marketplace medical plan. This count is also a subset of Consumers Eligible for QHP (Indicator 9).	N/A	
9.1. Consumers Eligible for QHP with Financial Assistance	Count of individuals on submitted applications (Indicator 7) who were determined eligible for enrollment in a Marketplace medical plan and eligible to receive APTC and/or CSRs. This count is also a subset of Consumers Eligible for QHP (Indicator 9).	• The definition includes consumers eligible to receive APTC equal to or greater than $0.	
9.1a. Consumers Eligible for QHP with Financial Assistance, Medicaid/CHIP Renewal	Count of individuals on submitted applications received by a Marketplace due to a Medicaid/CHIP denial or termination (Indicator 7a), who were determined eligible for enrollment in a Marketplace medical plan and eligible to receive APTC and/or CSRs. This count is also a subset of Consumers Eligible for QHP with Financial Assistance (Indicator 9.1).	• The definition includes consumers eligible to receive APTC equal to or greater than $0.	

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
21. Number of Plan Selections with Financial Assistance –	Count of unique individuals with a non-canceled Marketplace medical plan selection, where the consumer has elected to receive APTC in an amount greater than $0 and/or receives CSR. This count includes consumers with APTC and CSRs, consumers with only APTC, and consumers with only CSRs.	• Count of consumers includes individuals who elect to receive APTC in an amount of $0 or greater.	Count does not include plans that were selected but then canceled during the reporting month.
21a. Number of Plan Selections with Financial Assistance, Medicaid/CHIP Renewal	Count of unique individuals on applications received by the Marketplace due to a Medicaid/CHIP denial or termination, where the consumer has elected to receive APTC in an amount greater than $0 and/or receives CSR. This count includes consumers with APTC and CSRs, consumers with only APTC, and consumers with only CSRs. This count is a subset of Number of Plan Selections with Financial Assistance (Indicator 21).	• Count of consumers includes individuals who elect to receive APTC in an amount of $0 or greater.	Count does not include plans that were selected but then canceled during the reporting month.
169. Total BHP Enrollees	Count of unique individuals on submitted applications (Indicator 7) who were determined eligible for and enrolled in BHP. Count does not include enrollments that were canceled or individuals enrolled in Medicaid/CHIP programs that are not BHP.	N/A	
169a. BHP Enrollees, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by the Marketplace due to a Medicaid/CHIP denial or termination (Indicator 7a), who were determined eligible for and enrolled in BHP.	N/A	

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Measure Title	Definition	Pre-populated Footnotes	Additional Notes
172. Consumers Eligible for BHP	Count of all individuals on submitted applications (Indicator 7) who were determined or assessed eligible for BHP. Only individuals on submitted applications and requesting coverage are included. Count all individuals determined/assessed eligible even if the individual does not subsequently enroll in coverage.	N/A	
172a. Consumers Eligible for BHP, Medicaid/CHIP Renewal	Count of all individuals on submitted applications received by the Marketplace due to a Medicaid/CHIP denial or termination (Indicator 7a), who were determined or assessed eligible for BHP. Only individuals on submitted applications and requesting coverage are included. Count all individuals determined/assessed eligible even if the individual does not subsequently enroll in coverage.	N/A	

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Internal Template Logic Checks

Exhibit 6 lists the metric logic checks incorporated into Template 1.0.

Exhibit 6: Medicaid/CHIP Continuous Enrollment Condition Unwinding Metrics: Internal Logic Checks.

