

Identifying and Benchmarking the Number of Medicaid Beneficiaries with Comprehensive Benefits in 2017

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2017 TAF version 2

TAF data quality brief—Enrollment benchmarking

This analysis focused on the 46 states, the District of Columbia, and Puerto Rico. Mississippi, Missouri, Montana, and Nebraska were excluded from the analysis.

Key Findings

- This brief describes the most reliable method for identifying Medicaid beneficiaries with comprehensive benefits in the 2016 T-MSIS Analytic File and benchmarks the number of Medicaid beneficiaries with comprehensive benefits against an external source of data—the Eligibility and Enrollment Performance Indicator (PI) data.
- The most reliable method for identifying Medicaid beneficiaries with comprehensive benefits in the 2017 annual Demographic and Eligibility T-MSIS Analytic File is to use the CHIP code (or the eligibility group code if the CHIP code is missing) to identify Title XIX Medicaid beneficiaries and then to further subset the population by using the restricted benefits codes that indicate eligibility for comprehensive benefits.
- In 21 states, the T-MSIS Analytic File-based counts generated with this method were within 5 percent of the counts based on PI data. In 9 states, the T-MSIS Analytic File-based counts were within 5 to 10 percent of the PI counts.
- In 9 states, the T-MSIS Analytic File-based enrollment counts differed from the benchmark by 10 to 20 percent. In 8 states, the T-MSIS Analytic File-based enrollment counts differed from the benchmark by more than 20 percent. Among these 8 states, Colorado, North Dakota, Rhode Island, and Wisconsin each had a difference of more than 50 percent between their T-MSIS Analytic File-based and PI counts (shown in Table 3), and we considered their data to be unusable for identifying beneficiaries in Medicaid with the method used in this brief.
- T-MSIS Analytic File users are encouraged to use the eligibility group code only when the CHIP code is missing, as the CHIP code appears to be more reliable than the eligibility group code for distinguishing between Medicaid and CHIP enrollment.

Background

The research-ready T-MSIS Analytic Files (TAF) are an enhanced set of data on beneficiaries in Medicaid and in the Children’s Health Insurance Program (CHIP), on their claims, and on the participating managed care plans and providers that serve them. Because many TAF users

need to identify and count Medicaid beneficiaries¹ with comprehensive benefits,² this brief discusses the most reliable method for doing so in the most states and in the District of Columbia.³

Three variables in the annual Demographic and Eligibility (DE) TAF can be used to identify Medicaid beneficiaries who have comprehensive benefits (Table 1). These variables are CHIP code (CHIP_CD), eligibility group code (ELGLTY_GRP_CD), and restricted benefits code (RSTRCTD_BNFTS_CD). TAF users cannot identify Title XIX Medicaid enrollment by using the Medicaid enrollment days variable (MDCD_ENRLMT_DAYS) because that variable also includes days during the month in which the beneficiary was enrolled in the Title XXI Medicaid expansion CHIP, which is outside the scope of this brief.

Table 1. Potential TAF DE variables for identifying Title XIX Medicaid beneficiaries

Data element	Use in identifying Medicaid and CHIP beneficiaries
CHIP_CD	Identifies individuals in Medicaid (CHIP_CD = 1), Medicaid expansion CHIP (M-CHIP) (CHIP_CD = 2), and Separate CHIP (S-CHIP) (CHIP_CD = 3) ^a
ELGLTY_GRP_CD	Contains the eligibility group applicable to the individual, based on the state’s eligibility determination process Can be used to distinguish enrollment in Title XIX Medicaid (ELGLTY_GRP_CD = 1–60 or 69–75) ^b from Title XXI S-CHIP and M-CHIP (ELGLTY_GRP_CD = 31, 61–68)
RSTRCTD_BNFTS_CD	Indicates the scope of Medicaid benefits to which a beneficiary is entitled during the month Can be used to distinguish between individuals not eligible for Medicaid or CHIP benefits during the month (value of 0); those enrolled with full or comprehensive benefits (values of 1, 4, 7, A, B, or D); ^c and those enrolled with limited or partial benefits (values of 2, 3, 6, or C) RSTRCTD_BNFTS_CD = 5 indicates that the individual is eligible for Medicaid or M-CHIP, but for reasons other than alien, dual eligibility, or pregnancy-related status, is entitled to restricted benefits only (for substance abuse treatment, a medically needy designation, or other criteria, for example); this category includes a mix of beneficiaries with comprehensive and partial benefits (likely the medically needy) in some states and thus cannot consistently be used to distinguish between comprehensive and partial benefits.

