

Tracking Medicaid Coverage Post the Continuous Coverage Requirement: Using Data Dashboards to Monitor Trends

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Introduction

Medicaid and the Children's Health Insurance Plan (CHIP) programs have played a key role in the response to the COVID-19 pandemic, providing a vital source of health coverage for millions of people. The Families First Coronavirus Response Act (FFCRA) Medicaid "continuous coverage" requirement has allowed people to retain Medicaid coverage and get needed care during the COVID-19 pandemic. Enrollment in Medicaid and CHIP has grown sharply since February 2020, with over 12 million enrollees added to state rosters as of May 2021.¹ When continuous enrollment is discontinued, states will restart eligibility redeterminations, and millions of Medicaid enrollees will be at risk of losing their coverage.² The current lack of publicly available and timely Medicaid enrollment, renewal, and disenrollment data will make it difficult to understand exactly who is losing coverage and for what reasons. One effective way to monitor this type of information is through the use of Medicaid enrollment and retention dashboards.

This issue brief examines the current status of data collection to assess Medicaid enrollment and retention, summarizes potential forthcoming reporting requirements, and describes some of the best practices states should consider when developing a data dashboard to display this type of information. The issue brief lays out a phased set of priority measures and provides a model enrollment and retention dashboard template states could use to monitor both the short-term impacts of phasing out public health emergency (PHE) protections and continuous coverage requirements, as well as longer-term enrollment and retention trends.

Background

The federal government took two important steps to preserve Medicaid coverage for enrollees during the pandemic: 1) it required states to maintain continuous enrollment of Medicaid enrollees as a condition of receiving enhanced federal funding under FFCRA,³ and 2) it allowed states to pause renewals and disenrollments for their CHIP enrollees.⁴ Under current law, the continuous coverage requirement is tied to the federal PHE and will expire at the end of the month when the PHE expires.ⁱ Guidance issued by the Centers for Medicare & Medicaid Services (CMS) in August 2021 allows states to take up to a full year to catch up on delayed renewals and requires states to conduct a new review of eligibility before disenrolling anyone.⁵

Many are concerned that re-starting the redetermination process could have significant effects on coverage, especially for groups that have been economically and socially marginalized. As our colleagues at Manatt note, "Large-scale disruption in health coverage as a result of the expiration of the federal PHE will have a disproportionate impact on Black, Latino/a and other people of color, who are significantly overrepresented in state Medicaid programs."⁶ However, there is very little publicly available data that would help states or stakeholders understand the impacts of states' unwinding policies on their Medicaid enrollees in real time. Without up-to-date reliable data, states, policymakers, advocates, and other key stakeholders lose the opportunity to identify barriers populations may be facing in their efforts to enroll or renew their Medicaid coverage, as well as opportunities to identify potential effective solutions.

ⁱ The Build Back Better Act (BBB), which, as of the time of publication of this issue brief, has passed the House and awaits a vote in the Senate, would decouple the requirement from the PHE and instead phase out this enhanced Medicaid funding and allows states to resume processing renewals in April 2022. [More information can be found here.](#)

Existing Medicaid Enrollment Reporting

A **monthly enrollment report** published by CMS summarizes three key indicators of states' application and enrollment activities: the number of applications received, the number of people determined eligible, and the total enrollment at the end of the month.⁷ However, there is a significant delay in the availability of this data. Although states have to report this information to the federal government each month, there is currently a six-month lag before CMS publishes the data. Additionally, while states are **required to submit data on performance indicators in eleven different topic areas** (see box 1), CMS only publicly reports the three measures highlighted in red.

Box 1. CMS Performance Indicator Project: Monthly Indicators Call centers

- Indicator #1: Call Center Volume
- Indicator #2: Call Center Wait Time
- Indicator #3: Call Center Abandonment Rate

State Workload

- **Indicator #5: Number of Applications Received**
- Indicator #6: Number of Electronic Accounts Transferred
- Indicator #7: Number of Renewals Due
- Indicator #11: Number of Pending Applications of Redetermination

