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# CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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## **CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**

## **STATISTICAL ENROLLMENT DATA SYSTEM (SEDS)**

<https://seds.medicaid.gov/>

## **INSTRUCTIONS FOR DATA ENTRY**

**February 2015 Update**

# I. INTRODUCTION

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The Children's Health Insurance Program (CHIP) Statistical Enrollment Data System (SEDS) is a web-based application maintained by the Centers for Medicare & Medicaid Services (CMS) to collect enrollment data from states. The statistical reporting forms posted on the web (Forms CMS-21E, CMS-21PW, CMS-64.21E, CMS-64EC, CMS-21Waiver, and Race, Ethnicity, Gender) gather basic information about participation in federally-funded children's health insurance programs – CHIP and Medicaid. Also included in the system are forms that gather further information about the enrolled populations reported on the statistical forms. These informational forms gather data on employer sponsored insurance (ESI), dental wrap-around benefits and other optional benefits.

# II. SUBMISSION OF DATA

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States are required to submit quarterly enrollment data within thirty (30) days after the end of the quarter and aggregate annual data within thirty (30) days after the end of the fourth quarter. Federal fiscal year quarters and due dates are as follows:

- First quarter, October 1<sup>st</sup> through December 31<sup>st</sup>, data due January 30<sup>th</sup>;
- Second quarter, January 1<sup>st</sup> through March 31<sup>st</sup>, data due April 30<sup>th</sup>;
- Third quarter, April 1<sup>st</sup> through June 30<sup>th</sup> data due July 30<sup>th</sup>; and
- Fourth quarter, July 1<sup>st</sup> through September 30<sup>th</sup>, data due October 30<sup>th</sup>.

For states that allow retroactive eligibility, these initial enrollment reports will be deemed preliminary; and these states will also submit final reports thirty (30) days after the end of the next quarter. The final reports should include information about children whose eligibility was retroactive to the earlier quarter. So, for example, a state with retroactive eligibility would submit a preliminary report for the second quarter of the federal fiscal year (January 1<sup>st</sup> through March 31<sup>st</sup>) by April 30<sup>th</sup> and a final report for that quarter by July 30<sup>th</sup>. The final report for the second quarter would include information about children who applied in the third quarter (April 1<sup>st</sup> through June 30<sup>th</sup>) whose eligibility was retroactive to sometime in the second quarter.

## III. REPORTING FORMS

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The required reporting forms posted on the web collect information about children with three (3) different types of federally-funded health care coverage and for low-income pregnant women eligible for title XXI through the CHIP State Plan.

- **Form CMS-21E.** This form collects data on children enrolled in separate child health programs, or separate CHIP. Use one (1) copy of this form to report data for each separate child health program and/or operational entity. If, for example, a state operates one separate child health program that serves children with disabilities and a second separate child health program that serves other children, the state should submit two (2) Form CMS-21Es. The system will combine data from all forms to create an aggregate separate child health program report. States with a separate program for children eligible due to the loss of Medicaid based on the loss of income disregards (the 2101(f) protection) should report those enrollments on this form, but should not use an additional copy of the form.
- **Form CMS-64.21E.** This form collects data on children enrolled in Medicaid expansion CHIPs, that is, Title XXI-funded Medicaid coverage. Use one (1) copy of this form to provide data on all children covered by the state's Medicaid expansion. This form includes enrollment of children under 133 percent of the FPL transitioning from a separate CHIP to Medicaid.
- **Form CMS-64.EC.** This form collects data on children enrolled in the Medical Assistance Program—that is, Title XIX-funded Medicaid coverage, which we will refer to throughout this manual as “traditional Medicaid”. Use one (1) copy of this form to provide data on all children covered by traditional Medicaid.
- **Form CMS-21PW.** This form collects data on low-income pregnant women enrolled in CHIP through the state plan option.

All of the above forms collect enrollment data by age category, CMS-defined income levels, and type of service delivery system. Each report consists of screens (pages), one for each specified age group. Separate columns are designated for each income group, and separate rows for each type of delivery system in which enrollees may receive health program benefits.

