

Maximizing Enrollment

Transforming State Health Coverage

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New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance

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Introduction

Collecting, analyzing, and using data to monitor enrollment and retention can be a powerful tool to help states assess and improve performance in administering public and publicly subsidized insurance affordability programs like Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program, and state health insurance exchanges. *Maximizing Enrollment*, a national program of the Robert Wood Johnson Foundation, has been working intensively with eight states since February 2009 to assist their efforts in effectively using enrollment and retention data to improve coverage for eligible individuals.¹ The lessons learned by these states can help to inform other state and federal policymakers' decisions about how to measure the performance of enrollment initiatives. A relatively simple step states can take is to improve how they capture the reasons why an individual is denied coverage at application, or why an individual is disenrolled from coverage.

The *Maximizing Enrollment* program has worked intensively with eight states to help them more effectively use data to improve performance in enrolling and retaining eligible individuals. This brief shares specific recommendations for a method to classify denials and disenrollments, discusses why this is a powerful tool to understand the effect of policy changes, and shows how states can bridge from their current complex coding systems to a more streamlined system.

The way that states currently capture reasons for denial and disenrollment often relies on complicated, cluttered coding techniques that may not produce reliable information. States involved in the *Maximizing Enrollment* program have experienced firsthand the pitfalls of trying to work with their existing coding systems and have requested help designing an approach that would make these data more useful. This brief shares specific recommendations for a method to classify denials and disenrollments, discusses why this coding is a powerful tool to understand the effect of policy changes, and shows how states can bridge from their current complex coding systems to a more streamlined system.

Improving how denial and disenrollment reason codes are organized has three major benefits. First, moving to a simpler system for capturing this information will allow states to more easily produce and monitor reliable program metrics. Second, a more streamlined and standardized system will allow states to understand the underlying causes for denials and disenrollment, and address problems keeping eligible people from getting and staying enrolled. Third, enhanced federal funding for eligibility system improvements that is currently available makes this an opportune time for states to change the way they capture and use data.

This brief is the second in a series presenting recommendations on how states can better use data to monitor and improve policy implementation and program performance. These recommendations were developed by



Mathematica Policy Research, Inc., which is evaluating the *Maximizing Enrollment* program for the Robert Wood Johnson Foundation, in consultation with the National Academy for State Health Policy, the National Program Office for *Maximizing Enrollment*, based on their work with states to analyze and understand enrollment and retention figures collected through the course of the project. *Maximizing Enrollment* grantee states and technical experts reviewed and contributed to the development of these proposed codes.

The first brief in this series, *Using Data to Drive State Improvement in Enrollment and Retention Performance*, described a set of advanced performance metrics, including rates of retention for individuals who may potentially be eligible for coverage. In order for a state to be able to construct those measures, it needs to have reliable disenrollment and denial reason codes to describe why individuals are losing coverage.²

Background

Eligibility workers in most states currently use disenrollment and denial reason codes when an individual's application is denied or their period of enrollment in a program like Medicaid ends, but several problems limit the usefulness of existing systems.

First, the code sets are large and cluttered. Some states maintain well over 100 denial and disenrollment reason codes, many with overlapping or similar definitions. Each individual code may have been added for a good reason, but taken together, the sheer volume of codes, combined with complicated and confusing definitions, makes it difficult for eligibility staff to apply the codes consistently and reliably. Consequently, most states are not able to use this information to monitor and improve their programs.

Second, the code sets are, in some ways, too specific. States have added new codes over time to capture specific kinds of denials or exits. Often, the complexity arises because a single code is used to capture a person's status on several eligibility criteria. The following denial code used in one state illustrates the problem: "Childless adult, not pregnant, not disabled, not eligible for breast or cervical cancer treatment program, not long-term unemployed, unemployed not working for a small business; income less than or equal to 133% FPL." Complex codes are hard for eligibility workers to apply and make it difficult for policymakers to use the information.

