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An Introduction to Medicaid and CHIP Eligibility and Enrollment Performance Measures

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) recently established 12 new Medicaid and CHIP eligibility and enrollment performance indicators for states to report beginning in October 2013. These indicators provide insight into the performance of new eligibility and enrollment policies established under the Affordable Care Act (ACA). In December 2013, CMS released initial reports for a subset of the indicators. This brief provides an overview of the new performance indicators; the initial data; and the opportunities and challenges associated with reporting, analyzing, and interpreting the data. In sum it finds:

- Reporting of the new eligibility and enrollment performance indicators marks a significant improvement in timely and actionable data reporting for Medicaid and CHIP.
- The initial reported data suggest that enrollment in Medicaid and CHIP was off to a strong start since the beginning of open enrollment for the new Health Insurance Marketplaces.
- States are in varying stages of readiness to report the indicators, and data gaps and limitations constrain analysis of early data.
- CMS will update the performance indicators monthly and, over time, plans to report the full set of measures, which will offer a broader view of Medicaid and CHIP eligibility and enrollment performance.
- As the quality and completeness of the performance data improve, they will provide more insight into program operations and allow for greater analysis both within and across states over time.

BACKGROUND

The ACA makes key changes to Medicaid eligibility and enrollment. One key way the ACA seeks to reduce the number of uninsured is through an expansion of Medicaid eligibility to nearly all low income adults with incomes at or below 138% FPL. As enacted in the law, this expansion would occur nationwide, but the Supreme Court ruling on the ACA effectively made the expansion a state option. As of December 2013, 25 states and DC are moving forward with the expansion in 2014. The ACA also establishes new streamlined Medicaid eligibility and enrollment policies and a single application for Medicaid, CHIP, and subsidized Marketplace coverage. All states must implement these simplifications, which are designed to connect people to coverage regardless of where or through what means a person applies for coverage, regardless of whether they implement the expansion.[1] Performance data will be important for understanding the impact of these policies.

To implement the new eligibility and enrollment policies, most states needed to make major upgrades to their Medicaid eligibility and enrollment systems, providing an opportunity to improve data collection and reporting capacity. To support this work, CMS made available a substantially enhanced 90 percent federal matching rate for systems development. CMS also set a data reporting standard for the new systems to meet in order for states to qualify for the enhanced funding. Through a series of subsequent regulations and policy guidance, CMS indicated an intention to establish performance measures and, in August 2013, released 12 eligibility and enrollment performance indicators for states to begin reporting as of October (Box 1). However, by the time the indicators were released in August, many states had completed the bulk of their system builds, while others were still working with legacy systems, making it difficult for some states to accommodate the reporting requirements. Some states indicated that it will take time before they will be able to report the data as requested and that they will need to re-program their systems or manually extract data to do so.[2]

Box 1: CMS Guidance to Establish Medicaid and CHIP Eligibility and Enrollment Performance Data

April 2011: CMS established a 90 percent federal matching rate for state development of systems that support streamlined eligibility and enrollment processes and set data reporting and other standards for the systems to meet to qualify for the enhanced funding.[3]

March 2012: CMS issued interim final regulations to implement ACA eligibility policies, which described an intention to create eligibility and enrollment performance measures for states and broad parameters of such measures.

January 2013: CMS issued a request for information (RFI), proposing for public comment 17 indicators related to eligibility and enrollment and 14 indicators related to provider enrollment and payment.

August 2013: CMS issued a set of 12 Medicaid eligibility and enrollment performance indicators and provided definitions and specifications for each measure, which states began reporting in October.

December 2013: The first monthly report for a subset of the data was released.

KEY FINDINGS

Reporting of the new eligibility and enrollment performance indicators marks a significant improvement in timely and actionable data reporting for Medicaid and CHIP. States and the federal government have used performance data for many years for reporting, management, and evaluation, but reporting of timely and high-quality data has historically been inconsistent. Many states have been limited in their ability to utilize performance data because they have been relying on outdated or fragmented systems that do not provide for the collection and reporting of data.[4] At the federal level, state-reported data are aggregated and used for national reporting on enrollment, spending, use of services, and quality. However, to date, there have been limitations in the timeliness, consistency, quality, and scope of these national data.[5] Since 2009, CMS has undertaken cross-cutting efforts to improve the strength of Medicaid and CHIP data reporting and increase the use of these data in measuring program performance and informing decision-making.[6] The new eligibility and enrollment performance indicators are the first major product of this effort and will provide some of timeliest data on Medicaid eligibility that have ever been reported.