The quarterly report for each program should present unduplicated counts of enrollees (there should be no duplication between program types), disenrollees, enrollment months, and enrollees in a program on the last day of the quarter, for each program. A child who was enrolled in more than one program (e.g., separate child health program and a CHIP Medicaid expansion, or Medicaid expansion and traditional Medicaid) at different times during the quarter should be only counted in the program in which he or she was last enrolled.

- **Form CMS-21 Waiver.** This form collects data on adults enrolled in a CHIP section 1115 waiver for whom the state receives the title XXI federal matching rate for at least some of the expenditures.
- **Form Gender, Race, Ethnicity.** This form collects gender, race, and ethnicity data for all enrollees reported on the Forms CMS-21E, CMS-64.21E, and CMS-64EC.
- **Form Waiver Gender, Race, Ethnicity.** This form collects gender, race and ethnicity data for all enrollees reported on the form CMS-21 Waiver.
- **Informational Forms 21E, 21PW, 64.21E, 64EC, 21 Waiver.** These forms currently collect employer sponsored insurance (ESI) or dental wrap-around enrollment data for the applicable program. Other future categories of interest may also be added as an informational form. The enrollment data is a subset of the enrollment already reported on the program that the child or eligible adult is enrolled. (Aggregate enrollment reports count only the program forms, not informational forms.) For example: If the state reports 1,000 children on the CMS-21E, and, of that total, 60 children are enrolled in an ESI program, then the state would additionally report on a CMS-21EI form indicating the 60 children enrolled in the ESI program.

**Note on the “CHIPRA 214” lawfully residing option:** Some states have elected the option provided by section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 to lift the 5-year bar on coverage in Medicaid or CHIP for certain pregnant women and/or children who are lawfully residing in the United States. For those states that cover such lawfully residing children in Medicaid or CHIP, or pregnant women in CHIP (pregnant women in Medicaid are not captured in SEDS), those enrolled individuals should be reported in the same categories as other children and pregnant women. For children enrolled in a separate CHIP, it is not necessary to use an additional copy of the form to report lawfully residing children’s enrollment.

## IV. REPORTING CHANGES ASSOCIATED WITH THE AFFORDABLE CARE ACT

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The Affordable Care Act (ACA) makes many changes to eligibility and enrollment that affect both Medicaid and CHIP. Starting January 1, 2014, the law requires the application of new, standardized income counting rules based on Modified Adjusted Gross Income (MAGI), which may cause some shifts in eligibility; increases the mandatory Medicaid upper income limit for children from ages 6 up to 19 years old, which may cause some CHIP children to transition to Medicaid; protects certain children who lose Medicaid as a result of the loss of income disregards (2101(f) protection); and requires the use of a new, streamlined application for health benefits that includes more granular racial and ethnic categories. These changes may affect the way in which states currently report data into SEDS. The changes are summarized in Table 1 below.

To align with MAGI-based eligibility methodologies, effective with the second fiscal quarter of 2014, all SEDS forms that gather enrollment data based on income use the MAGI income and household methodologies. Enrollments are to be grouped based on the percent of FPL as determined using MAGI methods, rather than including the previous income disregards. In addition, we understand that because MAGI rules took effect during a fiscal year that the year 2014 will necessarily have inconsistent enrollment data between first fiscal quarter and the three following quarters.

States that covered children with family income below 133 percent of the FPL in a separate CHIP through calendar year 2013 must transition these children to Medicaid in 2014. Because expenditures for these children are still funded through CHIP, enrollment data must be entered on the CMS-64.21E for Medicaid Expansion. And a few states that enroll children protected by 2101(f) in a separate CHIP but do not otherwise use the CMS-21E form for separate child health program must enter 2101(f) children on this form.