Source: TAF Data Dictionary.

Note: These three data elements are available monthly in the TAF DE; the number of each month is appended to the end of the data element name (for instance, CHIP_CD_01 for January, CHIP_CD_02 for February, and so on). For simplicity, we did not include the monthly indicators in this brief because we used data from all months in 2017.

Maintenance assistance status and basis of eligibility (MASBOE_CD), which was constructed from the T-MSIS data elements MAINTENANCE-ASSISTANCE-STATUS and MEDICAID-BASIS-OF-ELIGIBILITY, has been phased out in favor of the new, more detailed T-MSIS eligibility group code; MASBOE_CD is not recommended for use.

We also did not include Medicaid enrollment days (MDCD_ENRLMT_DAYS) or CHIP enrollment days (CHIP_ENRLMT_DAYS) because they cannot be used to distinguish the Medicaid-only population whose coverage is funded through Title XIX. The variable for Medicaid enrollment days combines Medicaid with M-CHIP; CHIP enrollment days is just for S-CHIP. In addition, the TAF DE equivalent of the T-MSIS enrollment type variable

¹ This brief focuses on beneficiaries whose coverage is funded by Title XIX, which does not include Medicaid-expansion CHIP.

² Comprehensive benefits refers to coverage comparable to that provided to categorically needy Medicaid beneficiaries; it is considered to be minimum essential coverage under the Affordable Care Act. In addition, states can offer restricted Medicaid benefits to individuals on the basis of alien status, dual eligibility, or pregnancy-related status; some beneficiaries are eligible for only limited benefits, such as family planning or emergency services.

³ Two other TAF DQ briefs (see TAF DQ briefs #4031 and #4051) separately benchmark the CHIP population and all beneficiaries with comprehensive benefits.

(ENROLLMENT-TYPE) is enrollment type flag (ENRL_TYPE_FLAG), which groups beneficiaries in the same manner as Medicaid and CHIP enrollment days and therefore cannot be used to identify the Medicaid-only population.

^aCHIP_CD = 4 (individual was both Medicaid eligible and S-CHIP eligible during the same month) is not a valid value in later versions of the T-MSIS data dictionary. Five states (Georgia, Louisiana, Maine, Texas, and Wisconsin) were still reporting this code for a few beneficiaries in 2017.

^bThere are three invalid eligibility group codes in this range—10, 57, and 58—which should not be included.

^cA restricted benefits code value of 1 indicates comprehensive Medicaid or CHIP benefits; value 4 indicates that the individual, although eligible for Medicaid or CHIP, is entitled only to restricted benefits for pregnancy-related services; value 7 indicates Medicaid enrollment in an alternative package of benchmark-equivalent Medicaid benefits; value A indicates eligibility for Medicaid benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant; value B indicates eligibility for Medicaid benefits through a Health Opportunity Account; and value D indicates eligibility for Medicaid benefits under a Money Follows the Person rebalancing demonstration. We included beneficiaries with a restricted benefits code of 4 (restricted benefits for pregnancy-related services) because most states (except Arkansas, Idaho, and South Dakota) extend benefits that meet the minimum essential coverage requirements for beneficiaries in this category. For additional information on the restricted benefits code variable, please see DQ Brief #4161, “Usability of the Restricted Benefits Code in 2016.”

When data elements capture similar information, states should populate them consistently.⁴ For example, if the CHIP code identifies an individual as enrolled in Medicaid, then that individual should also be identified as a Medicaid beneficiary by the eligibility group code. However, the information from these two data elements is not always consistent. To determine which of these data elements is more reliable, either alone or in combination, for identifying Medicaid beneficiaries with comprehensive benefits, we analyzed the count of Medicaid beneficiaries with comprehensive benefits relative to an external benchmark. This brief describes the methods we used for this analysis and the results of the analysis.

