

**Request for Information: Performance Indicators
for Medicaid and Children’s Health Insurance Program (CHIP)
Business Functions: Solicitation of Public Input**

This solicitation seeks public input to aid in the development of an initial set of business process performance indicators for all state Medicaid and Children’s Health Insurance Program (CHIP) programs, which CMS indicated they would begin to collect in association with the development of new IT systems in the final rules entitled “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities” (75 FR 21950) and “Eligibility Changes under the Affordable Care Act of 2010” (77 FR 17144). We intend to begin collecting and reporting on indicators in two primary domains: individual (applicant and beneficiary) experience with eligibility and enrollment; and provider experience with enrollment and claims payment. This request for information seeks comment on which of the measures would be most meaningful, with specific focus on limiting the burden for states by using data that is already internally collected or would be easy to begin to collect by states. Additionally, this solicitation does not seek comment on benchmarks for determining sufficient or high performance. We intend to begin by generating baseline data and in subsequent years, as we progress in the development and testing of indicators, CMS and states will work together, with input from other stakeholders, to develop benchmarks and targets for performance improvement.

SUBMISSION OF PUBLIC COMMENTS:

Public comment on the issues discussed in this solicitation may be submitted electronically to CMCSPPACAQuestions@cms.hhs.gov. Comments would be most helpful if received by March 8, 2013.

FOR FURTHER INFORMATION CONTACT:

Julia Hinckley at Julia.Hinckley@cms.hhs.gov

I. Background

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, enacted on March 23, 2010) (the Affordable Care Act) expands access to health insurance coverage through improvements to Medicaid and CHIP and the establishment of Affordable Insurance Exchanges (“Exchanges”). It assures coordination between Medicaid, CHIP, and the Exchange so individuals are enrolled in the appropriate insurance affordability program and can retain coverage over time even as their circumstances change. We have issued guidance, tools and technical assistance to assist states as they design, develop, implement, and operate technology and systems projects related to the establishment and operation of Exchanges, as well as coverage expansions and improvements under Medicaid and CHIP. Our goal has been to help states develop and implement sophisticated, consumer-friendly IT infrastructure and achieve interoperability between the federal and state entities that will work together to provide health insurance coverage through the Exchange, Medicaid and CHIP.

We are working with states in numerous forums--some of which are discussed below--to ensure that Medicaid and CHIP support modern approaches to business processes and standards of performance management as are found in the private sector and high-performing public programs.

Many stakeholders, including the National Association of Medicaid Directors¹, the Bipartisan Policy Center’s Governor’s Council², and the Republican Governors Association Policy Committee³ have urged CMS to move from process-focused review of state activities toward the use of transparent, program-wide performance goals.

In the August 17, 2011 **Federal Register**, we published a proposed rule entitled “Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010” (76 FR 51148) which proposed rules on implementing several provisions of the Affordable Care Act related to Medicaid eligibility, enrollment and coordination with the Exchange and CHIP, and simplifying the current eligibility rules and processes in Medicaid and CHIP. We received a number of comments requesting additional information regarding the timeliness and performance indicators associated with various provisions of the rule. Specifically, many commenters suggested timeliness indicators for application processing and agency transfers. We also received comments requesting additional information with respect to the data reporting requirements for states to ensure that states, the federal government and the public have the information needed to ensure effective and efficient administration of Medicaid and CHIP and promote ongoing improvement in performance.

In the March 23, 2012 **Federal Register** (77 FR 17144) we published the final rule entitled “Eligibility Changes under the Affordable Care Act of 2010” (hereafter referred to as “the Medicaid and CHIP eligibility rule”), which included a provision related to timeliness, performance and coordination as an interim final rule with comment and provided for an additional 45-day comment period. The provisions delineate elements for which states must establish timeliness and performance indicators. They direct state Medicaid agencies to establish time standards for determining eligibility and note that these standards may not exceed 90 days in the case of individuals applying for Medicaid on the basis of disability and 45 days for all other applicants. The 90-day and 45-day eligibility determination requirements, consistent with current regulations, represent the outer permissible time boundaries.