Preliminary reported data suggest that enrollment in Medicaid and CHIP was off to a strong start since the beginning of open enrollment for the new Health Insurance Marketplaces. In December 2013, CMS reported on a subset of the performance indicators, focused on the number of applications received and the number of eligibility determinations made in October and November 2013 (Table 1). All 50 states and DC reported one or more of the measures, which is significant given the first-time nature of this data reporting. The data show that during October and November 2013:

- **More than 4.2 million applications were submitted directly to Medicaid and CHIP agencies.** These reflect applications for states' existing Medicaid and CHIP programs as well as for adults who became newly eligible for coverage in states that are implementing the Medicaid expansion effective January 2014.[7] In addition, State-Based Marketplaces (SBMs) received some 549,373 applications for Medicaid, CHIP, or advance premium tax credits for Marketplace coverage.
- **Together, state Medicaid agencies and SBMs made nearly 3.9 million total new determinations for Medicaid and CHIP.** These reflect determinations for all Medicaid eligibility groups, not just for adults made newly eligible for Medicaid by the ACA's Medicaid expansion. The bulk of the determinations were for Medicaid, reflecting the program's broader size and scope. The number of Medicaid and CHIP applications received and determinations made were lower in November than in October, which CMS attributed to the preliminary nature of the November data and fewer work days.
- **The data do not reflect Medicaid and CHIP applications initiated through the Federally-Facilitated Marketplace (FFM), which is determining or assessing Medicaid eligibility in 36 states.** In separate data, HHS reported that as of the end of November 2013, the FFM and SBMs had determined or assessed just over 803,000 individuals as eligible for Medicaid or CHIP, with most (534,000) performed by SBMs.[8] However, the Marketplace data aggregates Medicaid and CHIP determinations and assessments and it is not directly comparable to the determination data released by CMS. When CMS begins reporting the full set of performance indicators, they will provide more comprehensive information on Medicaid enrollment.

States are in varying stages of readiness to report the indicators, and data gaps and limitations constrain analysis of early data. Because states are continuing to develop their reporting capabilities, some were not able to report all of the indicators and some reported preliminary data. Moreover, the reported data are not consistent across states. For example, some states include data for CHIP or renewals in their application data, while others do not. In addition, there are some issues that arise from how the data are reported. For example, some types of applications that were counted as submissions to Medicaid and CHIP agencies in the baseline data are counted as submissions to SBMs in October and November, and the number of submitted applications does not equal the number of individuals applying for coverage, because more than one person may be included on an application. Many of these limitations reflect the first-time nature of the data collection, challenges in collecting consistent data across states, and operational and reporting differences across different entities (Medicaid and the SBMs). These limitations restrict the ability to draw significant conclusions and to make cross-state comparisons. Reporting will improve over time as states and CMS gain experience and retool the systems with which they collect data.