Methods

Using the 2017 TAF data,⁵ we evaluated the usability of different variables for identifying the Medicaid population with comprehensive benefits. To identify the most reliable approach, we compared monthly counts of Medicaid beneficiaries in the 2017 TAF DE to monthly counts from the Eligibility and Enrollment Performance Indicator (PI) data, which included only beneficiaries with comprehensive benefits enrolled as of the last day of the month.⁶ Although the PI data have quality issues that may limit their accuracy in some cases, they are the best available source for an external benchmark for the Medicaid and CHIP population because many of the data quality issues are known, and the data provide a consistent benchmark across multiple data quality briefs. Limitations relevant to the PI data are noted in the Table 3 footnotes.

To create the TAF-based counts, we counted individuals enrolled at any point (“ever enrolled”) in the month. We compared the performance of different variables by (1) evaluating the percent difference between the TAF-based enrollment counts and the benchmark for each month and then averaged across all 12 months, and (2) examining the standard deviation of

⁴ States are actively addressing many of the data quality and completeness issues raised in this brief. Some of these issues may have been resolved because these analyses were conducted or the issues were fixed in subsequent years of the TAF.

⁵ This analysis used the same TAF data as the T-MSIS Substance Use Disorder Data Book, which is not the version of the data that will be released as TAF Research Identifiable Files (RIFs).

⁶ Unfortunately, PI data do not include Puerto Rico or the U.S. territories. At the time of these analyses, Puerto Rico’s data were available in the TAF DE. We included these data in the tables in this brief, although a benchmark count was not available.

this measure to assess variation in the difference across months. Because the benchmark data can be viewed as a baseline and the TAF-based calculations as the comparison, the percent difference is calculated as a percent error or change: $\frac{(TAF - PI)}{PI} * 100$. Table 2 shows

the level of concern for the TAF Medicaid enrollment counts based on both the percent difference and the level of alignment between the TAF and the PI enrollment counts. Although we did not assign the level of concern based on the standard deviation, we provide this information in the tables, and TAF users may want to consider the monthly variability between TAF and the benchmark when determining whether the data are usable for their analysis.

Table 2. Level of concern for Medicaid enrollment counts

Percent difference between TAF counts and PI counts	Level of alignment	Level of data quality concern
≤ 5 percent	High	Low
5 to ≤ 10 percent	Moderate	Low
10 to ≤ 20 percent	Low	Medium
20 to ≤ 50 percent	Very low	High
> 50 percent	Very low	Unusable

We treated the restricted benefits code 4 group differently from how we treated the restricted benefits code 5 group. We made this decision because the comprehensiveness of benefits for the code 4 group is determined at the state level (i.e., the individuals in this group are eligible for Medicaid or CHIP but are entitled to restricted benefits for pregnancy-related services only). We could therefore alter the rules by state by (1) excluding the code 4 group in states that do not extend comprehensive benefits to this group (Arkansas, Idaho, and South Dakota) and (2) including the code 4 group in all other states. However, the code 5 group is a more heterogenous mix of beneficiaries, some of whom have comprehensive benefits in some states (i.e., the individuals in this group are eligible for Medicaid or Medicaid-Expansion CHIP, but for reasons other than alien, dual eligibility, or pregnancy-related status, they are entitled to restricted benefits only [for substance abuse, a medically needy designation, or other criteria]). Therefore, instead of developing state-level rules for the code 5 group, we conducted sensitivity analyses and provided recommendations on including this group.

Findings

We found that the most reliable method for identifying Medicaid beneficiaries with comprehensive benefits in the most states was to use the CHIP code (or the eligibility group code if the CHIP code was missing) to identify Medicaid beneficiaries and to then use the restricted benefits code to identify those with comprehensive benefits. Specifically, we used `CHIP_CD = 1` to identify the Medicaid population. If the CHIP code was missing, we counted beneficiaries with an eligibility group code that indicated they were eligible for Medicaid benefits (`ELGBLTY_GRP_CD = 01–60 or 69–75`). We then used `RSTRCTD_BNFTS_CD = 1`,

4, 7, A, B, or D to identify beneficiaries with comprehensive benefits.⁷ With this method, 21 states of the 47 included in the analysis had high alignment with the benchmark, 9 states had moderate alignment, 9 states had low alignment, and 4 states had very low alignment (Table 3). Four states—Colorado, North Dakota, Rhode Island, and Wisconsin—had a difference of more than 50 percent between their TAF-based and PI counts. We therefore determined that, if we used the method described in this brief, the data from these four states could not be used to identify the Medicaid population with comprehensive benefits.