Determinations

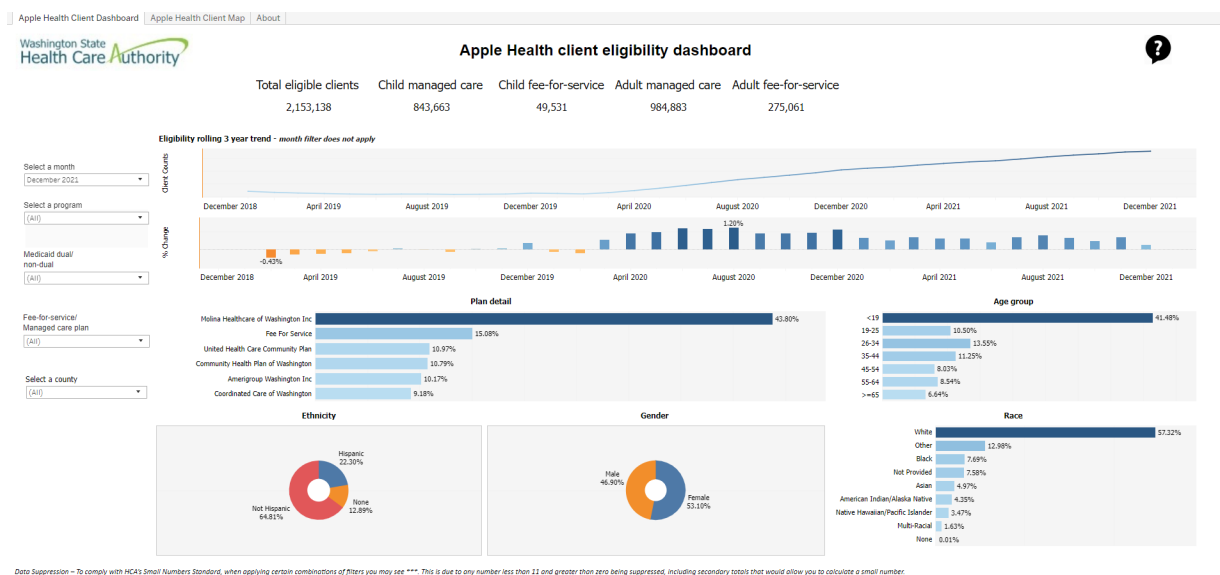
- **Indicator #9: Number of Individuals Determined Eligible**
- Indicator #10: Number of Individuals Determined Ineligible
- Indicator #12: Application Processing Time

Enrollment

- **Indicator #8: Total Enrollment**

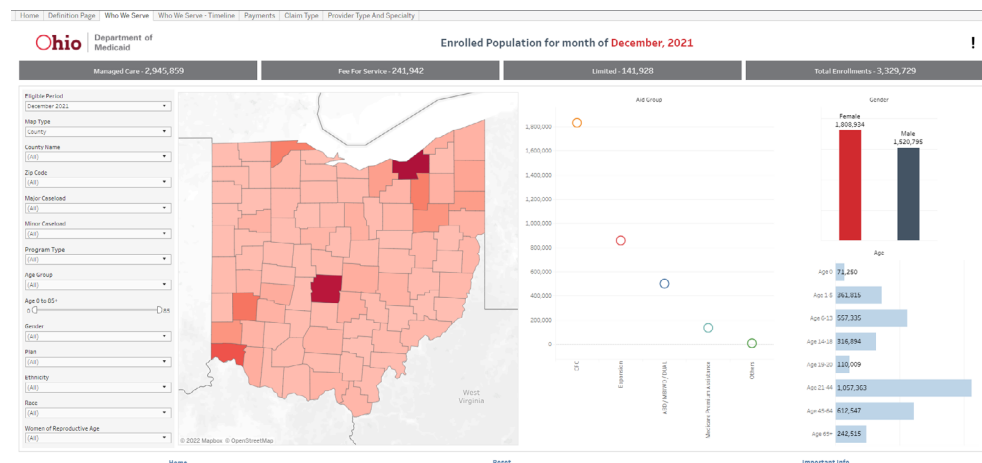
Many states also report eligibility and enrollment data (for at least some of their Medicaid programs) directly on their own public websites. A recent **enrollment tracker and data book published by Manatt in March 2021**, for example, identified 46 states who report some kind of Medicaid enrollment data.⁸ Our review of those states identified 19 who currently report enrollment data in near-real time (i.e., with a lag time of less than one month), as well as an additional seven states who report data within two months. A review of those websites also found that states commonly presented enrollment estimates in raw data tables or in monthly snapshot summaries with very little accompanying analysis or explanation, which made it difficult to spot or interpret trends. Of the states that regularly report Medicaid enrollment data, only six states—**New Hampshire, New Jersey, Ohio, Oklahoma, Oregon** and **Washington**—display some kind of trend data visually (rather than just in tabular form). Washington (Figure 1), Ohio (Figure 2), and Oklahoma (Figure 3) all use interactive, visual dashboards to display enrollment trends that allow users to see the data broken down by various categories. Five of the six states report monthly enrollment data, with the exception of Oregon, which reports weekly enrollment data (Figure 4).

Figure 1. Washington Enrollment Dashboard



Accessed December 6, 2021.

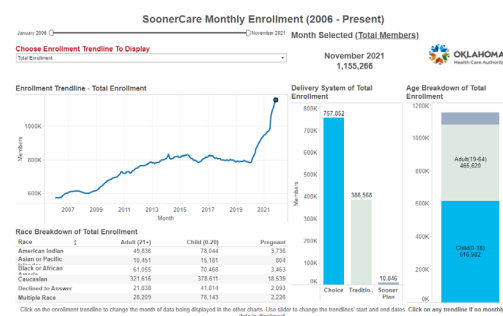
Figure 2. Ohio Enrollment Dashboard



Accessed December 14, 2021.

