MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Minuteman Ballroom, 5th Floor
Reserve Officers Building
1 Constitution Avenue, N.E.
Washington, D.C. 20002

Friday, January 28, 2011
10:11 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH

LU ZAWISTOWICH, ScD, Executive Director

AGENDA PAGE

PROCEEDINGS [10:11 a.m.]

CHAIR ROWLAND: Commission members, if we can get started again, please.

[Pause.]

CHAIR ROWLAND: We are going to reconvene now to really look at one of the central issues that will make our work possible or impossible, and that's what data are available about the program, administrative data, survey data; how do we go about answering the questions that Congress has posed for us in our statutory language; what is really needed for others to evaluate the program for the Department to administer the program from the federal level; and what does that mean in terms of state responsibilities, state burdens, and states' ability to understand what's going in other states as well.

So we are revisiting once again the issue of data, and April and Chris are going to give us some background on where we've come in terms of the chapter we want to prepare for our March report, looking at what we've now decided to call the spine, the data spine of Medicaid.

So, April and Chris, let's engage in a review of the contents of our data chapter and some of the possible recommendations we may be making.

IMPROVING MEDICAID AND CHIP DATA FOR POLICY ANALYSIS AND PROGRAM ACCOUNTABILITY

MS. GRADY: Thank you, Diane.

Before I start our presentation, I just want to reiterate that in the previous discussions we've had, we know that administrative data can tell us some things, and survey data can tell us others, and the combination of the two gets us a lot. But as we've discussed in these meetings, there are key policy questions that we can't answer right now without making improvements to the data, and

that's why we're here today.

We've provided a draft of the introductory chapter, and we've received your feedback, and actually this should be the data chapter and not the introductory chapter. And what we've heard from you is that we need to ensure that the chapter is driven by some key points, and the first one is that data are not an end in themselves; they're a means to answer policy questions and ensure accountability. So if we're going to be asking states to provide information to the federal government, there needs to be a clear purpose and use for that information, and that needs to be emphasized throughout. We are seeking your additional guidance and feedback given what you've seen in the chapter thus far.

The outline for what we're going to talk about today follows the structure of the chapter that you've received, and the first thing we'll talk about is what federal administrative data can tell us about Medicaid and CHIP. We'll then move on to talk about federal surveys and what they can tell us about access to care in particular in Medicaid and CHIP. And then we'll talk about some particular recommendations.

As I talk to you about federal administrative data, I just want to, you know, give you a reminder. Remember, it's the CMS 64 expenditure data that we discussed. It's the Medicaid Statistical Information System data that provides information on each person enrolled in the program and the individual services they've received. It's the program characteristics data, like eligibility, covered benefits, payment methodologies that we spent some time talking about earlier that states have to report to CMS. So there are a variety of federal administrative data sources. And these are important because they're the only source of information that provides a picture of Medicaid and CHIP at the national level. Fifty states, the District, and territories, but really the only

information that we have that provides a comprehensive overview is the federal administrative data.

In addition to providing this national picture, it's a source of comparable information across states because states collect their information in their own formats, they use it for their own purposes; but in order to have some continuity in what we're looking at across states, the federal data provide that. And it's an important source, as I mentioned, for answering policy questions and addressing accountability issues. And that's what we're focused on in this chapter.

In terms of some policy questions that the administrative data should answer, they include things like how do service use, quality, and outcomes vary for enrollees in fee-for-service and managed care. And in the discussions that we've had, we've heard about access to appropriate services. That's come up over and over again. Without information on the services enrollees are receiving, we're not going to know whether they're receiving appropriate care.

I think Commissioner Gabow had mentioned the procedures that people are actually getting. Once you know that someone has been screened, what kind of care do they receive? What stage of treatment are they in? Burt, Commissioner Edelstein, the CMS 416 data, and it being a fairly crude measure of the services that children receive, dental and otherwise. So there are a lot of possibilities in terms of the administrative data and improvements and looking at these issues.

Another issue that hasn't been well examined is churning between Medicaid and separate CHIP programs and how service use differs between the two. In particular, given that the programs tend to have different benefit packages, we have questions about how the services differ between those programs.

You heard at the December meeting from Chuck Milligan of Maryland about home and community-based care and how that affects future patterns of care and other service use, and that's

something that we would like to be able to do across states, not just in one state like Maryland. That's a very useful analysis, but we'd like to be able to do that for additional states.

And as we've heard repeatedly from CMS and from others during these presentations, there are questions about whether the existing federal administrative data sources are adequate for these and other policy analyses.

In addition to answering policy questions, there are also general accountability issues that the federal administrative data are useful for, and those include things like, can the federal government easily connect a state's request for federal reimbursement to the claims that they've paid. Right now, it's sort of a labor-intensive process. If CMS has questions, they need to go back to individual states to request that information, because the federal data are not timely or comprehensive enough to answer the questions that CMS may have about the states' request.

And on top of the states' program integrity efforts, every state is looking at their claims trying to ensure that there's no fraud and abuse or issues with provider billing. The federal government also wants to be able to monitor that issue on top of the efforts that states do, and that's pretty difficult right now.

Again, as we heard from you in reviewing this chapter, you want us to emphasize the purpose and the use of the federal administrative data. And as we talked about, these data are collected from states at different times, in different formats, for different purposes, and CMS has indicated that states currently report some of the same information more than once. And they're considering options for change, but I think where there could be some additional effort is to clearly identify the purpose and use of each of these administrative data sources. We've heard that very clearly from you. And once that's been done, there may be some opportunities to consolidate and simplify the

multiple sources that CMS has right now going on. I think you remember that chart that Penny Thompson put up, and nobody's happy with all of those little buckets coming from the states leading to the federal government. There should be some way to consolidate or simplify those sources.