Logic Check	Relevant Equation	Impact
Total Plan Selections ≥ Plan Selections, Medicaid/CHIP Renewal	Indicator 1 ≥ Indicator 1a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Plan Selections, Medicaid/CHIP Renewal = Active Plan Selections, Medicaid/CHIP Renewal + Automatic Plan Selections, Medicaid/CHIP Renewal	Indicator 1a = Indicator 1a.1 + Indicator 1a.2	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Number of Submitted Applications ≥ Number of Submitted Applications, Medicaid/CHIP Renewal	Indicator 6 ≥ Indicator 6a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers on Applications Submitted ≥ Consumers on Applications Submitted, Medicaid/CHIP Renewal	Indicator 7 ≥ Indicator 7a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP ≥ Total Plan Selections	Indicator 9 ≥ Indicator 1	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP ≥ Consumers Eligible for QHP, Medicaid/CHIP Renewal	Indicator 9 ≥ Indicator 9a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP ≥ Consumers Eligible for QHP, with Financial Assistance	Indicator 9 ≥ Indicator 9.1	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP, with Financial Assistance ≥ Consumers Eligible for QHP with Financial Assistance, Medicaid/CHIP Renewal	Indicator 9.1 ≥ Indicator 9.1a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP with Financial Assistance ≥ Number of Plan Selections with Financial Assistance	Indicator 9.1 ≥ Indicator 21	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Number of Plan Selections with Financial Assistance ≥ Number of Plan Selections with Financial Assistance, Medicaid/CHIP Renewal	Indicator 21 ≥ Indicator 21a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Consumers Eligible for QHP with Financial Assistance, Medicaid/CHIP Renewal ≥ Number of Plan Selections with Financial Assistance, Medicaid/CHIP Renewal	Indicator 9.1a ≥ Indicator 21a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.
Total BHP Enrollees ≥ BHP Enrollees, Medicaid/CHIP Renewal	Indicator 169 ≥ Indicator 169a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.

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Logic Check	Relevant Equation	Impact
Consumers Eligible for BHP ≥ Consumers Eligible for BHP, Medicaid/CHIP Renewal	Indicator 172 ≥ Indicator 172a	If data check is untrue, font of associated indicator values and entry in Data Validations tab turns red.

SBE Reporting Template Technical Specifications and Instructions

Template 1.0 Format and Contents

Template 1.0 includes multiple data collection tabs, as described in **Exhibit 7** below.

Exhibit 7: Template 1.0 Data Collection Tab Descriptions.

Tab Name	Description
Title Page	Provides general information about the data submission, including the report date, state name, and the type of data submitted.
Metrics	Contains high-level enrollment metrics pertaining to plan selections, applications, eligibility determinations, and BHP enrollment.
Data Validations	Lists the data validation checks in the Metrics tab and their definitions. Indicates failed validation with red font.
Verification	Contains data entry fields for SBEs to review and answer follow-up questions, verify data, and provide general explanatory comments to the SMIPG Enrollment Metrics Team.

Template 1.0 Functionality

Template 1.0 is a macro-enabled Excel workbook that displays data collection worksheets (called "templates"), based on SBE inputs provided during the enrollment metrics reporting process. SBEs select their state, submission date, and report submission type from drop-down lists on the Title Page tab, and the appropriate reporting templates are auto-generated for completion. Each data collection template contains visual data validation checks that use conditional formatting and pre-determined logic to aid SBEs during the data input process. The data validation checks allow SBEs to easily identify data discrepancies by highlighting values that violate reporting logic with red font.

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Single-Value Data Validation Checks

Template 1.0 contains multiple single-value data validation checks to ensure that SBE data are internally consistent throughout the template and aligns to SMIPG's reporting expectations. When SBE data violate the pre-determined logic, the values are highlighted with red font. Refer to **Exhibit 8**.

Exhibit 8: Single Value Data Check.

INDICATOR		MEASURE TITLE	MEASURE DEFINITION	METRIC
	1	Total Plan Selections	Count of unique individuals who have selected or automatically enrolled in a Marketplace medical plan. Count includes all new and re-enrolling consumers regardless of whether the consumer has paid the first month premium. Count does not include plans that were canceled.	75,046
	1a	Plan Selections, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by a Marketplace due to Medicaid/CHIP denial or termination determined eligible for a QHP (Indicator 9a), who have selected or were automatically enrolled in a Marketplace medical plan. This count is a subset of Total Plan Selections (Indicator 1).	24,521
	1a.1	Active Plan Selections, Medicaid/CHIP Renewal	Count of unique individuals on submitted applications received by a Marketplace due to Medicaid/CHIP denial or termination determined eligible for a QHP (Indicator 9a), who have actively selected a Marketplace medical plan. This count is a subset of Plan Selections, Medicaid/CHIP Renewal (Indicator 1a).	12,000

Data Validation Explanations

The Data Validations tabs indicate all data validation rules that have been broken. Any metric value displayed in red font will have a row in the corresponding "Data Validations" tab that will also be red to explain why the value is red and provide the related formula. A single metric value may turn red for multiple reasons. The user can search and/or filter the "Affected Indicators" column of the Data Validations tabs for a single indicator number to quickly identify all of the logic checks that include that particular indicator number.