Third, codes are not consistent across states. Every state has its own set of codes and similar concepts are coded differently across states. For example, the following reason codes are used in different states to capture income-related closures:

- *State A*: earned income increased, less support or expenses to disregard, more student income to disregard, and received a one-time case payment;
- *State B*: net income exceeds limits, income disregard ends, and child support payments increased;
- *State C*: no longer meets income or resource requirements, auto cancellation for spend down eligibility.

These differences in coding will become even more important as states increasingly work across state lines to coordinate on eligibility of individuals who live and work across state lines or move frequently between states in a post-Affordable Care Act (ACA) world. Having a common set of reason codes for disenrollment will allow a state to measure its performance against other states and to report quality assurance data on enrollment performance to federal agencies in the future. Common codes will also better enable policymakers to understand trends and policy drivers for denials and disenrollment across states, to enable development of future policies that can address these drivers when the need arises.

A smaller, more consistent, better defined set of reason codes would help states to answer a number of important questions, such as: When individuals lose Medicaid coverage, was it because their income changed? Was it because they did not return paper documentation that the state requires? When the state sees a spike in the number

of disenrollments in a month, can the state identify any common reasons why people left the program? How well is the state doing at keeping people enrolled in coverage who meet the program’s eligibility standards?

Virginia offers an example of a case where improving disenrollment codes helped the state to better understand its programs. When Virginia started its separate CHIP program, it set up a new set of denial reason codes, which were fewer in number than in Medicaid and applied through automated system rules. In the state’s Medicaid program, eligibility workers applying codes manually appear to rely on catchall codes, such as “individual no longer meets non-financial program requirements.” While catch-all codes are convenient for workers, because they can apply to a variety of situations—“non-financial program requirements,” for example, could apply to age, family composition, or citizenship status—they do not allow for useful differentiation of denials. The state found that CHIP’s streamlined, yet more precise codes have enabled more useful analysis of CHIP policies than can be obtained from the Medicaid program.³

Fundamentally, an improved code set would help states to better understand whether individuals leaving or denied coverage fall into one of three groups:

1. Cases where the state has ***established ineligibility***—that is, the state knows the individual is properly leaving the program because he or she does not meet the program’s eligibility guidelines due to age, income, or some other criteria.
2. Cases where the reason for coverage ending is ***not related to eligibility***—for example, when a person fails to make required premium payments.
3. Cases where individuals lose coverage because their ***eligibility cannot be established***—this is an outcome that can occur frequently because information on a program application or renewal form is incomplete or incorrect. Examples of these administrative or procedural denials may include cases where the person does not complete and return paperwork, or cannot be reached due to a bad address. The person may still meet the criteria of the program, but the state does not know that definitively.

States should work toward the ideal of establishing the eligibility of all those who should be enrolled or retained in coverage and confirming the ineligibility of the rest. In doing so, a state may reduce sharply the number of individuals churning on and off their programs, or that otherwise apply repeatedly. This can cut the time programs need to spend processing repeated applications and reduce periods of uninsurance that put individuals at serious risk for unmet health care needs and financial problems. A 2008 study in California found that children who lost Medicaid coverage for just three months had expenditures that were 1.7 times higher in the month they returned than in the months preceding their disenrollment, and that this was driven by an increase in inpatient hospital spending.⁴ Moreover, Louisiana found that reducing churn by expanding its use of automated renewal pathways saved over \$10 million in costs for printing and postage for correspondence, as well as costs for manpower necessary to process outgoing and incoming forms.⁵ Retaining as many of those eligible for coverage as possible may help states to realize administrative efficiencies, cost savings, and better health outcomes. These new disenrollment and denial reason codes will improve states’ capacity to monitor program performance so they can accomplish their enrollment and retention goals.