The other issue that we've discussed in the chapter is that the format of the administrative data that the federal government collects affects its usefulness, and this has come up in discussions about payment methodologies that we've had. The information is there at the federal level; it just may not be readily available in a way that is easily analyzed by states, by the federal government, because, in particular, the data on state program characteristics is stored in paper or electronic formats that can't be summarized easily, can't be linked with other data sources. And CMS is working on this. For example, they've compiled an eligibility and benefit information database that's current as of July 2010, but they are struggling with how to update that information, how to enhance it and make it useful over time.

They're also beginning a web-based submission process for state plan amendments, and that is only true for the new health homes benefit that was provided under the Affordable Care Act. But they're looking to expand that in the future.

So this has just been a really brief summary of what we've heard from you, what's in the chapter right now, and what we want to hear from you on the administrative data in particular is, you know, how do we move forward in presenting this information and perhaps getting to the recommendations that we'll discuss at the end of this presentation.

But right now I'm going to turn it over to Chris to talk about federal survey data.

MR. PETERSON: Thanks, April. And as we talk about survey data, I just want to remind

you, because a lot of times when we say surveys, we're talking about surveys of states, particularly in the Medicaid/CHIP context. And what we're talking about here are federal surveys of households. So this is where you're interviewing individuals, you're interviewing households.

This section of the chapter on the federal survey data will follow the same structure I'm using here in this presentation, which is first to ask what are the policy questions that state level survey estimates could answer with respect to access in Medicaid and CHIP; to review key existing federal surveys and options; and then to talk about an option for a new survey, a Medicaid/CHIP version of the Medicare Current Beneficiary Survey.

So what are the policy questions that state-level survey estimates could answer? I give this as an example, and I don't want Burt to get out his sword again because I don't want to be on the sharp end of that sword either. But I think actually we're on the same page, if I can describe it like this, because what this shows is service use, and I would say it like this: Service use is not access, but differing levels of service use may indicate where access problems exist. And so what we have here is you've got Medicaid and CHIP and ESI at one level, and the different level of service use for the uninsured could potentially tell you that there are access issues.

So I think ultimately we need to be more precise not to call these things access measures broadly because that makes you think that service use is access per se when it's not. And maybe the way to describe it is to say something like these are measures pertaining to access or measures that flag potential access problems.

But that was not the original intent of this slide. The original intent of this slide was to talk about access estimates in Medicaid/CHIP by state. They are not available. And so what that means in this context is (these are estimates that Jenny Kenney put together) they give you a national flavor.

You look at this and you say, well, Medicaid and CHIP for kids, well child visits, equal to ESI, this is great. But we know that there's going to be dramatic -- there could be dramatic variation by state.

So what if, if you could drill down by state, one state had 90 percent of their kids getting a well-child visit and another state had 50 percent? That's a different question. We cannot get at that right now. And so the second question then is what's driving these differences. Is it the cost of the service? Is it transportation? Is it language? Is it people's ability to get into the doctor's office and get something scheduled? And, again, we cannot get at these questions right now with the federal survey data.

I'm not going to read through this, but these two bullets make two points. One is that it is our obligation to review state-specific Medicaid and CHIP data, and that currently does not exist for access issues from the federal surveys. And two is the early-warning system mentions factors that adversely affect and have the potential to adversely affect access to care by Medicaid and CHIP enrollees. And so that is what we cannot get at, and so there is some impetus for improving the federal survey data, arguably.

We had this conversation at the last meeting about what the existing federal surveys are. That will be spelled out in greater detail in the chapter. There are several surveys that are included in the chapter. We're not going to go over that now.

The report, the March report, will also include an appendix, a compendium, that will list all of the federal surveys and the access-related measures that are in those surveys, so that should be a useful resource. But I am going to recap the four surveys that currently provide national estimates of sources of health insurance. They all tell you for the whole country what percentage of people are enrolled in Medicaid, CHIP, Medicare, ESI. They differ in that a pair of them support state-level

estimates, but they don't have any access questions. And the other pair have access questions, but they don't drill down by state. So how can we get there potentially?

The two surveys that support state estimates but would need access questions are the American Community Survey; it touches three million households per year. And then there's the Current Population Survey. The last time Judy had ask a question: Look, of these -- this is great information, but is there some sense that you can give us of which of these is better from a staff perspective? And I would say you don't even have to get it from a staff perspective. If the question is which provides you the best state-level and local area estimates, it's going to be the American Community Survey. The Census Bureau has said, this is our primary data source for annual state estimates. And I imagine that Trish and Sharon and others who have dealt with CHIP, the CPS probably raises your blood pressure because that used to be the basis of the CHIP allotment formula, and the states didn't like it. And so --

COMMISSIONER RILEY: But isn't it better? Isn't it better than it was ten years ago for that purpose, or not?

MR. PETERSON: Ten years ago, yes. But the little quote that I would give as CHIP reauthorization was happening was in New Hampshire the CPS estimates the number of low-income uninsured kids at 6,000, plus or minus 5,000. So if that's the basis of billions of dollars --

[Laughter.]

MR. PETERSON: -- of CHIP allotments, that's a little bit problematic. So, yes, it's better, but it still leaves a lot to be desired in that regard.

CHAIR ROWLAND: Small state issue.

MR. PETERSON: Yes. Small state issue.

CHAIR ROWLAND: Which is why you often saw that survey had to be pooled [off microphone].

MR. PETERSON: Right. Diane's point is that it take -- you had to pool several years together.

