February 28, 2013

**VIA ELECTRONIC SUBMISSION**

Centers for Medicare & Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8016

**Re: Request for Information (RFI): Performance Indicators for Medicaid and the Children’s Health Insurance Program (CHIP)**

To Whom It May Concern:

We appreciate the opportunity to comment on the recently released draft performance indicators for Medicaid and CHIP. We commend CMS for moving forward to establish a meaningful set of measures that will enable state and government officials and Medicaid and CHIP stakeholders to assess the performance of these key coverage programs for low-income children, families and other individuals. We urge CMS to evaluate the comments and finalize the initial set of indicators quickly so states can ensure that their IT systems are prepared to collect key data needed to calculate and report the measures starting in 2014.

**GENERAL COMMENTS:**

**Consider an incentive program that encourages states to prioritize the development of system capacity to collect and report performance indicators.** We believe that reporting all of the indicators should be required of all states, but given that some states are far along in their IT development while others are still in procurement, we expect that states will need time to ramp-up their data collection and reporting capability. We hope CMS and other federal policymakers will consider an incentive program that encourages states to make collecting and reporting the performance indicators a priority, and rewards states for early and robust reporting. The performance bonus program enacted by the Children’s Health Insurance Program Reauthorization Action (CHIPRA) exemplifies the kind of incentive program that could be effective in advancing the reporting of performance indicators.

**Move quickly toward establishing benchmarks and setting expectations for program improvement over time.** Collecting and reporting data is not enough. It will be critically important for CMS to quickly collect and analyze baseline data and establish performance benchmarks. Ultimately, the value in having data is to recognize where states are doing well and identify areas to make program improvements. A performance bonus program could evolve to reward states that show progress over time and meet or exceed federal benchmarks. To this end, CMS should work collaboratively with states and provide technical assistance to advance state analytic and process improvement skills and capacity.

**Ensure that performance data are publicly reported, promptly and on a regular basis.** Public engagement enhances the effectiveness of government programs and improves the quality of policy decisions. To ensure the public trust and foster collaboration among states and stakeholders, transparency must be a priority. We strongly urge CMS to ensure that performance measures are publicly reported routinely and promptly. Ideally, CMS should make performance data available on Medicaid.gov on a timely basis when data is most useful.

**Extend performance indicators to exchanges and add measures that span the continuum of coverage.** Subsidized coverage through exchanges is an essential aspect of the continuum of coverage created by health reform. Performance data on public coverage programs are incomplete without consistent measures across Medicaid, CHIP and the exchanges. Additional measures should be established to track individual transitions in order to determine average length of coverage and identify gaps in coverage. Achieving longer periods of continuous coverage is a key strategy in improving health outcomes and holding managed care plans accountable for better care and reduced costs over time.

**Standardize reason codes to ensure consistency and facilitate cross-state identification of best practices.** The proposed performance indicators clearly show that states will need to track ineligibility and disenrollment reasons. As explained in our detailed comments below, we strong encourage CMS to specify a limited number of reason codes that will enhance comparability and learning across states.

**DETAILED COMMENTS:**

The following detailed comments on the proposed indicators will focus on the Individual Experience with Eligibility and Enrollment.

***Timely and accessible coverage***

***1 – Eligibility Determinations Made;***

***1.1 – Individuals Determined Eligible;***

***1.3.1 – Individuals Ineligible for Eligibility Reasons, and***

***1.3.2 – Individuals Ineligible for Procedural Reasons***

The latter three of these measures represent a breakdown of the first measure and should equal the total of individuals reported in the Eligibility Determinations Made. The **#1** and **#1.1** measures indicate that the “determinations made” and “individuals determined eligible” should be reported by type including application, transfer and redetermination.

**Recommendation.** We suggest that CMS be very specific about the types of transactions and differentiate between redeterminations that are triggered by a changes in circumstances vs. those made at the time of renewal.

**Recommendation:** The final performance measures should also require that states track and report these data by program category such as children or pregnant women.

In particular, we support that the measures distinguish between and require separate reporting of denials for ineligibility vs. denials for paperwork or procedural reasons. The proposed indicators note that states will need to report ineligibility by reason but the reason codes are not specified. Reason codes are widely used currently but with very mixed results in the states. States often have multiple reason codes associated with a transaction, use extremely generic categories such “individual does not meet program requirements,” or do not set and enforce use standards to ensure consistency in how eligibility workers assign reason codes. In order to enable cross-state comparison, standardized reason codes are needed and CMS should work with states to ensure they are used appropriately and consistently.

**Recommendation:** We strongly recommend that CMS develop a standard set of reason codes that states are required to track. While states should have the flexibility to establish additional reasons, it is preferable that such codes be aggregated into the core set of standardized reason codes. We generally like the coding strategies detailed in ["New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance,"](http://www.mathematica-mpr.com/publications/pdfs/health/coding_strategies_state_enrollment.pdf) a report that was developed as part of the Maximizing Enrollment Initiative and developed in collaboration with eight states, the National Academy of State Health Policy and Mathematica Policy Research, Inc.