Exhibit 9: Data Validation Explanations.

Affected Indicators	Logic Check	Relevant Equation
1, 1a	Total Plan Selections ≥ Plan Selections, Medicaid/CHIP Renewal	Indicator 1 ≥ Indicator 1a
1a, 1a.1, 1a.2	Plan Selections, Medicaid/CHIP Renewal = Active Plan Selections, Medicaid/CHIP Renewal + Automatic Plan Selections, Medicaid/CHIP Renewal	Indicator 1a = Indicator 1a.1 + Indicator 1a.2
6, 6a	Number of Submitted Applications ≥ Number of Submitted Applications, Medicaid/CHIP Renewal	Indicator 6 ≥ Indicator 6a
7, 7a	Consumers on Applications Submitted ≥ Consumers on Applications Submitted, Medicaid/CHIP Renewal	Indicator 7 ≥ Indicator 7a
9, 1	Consumers Eligible for QHP ≥ Total Plan Selections	Indicator 9 ≥ Indicator 1

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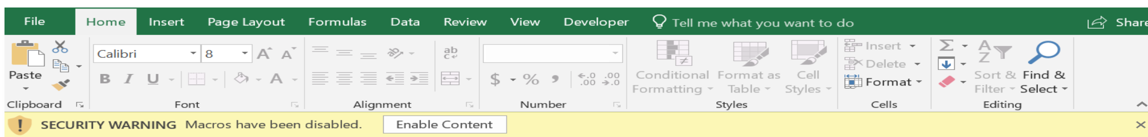
Template 1.0 User Instruction

Follow these key steps for populating and submitting enrollment metrics data in Template 1.0.

Step 1: Open Template 1.0 and Enable Content

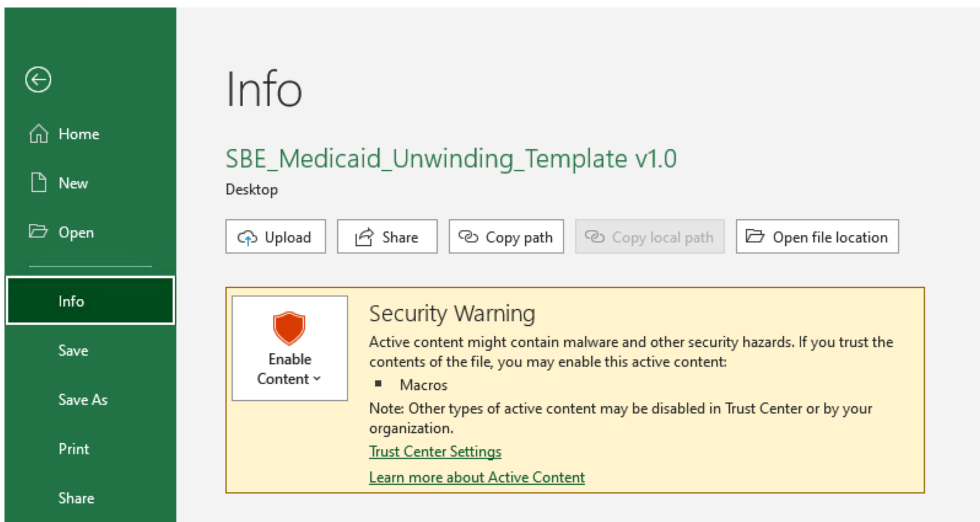
Open Template 1.0 and click ***Enable Content*** in the toolbar to enable macros. Refer to **Exhibit 10**.

Exhibit 10: Enable Content.



If the security warning does not appear in the toolbar when the template is opened, enable macros by clicking ***File*** in the toolbar. From the Enable Content drop-down, select ***Enable All Content***. Refer to **Exhibit 11**.

Exhibit 11: Enable Excel Macros in Template 1.0.



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Step 2: Populate the Title Page by Selecting the Appropriate Inputs

Insert today's date in cell A3 to indicate the date of the report submission. In the "State and Submission Detail" section, select your state and the correct report submission type from the drop-down menus. Upon making your selections, the Metrics and Data Validations tabs will appear. You also need to enter your Reporting Period Start Date and Reporting Period End Date; it is especially important to complete these fields if your Reporting Period differs from the standard listed in **Exhibit 4**. Refer to **Exhibit 12**.