States should begin to implement the changes in reporting to account for MAGI-based rules, transitioning children to Medicaid expansion and the 2101(f) protection effective at the beginning of the second federal fiscal quarter of 2014 (January 1 through March 31, 2014), for which reporting was due April 30, 2014. We are directing states that have already certified data for Quarter 2 and later to go back in the forms to make any necessary revisions to enrollment data and then recertify the data.

In addition, we are taking this opportunity to revise the income range groups on all of the forms such that the first group is now 0-133 percent FPL and the second group is now 134-200 percent FPL. The other income groups are unchanged. We have also modified the Gender, Race, Ethnicity form to give states the opportunity to report additional granularity for the Hispanic, Asian, and Native Hawaiian or Other Pacific

Islander categories. Please see Section V on Definitions and Rules below for more detail on the reporting changes associated with the ACA.

Changes to the income range groups on all forms and the categories and definitions for the Form Gender, Race, Ethnicity are effective as of a different date: the first fiscal quarter of 2015 (October 1 through December 31, 2014), for which reporting is due January 30, 2015.

**Table 1.**

<b>ACA Policy Considerations for SEDS Reporting</b>	<b>Programmatic Change</b>	<b>Reporting Considerations</b>	<b>Effective Date</b>
MAGI Eligibility & Methods	Set MAGI income standards for all covered groups; MAGI Methodology assurances and election of household composition and income counting options	States will need to report children in the appropriate FPL income categories, based on MAGI income, on the appropriate form.	Federal Fiscal Quarter 2/2014 (January-March, 2014)
Title XXI Medicaid Expansion	Set MAGI income standards for Medicaid expansion covered group; Some states will establish a new group for children ages 6 to 19 up to 133% of the FPL (MAGI)	States should report all Medicaid expansion children on Form CMS-64.21E. CMS will make this form available to states that will need it and do not currently use it.	Federal Fiscal Quarter 2/2014 (January-March, 2014)
Establish 2101(f) Group	Establish new coverage group for children who lose Medicaid only as a result of the loss of income disregards	States that create a separate CHIP to cover these children should report these enrollments on Form CMS-21E. CMS will make this form available to states that will need it and do not currently use it.	Federal Fiscal Quarter 2/2014 (January-March, 2014)
Application Approval and Processing	The single, streamlined application collects demographic information about applicants for health coverage	SEDS has been modified to give states the ability to report additional granularity for the Hispanic, Asian, and Native Hawaiian or Other Pacific Islander categories on Form Gender, Race, Ethnicity.	Federal Fiscal Quarter 1/2015 (October-December, 2014)

## V. DEFINITIONS AND RULES

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This section defines the various reporting categories specified on the forms and provides detailed reporting rules.

### A. HEADER ITEMS

The following items appear in the header of all enrollment data forms, except for the Gender, Race, Ethnicity forms which have a uniquely different header (see below).

**Quarter and Year.** Enter the quarter (1-4) and the Federal Fiscal Year (FFY) to which the data pertain. The FFY runs from October 1 through September 30. For example, the first quarter of FFY 2015 is October 1 through December 31, 2014; the second quarter is January 1 through March 31, 2015; the third quarter is April 1 through June 30, 2015; and the fourth quarter is July 1 through September 30, 2015.

**Program Code.** (This item appears only on Form CMS-21E, the separate child health program form.) States should report enrollment data for each separate child health program and/or operational entity on a separate copy of Form CMS-21E. The program code uniquely identifies the separate child health program to which the report pertains. To create a program code, enter the two-letter state abbreviation followed by a descriptive letter or number from 1 to 9. For example, the State of Florida would enter FL1, for its first separate child health program, FL2 for its second separate child health program, and so forth.

**Type of Eligible.** (This item appears only on Form CMS-64.21E, the Medicaid expansion form.) This two-character code identifies the Medicaid expansion group or groups to which the data pertain.

**U2.** Select "U2" if the state's Medicaid expansion covers only the 1905(u)(2) expansion group, optional targeted low income children. These are uninsured children under age 19 who meet Title XXI eligibility requirements who would not be eligible for traditional Medicaid under the state plan in effect on 3/31/97. Note: **U3** is no longer a valid selection.