Reason Code Principles

Several principles informed the design of the coding approach set forth in this brief:

- The codes should classify exits and denials into the **three basic categories** described previously: (1) cases where the state can *establish ineligibility* of a person based on available information, (2) cases where the person leaves coverage for a reason *not related to eligibility* (he or she opts not to enroll or

stay enrolled, or fails to make premium payments to stay enrolled), and (3) cases where *eligibility cannot be established* because the information needed to make a determination is missing or incomplete.

- Codes should be **mutually exclusive** so that any given reason fits into only one code. If, for example, a denial related to an individual aging out of coverage could be assigned to more than one code, the state runs the risk of the codes being inconsistently applied, and thus drawing incorrect conclusions from the data.
- Codes should be **few in number**, so that they can be managed as easily as possible.
- When multiple reasons apply in a single case, states may assign more than one code but there must always be one primary code and a **clear rationale for determining which code is primary**.

Suggested Standard Reason Codes

Exhibit 1 presents the proposed standard set of reason codes for denials and disenrollments. The rightmost column lists examples of existing state codes and shows how they would map to the new framework.

Exhibit 1: Proposed Standard Codes for Program Denials and Exits⁶

Code	Description	Examples of State Codes
GROUP ONE: Ineligibility Established		
1	Death of the applicant or enrollee	<ul style="list-style-type: none"> - Death, date unknown - Death, date known
2	Age is outside of the program's eligibility range	<ul style="list-style-type: none"> - Child reached maximum age - Program not available for adults - Recipient reaches age 65
3	Citizenship or immigration status is known and criteria not met	<ul style="list-style-type: none"> - Alien status or does not meet citizenship or non-citizen status rules - Adult does not meet citizenship requirement
4	Income, assets, or earnings exceed or fall below the program's eligibility thresholds; health care expenditure (spend down) requirements not met	<ul style="list-style-type: none"> - Income or unearned income in excess of program limits - Assets in excess of program limits - Asset transfer - Increase in social security income - Client no longer has enough bills to spend down
5	Household or family composition criteria not met (such as presence or absence of child(ren) in home; presence or absence of parent(s) in home)	<ul style="list-style-type: none"> - Child no longer in the home - Absent parent returned home - Marriage or remarriage of parent - No eligible child in the home
6	Time-limited eligibility period ended (including transitional medical assistance and presumptive eligibility period)	<ul style="list-style-type: none"> - 60-day time limited health benefit is ending - End of 24-month benefits—no request for extension - End of presumptive eligibility period - Postpartum period ended

GROUP ONE: Ineligibility Established		
7	Residency criteria not met (not in state; entered or discharged from an institution or facility; not in service area) ⁷	<ul style="list-style-type: none"> - Entered or discharged from institution or facility (criminal justice, mental health) - Not a resident of state; moved out of state - Moved out of service area
8	Requirements related to presence of other health insurance are not met ⁸	<ul style="list-style-type: none"> - Applicant is not uninsured (CHIP program) - Health insurance exchange applicant has access to affordable employment-based coverage
9	Medical/health status or condition, or need for a given level of care criteria not met ⁹	<ul style="list-style-type: none"> - Failure to meet disability requirements; recipient no longer disabled - Denied for medical exam or medical report - Does not meet level of care
10	Other categorical eligibility criteria not met (such as child support enforcement rules; deprivation standards; required number of work hours; required school attendance)	<ul style="list-style-type: none"> - Teen parent no longer meets school/GED requirement - Failure to cooperate with child support enforcement - No longer working, no longer meets work requirement - Did not cooperate with quality control
GROUP TWO: Not Related to Eligibility		
11	Declined enrollment (e.g., after Express Lane Eligibility or ex parte determination ¹⁰) or requested to be disenrolled	<ul style="list-style-type: none"> - Voluntary withdrawal or written request to terminate all benefits. - Will reapply later, not currently interested - Recipient requested closure; appears to remain eligible - Unhappy with program
12	Failed to make required premium payment	<ul style="list-style-type: none"> - Non-payment of premium - First premium never received
GROUP THREE: Eligibility Cannot Be Established		
13	Lost to follow up, unable to locate	<ul style="list-style-type: none"> - Whereabouts unknown, no mail returned - Whereabouts unknown, mail returned - Cannot locate
14	Missing forms, verification, other information ¹¹	<ul style="list-style-type: none"> - Failure to complete or return application or renewal form - Failure to provide documentation or verification (identity, SSN, citizenship, income, assets, health status, medical condition, other) - Failure to schedule an eligibility review