Overall, there was little month-to-month variation in how the TAF-based counts performed against the benchmark in 2017. The states in which the variability was greatest were Wisconsin (standard deviation (SD) = 43.8), followed by Illinois (SD = 27.7) and Minnesota (SD = 21.3). Before October 2017, there were no beneficiaries with comprehensive benefits in the TAF in Wisconsin. However, the alignment of the TAF with the benchmark improved dramatically—from very low to high alignment—starting in October 2017, when the state began to report Medicaid beneficiaries with comprehensive benefits who could be counted by using the method in this brief. There were almost no beneficiaries with comprehensive benefits counted in the TAF for Illinois in January 2017, but the alignment between the TAF and the PI data was high for all other months once the TAF reporting improved. Minnesota's TAF counts were substantially lower in March 2017 than they were in all the other months, which drove the high variability between the TAF and the benchmark in the state. The PI counts were fairly consistent in all three states across all 12 months of 2017, suggesting that it was the TAF enrollment counts, not the PI data that raised concerns about data quality.

Using the CHIP code—and the eligibility group code when the CHIP code was missing—was more reliable than using the CHIP code alone to identify Medicaid beneficiaries. Although this approach did not change the TAF alignment status in any of the states, the alignment still improved in seven states when the eligibility group code was used when the CHIP code was missing; these states are Arkansas, Colorado, Idaho, Nevada, North Dakota, Rhode Island, and West Virginia. In four states (Ohio, Texas, Wisconsin, and Wyoming), the alignment became worse when this approach was used, but it was not significant enough to reduce the alignment to a lower level.

As a sensitivity test, we investigated whether the TAF's alignment with the benchmark improved when we included beneficiaries with a restricted benefits code of 5 in the group with comprehensive benefits. In most states, very few beneficiaries have this restricted benefits code, so including it did not change the extent to which the TAF-based counts in these states aligned with the benchmark. However, in four states, the TAF's alignment with the PI data changed when the code 5 group was included. In one of these states, the alignment became worse (Vermont's TAF data moved from high to moderate alignment), suggesting that most beneficiaries in the code 5 group in Vermont do not have comprehensive benefits. The alignment improved in three states: Arkansas, New Mexico, and North Carolina. The improvement was particularly dramatic in New Mexico, whose TAF data moved from a very low level of alignment to a high level of alignment. There was a positive change in Arkansas as

⁷ We excluded the code 4 group that has restricted benefits in the three states that do not extend comprehensive benefits to women in the pregnancy group (Arkansas, Idaho, and South Dakota).

well, albeit not as dramatic as the change in New Mexico. The alignment of Arkansas’ data with the benchmark moved from very low to moderate. Both states appear to be placing a larger-than-average number of beneficiaries in the code 5 group; because including the code 5 group dramatically improved the TAF’s alignment with the benchmark, the majority of these beneficiaries might have comprehensive benefits.

For TAF users who wish to treat the restricted benefits code 5 group in the same way across all states, we recommend not including that group when identifying Medicaid beneficiaries with comprehensive benefits. We did not include the group in Table 3. However, TAF users who are willing to vary their approach to the restricted benefits code 5 group by state would be best served by including beneficiaries in the code 5 group in Arkansas, New Mexico, and North Carolina, where alignment improved when these beneficiaries were included.

Table 3. Comparison of TAF DE counts with PI counts for Medicaid beneficiaries with comprehensive benefits, 2017