**Age of Children or Pregnant Women.** Each reporting form has screens (pages) for each age group of eligible individuals. The age groups are defined as follows:

- "Under 0": conception to birth (CMS-21E only);
- "0-1": infants from birth to under age one (up to the first birthday);
- "1-5": age one through age five;
- "6-12": age six through age 12;
- "13-18": age 13 through age 18 inclusive (up to but not including age 19);
- "19-20": age 19 through age 21 inclusive (up to but not including age 21) (CMS-64EC only); and
- "19-64": age 19 through age 64 (CMS-21PW and 21 Waiver only).



Age is defined as the enrollee's age on the last day of his or her enrollment during the quarter.

Note that states electing the option to cover pregnant women in CHIP may enroll some pregnant women under age 19. These enrollments should still be captured on the CMS-21PW form.

**Family Income.** States report data separately for all income range groups, as applicable. Each income range group is specified in relation to the federal poverty level (FPL). Beginning in the second federal fiscal quarter of 2014, the FPL is determined using MAGI-based income counting and household composition rules.

Each form provides five (5) columns, to allow states to report data in the five (5) income range groups defined as a percent of the FPL using MAGI. For all quarters through the fourth federal fiscal quarter of 2014 (July 1 through September 30, 2014), the income groups are as follows:

- 0-100;
- 101-200;
- 201-250;
- 251-300;
- 301-state specified.

Beginning in the first federal fiscal quarter of 2015 (October 1 through December 31, 2014), for which reporting is due January 30, 2015, the 100 percent break point is modified to 133 percent. Beginning in this quarter, the income groups appear on each form as follows:

- 0-133;
- 134-200;
- 201-250;
- 251-300;
- 301-state specified.

Please note that the upper limit in income range group 5 is state-defined. Therefore, each state with a maximum income level exceeding 300 percent of the FPL must enter the maximum income level as approved in the state plan.

For example, if a state program has a MAGI upper income limit of 228 percent of the FPL, then an enrollee with a MAGI family income at 220 percent of the FPL is counted in the 201-250 FPL group and an enrollee with a MAGI family income at 182 percent of the FPL is counted in the 134-200 FPL group.

## **B. HEADER ITEMS for Gender, Race, Ethnicity forms.**

The following items appear in the header of each of the three Gender, Race, Ethnicity forms.

**Quarter and Year.** Enter the quarter (1-4) and the Federal Fiscal Year (FFY) to which the data pertain. The FFY runs from October 1 through September 30. For example, the first quarter of FFY 2015 is October 1 through December 31, 2014; the second quarter is January 1 through March 31, 2015; the third quarter is April 1 through June 30, 2015; and the fourth quarter is July 1 through September 30, 2015.

**Program Forms.** States must report each enrollee's gender, race, and ethnicity on the Gender, Race, Ethnicity forms. Each of these forms have five (5) columns, the first column "21E Enrolled", the second column "64.21E Enrolled", the third column "Total CHIP Enrolled", totals the first two columns, and the fourth column "64EC Enrolled", the fifth column "21PW Enrolled".

However, the Gender, Race, Ethnicity form for waivers has only one (1) column, "Waiver Adults."

### **C. CATEGORIES OF SERVICE DELIVERY SYSTEM**

States must report each descriptive statistic (e.g., unduplicated number of new enrollees) by the type of delivery system in which the children were served: fee-for-service (FFS), a managed care arrangement, or primary care case management (PCCM). Each child, pregnant woman, or waiver adult should be grouped in one of these three categories based on the system in which he or she was last covered during the quarter. This categorization should reflect the basic plan in which the individual was enrolled. For example, an individual enrolled in a FFS plan who receives mental health services through a "carve-out" to a prepaid health plan should be counted in the FFS group. The three types of service delivery systems are defined as follows.