***1.2 Data Driven Eligibility Determinations***

We strongly support measuring the extent to which states have achieved a paperless system. However, this measure implies that states are using electronic data rather than requiring paper documentation. In fact states that accept self-attestation are not necessarily making data driven eligibility determinations. If this measure is intended to assess the extent to which states continue to require paper documentation, perhaps it should amended to track the number of determinations that require the submission of a paper document. Additionally, it would be useful to track these data by either type of document or eligibility criteria that needed to be verified by paper. This will help states pinpoint where policy or procedures could be enhanced.

***1.4 – Share of Eligibility Determinations Made with Little or Not Time Elapsed***

***1.5 – Rate of Timely Eligibility Determinations***

***2 – Average Time to Process***

We strongly support tracking the extent to which determinations are being made in real or near-real time (within 24 hours). The two measures could be collapsed into a single breakdown the proportion of applications determined with specific periods of time, i.e. within 24 hours, within 5 days, within 10 days, and within 30 days. Additionally, we are less enthusiastic about a measure that establishes an average processing time. Such an average can mask issues with timeliness and its usefulness is questionable.

**Recommendation:** Collapse **1.4 and 1.5** into a single measure.

**Recommendation:** Eliminate **2** – Average Time to Process.

***Program Enrollment, Retention and Timely Transitions***

***3 – Total Enrollment***

We support a point in time count over a count that encompasses the number of people ever enrolled in the month. We also support specifying a consistent day of the month for which enrollment is reported.

***4 – Total Disenrollment***

***4.1 – Individuals Disenrolled for Procedural Reasons***

***4.2 Individuals Disenrolled for Eligibility Reasons***

These data are embedded in **1.3.1** and **1.3.2** and may be duplicative. By reporting ALL types of determinations (i.e. new application or redeterminations), any ineligible determination at renewal or when a change is processed results in a person being disenrolled. If you report reasons for ineligibility by type of transaction, you arrive at this measure. The redundancy could be handled by ensuring sufficient breakdowns of types in **1.3.1** and **1.3.2**, or by requiring that only new applications and transfers be reported in **1.1, 1.3.1** and **1.3.2** and keeping measures **4, 4.1** and **4.2** separate.

**Recommendation:** We strongly recommend that disenrollment at renewal should be tracked separately. Loss of coverage at renewal is a well-documented problem in Medicaid and CHIP with an estimated average of 30% of eligible but not enrolled children having been enrolled in the previous year. Working to eliminate loss of coverage at renewal for procedural reasons, as Louisiana has succeeded in doing, is critical to reducing churn, avoiding gaps in coverage, promoting better health outcomes and measuring the quality of care.

***Automatic Renewals***

The ACA requires states to access their electronic data sources to automatically renew eligibility without requiring enrollees to take action if the data on which the renewal determination is based is accurate and current. We strongly recommend that CMS add a measure to track the proportion of renewals that are made automatically.

**Recommendation:** Add a measure “Individuals Automatically Renewed” that tracks the proportion of renewals that are made based on available electronic data.

***5.1 – Internal Churn Rate***

At one time, churn was defined as people moving between coverage and being uninsured. More recently, it seems that the definition of churn has evolved to mean transitions between programs. An internal churn rate provides very little actionable data if you are not able to identify whether the individual lost coverage or moved to another coverage program. As noted early in our comments, we believe it is important for CMS and states to figure out how to assess continuous coverage across programs and only count churn when someone leaves one of the insurance affordability programs without enrolling in another but returns to one of the programs within six months.

***High degree of customer satisfaction with application and enrollment experience***

***6 – Beneficiary Application and Enrollment Satisfaction Rate***

We support that states should conduct surveys of new enrollees, established enrollees and recent disenrollees on a regular basis and that “customer satisfaction” should be a key measure of program success. Such a survey should be scientifically administered and unbiased. Additionally, survey questions should be standardized for comparison across the states.

***Accurate eligibility determinations***

***7 – Appeal Rate***

While this is an interesting measure, we are concerned that it is much less an accurate measure of eligibility determinations than can be determined by quality assurance programs. It is not at all clear what proportion of people who are denied or disenrolled actually file an appeal. Thus, this is not a representative sample of accurate or inaccurate eligibility determinations. In fact, if a disproportion number of individuals who are inaccurately denied coverage actually file appeals, a high successful appeal rate could misrepresent the accuracy of eligibility determinations.

***8 – Accurate Transfer Rate***

We strongly support a system that tracks transfers between programs and the disposition of eligibility by the receiving agency. This system should go further than determining the accurate transfer rate and ensure that no individual slips through the cracks. Such a system could identify an individual for which the disposition of the transfer has not been reported, prompting further action by one of the agencies to ensure that every transfer results in a determination, denial or transfer back if necessary.

***Cost effective application and enrollment processes***

***9 – Cost per Application***

While it would extremely useful to have better data on administrative costs, researchers have found it very difficult to arrive at any precision in estimating administrative costs. CMS would need to be very prescriptive about what costs to include or not. Additionally, it is not clear why cost “per application” versus “determination” is proposed.