Table 1: Medicaid and CHIP Applications and Determinations, October 1, 2013 – November 30, 2013				
State	**Type of Marketplace***	**New Applications Submitted to Medicaid/CHIP Agencies**	**Applications for Financial Assistance Submitted to SBM**	**Total New Medicaid/CHIP Determinations**
Total		**4,209,742**	**549,373**	**3,926,068**
Implementing Medicaid Expansion in 2014				
Arizona	FFM	298,066	N/A	108,676
Arkansas	Partnership	117,511	N/A	140,759
California	SBM	434,121	244,021	472,660
Colorado	SBM	71,103	-	28,728
Connecticut	SBM	51,426	10,996	41,325
Delaware	Partnership	3,461	N/A	3,376
District of Columbia	SBM	12,917	1,126	13,402
Hawaii	SBM	15,260	-	7,791
Illinois	Partnership	100,171	N/A	32,269
Iowa	Partnership	40,341	N/A	21,341
Kentucky	SBM	69,559	86,429	39,186
Maryland	SBM	77,219	22,287	79,977
Massachusetts	SBM	93,235	-	-
Michigan	Partnership	141,020	N/A	95,383
Minnesota	SBM	76,985	-	33,046
Nevada	SBM	20,983	-	10,630
New Jersey	FFM	40,734	N/A	14,457
New Mexico	Supported SBM	41,587	N/A	29,147
New York	SBM	-	-	123,563
North Dakota	FFM	4,541	N/A	5,152
Ohio	FFM	319,886	N/A	80,036
Oregon	SBM	17,539	11,865	99,272
Rhode Island	SBM	11,565	-	5,297
Vermont	SBM	32,224	13,463	119
Washington	SBM	-	159,186	159,186
West Virginia	Partnership	46,488	N/A	90,302
Not Moving Forward with Medicaid Expansion in 2014				
Alabama	FFM	31,615	N/A	59,379
Alaska	FFM	7,537	N/A	4,061
Florida	FFM	560,950	N/A	303,594
Georgia	FFM	197,562	N/A	153,252
Idaho	Supported SBM	10,589	N/A	14,925
Indiana	FFM	157,186	N/A	81,076
Kansas	FFM	16,353	N/A	18,139
Louisiana	FFM	53,027	N/A	39,003
Maine	FFM	3,779	N/A	3,181
Mississippi	FFM	66,876	N/A	46,468
Missouri	FFM	84,556	N/A	48,740
Montana	FFM	5,697	N/A	9,256
Nebraska	FFM	15,847	N/A	16,217
New Hampshire	Partnership	6,770	N/A	3,332
North Carolina	FFM	132,118	N/A	107,476
Oklahoma	FFM	67,542	N/A	44,898
Pennsylvania	FFM	233,134	N/A	72,500
South Carolina	FFM	57,621	N/A	139,335
South Dakota	FFM	3,252	N/A	2,598
Tennessee	FFM	7,065	N/A	3,338
Texas	FFM	200,787	N/A	846,829
Utah	FFM	45,245	N/A	142,175
Virginia	FFM	58,633	N/A	26,822
Wisconsin	FFM	40,144	N/A	-
Wyoming	FFM	7,915	N/A	4,394

Source: CMS Medicaid and CHIP Monthly Applications and Eligibility Determinations Report, December 3, 2013 and December 20, 2013.
*In Partnership Marketplaces, states administer plan management functions, in-person consumer assistance functions, or both, and HHS performs the remaining functions. In supported SBMs, states maintain plan management and consumer assistance functions and HHS operates enrollment systems. Seven states (KS, ME, MT, NE, OH, SD, and VA) conduct plan management activities to support the FFM.

CMS will update the performance indicators monthly and, over time, plans to report the full set of measures, which will offer a broader view of Medicaid and CHIP eligibility and enrollment performance. The initial data released in December are a subset of the full new set of 12 eligibility and enrollment performance indicators that CMS has asked states to report (Box 2)[9]. Appendix A provides a more detailed overview of the information each measure will provide and Appendix B provides measure definitions and reporting specifications. Together, the measures will provide insight into call center operations, overall demand for Medicaid and CHIP coverage, how applications are flowing through the system, Medicaid/CHIP agency workloads, the efficiency of eligibility and enrollment systems, and enrollment changes. This information can identify trends and potential areas of efficiency and inefficiency and will provide early information on the impact of the ACA's new eligibility and enrollment policies.

Box 2: Medicaid and CHIP Eligibility and Enrollment Performance Indicators

Call Center Operations

1. Total Call Center Volume
2. Average Caller Wait Time
3. Rate of Abandoned Calls

Applications, Transfers, and Renewals

4. Total Number of Medicaid and CHIP Applications Received in Previous Week *
5. Total Number of Medicaid and CHIP Applications Received in Previous Month**
6. Total Number of Medicaid and CHIP Applications Received through Transfers from Marketplace
7. Total Number of Accounts up for Renewal

Determinations

8. Total Number of Individuals Determined Eligible for Medicaid or CHIP*
9. Total Number of Individuals Determined Ineligible for Medicaid or CHIP

Efficiency of Application Processing

10. Total Number of Applications and Redeterminations Pending a Determination
11. Processing Time for Eligibility Determinations

Enrollment

12. Total Enrollment

* Weekly application data has not been reported

** This measure was included in CMS' December reports; the reports also included information on applications through SBMs.