In many cases, policy changes under the Affordable Care Act and technological improvements will make it possible for eligibility determinations to be made in a single online session. Consequently, additional timeliness indicators are needed to reflect this new environment. The eligibility rule distinguishes between performance and timeliness standards, and directs state Medicaid and CHIP agencies to establish both. The rule provides that states set performance standards, defined as “overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction,” and that the Department of Health and Human Services (HHS) will provide additional guidance to promote accountability and consistency of high-quality consumer experience among states and across the Exchange, Medicaid, and CHIP. Through this solicitation, we are seeking public comment to aid in the development of such guidance.

1 NAMD White Paper “Creating a Culture of Innovation,” issued November 2011

2 Reforming Medicaid Waivers: The Governor’s Council Perspective on Federalism Today, March 2012, available at <http://bipartisanpolicy.org/sites/default/files/Federalism%20Paper.pdf>

3 [RGCCP Medicaid Report](#)

In the April 19, 2011 **Federal Register** (75 FR 21950), we published the “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities” final rule, hereafter referred to as “the 90-10 rule,” which made available 90 percent federal financial participation (FFP) for the design and development of Medicaid eligibility systems which meet a number of standards and conditions, including seven new standards and conditions which address the performance, flexibility, accuracy and timeliness of the systems. One of the seven conditions and standards directs systems to support “accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.” Another condition specifies that a system “produce transaction data, reports and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.” Finally, a third condition specifies that systems “ensure seamless coordination and integration with the Exchange.” Commenters on the 90-10 rule requested additional details regarding how CMS would measure accurate and timely processing and adjudications, and coordination with the Exchange, and what data systems would need to produce to support accountability.

While the focus of this solicitation is performance on basic business processes related to getting and keeping eligible people covered and efficiently managing provider enrollment and payment, Medicaid and CHIP should ultimately be evaluated by how well they meet the overall goal of improving health, raising the quality of care, and lowering costs. The indicators included in this solicitation are an important piece of that broader goal, and we, along with states, are already at work in various forums towards that larger aim. For example, the Affordable Care Act added quality measures for adults, consistent with some of the previous quality measures for children. An initial set of children’s health care quality indicators was released publicly in February 2011 (<http://www.cms.gov/smdl/downloads/SHO11001.pdf>) and states began voluntary reporting in the same year. The initial core set of health care quality indicators for adults eligible for Medicaid was published in January 2012 and states will begin to voluntarily report the core quality indicators in 2013 (<https://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality-indicators-for-medicaid-eligible-adults>).

This solicitation seeks comment to support the development of a system for assessing the performance of the programs’ business functions through reporting on key indicators. Indicators and questions included in this notice are based on CMS’ experience in overseeing Medicaid and CHIP, as well as discussions with states and other stakeholders and the public comments received on the regulations discussed above. We have also relied upon CMS’ Medicare expertise in beneficiary and provider business processes and best-practices from the private sector in these areas. Prior to creating this solicitation, we consulted with a group of state partners engaged in an ongoing “learning collaborative” on data analytics, to discuss performance indicators across various areas. Additionally, we reviewed materials from states related to state use of administrative data to measure business process performance and performed an environmental scan on Medicaid and CHIP performance measurement, including the data and measurements that states already rely on. We also reviewed the experience of states reporting annually on CHIP eligibility and enrollment in the CHIP Annual Report Template System (CARTS) and the work of the 11 states participating in the pilot for transforming the Medicaid Statistical Information System (MSIS).

II. Provisions of the Solicitation

This solicitation seeks input on a set of potential indicators in two primary domains: individual (applicant and beneficiary⁴) experience of eligibility and enrollment and provider experience in enrollment and claims processing. We are considering the development of Medicaid and CHIP performance business process reporting, beginning with these areas. These reports would be publicly available, with state-level data, and would help state and federal policymakers, as well as external stakeholders and the public, evaluate the efficiency and effectiveness of certain aspects of Medicaid and CHIP administrative and business processes.