Exhibit 12: Template 1.0 Title Page Inputs.

Medicaid/CHIP Continuous Coverage Unwinding Data Submission

Template 1.0 Version 1.0 - 3/27/2023
Form Pending Approval

Center for Consumer Information and Insurance Oversight (CCIIO)

OMB No: 0938-1119

Today's Date: Enter Date

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Instructions:
*Please select your state and the correct report submission date below to automatically generate the appropriate reporting template(s). To complete your enrollment data submission, populate the workbook and submit it to SBE_Enrollment_Metrics@cms.hhs.gov and SBE.Enrollment.Metrics@Cognosante.com. By submitting your data file, you are confirming the accuracy of **all** enrollment metrics data included herein.*

Please Enter Your State and Submission Detail:	
State	*Select your State*
Report Submission Type	*Select Report Submission Date*
Reporting Period Start Date	
Reporting Period End Date	
General Comments About this Data Submission:	

Step 3: Input Enrollment Metrics Data in the Metrics Tab

Populate the Metrics tab by adding numeric values in Column E for each indicator. If data are not available or your SBE does not collect an indicator, input "N/A" into each of the relevant cells. If the data value is "0," the SBE should enter "0." SBEs should include a comprehensive footnote beside each indicator marked "N/A" or "0," explaining why data is absent or omitted.

NOTE: Populate all cells with numeric values or "N/A" to ensure that each indicator in Template 1.0 is assigned a value. SBEs will be asked to populate all blank cells during the verification process.

Step 4: Input Footnotes in the Metrics Tab

Add explanatory footnotes beside each indicator, as needed. All relevant footnotes should be selected from Column F using the Excel drop-down menu. The template is formatted to allow SBEs to select multiple footnotes. SBEs are encouraged to select multiple footnotes, as needed. If the relevant footnote includes instructions to provide further information or clarification, SBEs should enter this information as free-form text in the "Expanded Footnotes" column (Column G).

NOTE: SBEs should select all relevant footnotes from the "Footnotes" column (Column F) and provide as much detail as possible in Column G to ensure accurate reporting.

Step 5: Review Data and Footnotes for Accuracy and Completion

Review all data and footnotes included in the file for accuracy and completion, addressing each of the embedded logic checks. All values highlighted in red font should be corrected or explained through clarifying footnotes.

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Step 6: Provide General Notes to Reviewers as Needed

Provide general notes, as needed, to explain the contents of your data submission in the "General Comments About this Data Submission" section of the Title Page tab. Refer to **Exhibit 13**.

Exhibit 13: General Comments About this Data Submission.

General Comments About this Data Submission:
Use this box to provide general notes about your data, as needed. For example, please delete this text and include notes about deviations from the reporting period (e.g., if your state's data submission represents data for a different date range, or if your state ran automatic renewals or some other large batch process). *Note: If you have a comment about a specific metric, please do not include it here. Rather, select or provide your metric-specific notes beside the specific metric in the footnotes columns on the appropriate tabs.*

Step 7: Submit the Data Submission Template to the SMIPG Enrollment Metrics Team

Save the file using the following naming convention: State Abbreviation_Metric Type Data Submission_Today's Date (e.g., CA_Medicaid Unwinding Data Submission_05-08-23). Email the file to the POCs listed above in **Exhibit 2**. CMS presumes the SBEs have submitted accurate data, unless the SBE notifies CMS of any potential discrepancies.

Template 1.0 Verification Instructions

The SMIPG Enrollment Metrics Team reviews each SBE's data submission for accuracy and completion, and requests verification from SBEs when follow-up items or discrepancies are identified. SBEs should follow the instructions below, which outline the key steps to verify their enrollment metrics data submission in Template 1.0 during Medicaid/CHIP Continuous Enrollment Condition Unwinding metrics reporting.

Reporting Verification Process

During Medicaid/CHIP Continuous Enrollment Condition Unwinding monthly reporting periods, the SMIPG Enrollment Metrics Team reviews data submissions upon receipt to identify discrepancies or data entry errors. If the team identifies any items that require attention, the team will email the SBE to request clarification or updates within one business day of receiving the data submission. SBEs should address all follow-up items as soon as possible, but no later than one business day following receipt of the data verification questions, to ensure CCIIO is able to report timely and accurate data to CMS stakeholders.