Sub-Codes and Analysis of Sub-Groups

Exhibit 1 lays out a general framework for organizing denial and disenrollment reason codes, but states will also have circumstances and policies that they will want to track specifically. This was the case in Louisiana, where the state needed to track Medicaid disenrollments related to people displaced by Hurricane Katrina who left the state. However, most if not all codes needed to track reasons for denials and disenrollments can fit within the framework presented here. States can add more detailed “sub-codes” within the standard set to capture these data, while still allowing for comparison among states at the level of the 14 main codes. In our example, Katrina displacements fall within the “residency” category. As with the standard set, any sub-codes must be mutually exclusive and as few in number as feasible. States should limit the use of sub-codes to capture only essential information so the coding scheme stays streamlined and easy to apply consistently.

States may also want to track and analyze denials and disenrollments for discrete groups of individuals, but it is recommended that this generally not be done through sub-codes. For example, states may want to continue to track the number of children losing coverage because they aged out of child coverage. Code #2, “Age is outside the program’s eligibility range” captures this circumstance, as well as other instances such as individuals who have reached age 65. How should a state differentiate these two cases? Rather than adding a sub-code for “child reached maximum age,” and every other age-related instance, the state should instead produce reports that break out the number of disenrollments processed with Code #2 by eligibility category. Modern eligibility systems and relational databases have the ability to produce such data reports. This will allow the state to easily distinguish children who lose coverage for age-related reasons from adults, without adding a large number of sub-codes.

Failure to Pay Premiums

Failure to pay premiums is a common reason code that merits further discussion. There are many possible reasons why a person might not pay a premium. Sometimes people remain eligible, but do not have the money to pay, forget to make the payment, or no longer want to be enrolled in the program. In other cases, people may not make payments because they became ineligible; for instance, they may have moved out of state or obtained other coverage. Often the program will not know why the premium has not been paid, but if the program knows someone is in fact no longer eligible for one of the Group One reasons, that should be the primary reason assigned to the case. If the state decides to track more than one reason code, failure to pay premiums will be a secondary reason.

Changes in Eligibility Category and Transfers Between Programs

The codes presented in this brief capture the reasons why an individual is *denied* or *exits* coverage. They do not look at ***movement from one category to another*** within a program – such as when an individual ages out of a “child” Medicaid coverage category, and is determined eligible to move into an adult category. Cases that close when a person transfers from one eligibility category to another within the same program are not the same as an exit from the program, so transfers like this should be tracked separately from denials and exits from the program.

Similarly, when someone ***transfers from one program to another***, such as from Medicaid to CHIP, it is important to capture the reason why the person is no longer eligible for the program he or she is leaving. For example, when a person’s income increases and the Medicaid program transfers the person to CHIP, the primary exit reason would be that income increased rather than “transfer to CHIP.” While it is also important to track the transfer to another program, this is not the underlying reason for program ineligibility. The tracking of individuals’ movements from one program to another will become even more important as coverage expansions through the ACA take effect. By separating the information on transfers (both within and across programs) from information on true exits and denials, states will be in a better position to tally and understand these different types of movement.

Conclusion

As states think forward to bringing millions of new individuals into health insurance programs, enrollment and retention data will be a vital source for states in assessing their performance and in benchmarking with other states. In order to make data about denials and disenrollments meaningful, states need a simple, usable framework for tracking why individuals fail to enroll or leave coverage, and whether policies intended to reduce the paperwork burden on beneficiaries are having their intended effect. Taking the opportunity afforded by the ACA, states can put a more standardized, simpler system in place that should give them a much clearer picture of how well they are doing at achieving their goals for enrollment and retention.