State	Average monthly TAF enrollment count	Average monthly PI enrollment count	Average monthly difference between TAF and PI counts ^a	Average monthly percent difference between TAF and PI counts (%)	Standard deviation of the average monthly percent difference between TAF and PI counts (%)
High alignment between TAF and the benchmark (n = 21 states)—low data quality concern					
Massachusetts	1,504,120	1,500,304	3,816	0.3	1.7
Tennessee	1,451,719	1,458,279	-6,560	-0.5	0.2
Nevada	597,875	594,237	3,638	0.6	0.2
Vermont	164,255	162,482	1,773	1.1	0.4
California	11,138,796	11,004,112	134,685	1.2	0.2
Iowa	591,121	584,928	6,193	1.2	3.7
Maryland	1,177,761	1,162,787	14,974	1.3	0.2
Michigan ^b	2,341,083	2,311,231	29,852	1.3	0.4
Ohio ^c	2,718,156	2,671,630	46,526	1.8	4.9
Washington ^b	1,708,533	1,740,261	-31,729	-1.8	0.3
Idaho ^c	267,521	272,934	-5,412	-2.0	0.4
South Carolina	975,263	955,903	19,359	2.0	0.5
South Dakota	99,394	102,996	-3,602	-3.5	0.1
New Jersey	1,527,733	1,584,598	-56,865	-3.6	0.6
New Hampshire	167,937	174,777	-6,840	-3.9	1.5
Minnesota	1,022,274	1,065,416	-43,142	-4.1	21.3
Texas	3,913,887	4,096,520	-182,633	-4.1	5.8
Connecticut ^b	809,381	777,556	31,825	4.2	3.6
Arizona	1,716,362	1,645,537	70,826	4.3	0.6

Table 3 (continued)

State	Average monthly TAF enrollment count	Average monthly PI enrollment count	Average monthly difference between TAF and PI counts ^a	Average monthly percent difference between TAF and PI counts (%)	Standard deviation of the average monthly percent difference between TAF and PI counts (%)
Alaska	189,229	181,412	7,817	4.4	1.4
Oregon	926,436	886,240	40,196	4.6	2.5
Moderate alignment between TAF and the benchmark (n = 9 states)—low data quality concern					
Wyoming	59,844	56,926	2,918	5.1	1.7
Kansas	367,247	348,490	18,757	5.5	2.7
Oklahoma	648,767	688,813	-40,046	-5.8	1.8
District Of Columbia	239,311	256,057	-16,746	-6.5	2.3
Georgia	1,701,082	1,588,615	112,467	7.1	1.1
Pennsylvania	2,576,110	2,782,371	-206,261	-7.4	1.2
Illinois ^c	2,590,092	2,825,452	-235,360	-8.3	27.7
Virginia	969,522	889,743	79,779	9.0	0.4
North Carolina	1,682,065	1,858,255	-176,189	-9.5	0.6
Low alignment between TAF and the benchmark (n = 9 states)—medium data quality concern					
Alabama	808,192	733,669	74,523	10.2	0.4
Utah ^b	286,921	259,626	27,295	10.5	0.2
Delaware	208,664	233,861	-25,197	-10.8	0.1
Hawaii	357,999	322,744	35,255	10.9	0.4
Indiana ^c	1,236,563	1,394,337	-157,775	-11.3	0.8
West Virginia	470,955	530,817	-59,862	-11.4	8.8
Kentucky	1,330,807	1,172,731	158,076	13.5	0.7
Florida	3,479,289	4,137,283	-657,994	-15.9	0.2
New York ^b	4,773,632	5,867,696	-1,094,063	-18.7	0.1
Very low alignment between TAF and the benchmark (n = 4 states)—high data quality concern					
Maine	205,296	262,577	-57,282	-21.8	0.3
Louisiana	996,884	1,325,061	-328,177	-24.8	0.9
New Mexico	470,662	755,460	-284,798	-37.7	0.4
Arkansas ^b	418,813	836,211	-417,398	-49.9	1.0
Unusable data under recommended method (n = 4 states)					
Colorado	597,427	1,312,433	-715,005	-54.5	0.5
Wisconsin ^c	245,266	976,425	-731,159	-74.7	43.8
North Dakota	22,419	91,543	-69,125	-75.5	1.5
Rhode Island ^c	55,691	285,160	-229,469	-80.5	0.3

Table 3 (continued)

State	Average monthly TAF enrollment count	Average monthly PI enrollment count	Average monthly difference between TAF and PI counts ^a	Average monthly percent difference between TAF and PI counts (%)	Standard deviation of the average monthly percent difference between TAF and PI counts (%)
No benchmark data available (n = 1 state)					
Puerto Rico	2,413,950	—	—	—	—
Removed from analysis (n = 4 states)					
Mississippi	DQ	DQ	DQ	DQ	DQ
Missouri	DQ	DQ	DQ	DQ	DQ
Montana	DQ	DQ	DQ	DQ	DQ
Nebraska	DQ	DQ	DQ	DQ	DQ

Source: 2017 TAF DE as of January 2019 and PI enrollment counts.