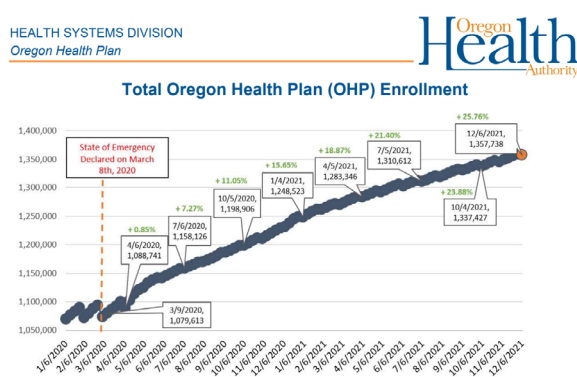
Figure 3. Oklahoma Enrollment Dashboard

SOONERCARE ENROLLMENT BREAKDOWNS AND MEMBER DEMOGRAPHICS BY MONTH



Accessed December 14, 2021.

Figure 4. Oregon Health Plan Weekly Enrollment Report



Accessed December 6, 2021.

Other Types of Reporting

Nevada was one of the few states we identified that included information beyond just enrollment data on their dashboard, such as the number of pending applications (Figure 5).

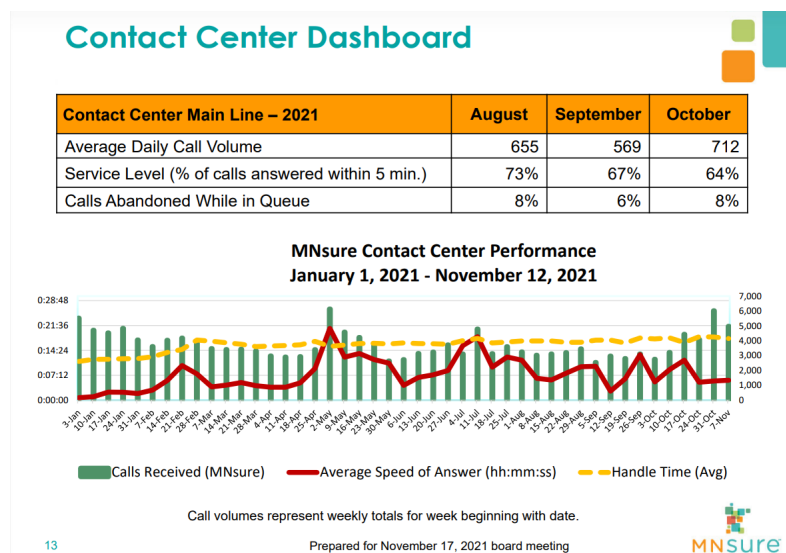
Figure 5. Nevada Dashboard: Average Processing Time



Accessed December 6, 2021.

Call center statistics, which comprise three of the existing CMS Performance Indicators, can be another extremely useful set of metrics that could help serve as an early warning sign as to how applicants and enrollees are faring as renewals and redeterminations begin. Several states with state-based marketplaces (SBMs) report this information on their SBM websites or to their marketplace Board of Directors. [Minnesota](#), for example, reports call center statistics at their monthly Board meeting (Figure 6). Very few states, however, make their call center data and Medicaid enrollment or renewal data available in the same place, making it difficult to determine if the trends in one area are correlated with another.

Figure 6. MNsure Contact Call Center Dashboard



Accessed December 6, 2021.

Potential New Reporting Requirements

According to [guidance published in December 2020](#) regarding resuming Medicaid operations at the conclusion of the PHE, CMS plans to require states to submit data demonstrating progress in completing outstanding eligibility and enrollment actions related to applications, verifications, changes in circumstances, and renewals post-PHE. CMS has been working on identifying the data elements to be reported and indicated that they will provide a reporting template for states to use, however this information has not been released publicly.

The Build Back Better Act (BBB), if passed in its current form, also contains language that will require those states who accept the phased-down federal medical assistance percentage (FMAP) increase to collect and report additional enrollment and renewal data. The legislation requires that, beginning April 1, 2022, states submit monthly reports on the following⁹:

- The number of eligibility renewals initiated
- The number of beneficiaries renewed
- The number of individuals whose eligibility was terminated
 - The number of cases in which eligibility was terminated due to procedural reasons such as an individual's failure to return a renewal form or other information needed by the state to make an eligibility determination.
 - The number of such cases in which eligibility was terminated pursuant to a redetermination of ineligibility based on a known change in circumstance.
 - The number of individuals whose coverage was terminated whose accounts were transitioned to the Exchange, CHIP, or basic health program.
- The daily average volume, wait times, and abandonment rate for each call center during such month.