As the quality and completeness of the performance data improve, they will provide more insight into program operations and allow for greater analysis both within and across states. The data's greatest analytic value may be in measuring progress over time, identifying for example, changes in application volume or improved efficiency in application processing. As more consistent data are reported over a period of time, it will become possible to develop standards or benchmarks, which do not currently exist. However, when examining the data across states, it will still be important to recognize differences in state policies, operations, and demographics that may contribute to substantial variation in the performance measures.[10] States have made different policy choices and have achieved varied progress to date in implementing the Medicaid eligibility and enrollment changes under the ACA, which challenge data interpretation.[11]

CONCLUSION

The new collection and reporting of eligibility and enrollment performance indicators are a significant step forward in the ability to use timely data to drive program improvement and assess performance in Medicaid and CHIP. With the new Marketplace enrollment metrics, the data will help provide an understanding of enrollment performance across coverage programs. Ultimately, states and the federal government will be able to employ these data as a management tool to guide decision-making, strengthen processes and inform policy changes and resource allocation. Over time, the measures can begin to provide insight into program performance by examining changes within a state, by examining measures across states or to develop national standards or goals. However, analysis of early performance data remains limited due to gaps and variations across states in reported data.

Looking forward, as the completeness, consistency, and quality of the data improve, it will allow for greater analysis and interpretation. Even then, the new performance measures alone will not provide a holistic assessment of whether Medicaid and CHIP are meeting ACA coverage goals. Fully assessing the impact of ACA will require broader outcome measures such as the reduction in the number of the uninsured, the rate at which eligible people enroll in coverage, and continuity of coverage for people over time. These measures generally are obtained through survey data and often can take years to establish.

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APPENDIX A: OVERVIEW OF MEDICAID AND CHIP ELIGIBILITY AND ENROLLMENT PERFORMANCE INDICATORS

Call center operations. CMS established three measures for call center operations: call volume, average wait times for a call to be answered, and the rate at which calls are abandoned. These measures will provide insight into consumers' level of demand for call center assistance.[12] Average wait times and call abandonment rates will also inform high-level assessments of the extent to which the call centers manage call volume efficiently and effectively. These measures do not provide information on the types of assistance consumers seek through the call centers or their levels of satisfaction with the assistance they receive. States may define "call center" as any call center, hotline, or combination of hotlines that take a significant number of calls regarding applying for or enrolling in Medicaid or CHIP, so the data may not be comparable across states. The measures will not reflect calls related to Medicaid and CHIP that are received by call centers overseen or operated by the Marketplaces.

Numbers of applications, transfers, and renewals. The total number of Medicaid and CHIP applications received and accounts up for renewal will indicate the overall volume of traffic to Medicaid and CHIP eligibility and enrollment systems, informing assessments of overall Medicaid/CHIP agency workload and the demand for coverage. This demand may fluctuate for a variety of reasons, including due to responses to outreach campaigns, changing economic conditions, or state policy choices. States will also report the total number of Medicaid and CHIP cases transferred from Marketplaces. This measure will provide an indication of what share of total Medicaid and CHIP applications are initiated through the Marketplaces as well as of the volume of coordination occurring between the Medicaid/CHIP agency and the Marketplace. The measure will not provide significant insight into how well or seamlessly that coordination is occurring, since there are no measures to indicate whether any transfers are unsuccessful or whether individuals experience any gaps or disruptions in coverage. Additionally, states will report the number of applications consumers submit online, by mail, in person, or by phone, providing insight into consumers' preferred mode of application submission. The share of initiated applications that are completed and overall consumer experiences with the application process are not being measured.

Eligibility determinations. The total number of individuals determined eligible or ineligible for Medicaid or CHIP during the reporting period will provide information into the outcome of submitted applications. [13] In reporting the number of individuals determined ineligible for Medicaid and CHIP, CMS has requested that states separately report the number determined ineligible and those denied due to lack of necessary information. This will enable analysis of how many and what proportion of negative determinations that are made due to difficulties obtaining necessary information.[14] States will also separately report administrative eligibility determinations that states make using data from other programs like SNAP. As of December 2013, five states are enrolling eligible individuals in Medicaid based on data available through SNAP and three are enrolling eligible parents based on existing Medicaid and CHIP enrollment data for their children [15]

Application processing times and pending applications. Beginning in 2014, states will also report application processing times and the number of applications still pending as of the last date of the reporting period. These indicators will provide information on the efficiency of application processing through the system, and can help states and CMS identify potential delays or problems with processing. [16]

Total enrollment. States will report total enrollment of all individuals in Medicaid and CHIP as of the last day of the reporting period. Enrollment will be reported separately for children and adults and for individuals determined eligible based on Modified Adjusted Gross Income (MAGI) as well as those determined eligible under other standards. This measure will provide insight into overall trends in enrollment over time and allow for comparisons between these groups. The data will not separately identify enrollment among individuals made newly eligible by the Medicaid expansion for low-income adults, making it difficult to draw conclusions about the impact of the Medicaid expansion using this data.