Note: The TAF-based enrollment counts for Medicaid beneficiaries with comprehensive benefits for comparison with the PI data were calculated as CHIP_CD = 1, and if CHIP_CD was missing, we used ELGBLTY_GRP_CD = 01–60 or 69–75 and RSTRCTD_BNFTS_CD = 1, 4, 7, A, B, or D in all states except Arkansas, Idaho, and South Dakota. These three states do not provide comprehensive benefits to Medicaid beneficiaries who are eligible because of pregnancy. In these states, we used RSTRCTD_BNFTS_CD = 1, 7, A, B, or D to indicate comprehensive benefits.

High alignment is a difference of 5 percent or less when the percent difference is calculated on a monthly basis and then averaged across all 12 months of the year. Moderate alignment is a difference of greater than 5 percent and less than or equal to 10 percent. Low alignment is a difference greater than 10 percent and less than or equal to 20 percent. Very low alignment is a difference greater than 20 percent and less than or equal to 50 percent. In states with unusable data, the difference between the TAF-based count and the benchmark is greater than 50 percent.

The average monthly TAF enrollment count is calculated as $\frac{\sum_1^{12} TAF_m}{12}$, where m is each month. The average

monthly PI enrollment count is calculated as $\frac{\sum_1^{12} PI_m}{12}$, where m is each month. Because the benchmark data can be viewed as a baseline and the TAF-based calculations as the comparison, the percent difference between TAF and the PI counts for a given month is calculated as a percent error or change: $X_m = \frac{(TAF_m - PI_m)}{PI_m} * 100$. The average

monthly difference between the TAF-based count and the PI count is calculated as $\frac{1}{12} * \left(\sum_1^{12} (TAF_m - PI_m) \right)$ The

average of the monthly percent differences between the TAF-based count and the PI count is calculated as

$\mu = \frac{1}{12} * \left(\sum_1^{12} \left(\frac{(TAF_m - PI_m)}{PI_m} * 100 \right) \right)$ standard deviation of the monthly percent differences between the TAF-based

count and the PI count is calculated as $\sqrt{\frac{\sum_1^{12} (X_m - \mu)^2}{12}}$, where X_m is the percent difference in month m and μ is the average of the monthly percent differences.

^aThe difference between TAF and PI enrollment is based on an average of the monthly differences between these two data sources. As a result, it may not equal the difference between the average annual TAF enrollment and average annual PI enrollment.

^bThis state had a known data quality issue with its PI data at the time of the analysis. Arkansas’s PI data included private option beneficiaries. Connecticut and Michigan’s PI data may not include all beneficiaries. New York’s PI data included partial-benefit beneficiaries and estimated retroactive enrollment. Utah’s PI data included beneficiaries in other financial assistance

Table 3 (continued)

programs who are not enrolled in Medicaid or CHIP. Washington's PI data included individuals enrolled at any time in the month (not a point-in-time count).

^cThis state had a known T-MSIS data quality issue at the time of the analysis. The restricted benefits code (RSTRCTD_BNFTS_CD) for the majority of beneficiaries in Ohio, Rhode Island, and Wisconsin was missing in 2017. The majority of beneficiaries in Illinois had RSTRCTD_BNFTS_CD = 0 (the individual was not eligible for Medicaid or CHIP during the month) for 2017. Rhode Island was missing CHIP_CD on all records in 2017, and Idaho and Indiana were missing CHIP_CD on 20 to 30 percent of records in 2017. States are actively working to resolve these issues.

DQ = Mississippi, Missouri, Montana, and Nebraska were excluded from the analyses because of a very low volume of claims.

Laura Nolan¹, Allison Barrett¹, Mary Allison Geibel¹, Kimberly Proctor², and Jessie Parker². "Identifying and Benchmarking the Number of Medicaid Beneficiaries with Comprehensive Benefits in 2017." TAF DQ Brief #4062. Baltimore, MD: CMS, 2019.

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