Although we do not yet have detailed definitions for these metrics, it appears that some of these required measures (e.g., the call center statistics and the number of individuals whose eligibility was terminated) are already being submitted through CMS' Performance Indicator Project, but are not currently published openly. The remaining measures appear to represent new information that states will need to submit. It is unclear at this point which (if any) of these measures CMS will report publicly.

A Role for Dashboards in Monitoring the Unwinding of the Continuous Coverage Requirement

A typical data dashboard is designed to organize complex data in an easy-to-digest visual format, thus allowing the audience to easily interpret key trends and patterns at a glance. This approach lends itself well to a state's objective of monitoring the impact of the end of the continuous coverage requirement on Medicaid enrollment. A dashboard imparts several benefits that can be especially helpful in this specific situation, including:

- **Ease of Interpretation:** Visual displays of trend data (rather than tables of raw numbers) can help make it easy to spot early warning signs of large numbers of people losing Medicaid coverage.
- **Transparency and Accountability:** Designing an easy-to-understand dashboard that is accessible to all interested stakeholders—state or county program staff, navigators or enrollment assisters, and advocates—will help these groups understand who is losing Medicaid coverage and why. Access to this data gives stakeholders an opportunity to take action, such as by adjusting outreach strategies or modifying communication messages with enrollees, in order to minimize needless loss of coverage.
- **Highlighting Inequity:** Dashboards can clarify variations within states that might not be obvious otherwise. Data broken down by various population characteristics (e.g., age, race/ethnicity, income, gender, language, or program type) or geographic areas (e.g., urban, rural) make it easier to understand the potentially disproportionate impact of administrative enrollment and renewal policies on communities of color, persons with lower incomes, and other populations that face disparities.

Measurement Priorities and Medicaid Enrollment Dashboard Mock Example

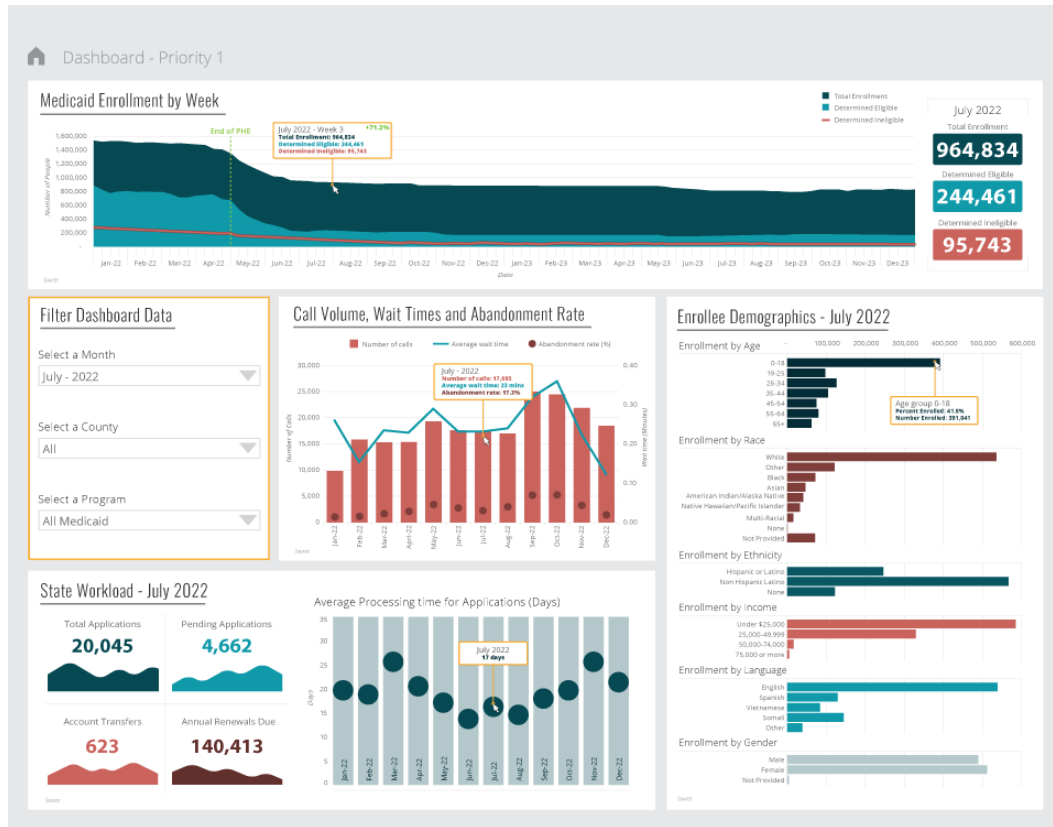
One of the most challenging aspects of developing a useful data-monitoring strategy can be prioritizing which among the many measures available are best for reporting and sorting through the myriad options for visualizing the data. Below, we outline approaches that states can consider for prioritizing information and provide a template for developing a useful enrollment dashboard.