For each area, we have proposed what is intended to be a small number of indicators and we have included indicators in each area across several common performance standards:

Area	Applicant and Beneficiary Eligibility and Enrollment	Provider Enrollment and Claims Payment
Performance Standards	Positive Customer Experience Timely Transactions Efficient Administrative Costs Accurate Transactions	Positive Customer Experience Timely Transactions Efficient Administrative Costs Accurate Transactions

The solicitation does not propose benchmarks for determining sufficient or high performance. We intend to begin by generating baseline data and in subsequent years, as we progress in the development and testing of indicators, CMS and states will work together, with input from other stakeholders, to develop benchmarks and targets for performance improvement. While we will not initially identify benchmarks for high performance, we will place emphasis on the importance of consistency of reporting across states and will prioritize indicators that will allow for precision in reporting and useful cross-state comparisons. CMS will provide detailed specifications for each indicator selected for inclusion, and will provide technical assistance to states as they develop and enhance their data reporting systems.

A brief discussion of each area is presented below, followed by a list of the proposed indicators. We have also included a number of questions for states and other stakeholders to use in responding to this notice. We welcome commenters addressing additional issues about the indicators that are not listed here.

Eligibility and Enrollment

Under the Affordable Care Act, CMS and states are in the process of making policy and operational changes that will support the new streamlined eligibility and enrollment processes that will include a high degree of coordination across Medicaid, CHIP and the Exchange. State and federal officials will seek to evaluate progress in providing timely and accurate access to coverage, retaining eligible individuals in coverage, effectively transitioning individuals between coverage programs, reaching a high degree of consumer satisfaction, and succeeding in reducing uninsured rates.

⁴ Applicants are individuals who have applied for coverage, and beneficiaries are individuals who have been determined eligible for coverage

Although reporting at the federal level on these areas of performance will be largely a new undertaking for states and CMS, most states regularly use extensive, frequent reporting on eligibility and enrollment data to manage their programs today. We expect high interest at the federal and state level in understanding, on a timely basis, progress in implementing the Medicaid eligibility and simplification changes, coordinating with Exchanges and achieving continuity of coverage. We have a goal of a core shared set of uniform indicators related to eligibility and enrollment that are shared across Medicaid, CHIP and the Exchanges--both state-based and federally-facilitated Exchanges. Therefore we are also soliciting comments on whether or not these proposed indicators are appropriate to use for Exchange measurement as well.

Over the next year and half, we are working towards a modernized consolidated shared data structure, called T-MSIS (Transformed MSIS) that will replace the fragmented data sets states currently send to CMS, and will provide high quality data and analytics for CMS and states. T-MSIS will improve CMS and states' analytic abilities related to both eligibility data and provider and claims data. We seek input on whether potential measures should be calculated from or collected through this new system.

Provider Experience

Providers are critical partners in the delivery of high-quality care to Medicaid and CHIP beneficiaries. As such, a prompt, simple system for providers to enroll and seek payment is important. The Affordable Care Act established a new approach for Medicaid and CHIP provider enrollment including establishing a risk-based enrollment system to adjust levels of scrutiny based on type of provider and improving the sharing of enrollment and termination data among Medicare, Medicaid and CHIP. Currently, there are no requirements in Medicaid or CHIP statute or regulations regarding timely action on applications for enrollment by providers.

Another important interaction between providers and Medicaid and CHIP programs is in the intake, adjudication, and payment of claims. Medicaid and CHIP agencies, and their contractors, process a large volume of claims every year. To manage their revenues and minimize their administrative costs, providers are highly dependent on state claims processing operations to accept claims submissions based on industry standards, adjudicate claims fairly and accurately, and make timely payments. Accurate and efficient decisions on claims are also a central tenet of program integrity for Medicaid and CHIP. At this time, the central measurement of claims processing at the federal level is the PERM program, under which a statistical sample of a state's claims is audited every three years. The PERM measurement is of payment accuracy only, and does not contain any information on timeliness of adjudication or payment.