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Notes

¹ The eight states are Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin. The program was originally launched as *Maximizing Enrollment for Kids* in 2008, but expanded its focus to include state efforts to ready enrollment systems for newly eligible individuals in 2014 after the enactment of the ACA in 2010.

² See *Using Data to Drive State Improvement in Enrollment and Retention Performance*, available at <http://www.maxenroll.org/resource/using-data-drive-state-improvement-enrollment-and-retention-performance>.

³ Interview with Rebecca Mendoza, Director, Division of Maternal and Child Health, Virginia Department of Medical Assistance Services, May 17, 2012.

⁴ Gerry Fairbrother and Joseph Schuchter, Child Policy Research Center. “Stability and Churning in Medi-Cal and Healthy Families,” March 2008. <http://www.cincinnatichildrens.org/workarea/linkit.aspx?linkidentifier=id&itemid=89566&libid=89262>.

⁵ Don Gregory, Medicaid Director, Louisiana Department of Health and Hospitals, “How We Transformed the Medicaid Eligibility Process in Louisiana.” Presentation to Alliance for Health Reform, Washington DC, May 20, 2011. Retrieved June 4, 2012 from http://allhealth.org/briefing_detail.asp?bi=213.

⁶ Note that these codes are intended to capture the full range of potentially applicable reasons for denial or exit; some reason codes will not apply in every program.

⁷ In some cases an individual entering a criminal justice or mental health institution will have their eligibility suspended until they are discharged. These cases would be included in this reason category; states could opt to use a sub-code to distinguish “suspensions” from disenrollments.

⁸ Under current law, CHIP requires applicants be uninsured at the time of enrollment, and some states require that applicants be uninsured for a number of months prior to enrolling in CHIP. In 2014, the ACA empowers either state or federally facilitated health insurance exchanges to deny applicants for coverage if they have access to “minimum essential coverage”, including the opportunity to enroll in affordable employer-sponsored insurance.

⁹ Cases where required documentation or verification of medical condition, health status, or level of care is missing should be captured using code 14 (missing forms, verification, other information).

¹⁰ Express Lane Eligibility is an expedited enrollment pathway by which a Medicaid agency accepts an income finding from another program, such as the Supplemental Nutrition Assistance Program, in order to make a Medicaid eligibility determination without requiring additional information from the individual. Similarly, “ex parte” determinations rely on data from sources other than the individual in order to make an eligibility determination or renewal.

¹¹ Under current law, most states require paper documentation to verify eligibility, but the ACA will dramatically change documentation processes and requirements for states, increasing the burden on states to verify eligibility through electronic data matches, wherever possible. In addition, the ACA requires states to use electronic data to verify continued eligibility at renewal to the greatest extent possible and to provide streamlined prepopulated forms to renew coverage via mail, phone, online or in person, at the individual’s option. Both of these new requirements reduce the likelihood that states will be determining ineligibility for coverage based on absent forms in future, but there will still be a need for this code in less frequent cases where the applicant fails to respond to requests for documentation or renewal verification.

ABOUT MAXIMIZING ENROLLMENT

This issue brief is a product of *Maximizing Enrollment: Transforming State Health Coverage*, which is a \$15 million, four-year initiative of the Robert Wood Johnson Foundation (RWJF). Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, *Maximizing Enrollment* aims to help states transform their eligibility and enrollment systems to improve enrollment and retention of individuals who are now eligible for Medicaid and the Children’s Health Insurance Program (CHIP), and to prepare to enroll newly eligible individuals and families in public and publicly subsidized health coverage. By helping selected states improve their systems, policies and procedures—and measure the impact of these changes—RWJF hopes not only to increase the efficiency and effectiveness of these programs in enrolling and retaining those eligible, but to share knowledge about what works to increase enrollment and retention within public and publicly subsidized health coverage in all states. www.maxenroll.org

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