If the SMIPG Enrollment Metrics Team does not identify any immediate follow-up items, the Team will email SBEs a confirmation acknowledging that no follow-up items were identified.

If you receive a verification request, please complete the verification steps outlined below and return your completed verification file via email to the enrollment metrics contacts identified above in **Exhibit 2** by the deadline identified in the verification email.

Step 1: Confirm the Verification Date

Confirm the date in the top-left corner of the Verification tab is today's date. If the date is not accurate, provide the correct date by entering an updated value in the cell.

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Exhibit 14: Sample Report Date.

Health Insurance Exchange Enrollment Data Verification
Center for Consumer Information and Insurance Oversight (CCIIO)

Date: Enter Date

CMS

Instructions: *Please review your data submission, indicate the correct verification status, address the specific follow-up items listed below, and provide general notes as needed. Return your completed submission to SBE_Enrollment_Metrics@cms.hhs.gov and SBE.Enrollment.Metrics@Cognosante.com. Your data will not be considered verified unless you have marked one, **and only one,** of the verification status options below. By submitting your verification file, you are confirming the accuracy of **all** enrollment metrics data included herein.*

Step 2: Review Data and Footnotes for Accuracy and Completion

Review the data and footnotes in the template for accuracy and completion. If you need to provide new or updated data for any indicator(s), input the correct data in the corresponding data submission tab and note the correction in the box titled “General Notes Provided by State,” on the Verification tab.

Step 3: Review Data Checks

Review and address all data checks to ensure your SBE’s data satisfy the pre-determined logical conditions listed above. If you need additional time to review your data, please notify the SMIPG Enrollment Metrics Team and provide a timeline for resolution.

NOTE: SMIPG provides multiple enrollment metrics reports to CMS stakeholders to support program oversight. It is important for SBEs to address all verification items as quickly and accurately as possible to ensure accurate and timely reporting.

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Step 4: Address All Follow-up Items

Address each of the items listed in the “Specific Items for Follow-Up” section by responding in the corresponding “Resolution” cell. Refer to **Exhibit 15**. Please provide as much detail as possible in your responses to ensure accurate reporting.

Exhibit 15: Sample Verification Follow-up Question and Response.

Specific Items for Follow-Up			
Follow-Up Item		Resolution (Provided by State)	
1	Can the state explain why the total number of plan selections reported for Indicator 1 is greater than the number of consumers eligible for QHP reported for Indicator 9?	1	There was an error in the query that has been resolved. Indicator 9 has been updated.
2		2	
3		3	
4		4	

Step 5: Mark the Appropriate Verification Status

After completing Steps 1–4, indicate the appropriate verification status by marking one of the verification status boxes with an “X.” If the data in the original submission is correct, select the first status option. If new or updated data are provided in the verification file, select the second option. SBEs should only select one verification status. Although SBEs are requested to verify data by marking the status boxes to assist with data review, CMS presumes the accuracy of data submitted by the SBE, unless otherwise notified of any potential discrepancies. Refer to **Exhibit 16**.

Exhibit 16: Sample Verification Status.

Verification Status	
Please indicate the correct verification status by marking the appropriate statement below with an "X"	
	The state verifies the data as it appears in this template without any modifications during the verification process. The state further acknowledges that all follow-up items listed below have been sufficiently addressed.
	The state is providing data changes and/or new data in this template, as described in the "General Notes Provided by State" section below. All other data has been reviewed and verified. The state further acknowledges that all follow-up items listed below have been sufficiently addressed.

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Step 6: Provider General Notes to Reviewers

Provide general explanatory notes and list all indicators that were modified during the verification process in the "General Notes Provided by State" box. If your SBE does not have any explanatory notes or data changes, write "None." Refer to **Exhibit 17** for guidance on how to list data changes.

Exhibit 17: Listing Data Changes on the Verification Tab.

General Notes Provided by State
Please list all data changes and provide explanatory notes to assist reviewers during analysis of your state's data.
The state provided updated data for the following indicators: 1, 6a, and 7a.

Step 7: Submit the Verified Template to the SMIPG Enrollment Metrics Team

Save the file using the following naming convention: State Abbreviation_Metric Type Verified_Today's Date (e.g., NY_ Medicaid Unwinding Data Verified_05-10-23). Send the file to the points of contact listed in **Exhibit 2** above.

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