Now, on the flip side, we have the surveys that provide us with great access estimates nationally. That was the figure, the basis of that figure that I showed you, but you can't get it by state. That's the National Health Interview Survey and then the Medical Expenditure Panel Survey. Again, going back to Judy's question from last time, which of these would you go with? And I think as a practical matter you would have to go with NHIS because MEPS is built on NHIS. So you have the NHIS-interviewed people, and then MEPS comes along and says, okay, we're going to interview some of those people. So as a practical matter, you have to start with NHIS between these two.

That narrows it down to two. This is a little hard to see, for which I apologize. Fortunately, the structure of the proposed recommendation is not to make you choose. The recommendation we'll see in a bit is that the Secretary should consider improving or improve existing federal survey data to permit state-by-state analyses. But the point with this slide is that there are real trade-offs between these two: that if you want the ACS, it's going to take three to five years before we get any answers from this; whereas, the NHIS, it would be relatively sooner.

There's somewhat of a cost differential. The ACS would take two to three million dollars one time, just adding these questions and testing them; whereas, if you're going to bulk up NHIS, it's going to take a lot of money. And the chapter -- and there will be an appendix describing the basis of these estimates here, the 20 to 40 million, because you can make a lot of policy choices about how you want this structured, and that's going to drive the costs. And then there are other issues.

The ACS includes institutionalized; NHIS doesn't. The ACS has an undercount, a larger undercount of Medicaid and CHIP enrollees compared to NHIS.

On the other hand, it's also important to note that if one wanted to go down and add access questions to the ACS, you're only going to get one or two or three, because it's a mail form and the Census Bureau will say, well, you're not going to add a whole bunch to this. And NHIS currently has 33 access measures. That's not even including the service use. I'm talking about the true access measures, there's 33. So it will never compare. ACS, you just can't get there. And then you've got the unparalleled state and local estimate ability in ACS; whereas, in NHIS, even if you enhance it, it's not going to get to the same level.

I also want to review an option for a new survey -- again, this was mentioned last time -- to take the structure of the Medicare Current Beneficiary Survey and then do something new, a new effort that is focused on Medicaid and CHIP enrollees. And MCBS is a continuous multi-purpose survey currently for Medicare enrollees, and it produces valuable data files for analyses of Medicare. It is funded currently at $15 million a year.

Some of the key features is that it follows people over time so you can track their changes. It also provides some information on non-Medicare-covered services, so that is helpful as well. It can be linked with the administrative data, so that is a key component of this. And I should note that in the June report there will be a discussion on dual eligibles, and the use of the MCBS with respect to duals will be discussed more specifically there.

So if we wanted to use the MCBS as a model for Medicaid and CHIP, it would have some of these same advantages of monitoring changes in access over time, other challenges to access, like transportation and language. It would help assess whether federal objectives are being met, but it

would cost a lot more than the current MCBS because ostensibly you would want to get at state-level estimates. So we're talking $45 million a year, so this would be big.

And there are other challenges. Again, you'd have to get at the state-level estimates. Also, the Medicaid and CHIP enrollees, they're different from Medicare enrollees. So that raises a different set of challenges in trying to interview these people, to follow them, so that is an issue as well as the cost of starting a brand-new effort given the fact that MCBS, the current MCBS is having funding challenges, and so, you know, what are the implications of trying to start a new effort like this?

If the purpose is to provide comparisons of access to other sources of coverage, this won't get you there because this is focused on Medicaid and CHIP per se. And there are lags in data availability.

Also, to the extent that the current MCBS is useful because you can link with the claims data, then to the extent our current administrative data, there are gaps there, then one could contend that April's discussion and those recommendations kind of need to happen first before we can get the full level of analyses that are necessary in this kind of survey.

Okay. So now we'll talk about the potential recommendations.

MS. GRADY: Okay, and the first two recommendations are specific to the administrative data, and those are the ones that I'll talk about.

The first potential recommendation is that the Secretary should consolidate or simplify the collection of Medicaid and CHIP administrative data from states to both reduce administrative burden on the states and improve data quality.

Now, the rationale for this recommendation is that the consolidation or simplification of these data sources could reduce state burden, as we mentioned, but it could also improve quality by

leaving the remaining data sources to be used more frequently and for a wider range of purposes. Again, this is getting to the purpose and use. Why are we collecting multiple data sources, multiple pieces of information at different times?

The inconsistencies across the data sources that we've discussed are a concern because they raise questions about whether the variations we see across states are real or whether they're just a factor or a result of the way states are reporting their data to the federal government. And to the extent that policy decisions are being made on the basis of questionable or absent data from the states, both the states and the federal government have an interest in improving its quality.

The implications of this recommendation are perhaps that CMS would incur additional administrative costs, but depending on the changes that CMS implemented, there could be some additional cost to states in altering their data systems, and that would, again, vary depending on what CMS did. The federal government would pay at least 50 percent of those costs and up to 90 percent, depending on how this was implemented. Although there would be up-front costs, the initial investment could be offset in later years by a more efficient allocation of federal resources and a reduction in state burden. And it would allow us a better analysis of policy issues that are relevant to enrollees, and the impact on providers would depend on whether there were changes to data reporting systems that they're a part of.

The second potential recommendation is that the Secretary should collect and disseminate information on Medicaid and CHIP state program characteristics in a structured format with classifications that allow the information to be compared across states and linked with other data sources. Again, when we talk about program characteristics, we're talking about eligibility information, covered benefits information, payment methodologies, other aspects of state programs

that reside mostly on paper right now in the state or the federal regional offices.