Priority One – CMS Performance Indicators

We encourage states interested in publishing a public Medicaid enrollment data dashboard to use a phased approach to incorporating measures, starting with the data that are already collected and submitted to CMS. This includes measures under the 11 Medicaid performance topics described previously in the first section of this brief (see Box 1). Making all of this existing data public would be an important first step toward transparency and accountability for states and would help stakeholders and program staff to adjust outreach strategies in timely ways to ensure eligible individuals remain enrolled.

For each of the 11 performance indicator topics, we recommend displaying the top-level metric on a public-facing data dashboard. Below we provide an example of a model data dashboard that summarizes these performance indicator measures (Figure 7). This model template uses mock data to illustrate how to incorporate some of our data visualization best practices (see Box 2) with the application, enrollment and renewal data states are required to report, and it displays the data broken down by program type, age, gender, race/ethnicity, income, language, and geography.

Figure 7. Mock Data Dashboard Example



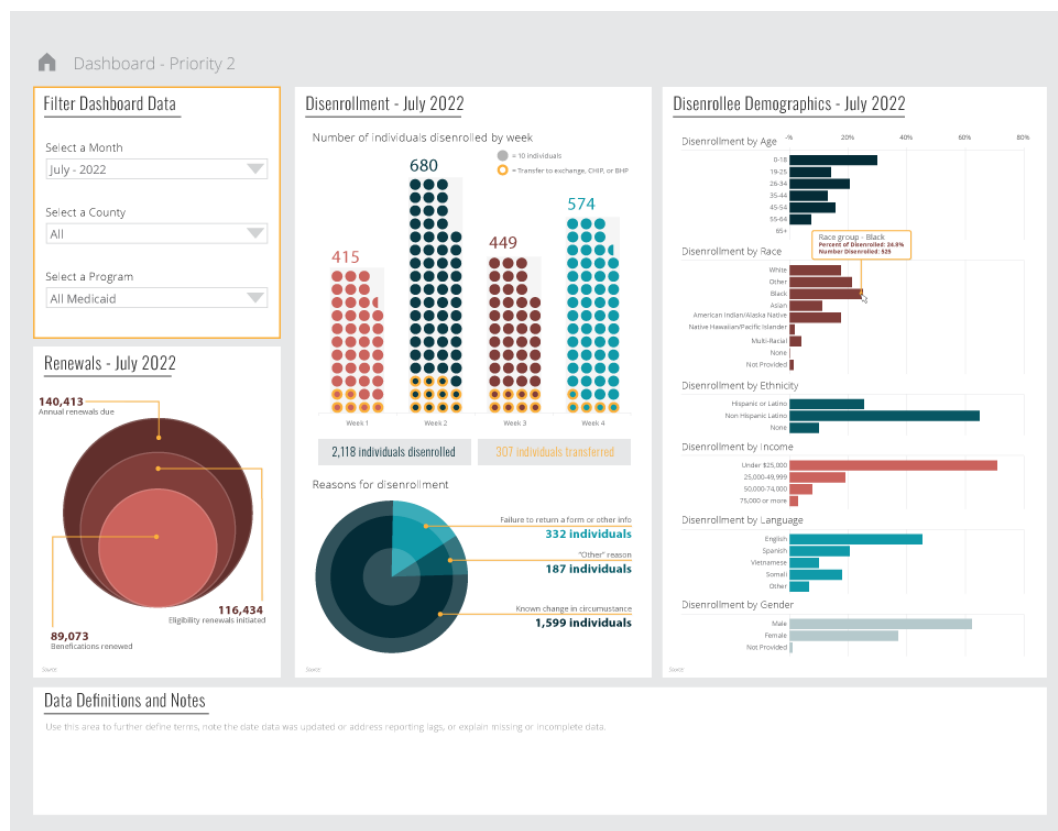
Priority Two – New BBB Requirements

Regardless of whether BBB passes or not, the data elements laid out in the BBB could help states more fully understand the impact of restarting Medicaid renewal processes, including who is losing coverage and why. The data source for several of these requirements will most likely be states' denial and disenrollment codes. States will need to assess how well their existing coding structures align with the data that CMS is requesting. We know from [previous research](#), as well as a more [recent analysis](#), that existing denial and disenrollment coding systems often make it difficult for states to track the reasons people fall off of Medicaid, or are denied coverage in the first place. Several states have indicated that their existing denial codes are either not specific enough or are not used consistently enough to be helpful in understanding the reasons people are being disenrolled. In addition, sometimes states' computer systems automatically close cases in certain situations, and these types of closures might not include a reason.¹⁰ If the BBB act passes, some states may need to implement a new code or flag in order to identify cases in the manner that the language requires, including codes for:

- Those individuals that are disenrolled due to failure to return forms or other needed information;
- Those individuals that are disenrolled due to a change in circumstance; and/or
- Those individuals that are disenrolled and transferred to another program.