APPENDIX B: DEFINITIONS OF MEDICAID AND CHIP ELIGIBILITY AND ENROLLMENT PERFORMANCE INDICATORS

Measure	Definition
Call Center Operations	
Call Volume[1,3]	Total number of calls received by call centers (including helplines or hotlines) that receive a significant number of calls about applying for or enrolling in Medicaid and CHIP. Excludes SBM call centers but includes call centers that receive calls about applying for other programs like SNAP. The types of calls include calls from individuals applying over the phone, calls with eligibility questions, and calls about enrolling in Medicaid/CHIP managed care. CMS also asked states to describe the call centers, helplines, and hotlines.
Average Caller Wait Time[1,3]	Average time that a caller waits before being connected to an agent (reported by call center and as a weighted average across call centers).
Rate of Abandoned Calls [1,3]	Percentage of all calls abandoned by callers (reported by call center and as a weighted average across call centers).
Applications, Transfers and Renewals	
Number of Applications Received Each Week/Month[2]	Total number of Medicaid and CHIP applications received in previous week/month, including any received by an SBM. Applications transferred from FFM are excluded. Applications are reported by source agency and by means of submission (online, mail, in-person, phone, other).
Number of Electronic Account Transfers From Marketplaces to Medicaid/CHIP[1,2]	Number of electronic accounts transferred from the FFM (or an SBM that does not have an integrated eligibility system) to state Medicaid agencies. In both assessments and determinations will be reported, as well as cases in which an individual assessed as ineligible requests a full determination by a state agency. Medicaid and CHIP agencies will report the number of cases they transfer to CHIP or Marketplaces for those programs to make eligibility determinations.
Number of Renewals[2]	Number of accounts up for annual renewal of eligibility. (Renewals that take place due to a change in beneficiaries' circumstances are not included). Renewals are reported by CHIP and MAGI and non-MAGI Medicaid applications.
Determinations	
Number of Individuals Determined Eligible[1,2]	Number of individuals determined eligible for Medicaid or CHIP at application or renewal. Includes all determinations of eligibility made by Medicaid agencies, CHIP agencies, and SBMs, but does not include determinations made by FFMs. Determinations are reported by MAGI and non-MAGI populations and by application type (application, renewal, administrative determination, or other). Some individuals may be both MAGI and non-MAGI eligible; such individuals may be reported as having two eligibility determinations.
Number of Individuals Determined Ineligible [1,2]	Number of individuals determined ineligible for Medicaid or CHIP through application or renewal. Includes all determinations of ineligibility made by Medicaid agencies, CHIP agencies, and SBMs, but does not include determinations made by FFMs. Determinations are reported by application type (application, renewal, or administrative determination). States also report the number of cases determined ineligible due inadequate documentation or lack of follow up. (Individuals who request disenrollment or are disenrolled after not paying premiums, as well as children who are eligible but not enrolled due to being subject to a waiting period or premium lock-out, are not included.)
Application Processing Efficiency	
Pending Applications and Renewals[2]	Number of applications and redeterminations for Medicaid and CHIP pending as of the last day of the reporting period, regardless of the date of application or the date for renewal. This indicator measures the time between when a Medicaid and CHIP agency receives an application and when the agency makes a decision on that application.
Application Processing Time[2]	Processing times before determination for all applicants who received a determination during the reporting period, regardless of the date of application. States will report medians and distribution of processing times for both MAGI and non-MAGI populations and break down processing times by the source of the application (i.e., whether it is a direct application or a transfer from another program).
Enrollment	
Total Enrollment[1,2]	The total number of individuals enrolled in Medicaid and CHIP coverage as of the last day of the reporting period. (Individuals with retroactive, conditional, and presumptive eligibility are included; CHIP children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and are excluded.) Enrollment is reported for children and adults and MAGI and non-MAGI populations. It will include people who are eligible for comprehensive Medicaid coverage (this measure excludes enrollment in limited benefit coverage such as family planning).

[1] Measures with this note are collected by CMS weekly during open enrollment (October 1, 2013 to March 31, 2014)
[2] Measures with this note are collected by CMS monthly.
[3] Measures with this note are collected by CMS monthly outside open enrollment (April 1, 2014 and after).

ENDNOTES

[1] S. Artiga and R. Rudowitz, "The Many Roads to Medicaid: An Overview of How People are Connecting to the Program Today," Kaiser Commission on Medicaid and the Uninsured (December 2013).