**RESPONSES TO THE QUESTIONS:**

1. Overall, we believe these indicators with our recommended changes will provide key information for states that will help identify where improvements are needed and what strategies could be taken. Reason codes are essential to making data actionable. Additionally, having state-by-state comparisons will be critical to identifying states that are leaders on a particular indicator and states that can make improvements. States with better outcomes can demonstrate best practices that can be adopted in order to improve outcomes in states in need of improvement.
2. It is common for states to track enrollment, denials by reason and disenrollment by reason. Average days to process would be another common data point. States that participate in learning collaboratives and receive technical assistance from data experts are likely to have gone further in their ability to collect and use data. However, routine public reporting of detailed data beyond enrollment is a rarity. Some states are responsive to specific requests for data but have not implemented procedures to routinely report and make these data available publicly.
3. States point to their out-of-date, inflexible eligibility systems in explaining why it is difficult to collect and report. Often reports require special programming and resources are also an issue. However, a key goal in providing states with enhanced resources for IT development was to move to systems that not only can process real-time data-driven eligibility decisions, but also produce quality performance data. To maximize this opportunity, it will be very important for CMS to prepare detailed specifications and provide technical assistance to the states in implementing these measures. As noted previously, establishing an incentive program would help encourage states to make data reporting a priority.
4. To the greatest extent possible, CMS should collect and analyze data on behalf of the states to ensure consistency and comparability in the measures. It would be desirable for CMS to collect data that is not currently collected in order to directly calculate and report as many measures as conceivable.
5. Ideally, states should start reporting these data starting in 2014 when new systems need to be ready to comply with ACA requirements. Unfortunately, a number of states have gotten a late start on their system development and may continue to rely on elements of their outdated legacy-based systems while new system functionality is being phased in. Although states have known that reporting on performance indicators was a condition of the enhanced federal match, it may not be reasonable to expect that every state will be ready on January 1, 2014.
6. Most data should be reported monthly so that states and stakeholders can identify trends. For example, back-to-school outreach campaigns generate additional application volume for Medicaid and CHIP in late summer and early fall. Detecting these trends can help states not only anticipate when additional staff capacity is needed but also assess the effectiveness of marketing and outreach campaigns.
7. For many purposes of program management and process/policy improvement, person-level data is not required. However, if CMS has any thought of establishing an all-program database in order to assess continuous coverage and churn rates, being able to track individuals across programs requires person-level data. It would be more cost-effective and ensure consistency in data analysis if a central repository of person-level data was created.
8. Aggregate data with sufficient breakdowns by category of coverage (i.e. children, pregnant women, etc.), type of transaction (application, renewal, change, transfer) and reason is generally sufficient for program evaluation.
9. Actual counts are not helpful to compare between states because of the differences in population size and demographics. However, converting most of the counts to percentages (for example, the proportion of ineligible determinations for eligibility reasons vs. procedural reasons) and comparing will be useful. While establishing benchmarks may take some time, it will be clear from the beginning the states that are on track to achieving the vision of streamlined, coordinated eligibility over the continuum of coverage programs.
10. Most of the measures have value in ensuring efficient and effective program management. In particular, **1.2 Data Driven Eligibility Determinations** (with suggested amendments), and **“automatic renewals”** (as we have recommended)are two key measures for ensuring efficient and effective program. Indicators that assess the prevalence of procedural denials or disenrollments also point to whether policies and procedures are effectively using electronic verifications to reduce red tape and paperwork barriers to enrollment and retention.
11. No comment.
12. The data definitions should be clearly defined without ambiguity. Comparability cannot be assured if states are allowed to develop alternative definitions.
13. No comment.
14. Online application abandonment rates, and at what point the online application is abandoned, offer an opportunity to measure user experience. An annual survey that is suggested in the **Beneficiary Application and Enrollment Satisfactory Rate** could be crafted to include a limited number of questions that will assess other areas of customer satisfaction. We also believe that CMS should develop standards and measures for assessing the effectiveness and consumer satisfaction with brokers, navigators, in-person assisters and certified application counselors.
15. See our comments on **Internal Churn Rate**.
16. We think it is important to differentiate disenrollment at renewal from disenrollment resulting from changes in family circumstances. Just as the eligibility determinations will be reported by type (i.e. application, transfer), disenrollment at renewal should be reported separately from other disenrollments. Additionally, as our comments reflect, it will be helpful to include a measure that reports the proportion of renewals that are redetermined automatically.
17. All indicators should be reported on a subgroup level (i.e. children, pregnant women, etc.)
18. We believe all of the measures should be applied to subsidized coverage in the exchange, along with data regarding plan enrollment. It will be particularly important to identify additional user satisfaction indicators that measure the QHP plan comparison, selection and enrollment process. While complicated, it will also be important to evaluate how advanced premium tax credits compare to actual premium tax credits and in particular identify the extent to which individuals and families are required to repay advance credits because actual income exceeds projected income.

Again, we thank you for the opportunity to provide feedback on the proposed performance indicators. If you have questions about our comments, please contact Tricia Brooks at pab62@georgetown.edu.

Sincerely,

Georgetown University Center for Children and Families.