There are a couple of rationales for this recommendation. One is that the federal government could better meet its oversight and program integrity responsibilities if there were more centralized and easy access to information about what states were doing. Again, paper information, very difficult to get to in some cases at this point. It would also allow states access to information about what other states are doing, and that would serve as a resource for them as they consider program changes. And then, finally, it could help analysts better identify the effects of different policy levers on enrollment, expenditures, and service use. For example, we would have better information about when an eligibility level was changed, when a co-payment was added, when a payment methodology was changed. We could connect that information with the actual use and outcomes that we see in the claims and expenditure data.

With this recommendation CMS could incur additional administrative costs, and states generally wouldn't be expected to incur additional costs because the information we're talking about wouldn't generally require them to alter their data systems. They would be reporting the same information, just in a slightly different format. And, again, they usually don't come out of the automated data systems, so there shouldn't be a state cost here.

Again, there could be a more efficient allocation of federal resources and a reduction in state burden. For example, right now states respond to a lot of ad hoc surveys from various organizations because we want to get information on eligibility levels, covered benefits, what they're doing. If this was available at the federal level, there would be less need for that kind of survey to go on. And then, depending on how the data are analyzed -- this is a very secondary impact -- providers could be affected by changes in federal or state policies.

MR. PETERSON: Then for the survey data, this potential recommendation is that the Secretary should improve or should consider improving existing federal survey data to permit state-by-state analyses of Medicaid/CHIP enrollees' access to health care and work with other executive branch agencies as necessary. And that last piece is because the ACS is run by the Census Bureau, so that's a different executive branch agency.

The rationale is to enhance the ability to track by states Medicaid and CHIP access to care and factors that affect access straight from our statutory mandate and to augment the tool kit that's under development for the early-warning system to meet other MACPAC statutory obligations. And this one is really making use of what's already out there.

The implications in terms of federal costs range depending on whether it's the ACS or NHIS. There are no state costs associated with this and really no direct enrollee/provider impact. There could be direct impacts to the extent that policy changes result as a result of the findings.

And then recommendation four, the Secretary should consider developing a survey similar to the Medicare Current Beneficiary Survey for Medicaid and CHIP enrollees; that this could answer Medicaid and CHIP policy questions not available in current federal surveys, although one could augment the federal surveys to get at some of these things if that were the preferred option; able to focus analyses on particular subgroups, foster children, for example; and it's easy to tailor and revise the questions in response to certain policy developments.

The implications are that this would cost $45 million annually and, again, no state costs or direct enrollee or provider impact.

MS. GRADY: Then the final recommendation is that the Secretary should dedicate sufficient resources to implement these recommendations and, as necessary, seek additional funding from the

Congress to support these efforts.

The rationale is that it's unlikely that some of these recommendations can be implemented without additional federal administrative resources, and it would be necessary for the Secretary to submit a budget proposal to the Congress that estimates the amount that's needed to implement the recommendations.

To the extent that additional funding is provided by the Congress, there could be costs incurred by taxpayers, and depending on federal actions, there could be costs and benefits for states, enrollees, and providers, as was discussed under each recommendation.

We welcome your comments and feedback.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I think this is -- you know. This is obviously a mire of complexity, and you did a great job in the paper, I think really showing that complexity and did a nice synthesis.

I think the key for the paper -- I have a couple of issues. A key for the paper is I'd love to see instead of -- that's going to be lost on, I suspect, everybody, so to our discussion yesterday, how to streamline it. It seems to me a chart would be extremely helpful, maybe difficult to do, that sort of answers these questions: What reports are now presented? When do they come in? When are when are they required? What questions do they answer? And how are they used by the state and federal government?

My worry about this whole section -- as sort of a starting point, my worry about this whole section is it seems I'm not ready for these recommendations because I think we need to step a little bit back, particularly around state burden.

The reality is we have this complex system of data, but we have never had the process, I don't think, to answer, to determine what are the 10 most important questions we need to answer to operate this program from the state and federal level. That seems to me the starting point. That's what I would like to recommend, a process whereby the Secretary moves quickly to start us from what do we need to know and why because we tend to collect data and think it will answer questions without asking the questions first, and I think we need that process.

I worry, and I think we need to reflect in the report, about state burden. Right now, states are stripped of most of their administrative capacity. The budget is brutal, as we all know. They're dealing with ICD-10. They're dealing with meaningful use. They're beefing up fraud and abuse in an environment of budgets, and they're trying to do what they can to manage the program.

Unequivocally, the states have an obligation to report timely, accurate data, but it begs the question of why don't they. They don't because it's irrelevant to their management needs, it's costly, or it doesn't matter. They don't think anybody is reading them, and nobody is holding them accountable to it.

So that gets me back to a recommendation that would start with a process of what questions do we need to answer, then an inventory about can we answer them from our current capacity, what can we stop doing, and then recommendations for action. But I'm really nervous about moving too quickly without an agreement on what the questions are and maybe engaging the Congress too, and I think MACPAC has a particular role there.

CHAIR ROWLAND: Okay, Sara, then Burt.

COMMISSIONER ROSENBAUM: Thank you for a very nice job. I'm going to show my utter and total ignorance of data collection. I have one -- I have two questions.

The first one is sort of a minor question but just out of curiosity. Why does it take three to five years to add a question to the American Community Survey?

MR. PETERSON: There are a couple of reasons, and you guys could actually recommend that Congress bypass that, if you wanted. That would make a lot of researchers happy because there is definitely frustration about the length of time it takes to do this.

But the rationale that the Census Bureau would give is as follows: One, they go through a detailed testing, field-testing process. In addition, if any question is ever going to be added, it takes a long time just because of the bureaucratic resistance to that because, again, it's a mail-back form and they're not anxious to get more questions added.

COMMISSIONER ROSENBAUM: Okay. So my second question is more of a sort of a bigger question. The chapter is predicated on the notion that what we are trying to do here is sort of a collection of information that states have to provide, just as Trish was describing, as Commissioner Riley was describing, with sort of this going forward added effort on top of what's already happening.