TABLE 1: Proposed Indicators

INDIVIDUAL EXPERIENCE with ELIGIBILITY and ENROLLMENT	
Timely and accessible coverage	
1	Eligibility Determinations Made Example: # individuals with eligibility determinations made within the month (by type including application, transfer, redetermination)
1.1	Individuals Determined Eligible Example: # individuals determined eligible within the month (by type including application, transfer, redetermination)
1.2	Data Driven Eligibility Determinations Example: # of eligibility determinations completed without the need for the submission of documentation
1.3.1	Individuals Ineligible for Eligibility Reasons Example: # individuals denied for failing to meet eligibility criteria (by reason) within the month
1.3.2	Individuals Ineligible for Procedural Reasons Example: # individuals denied for failing to meet procedural criteria (by reason) within the month
1.4	Share of Eligibility Determinations Made With Little or No Time Elapsed Examples: % of eligibility determinations made within the month that were completed in a single application session or within 24 hours
1.5	Rate of Timely Eligibility Determination Example: % of eligibility determinations made within the month that were completed within 5 days, 10 days, 30 days
2	Average Time to Process Example: average time to determine eligibility, by type of application (including transfers) (# of days from application receipt date to eligibility determination date for all applications with eligibility determinations made within the month/# of applications with eligibility determinations made within the month)
Program Enrollment, Retention and Timely Transitions	
3	Total Enrollment Example: # of individuals eligible on the 1st of the month
4	Total Disenrollment Example: # of individuals with eligibility ending within the month, by reason (including, e.g., at time of redetermination)
4.1	Individuals Disenrolled for Procedural Reasons Example: # individuals disenrolled for failing to meet procedural criteria (by reason) within the month
4.2	Individuals Disenrolled for Eligibility Reasons Example: # individuals disenrolled for failing to meet eligibility criteria (by reason, including transfer) within the month
5	Internal Churn Rate Example: # of disenrolled beneficiaries reenrolling within 6 months (# of individuals disenrolling 6 months prior to the reporting month and then reenrolling by the reporting month /# of individuals disenrolling 6 months prior to the reporting month)
High degree of customer satisfaction with application and enrollment experience	
6	Beneficiary Application and Enrollment Satisfaction Rate Example: % of individuals satisfied with application and enrollment experience (annual) (# of individuals rating their experience “very good”/# of individuals surveyed)
Accurate eligibility determinations	
7	Appeal Rate Example: % of successful applicant appeals (annual) (# of eligibility appeals decided for the applicant/# of eligibility appeals decided)
8	Accurate Transfer Rate Example: % of individuals transferred to Medicaid, CHIP, or the Exchange, as applicable, who are determined eligible by that agency (# of individuals transferred who we determined eligible by the receiving agency within the month/# of individuals transferred within the month)
Cost effective application and enrollment processes	
9	Cost per Application Example: average administrative cost per application (administrative costs associated with application and enrollment/# of applications received)

PROVIDER EXPERIENCE with ENROLLMENT and CLAIMS PAYMENT (Medicaid/CHIP only)**Timely enrollment of qualified providers**

1	New Provider Applications Example: # of provider applications received within the month
1.1	New Providers Enrolled Example: # of provider applications received within the month whose application for enrollment in the program was accepted
2	Average Provider Application Time Processing Example: average processing time for provider applications (# of days from receipt of provider application to application adjudication for all applications adjudicated within the month/# of applications adjudicated within the month)

Quality assurance of provider participation

3	Providers Terminated Example: # of providers who were terminated from participation within the month (by reason)
4	Enrolled Providers Example: # of providers with at least one day of enrollment in the program during the month number
4.1	Billing Providers Example: # of providers with one paid claim in the month
4.2	Inactive Providers Example: % of providers who are inactive (# of providers eligible to bill with no paid claims in the last 12 months/# of providers eligible to bill with at least one day of enrollment in the program during the month)