**Fee-for-service (FFS).** FFS is defined in this context as a payment system in which providers submit claims to the state (or a claims processing firm that contracts with the state) and are paid a specific amount for each service performed. Enrollees are free to visit any state-certified provider. Count an individual in the FFS category if FFS was the last system in which he or she was covered for basic services during the quarter.

**Managed care arrangements.** Managed care is defined in this context as a system in which the state contracts with health maintenance organizations (HMOs) or health insuring organizations (HIOs) to provide a comprehensive set of services on a prepaid capitated risk basis. Enrollees choose a plan and a primary care provider (PCP), who will be responsible for managing their care. Count an individual in the managed care category if managed care was the last system in which he or she was covered for basic services during the quarter.

**Primary care case management.** PCCM is defined in this context as a system in which the state contracts directly with PCPs who are responsible for providing or coordinating medical services to the CHIP or Medicaid enrollees under their care. Most state PCCM programs reimburse PCPs on a FFS basis for medical services

and also pay them a monthly management fee; other programs operate on a partial capitation basis. Count an individual in the PCCM category if PCCM was the last system in which he or she was covered for basic services during the quarter.

#### **D. ENROLLMENT MEASURES FOR FORMS CMS-21E, CMS-21PW, CMS-64.21E, CMS-64EC, AND CMS-21 WAIVER.**

This section defines each enrollment measure and outlines rules for counting enrollees, new enrollees, disenrollees, and enrollment months. Some key rules are highlighted in the Appendix.

**Unduplicated Number of Children (Pregnant Women, or Waiver Adult) Ever Enrolled During the Quarter.** Report each child, pregnant woman, or waiver adult enrolled in the program for any length of time during the quarter. Count each individual only once on each quarterly report regardless of the number of times he or she was enrolled or re-enrolled in the program during the quarter. However, if a child was enrolled in multiple programs – e.g., separate child health program or CHIP Medicaid expansion – at different times during the quarter, count the child on the quarterly report in the program in which he or she was last enrolled.

Note that any child, pregnant woman, or waiver adult reported as a new enrollee or disenrollee during the quarter must also be reported as ever enrolled. Report each child under the service delivery system in which he or she was last covered for basic services during the quarter.

Report individuals with retroactive eligibility as “ever enrolled” in the quarter in which they applied, and if their coverage became effective in an earlier quarter, report them as “ever enrolled” in that quarter as well (on the final report for that quarter, as described in Section II).

**Unduplicated Number of New Enrollees in the Quarter.** Report as a new enrollee any child, pregnant woman, or waiver adult enrolled in the program at any time during the quarter who was not enrolled in the program as of the last day of the previous quarter. Count each individual once on each quarterly report regardless of the number of times he or she enrolled and re-enrolled in the program during the quarter. If, for example, a child was enrolled for the first time in a state’s separate child health program in the first month of a quarter, disenrolled in the second, and re-enrolled in the third, he or she should be counted as one new enrollee on the report for that quarter. Report each new enrollee under the service delivery system in which he or she was last covered for basic services during the quarter. In the case of new enrollments in multiple different programs during the quarter – e.g., separate child health program or CHIP Medicaid expansion – count the child on the quarterly report in the program in which he or she was newly enrolled last.

An individual with retroactive eligibility should be reported as a new enrollee in the quarter in which his or her coverage became effective. If a child’s eligibility is retroactive to an earlier quarter, the state should report him or her as a “new enrollee”

(as well as “ever enrolled”) in that earlier quarter when it submits its final (updated) report for that quarter. (See Section II.)

**Unduplicated Number of Disenrollees in the Quarter.** Report as a disenrollee any child, pregnant woman, or waiver adult who disenrolled from a program at any time during the quarter and who was not re-enrolled as of the last day of the quarter. Count each individual once on each quarterly report regardless of the number of times he or she enrolled and disenrolled from the program during the quarter. Report each disenrollee under the service delivery system in which he or she was last covered for basic services during the quarter. In the case of disenrollments from multiple different programs during the quarter – e.g., separate child health program or CHIP Medicaid expansion – count the child on the quarterly report in the program from which he or she was disenrolled last.