Where I'm lost is why we are not making much more ongoing use, and I understand that there is cost involved, of state MIS systems. Why are there not programs being developed by states and the federal government together that just on a routine basis mine data out of the MIS subsystems and provide a lot of detailed information about program design and operations?

Now that is not to say that there aren't costs, but the focus of our chapter right now is on essentially sort of deliberately surveying to answer research questions when it seems to me we might want to broaden the focus to reach making much more efficient use of the high volume of data that every Medicaid program routinely produces for its own use and that all Medicaid programs must

produce because of the basic requirements of MIS systems.

MR. PETERSON: I'm going to let April answer this, but just on the survey stuff, again just to be clear that the surveys are, that I'm talking about, are surveys of individuals. This has no state bearing.

And so your fundamental question is trying to get the best available stuff out of what's already there, and I think that's really the spirit of what April is talking about, and I'll let her answer.

MS. GRADY: I think there's an inherent tension between the way the MIS systems work and are individualized among the states. Many of them work with the same vendors, for example, to process their claims, and so presumably there is some consistency there across states. But ultimately, what we're talking about is 50 versions of a system. And therefore what CMS has done to date is to require that the individual states take whatever their information looks like, whatever their system and to pull out certain elements, certain pieces, and then report that to the federal government in the consistent format, so that when the federal government looks at it they can say, okay, yes, this is the same piece of information across states.

So I think what you're getting at is perhaps working more with the existing infrastructure at the state level?

COMMISSIONER ROSENBAUM: No. I'm saying why doesn't the federal government put the money into -- I realize the standardization issue is the horse out of the barn problem, but this is not the first time that information gathering and development has had to make sense out of multiple systems. So why wouldn't the more efficient thing be to put the money into a federal program that can actually do the data mining instead of having states individually having to prepare these reports? Why should states be doing any of this? The data sit there for the federal government to pull.

And I assume large health systems do this; they mine data. Large insurers mine data. And so I'm wondering why any burden needs to be put on the states at all.

MR. PETERSON: And I would just respond. I mean the 416 is kind of the potential classic example where states have to go through a separate process to report this information.

And the recommendation about consolidation is, look, if we could make the existing systems that are where this information is provided, if states would actually provide this information, then you wouldn't need to do this form. We would be able to produce from those data this information.

COMMISSIONER ROSENBAUM: Right. I just don't want the states to have to be the ones to have to provide the information, other than to make their systems accessible to federal information collection. That's all.

COMMISSIONER EDELSTEIN: I really appreciate this presentation as well and thank you, Chris, for acknowledging the issue about the difference between access and utilization.

Essentially, what we've said -- and I'm still very much at the starting line, not nearly ready to think about the recommendations yet because our name is access and payment, and the closest we're coming are utilization measures as proxies or, at best, representations of some underlying access issue. There are no direct measures of access.

One of the components of access that we discussed yesterday is the participation level of providers. And whenever one tries to assess program modification, program reform for its benefit, for its outcome, we're stuck not knowing what the level of impact is on the provider participation. So I'm wondering if, as Commissioners, we should be thinking about at least one of the factors that closer to access per se, i.e., whether or not the doors are open, by seeking some measures of provider participation.

CHAIR ROWLAND: Well, let me ask April and Chris. In the databases that you have reviewed, is there any indication of provider participation?

MR. PETERSON: Well, these are --

CHAIR ROWLAND: I know they're not in the national surveys unless you go to physician surveys, but in the administrative data we don't, or the federal government does not, collect that information.

MS. GRADY: What we do collect for the Medicaid program is claims level data where there is a provider number on each claim.

And the issue, as I understand it right now, is that in the transition to a national provider identifier the data are still pretty messy, and there are issues with multiple IDs and being able to tie that back and figure out okay, if I'm seeing these provider IDs in the Medicaid claims, what percentage of the total provider base does that represent. That's one issue just because of the messiness of the data.

The second issue is that some of the providers in the Medicaid program are not sort of traditional providers or medical services and therefore don't actually have a national provider identifier. So we're talking about maybe transportation services, other sorts and even personal care, that sort of thing. Folks are not in a national database. So therefore, you have to work with state-level information about the total number of providers. It's hard to get the participation that way.

CHAIR ROWLAND: And what about managed care?

MS. GRADY: With managed care, the federal government does not, for Medicaid, collect information specifically I believe on provider participation, but some of the other Commissioners

might be able to speak about that.

CHAIR ROWLAND: But the claims data is all fee-for-service.

MS. GRADY: The claims data is -- yeah, it's not in a complete state right now.

CHAIR ROWLAND: Burt has some follow-up.

COMMISSIONER EDELSTEIN: Yeah, I just wanted to echo what April was saying. Even if we could derive from a cleaner data set the actual participation based on claims, trying to relate that back to overall access, that would be our numerator. The denominator is even tougher to get our hands on because there would be, inherent in that, no basis to understand how large a pool of potential providers there could be.

So I think for us in trying to assess access, we really have a fundamental problem of sorting out what the essential components are of access and then because payment we know is one of them that then leads to provider participation, what the essential components are of access and then determining some way of measuring them.

And the only deficit I found in the approach in the chapter is that it went from -- it went directly to utilization measures because that's what's available, administrative data and national surveys. But that middle piece which is more central to our concerns, the access per se, is something we need to brainstorm about how to get our hands on.

CHAIR ROWLAND: David, then Patty and Judy.

VICE CHAIR SUNDWALL: Yeah, I'm going to, first of all, follow up and just tell you all the dentists in Utah tell me they don't participate because of the complexity of getting paid. Of course, they don't tell you it's really the payment rate, but they say it's hard to get paid. I don't know why.