2 National Association of Medicaid Directors, "NAMD ACA Snapshot –Open Enrollment, Week 3;" (October 21, 2013); "NAMD ACA Snapshot—Open Enrollment, Week 4," (October 28, 2013) "NAMD ACA Snapshot – Open Enrollment, Week 5" (November 4, 2013); "NAMD Open Enrollment Snapshot –Open Enrollment, Week 7" (November 25, 2013); "NAMD ACA Snapshot – Open Enrollment, Week 10" (December 16, 2013) http://medicaiddirectors.org/.

3 These systems would otherwise have been matched at the 50 percent Medicaid administrative matching rate. CMS is matching the costs of developing and building systems at 90 percent; the cost of operating the systems will be matched at 75 percent.

4 "Performance Measurement Under Health Reform, Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider, Kaiser Commission on Medicaid and the Uninsured, (December 2011); "C. Trenholm et al.,"Using Data to Drive State Improvement in Enrollment and Retention Performance," Maximizing Enrollment for Robert Wood Johnson Foundation (November 2011). .

5 P. Thompson, "CMS Initiatives to Improve Data for Medicaid Program Operations and Evaluation," presentation to the Medicaid and CHIP Payment and Access Commission (October 28-29, 2010), available at: https://docs.google.com/viewer?pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NDlmNTk3YzJlYzZkZDAzMg

6 P. Thompson presentation.

7 23 states were implementing the Medicaid expansion at the start of October 2013. Ohio and Michigan are also implementing the expansion, but had not yet begin processing applications for newly eligible adults as of October.

8 ASPE Issue Brief, "Health Insurance Marketplace: December Enrollment Report For the Period: October 1-November 30," December 11,2013' ASPE Issue Brief, "Health Insurance Marketplace: November Enrollment Report," November 13,2013.

9 CMS notes that data released for the first three months of open enrollment through the Marketplace (October 2013-December 2013) will remain focused on applications and eligibility determinations. The agency anticipates reporting on additional indicators, including total enrollment, after Medicaid coverage for newly eligible individuals begins in January 2014.

10 National Association of Medicaid Directors, "NAMD Open Enrollment Snapshot –Open Enrollment, Week 7" (November 25, 2013) http://medicaiddirectors.org/.

11 M. Heberlein et al., "Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive." Kaiser Commission on Medicaid and the Uninsured (November 2013).

12 Because of the definition of 'call center' used by CMS, data from different states may not be comparable. The measures may be subject to overcount, as helplines may receive calls about other benefits such as TANF and SNAP. Conversely, a state may experience undercount, due to calls about Medicaid that are directed to a FFM exchange or if a call center is excluded from the report because it lacks the capability to report on call volume.

13 This data will not inform observations about the accuracy of eligibility determinations. CMS is developing approaches to measuring the accuracy of determinations of eligibility and ineligibility that align with Affordable Care Act eligibility rules. Guidance in letter to states from D. Taylor and C. Mann, Centers for Medicare and Medicaid Services, " Payment Error Rate Measurement (PERM) eligibility reviews, Medicaid Eligibility Quality Control (MEQC) Program, and development of an interim approach for assessing payment error for eligibility," SHO 13-005 (August 2013), available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf

14 CMS is not as part of this measurement effort collecting disenrollment and denial reason codes, which would provide data that CMS and states could use to identify, for example, whether individuals are denied because of an increase in income, a move out of state, or because they were missing information or verification. M. Harrington, C. Trenholm, A. Snyder, "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance," Maximizing Enrollment Issue Brief, published by the Robert Wood Johnson Foundation and National Academy for State Health Policy (October 2012).

15 Table published online, "Targeted Enrollment Strategies." Centers for Medicare and Medicaid Services (October 2013), available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html

16 CMS has long set timeframes for the time required to make eligibility determinations of 45 days for most Medicaid populations and 90 days for beneficiaries whose eligibility is based on being disabled. CMS has recently reiterated those outer limits, but also stated an expectation that eligibility determinations can be carried out significantly more quickly, and in most cases in "real time," due to simplified rules and improved technology. Center for Medicaid and CHIP Services, "Request for Information: Performance Indicators for Medicaid and Children's Health Insurance Program Business Functions: Solicitation of Public Input" and final regulation 77 CFR 17144, "Eligibility Changes under the Affordable Care Act of 2010," (March 23, 2012).