Below, we provide another example of a model data dashboard, using mock data, to illustrate how a state could add visualizations representing the BBB required reporting to their data dashboards (Figure 8). As in our first example, these modules incorporate some of our data visualization best practices and would allow the user to display the data broken down by program type, age, gender, race/ethnicity, income, language, and geography.

Figure 8. Model BBB Dashboard




Click to expand

Box 2. Dashboard Best Practices

Most states already have experience setting up and maintaining data dashboards, such as with their COVID-19 data. Many of the best practices suggested for those types of dashboards apply to any potential Medicaid enrollment dashboard as well, including recommendations to:

Consider the audience. Before designing a dashboard, make sure to clearly identify who is the intended audience. Different levels of detail, explanation, or source information may be necessary depending on whether the intended audience is state agency leadership, political leadership, or the general public. In this case, we recommend making high-level enrollment and renewal data available to the general public.

Prioritize key measures. (See below for our suggestions for prioritization.) Because timeliness of this data is so important, the dashboard needs to have enough data points to convey key information, but be limited enough to update quickly.

Prioritize disaggregating data. At the minimum, we recommend displaying data breakdowns by program type, age, race, ethnicity, language, income, and geography (ZIP code is best, but county or any other level lower than just statewide is helpful). States should also consider additional breakdowns as the data is available, such as disability status and sexual orientation and/or gender identity. For example, in this case, reporting by income or Federal Poverty Level (FPL) might be important to signify whether someone is losing eligibility because of a change in policy or falling off because of an administrative hurdle.

Report on the same set of measures consistently, and on a set schedule. To effectively monitor enrollment data, weekly data updates are ideal but at least monthly is recommended.

Box 2 Cont. Dashboard Best Practices

Display time-series data. Visually displaying time-series data is an effective way to track changes. In order to improve readability, try to ensure that all time-trended data on the dashboard starts with the same date and covers the same time period, if possible. Use graphic depictions to highlight key messages.

Address reporting lags. States often have to make various adjustments retroactively to an enrollment dataset as additional information is collected. Through the passage of time, the reported count for a particular month may progressively move closer to the actual final count. States do not need to wait until data is final to post it publicly. They can address the time lag issue in their dashboards by including language about when a specific month's enrollment count is considered complete, or by highlighting or shading data points that are still preliminary in a way that makes that distinction obvious.

Include both proportions and counts. Proportions are especially useful to help make comparisons across states, but counts are critical for understanding the magnitude of impacts within states.

Keep organization and layout simple. It is helpful to have a landing page that makes all indicators visible to users with limited scrolling, but also provides users with the ability to “drill down” to more detail—comparisons, methodology, etc. If it is not possible to show all indicators, there should be an obvious and intuitive option for the user to “hover” over a list and get an “at-a-glance” view of the available content.

Include data labels, definitions, and sources. Provide clear data labels and documentation. Although you should avoid “cluttering” a dashboard with extensive text, it is also important to provide the audience with information about data definitions and sources. If there is not room for a notes or definitions section on the dashboard consider using a “hover” function to display additional information.

Utilize visualizations. Choose visualizations that are clean and compliant with a range of browsers. Simple visualizations can also help users interpret more complex data “at a glance.” For example, many dashboards use up or down arrows to indicate whether most recent data show improvements or declines.

Priority Three—Longer Term Monitoring of Enrollment and Eligibility

These dashboards could also be modified and expanded to serve Medicaid programs beyond the phasing out of the continuous coverage requirement. For example, states could consider adding additional measures to address issues of transitions between programs and *churn*—the moving in and out of coverage—that frequently occurs in Medicaid and CHIP. Understanding churn is important because recent research has found that churning results in higher administrative costs, less predictable state expenditures, and higher monthly healthcare costs due to pent-up demand for healthcare services.¹¹

Prior work done at the time of the initial implementation of the Affordable Care Act, such as the **Maximizing Enrollment project**,¹² identified several cross-program enrollment data metrics that are still potentially useful today. Many of the measures recommended drawing from existing data sources and would not require new data collection, but would require additional analysis and data linkages that states may not be doing routinely now, such as linking a person's enrollment over time/program(s). The Maximizing Enrollment Project identified several potential measures that address this topic, including measures of¹³:

- **Churn.** The number of program disenrollees in a given month who later re-enroll in the program following a gap in coverage of one to six months.
- **Overall retention at 6, 12, and 18 months.** The proportion of individuals entering the program 6, 12, or 18 months ago and who are still enrolled this month.
- **Seamless transitions.** The number of people who leave the program in a given month and enroll in another insurance affordability program with no gap in coverage.
- **Non-seamless transitions.** The number of people who leave the program in a given month and enroll in another insurance affordability program, with a gap in coverage (e.g., of one to six months).
- **Long-term departures.** The number of people who leave the program in a given month and do not re-enroll in any program for more than six months.