Just a general statement. I really think this is going to be an important chapter. When we ran around and made some Hill visits on both parties, data are really on their minds. I mean they really told me and Diane at Senator Hatch's office, they really want solid information as they move forward to make changes in Medicaid, whatever they do. So this chapter is going to be important.

Having said that, you started off just great, April. The very first statement was consolidation and simplification. That has such a welcome sound to people at the state level or the federal level.

What disturbed me is when you went on to talk about the various surveys and then did the cost estimates of the impact. Tens of millions of dollars more to simplify and consolidate? Is there not some way where we can link the potential savings of this improved data system without slapping them right in the face with an oh, by the way, it will be 45 million more to do what we think is necessary to get the savings down the road?

And I don't know how. I mean you're probably being honest, and you're trying to say what it would cost. But I think the message from the Commission would be very well received if we focus on consolidation, simplification to make informed reforms and that this will in fact save money in the process, but acknowledging there may be some investment up front.

But really, I keep looking at our recommendations as how our audience is going to receive them, and this one in general would be very welcome and important, but not how it's now couched.

MS. GRADY: I just want to make a clarifying point. So the consolidation and simplification recommendation that we talked about is specific to the federal administrative data. The federal survey recommendations that Chris talked about were the ones that could potentially cost were they to be implemented.

CHAIR ROWLAND: Patty and then Judy.

COMMISSIONER GABOW: This is probably a dumb question which shows the fact that I'm not a sophisticated computer user, but just to take our system, Denver Health which is a safety net, an integrated model, but you know 42 percent of our users can't pay us. So we don't have a lot of money to put things. But our IT system links all of our data -- our demographic data, our billing data, our lab data, our radiology data, our pharmacy data -- and it's all in a data warehouse. It's all available in real time. So if you want analytics on all your hypertensive patients and their prescription, you can get that.

Initially, when we started, it was a warehouse in which things went in and never came out, but it now is really quite robust.

So I understand that there are questions that cannot be answered off of that kind of data, but there are a lot of questions which can be answered off of that kind of data.

So I say everyone is billing Medicaid electronically. All your billing data is electronic. We are going to meaningful use. We have these REOs in all the regions that are collecting all this individual data. The feds have put a lot of money into the REOs, which we could have a whole lot of discussion on. And we all have provider numbers that are specific.

So I think we need to stand back and say if all this data is going electronically there has to be a way, as Sara was saying, to manipulate the data in a federal data warehouse without asking anybody to do anything else.

I mean -- and maybe the data is imperfect, but if you asked every hospital. Let's just start with what we have. Every hospital that's billing Medicaid, like us, you know if we're a safety net and we have all this, to send this data to the feds electronically, they could have a data warehouse.

And if they're going to put money in, they should put it in once, in developing the analytics to

use the data, not 45 million ever year to a survey.

Now I understand there are data that you get from a survey that you wouldn't get from this, but I think it's standing back to the question that Trish says. You know, there's a dream world in which we could have perfect data, but there's a lot of data that we have right now. And the question really should be what analytics can we apply to the existing data that can inform our investment in this program and analyze the use. That's a first step.

And somehow combining all the information that comes out of systems or come out of the REOs or come out of the billing process seems to me to be the place to start because while it isn't perfect I really believe don't let the perfect be the enemy of the good here.

So maybe I'm just being simplistic, but if we can do a data warehouse with all of this in one system I really don't understand why this would be impossible at a bigger level.

COMMISSIONER EDELSTEIN: Yeah, Patty, that's exactly what I was calling for, from administrative data from claims sets rather than surveys. I wasn't intending surveys. Just asking us to focus on some of the elements that are measurable that in fact are about access per se.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I want to go back to a little bit bigger point, and then maybe we can come back to this one. The chapter is very nice in terms of describing the pieces that we need to look at, and I wonder if we can get a little bit more in an overview that addresses our need for data and the priorities and some of the expressions of interest here about doing with, enhancing what we might already have and minimizing new and very expensive things. But that's just a kind of a minor detail that I would suggest.

One of the things I wanted to say is CMS is moving. We did hear from Penny Thompson

about their work. They have moved to ask, I think, the questions about what they need, and what states need and want. And I think it is a good idea for us to give some push to that in terms of a recommendation. It will help them because they have to set their own priorities for their own staff resources, and I think it will help them to have us say that's an important thing they're doing and they should continue to do it. I mean we don't have to mention Penny by name, but you get the gist of that.

And I think that it can address some of the things that Sara brought up and that others have been talking about also, that we move towards changes in the MMIS and the MSIS at the federal level that allow for more help to the states who want to have uniform -- who want to have choices among several approaches that could then feed into a better federal, national system.

I'm probably not articulating this very well.

There are, as I think Donna said, five, six, eight contractors who do MMIS. And the federal government has never been as prescriptive as I think we should start pushing them to be on the requirements in those systems, so that when it comes in it is more uniform and it can be used both at the federal and the state level.

I hear state people, and I've said this before. I hear state people asking for more guidance, more options, you know, more templates, more models. I'm not saying that we need to tell every state to do it this way or no way. I'm saying that we should give them some more technical assistance and not put them always at the mercy of one RFP in their state and several contractors and what they may or may not want to provide for whatever amount of money they've got.

CHAIR ROWLAND: Donna and then Denise.

COMMISSIONER CHECKETT: I think following upon Judy's comments I know that a lot

of states, but I don't know if all 50 obviously, but a lot, even many states have very sophisticated subsystems in that allow them to analyze a lot of data and produce very impressive reports. They get it through sometimes data warehouse additions that they provide to their MMIS contract.