Timely payment to providers

5	Average Days to Pay Claims Example: average number of days to pay providers (# of days from receipt of clean claim to adjudication of claim for all claims adjudicated/# of claims adjudicated)
5.1	Average Days to Pay 90 percent of Claims Example: average number of days to achieve adjudication of 90% of clean claims (excluding the 10% of claims with the largest number of days to adjudicate, # of days from receipt of clean claim to adjudication of claim for all claims adjudicated/# of clean claims adjudicated)
5.2	Average Days to Pay 99 percent of Claims Example: average number of days to achieve adjudication of 99% of clean claims (excluding the 1% of claims with the largest number of days to adjudicate, # of days from receipt of clean claim to adjudication of claim for all claims adjudicated/# of clean claims adjudicated)

High degree of customer satisfaction with enrollment and claims payment experience

6	Provider Enrollment and Claims Payment Satisfaction Rate Example: % of providers satisfied with enrollment and claims payment experience (annual) (# of providers rating their experience "very good"/# of providers surveyed)
---	--

Accurate payment to providers

7.1	First Pass Resolve Rate Example: % of claims adjudicated on the provider's first submission (# of claims adjudicated on the first submission/# of claims adjudicated)
7.2	Denial Rate Example: % of clean claims denied (# of claims denied/# of clean claims adjudicated)

Cost effective claims processing

8	Administrative cost per claim Example: average administrative cost per claim (administrative cost/# of claims processed)
---	---

Questions:

- (a) Will these indicators provide information on key questions for states and others? Will they provide information that will be actionable in terms of identifying areas in need of improvement?
- (b) Which of these indicators are currently in use by states for internal use and/or sharing with stakeholders? Which indicators are states planning to implement as they prepare for their Exchange implementation and Medicaid changes in 2014? What key indicators are states planning to implement that are not included here?
- (c) What is the level of difficulty and/or resources needed for states (or CMS) in producing or calculating each of the proposed indicators?
- (d) Which of these indicators should CMS consider calculating based on MSIS and other data states already submit to CMS? Are there any indicators for which CMS might have the relevant data (for example, through MSIS or CARTS) but which states would not recommend CMS use such data for these purposes?
- (e) When would states be prepared to begin reporting? If reporting is phased in, which indicators should be included in early phases?
- (f) How frequently should the indicators be reported?
- (g) For which of these indicators should states report person-level data?
- (h) For which of these indicators should states report aggregate data based on states' calculations?
- (i) Which indicators, if any, would be most relevant for states to assess their performance in the context of other states?
- (j) Among the indicators proposed, which indicators are most important to ensuring efficient and effective program management?
- (k) Which indicators would require the most amount of start-up time or effort, which would require the least, and when should this data collection begin?
- (l) Are there any particular cautions or issues for CMS to consider in developing data definitions for these indicators?
- (m) Are there any particular special cases or conditions that should be adjusted for or accounted for in the indicators, the data definitions, or the data?
- (n) What indicators, if any, should CMS consider related to user experience?
- (o) What indicators should CMS consider related to monitoring the continuity of coverage over time and across Medicaid, CHIP, and the Exchange? How could such indicators be measured?

- (p) What indicators, if any, should CMS consider related to annual redetermination?
- (q) For each of the indicators, are there sub-group indicators that would be important to collect (for example, for the eligibility and enrollment indicators showing data broken out by MAGI and non-MAGI determinations, determinations based on disability status, or determinations for children versus adults; for the provider indicators, for example, breaking the data out by provider types.)
- (r) Would performance indicators established for Medicaid and CHIP eligibility and enrollment be appropriate in measuring the performance of the Exchange, as a component of an overall Exchange performance measurement strategy that will also address other operational areas?