Since these measures are typically considered over a longer time period than the CMS Performance Indicators or BBB required measures (over six months versus one month, respectively), we would suggest creating a separate “churn” dashboard to display this information rather than including it on your main enrollment dashboard.

Priority Four – Understanding the Enrollee Experience

A fourth priority for states interested in even more deeply understanding how enrollees or applicants experience the application, enrollment, and renewal process would require new data collection. States could field a disenrollment survey in order to gather both quantitative and qualitative data that could be used to understand both the enrollee’s experience navigating Medicaid processes as well as the consequences of disenrollment. Potential survey topics could address experience enrolling in Medicaid; understanding and knowledge of coverage options; the reasons for disenrollment; resulting financial burden, stress, and impact on healthcare access; and subsequent health insurance status of disenrolled individuals. In the interest of better understanding coverage transitions and reasons for disenrollment, these surveys can rely on a convenience sample of respondents to an online survey sent to disenrolled individuals via text or email, which can greatly reduce the cost and limit burden on staff time.

If a state has in-house expertise, funding, or can leverage an existing partnership (e.g., a state-University partnership), they could also consider a more robust mixed method survey that employs a mailed survey, with an online option supplemented by interviews. For example, in 2019, Iowa conducted a survey of members who were disenrolled from its Iowa Health and Wellness Plan, the program the state used under its 1115 waiver to expand Medicaid to individuals with income up to 138 percent of FPL. That survey found that disenrollment had negative effects including stress, financial burden, and engaging in behaviors such as skipping medication and postponing medical or dental care. It also found disenrollees were often unable to enroll in health insurance.¹⁴

Considerations

As states consider whether and how to implement public facing data dashboards they will have to take several issues into account:

- **Staffing and analytic capacity.** Analytic capacity varies considerably across states—some have entire departments dedicated to analytics, while others have only a single person. As previously mentioned, as states look to expand data collection beyond the existing CMS performance indicators, they likely will have to perform more complex data analysis and/or establish data linkages to other systems. Not all states will have the capacity to do this initially, which is why we recommend states leverage the data they already have available rather than first attempt to report new data. To limit staff burden we also encourage states to set up dashboards that update automatically with as little manual input as possible; building direct feeds from their Medicaid Information Systems to Tableau displays, for example.
- **Availability of funding to support data reporting & analytics.** States may be able to request federal financial support information technology (IT) for new data efforts. The December 2020 PHE unwinding guidance from CMS, for example, indicates that states can submit emergency IT funding requests to obtain federal financial participation in their expenditures to expand the state’s ability to support automated data processing systems. Emergency IT funding requests can also be submitted for IT infrastructure enhancements necessary to support the state’s plan, including “claims processing, eligibility determinations, reporting, analytics, data collection, and applied research.”¹⁵ This authority is not limited to the period of the COVID-19 PHE declaration, and is intended to be more streamlined than the advance planning document process by which states typically request funding approval.¹⁶

- **Coordination between Medicaid and Marketplaces.** States will have to take into account their level of coordination and ability to share data with their state-based marketplace (SBM) or the federally facilitated marketplace (FFM) in order to produce some of the recommended metrics, such as call-center data or information on the number and outcome of electronic transfers. For states in which the same agency operates its Medicaid program and the SBM, there may be fewer barriers to linking the data. However, for states whose exchanges are run by independent agencies and states relying on the FFM, there may be more substantial barriers to linkages, such as coordinating across agencies to determine what data are available in their different systems and how data from the different agencies' systems may be linked, as well as developing data use agreements and procedures for securely sharing data.
- **Addressing missing or incomplete data.** We know many states have high levels of missing or incomplete race and ethnicity data for their Medicaid enrollees, and that the type and granularity of information that states collect varies considerably. States may need to invest in updates to their question wording, instruction, online interfaces, and enrollment or assister training in order to improve their demographic data to a point that it is useful. In the meantime, states can apply small numbers standards (i.e., rules to suppress small numbers in analyses) in order to protect privacy and confidentiality of individuals when they display data broken down by demographic groups. For states that do report data on breakdowns where there are potentially large amounts of missing data, such as by race, we recommend including detail about the scope of the missing data (and the reason, if possible) to help users interpret the findings.