I don't know if we have that information, if we could get that from CMS or if CMS has asked the states that, but as we continue to grapple with how do we access the information we need. The chapters focus so much on federal survey data. One federal survey might simply be to find out what states could actually give us now. I think there might be a degree of surprise about how sophisticated a lot of the data is from states and their capabilities in analysis.

COMMISSIONER MOORE: But there's still that question about whether it would be comparable, so that you could aggregate it. So you want to work --

COMMISSIONER CHECKETT: I bet you'd be surprised. It wouldn't be 50, but I bet you would be surprised at how common that is now.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: Go ahead.

VICE CHAIR SUNDWALL: I was just going to say we have pretty good data on provider participation right now in Utah, and I wouldn't be surprised if other states do. It's not perfect, but it certainly gives us a general picture of who is participating anyway.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: I just wanted to point out that this is actually an opportune time because CMS is -- I believe it's CMS. Actually, they certify EMR systems, so electronic medical records systems, and there are some incentive payments to providers to institute electronic medical records. And I'm talking kind of providers more at your local doctor level, but even hospital systems

I think are actually eligible for these payments right now, to implement. So if they're still on paper, it's to implement their electronic medical records systems.

So I think if CMS said okay, as part of the certifying process, this electronic medical record that's going to take care of this patient needs to be able to give us some -- you know, to link with the administrative data that they need to report, to help states make decisions and to help the feds make decisions.

I think that that needs -- and maybe it's already there, but I think that needs to be part of their certifying processes, that they talk to each other because the EMR that I use right now, I like it for taking care of the patient, but it doesn't talk to my management system very well. So it doesn't necessarily talk to like the schedulers and, you know, the address and the phone numbers and those kinds of things. And it doesn't aggregate data very well.

So I want to know how many patients I have that have a diagnosis of threaten in pre-term labor, I can't get that from my EMR system. I have to get it from the billing system.

So somehow there has to be better linkage between those two, and I think one way to get that is to make sure that when you certify the systems, that they talk to each other.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I had a general comment on the chapter because my perception was that almost all the commentary refers to acute care physical health. Given how broad Medicaid is, it seemed like it would be worthwhile to point out -- I assume this is true -- that we're not really talking about behavioral health data, DD, long-term care because the comment about electronic reporting is totally N/A or bogus in certain other spheres of Medicaid. I wish we had electronic claims reporting, but it is just not there. Maybe that's a story for another day. So I think what we're

talking about is primarily acute care physical health.

The other thing that -- one of the things that I'd like more comment on is I think it's generally true that most Medicaid programs have sort of outsourced, so to speak, the delivery of care and claims payment to MCOs. There wasn't a lot on MCO data that I saw, or requirements specifically. It seems like we ought to address that a little bit.

And maybe consolidate and simply would get you to the same place, but I like the word "eliminate" because I think we've just sort of accumulated a whole bunch of data reporting requirements, and it seems to me like it's a good time for a do-over. Approach it from like a standpoint of

[Laughter.]

COMMISSIONER HOYT: Really, like zero-based budgeting.

COMMISSIONER HENNING: The 10 questions.

COMMISSIONER HOYT: What is this report? Why are we doing it? Who uses it?

Costs justify this. I mean everybody is concerned about general administrative expense or cost. The plans are getting hammered with MLR requirements. Everybody has seen that. So what are we collecting and why, and inventory that way.

But I would question if we report that we've got it we should make it rejustify itself as to why are we doing this and does it reflect the state of the art now. So much has changed in the last five to ten years in technology with the delivery of health care, how care is managed. I don't think the data systems we've got reflect that.

And then I don't know if we want to go there or not. Maybe this would just be fleshed out in some of the things I just discussed, but I mentioned before I think there are other examples like this.

The EPSDT reporting -- I understand why we do it and the importance of the program, but I think with the introduction of managed care we're now getting in a lot of cases what I would call false negatives.

PARTICIPANT: [Inaudible.]

COMMISSIONER HOYT: Yeah, where the -- if you take the data or the reports now at face value, it would say managed care is really bad for Medicaid in some cases. You know. Kids are not being served. This isn't happening. That's not working right.

And I don't really think that's true, at least the things that I have, or our firm has, looked at. I don't think that's true at all. I think it's a data reporting function. So the recommendation in my mind should be fix the data reporting, so that we get a true read, or drop it and do something different.

CHAIR ROWLAND: It seems to me that we are really focusing on two sides here that are complementary, but we're not delineating them sufficiently. If we start with the administrative data issues that April has raised, what can we learn and what questions can we answer from the administrative data? What can't we answer from the administrative data that we could if we had better administrative data? And what are we collecting that we don't even need that we're not focusing on any question? Because it is the administrative data that gives you the ability to go to all 50 states. It is the state-level database. And then when we get to the survey data, it's a question of what can we not ever get from good administrative data that we need to get from surveys. And to what extent can we do that with existing surveys?

Because we answered different questions with the two databases, and I think if we have that as a focus of our chapter, it will make it clearer both what has to happen on the administrative side,

and then it will justify, if there are data issues that we need to evaluate the program that have to go to national surveys, why it would potentially be worth the cost. And the Congress and others can decide that to get that information is worth $10 million or $15 million added on to a different survey.

So I think that's an important way to sort through what we're doing, and I think the place that we need to start really is with: What do we now collect on the program administratively? How can that be streamlined, eliminate what's irrelevant, and what's missing? I mean, we've been talking about earlier on the payment side about how little information there is. So do we have too much on some things in the administrative data, not enough on other things? What do we really need?