Two circumstances – “aging out” and disenrollment at the end of a quarter – warrant particular attention. A child who “ages out” of a program during the quarter (for example, a CHIP enrollee who turns 19) should be counted as a disenrollee during that quarter. A child who is disenrolled at the end of the quarter should be reported as a disenrollee in that quarter. That is, a child who is enrolled through the last day of the quarter for which the state is reporting data but who is no longer enrolled as of the first day of the next quarter should be counted as a disenrollee in the earlier quarter (the quarter being reported).

This rule ensures that each individual is reported as a disenrollee only in a quarter in which he or she is reported as ever enrolled.

**Number of Member-Months of Enrollment in the Quarter.** Tally member-months for each child, pregnant woman, or waiver adult ever enrolled during the quarter. Count one month for each month in which the individual was enrolled for at least one day. Count all of an individual’s member-months for a quarter under the service delivery system and program type in which he or she was last covered for basic services during the quarter. In the case that a child has member months in multiple different programs during the quarter – e.g., separate child health program or CHIP Medicaid expansion – count the member months in the program in which he or she was enrolled last.

**Average Number of Months of Enrollment.** The system automatically calculates the average number of months of enrollment by dividing the figures entered in section 4 (member-months of enrollment) by the corresponding figures in section 1 (number ever enrolled).

**Number of Children (Pregnant Women, or Waiver Adults) Enrolled at Quarter’s End.** Report the number of children, pregnant women, or waiver adults enrolled in the program on the last day of the quarter. Report each individual under the service delivery system and program type (e.g., separate child health program or traditional Medicaid) in which he or she was covered for basic services on that day. This point-

in-time number will always be less than or equal to the number ever enrolled during the quarter.

**Unduplicated Number of Children (Pregnant Women, or Waiver Adults) Ever Enrolled in the Year.** This item appears only on the report for the fourth quarter of the FFY. Report each child enrolled in the program at any time during the FFY (October 1 through September 30). Count each child, pregnant woman, or waiver adult once, regardless of the number of times he or she was enrolled or re-enrolled in the program during the year. As with quarterly enrollment, report each individual under the service delivery system in which he or she was last covered for basic services during the year. And if a child was enrolled in multiple programs – e.g., separate child health program or CHIP Medicaid expansion – at different times during the year, count the child in the program in which he or she was last enrolled.

**Unduplicated Number of New Enrollees in the Year.** This item appears only on the report for the fourth quarter of the FFY. Report each child, pregnant woman, or waiver adult newly enrolled in the program at any time during the FFY (October 1 through September 30). Count each individual once, regardless of the number of times he or she was enrolled or re-enrolled in the program during the year. Report each individual under the service delivery system in which he or she was last covered for basic services during the year. In the case of new enrollments in multiple different programs during the year – e.g., separate child health program or CHIP Medicaid expansion – count the child on the report in the program in which he or she was newly enrolled last.

**Unduplicated Number of Disenrollees in the Year.** This item appears only on the report for the fourth quarter of the FFY. Report each child, pregnant woman, or waiver adult disenrolled from the program at any time during the FFY (October 1 through September 30). Count each individual once, regardless of the number of times he or she enrolled and disenrolled from the program during the year. Report each individual under the service delivery system in which he or she was last covered for basic services during the year. In the case of disenrollments from multiple different programs during the year – e.g., separate child health program or CHIP Medicaid expansion – count the child on the report in the program from which he or she was disenrolled last.

## **E. CATEGORIES AND DEFINITIONS FOR GENDER, RACE, ETHNICITY FORMS.**

Each “Gender, Race, Ethnicity” form has three sections.

**Gender.** This section has three (3) categories, Female, Male, and Unspecified Gender. States should submit the number of enrollees who self report that they are Male or Female, and if Gender is not reported or is unknown, states should report that the enrollee is an Unspecified Gender.