States are already collecting a significant amount of data that could describe how successful they are in enrolling or retaining eligible individuals in Medicaid. Making that data publicly available in an easy-to-digest, visually appealing way, such as through a data dashboard, would be an important first step in efforts to improve the transparency, accountability, and equity of the Medicaid program. It also would allow key stakeholders, including state staff, policymakers, and advocates to more fully understand the impacts of changes to Medicaid policies and procedures on enrollees' ability to access health coverage during these unprecedented times, and give them an opportunity to modify or implement intervention strategies as needed. As states gain experience publicly reporting this data, and data systems and expertise evolve, they can consider adding additional data collection activities and measures that would more fully elucidate the enrollee experience.

ENDNOTES

1. Centers for Medicaid & Medicare Services (CMS). (September 2021). *May 2021 Medicaid and CHIP Enrollment Trends Snapshot* [PowerPoint slides]. Medicaid and CHIP Learning Collaboratives. <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2021-medicaid-chip-enrollment-trend-snapshot.pdf>
2. Buettgens, M. & Green, A. (September 2021). *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?* [Research report]. Urban Institute. https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf
3. Families First Coronavirus Response Act, **HR 6201**, § 6008(b)(3).
4. Centers for Medicare & Medicaid Services (CMS). (2012, January 10). *Example of CHIP Disaster Relief State Plan Amendment*. [chip_disaster_relief_spa_sample_01102012.pdf](https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/chip_disaster_relief_spa_sample_01102012.pdf) (medicaid.gov)
5. Centers for Medicare & Medicaid Services (CMS). (2021, August 13). *Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency* [SHO# 21-002]. Department of Health & Human Services (DHHS). <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>
6. Boozang, P. & Striar, A. (2021, October 5). *The End of the COVID-19 PHE and Medicaid Continuous Coverage: Health Equity Implications*. Manatt Health Highlights. <https://www.manatt.com/insights/newsletters/health-highlights/the-end-of-the-covid-19-phe-and-medicaid-continuu>
7. Centers for Medicare & Medicaid Services (CMS). (n.d.). *Medicaid and CHIP Enrollment Trend Snapshot*. Medicaid.gov. <https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>
8. Mann, C. & Striar, A. (2021, March 5). *Tracking Medicaid Enrollment Growth during COVID-19 Databook*. State Health & Value Strategies (SHVS). <https://www.shvs.org/resource/tracking-medicaid-enrollment-growth-during-covid-19-databook/>
9. Rules Committee Print. (2021, November 3). Build Back Better Act, **HR 5376**.
10. Rosenbaum, D. (2015, March 20). *Lessons Churned: Measuring the Impact of Churn in Health and Human Services Programs on Participants and State and Local Agencies*. Center on Budget and Policy Priorities (CBPP). <https://www.cbpp.org/research/lessons-churned-measuring-the-impact-of-churn-in-health-and-human-services-programs-on>
11. Sugar, S., Peters, C., De Lew, N., & Sommers, B. (2021, April 12). *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* [HP-2021-10]. Office of the Assistant Secretary for Planning and Evaluation (ASPE). <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>
12. Trenholm, C., Harrington M., Snyder, A., & Weiss, A.M. (2011, November 1). *Using Data to Drive State Improvement in Enrollment and Retention Performance*. Robert Wood Johnson Foundation (RWJF). <https://www.rwjf.org/en/library/research/2011/11/using-data-to-drive-state-improvement-in-enrollment-and-retentio.html>
13. Trenholm, C., Harrington M., Snyder, A., & Weiss, A.M. (2011, November 1). *Using Data to Drive State Improvement in Enrollment and Retention Performance*. Robert Wood Johnson Foundation (RWJF). <https://www.rwjf.org/en/library/research/2011/11/using-data-to-drive-state-improvement-in-enrollment-and-retentio.html>
14. Askelson, N.M., Brady, P., Wright, B., Bentler, S., Momany, E.T., & Damiano, P. (2019, December 6). Purged from the Rolls: A Study of Medicaid Disenrollment in Iowa. *Health Equity*, 3(1), 637-643. <https://doi.org/10.1089/heq.2019.0093>
15. Centers for Medicare & Medicaid Services (CMS). (2020, December 22). *Updated Guidance Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency* [SHO# 20-004]. Department of Health & Human Services (DHHS). <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>
16. Centers for Medicare & Medicaid Services (CMS). (2020, December 22). *Updated Guidance Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency* [SHO# 20-004]. Department of Health & Human Services (DHHS). <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>

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ABOUT STATE HEALTH ACCESS DATA ASSISTANCE CENTER (SHADAC)

This issue brief was authored by Emily Zylla and Lindsey Theis. SHADAC is an independent, multi-disciplinary health policy research center, housed in the School of Public Health at the University of Minnesota, with a focus on state policy. SHADAC produces rigorous, policy-driven analyses and translates its complex research findings into actionable information for states.