**Race.** This section has nineteen (19) categories: White, Black or African American, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean,

Vietnamese, Other Asian, Asian Unknown, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Native Hawaiian or Other Pacific Islander Unknown, Some Other Race, Two or more races (regardless of ethnicity), and Unspecified Race. States should submit the number of enrollees who self report that they are any of the above. Respondents who self report that they are more than one of the above racial categories should be counted only in the Two or more races category. The definitions of each self-reported category are identified on the form as follows:

- **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Black or African American.** A person having origins in any of the Black racial groups of Africa. Terms such a “Haitian” or “Negro” can be used in addition to “Black or African American.”
- **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

These categories are part of the current OMB standard

**Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. This includes people who indicated their race(s) as “Asian” or reported entries such as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” and “Other Asian” or provided other detailed Asian responses:

- **Asian Indian.**
- **Chinese.**
- **Filipino.**
- **Japanese.**
- **Korean.**
- **Vietnamese.**
- **Other Asian.** A person whose specific Asian subgroup is not available in the list of options above (e.g., Hmong, Laotian, etc.)

These categories roll up to the Asian category of the OMB standard

- **Asian Unknown.** A person whose specific Asian subgroup is unknown. The person’s race may be reported only as “Asian.”

**Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoan, or other Pacific Islands. This includes people who indicated their race(s) as “Pacific Islander” or reported entries such as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” and “Other Pacific Islander” or provided other detailed Pacific Islander responses:

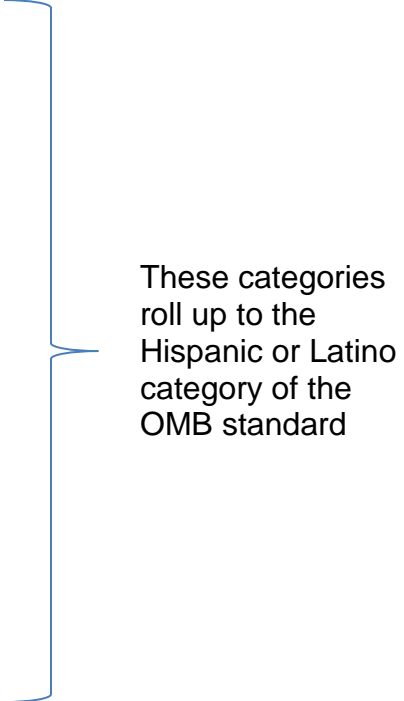
- **Native Hawaiian.**
- **Guamanian or Chamorro.**
- **Samoan.**
- **Other Pacific Islander.** A person whose specific Pacific Islander subgroup is not available in the list of options above (e.g., Fijian, Tongan, etc.)
- **Native Hawaiian or Other Pacific Islander Unknown.** A person whose specific Native Hawaiian or Other Pacific Islander subgroup is unknown. The person’s race may be reported only as “Native Hawaiian or Other Pacific Islander.”

These categories roll up to the Native Hawaiian or Other Pacific Islander category of the OMB standard

- **Some Other Race.** All other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above. Respondents reporting a Hispanic or Latino group (for example, Mexican, Puerto Rican, Cuban or Spanish) in response to the race question are included in this category.
- **Two or More Races (regardless of ethnicity).** Respondents who self report that they are more than one of the above racial categories, as well as those reporting entries such as “multiracial,” “mixed,” or “interracial” should be counted only in this category. States should offer respondents the option of selecting one or more racial designations.
- **Unspecified Race.** If Race is not reported or is unknown, states should report that the enrollee is an Unspecified Race.

**Ethnicity.** This section has seven (7) categories, Not of Hispanic or Latino/a, or Spanish origin; Mexican, Mexican American, Chicano/a; Puerto Rican; Cuban;

Another Hispanic or Latino origin; Hispanic or Latino Unknown; and Unspecified Ethnicity.

- **Not of Hispanic, Latino/a or Spanish origin.** Respondents who self-report that they are not of Hispanic or Latino cultural origin should be counted in this category.
  - **Mexican, Mexican American, Chicano/a.** A person of Mexican, Mexican American, or Chicano/a cultural origin, regardless of race.
  - **Puerto Rican.** A person of Puerto Rican cultural origin, regardless of race.
  - **Cuban.** A person of Cuban cultural origin, regardless of race.
  - **Another Hispanic, Latino/a or Spanish Origin.** A person of another Hispanic, Latino/a or Spanish origin (e.g., Argentinian, Colombian, Dominican, etc.), regardless of race.
  - **Hispanic or Latino Unknown.** A person whose specific Hispanic or Latino subgroup is unknown, regardless of race. The person may be reported only as “Hispanic or Latino.”
  - **Unspecified Ethnicity.** If Ethnicity is not reported or is unknown, states should report that the enrollee is an Unspecified Ethnicity.
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- These categories roll up to the Hispanic or Latino category of the OMB standard

**NOTE:** Changes to the reporting of Asian subgroups, Native Hawaiian and Other Pacific Islander subgroups, and Hispanic or Latino subgroups, are effective for data reported for Quarter 1 FFY 2015.



## APPENDIX

# KEY RULES FOR REPORTING ENROLLMENT DATA

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- Effective January 1, 2014, each form that gathers enrollment data based on income uses MAGI-based methodologies for income counting and household composition. States must report enrollments in the income groups based on income as a percent of FPL determined using MAGI methods. Effective October 1, 2014, the income range groups on all of these forms are revised such that the first group is now 0-133 percent FPL and the second group is now 134-200 percent FPL.
- States transitioning children with family income below 133 percent of the FPL from a separate CHIP to a Medicaid Expansion must report these enrollments on the CMS-64-21E form. States with a separate program for children eligible due to the loss of Medicaid based on the loss of income disregards (the 2101(f) protection) should report those enrollments on the CMS-21E form. Both effective January 1, 2014.
- Each form (CMS-21E, CMS-PW, CMS-64.21E, CMS-64EC, and CMS 21 Waiver) for the quarter and for the year should present enrollment counts, unduplicated within program, of enrollees, disenrollees, and enrollment months for each program.
- A child who was enrolled in more than one program (e.g., separate child health program and a CHIP Medicaid expansion, or Medicaid expansion and traditional Medicaid) at different times during the quarter or during the year should be only counted in the program that he or she was last enrolled.
- Any child, pregnant woman, or waiver adult reported as a new enrollee or disenrollee during a quarter/year must also be reported as ever enrolled during the quarter/year.
- Children, pregnant women, or waiver adults should be grouped into service delivery system categories based on the delivery system in which they were last covered for basic services during the quarter/year.
- A “new enrollee” is a child, pregnant woman, or waiver adult who was enrolled in the program at any time during the quarter/year and was not enrolled on the last day of the previous quarter/year.
- Children, pregnant women, or waiver adults whose eligibility is retroactive to an earlier quarter should be reported as new enrollees in the quarter in which their

## APPENDIX

coverage became effective, not in the quarter in which they applied. They should be reported as ever enrolled in both quarters.

- A “disenrollee” is a child, pregnant woman, or waiver adult who was disenrolled from the program at any time during the quarter/year who was not re-enrolled as of the last day of the quarter/year.
- A child, pregnant woman, or waiver adult who was enrolled only through the last day of a quarter (no longer enrolled as of the first day of the next quarter) should be counted as a disenrollee in the earlier quarter/year.
- A child who “ages out” of a program during the quarter/year should be counted as a disenrollee in that quarter/year. (Or a pregnant woman who gives birth to a child during the quarter/year).
- An “enrollment month” is any month in which a child, pregnant woman, or waiver adult was enrolled for at least one day.
- All of a child’s, pregnant woman’s, or waiver adult’s enrollment months for the quarter should be counted under the service delivery system and program type in which he or she was last covered for basic services during the quarter.