COMMISSIONER RILEY: I think that's a great summary. I would just add, though, that the starting point should be what do we need to know and if de minimis is possible, because we collect lots of information. Assuming we're going to get something, we don't start with the question. And if we start with the questions and engage the states, part of the reason the states don't participate is they're so busy. Every minute you get a new legislative request for more data. States have plenty of data and are doing a lot of reporting, but clearly are not meeting what we need them to do with the federal government.

So I would simply tweak that a little bit to say start with the questions and make sure the states are partners in this so that they get what they need for their reporting, because I think that will enhance the likelihood of getting good data.

COMMISSIONER GABOW: I would add one other thing, that we also look at the current level of sophistication that comes out of systems and the robustness of their data, which may be representative. It may not be completely inclusive, but to develop -- to use that to develop a federal

data warehouse I think shouldn't be lost, nor should we lose how we can link this acquisition of data to the federal investment in REOs and to the federal investment in meaningful use. It seems that these silos should somehow still be pulled together.

COMMISSIONER HOYT: I just have one other shorter comment on the managed care data. Encounter data gets talked about a lot. Actuaries certainly use it for rate setting and lots of other things. I think it would make sense and it feels like we're saying we should make a recommendation to standardize the definitions of encounter data, reporting things like if somebody's treated in the emergency room, you know, is the physician encounter on the ER line or is it over in a physician line? When a baby's born, is the baby's cost, some of that baked into mom's cost? Is it separate out? You could just go on and on.

I talked to United, Aetna, Amerigroup, Centene, companies that contract state by state by state, and that's clearly one of the frustrations they've got, that they're required to do the exact same things -- or report the exact same events differently across state lines. I mean, that would eliminate a whole other layer of administrative expense as well as facilitate a whole slew of research projects. And that's really the reason I think that you cannot consolidate a lot of data. I mean, Mercer is a good size. We do work in more than 20 states, and it's almost impossible for us to consolidate our own data and draw conclusions.

COMMISSIONER ROSENBAUM: Just again to follow up on what I thought was your really nice formulation of this and then the amendments, to further note for Congress that the entire -- and I think this is what Patty was getting at -- that the entire concept of states having to report data may be one that needs a fundamental revisiting; that is that we have learned so much now from technology through large systems about mechanisms for collecting data that should be readily

available that actually reduce the burden by eliminating the concept of states having to collect and report and prepare and file when, in fact, the data flow may be using more modern technological approaches more continuously available to the government; that is, through the kinds of innovations that a large system uses, to simply take the data it's got and pull out the information that needs to answer a question. And I think that's the piece that to my mind is really missing right now from the discussion. I would like to see the burden on states actually be almost nothing and instead have the states, as Trish says, partnering with the federal government to figure out what they need to know and what all states really need to know at a 50-state level, what the federal government needs to know, and then have a national collection system that's going to serve everybody using all available data.

MR. PETERSON: I would just add this kind of sounds like to me all-payer claims databases where you're bringing all this in from all the different

COMMISSIONER ROSENBAUM: But it's not -- it's also not just the claims data. I mean, it may be claims. But there are questions from the eligibility sub-systems. There are questions from the coverage sub-systems. There are all kinds of questions that really go to access and even go to payment where it's not just wanting to have an all-payer claims system. And if the source of the information happens to be claims, at least in the non-managed care world, I think we ought to stay away from giving it monikers that immediately sink it. You know? The fact of the matter is if you're not in managed care, the claim is still going to be the source of important information. But as soon as we label it an all-payer claims system, it immediately give it, I think, a concept or a label that immediately raises hackles, when all we're saying is can't we use the modern techniques of data retrieval at a national level -- not a federal level but a national data retrieval system that everybody

could use, and that's where on a routine basis I would put my money.

COMMISSIONER RILEY: Just a quick follow-up. One of the issues that we've experienced as one of -- I think the oldest all-payer claims database is the issue of attribution. As more and more physicians' practices become parts of groups and parts of hospitals, which provider provided the service is a very difficult answer to get. So we ought to make sure these technical issues become front and center of this review.

VICE CHAIR SUNDWALL: One follow-up on that. You know, Chris, you've been out to Utah and seen our all-payer claims database, and it is dynamite as far as getting access data. And I can't imagine we should dismiss. There are some examples where it's been done statewide where we can tell you in San Juan County the level of depression or utilization of things is really very useful for access and a tool that I think we ought to not pass over.

COMMISSIONER MOORE: It sounds like there's a great interest in articulating this as our overarching goal while then also talking about what exists now and how to get from where we'd like to be in maybe a year or two, or even three or four, to there from where we are now. So that may be a missing piece that can go into the beginning of this. Because it's easier for us to talk about how wonderful it would be to use existing databases and put them all together and make it all nice for the feds and the states, but it's a lot harder to actually do. And there's a big long crosswalk between where we'd like to be and where people are now, and I think that crosswalk is something that would be very, very valuable for the Congress, for the federal government to see where we are, for providers to see where they might be a part of this, and obviously for states.

COMMISSIONER ROSENBAUM: Maybe the way to think about this is going back to Diane's original formulation: What can we do immediately to better make use of what we have? And

what would be a longer-term vision about where we really want Medicaid data to be on a national level using the tools that are available today, the trends in data collection and analysis that Patty and others have noted, the kinds of improvements that Mark has identified so that we are giving Congress in this chapter a road map that says in the here and now, here is what the Commission can help you understand; in the long run, for a program of this importance, here's where we think -- and that is this difficult and challenging for states and the federal government, here is what you ought to be thinking about.

COMMISSIONER HOYT: I was just going to say if this heightens the urgency of the recommendations ultimately, and states are getting ready or are making right now huge investments in IT in conjunction with the new law and with the exchanges specifically, even though the exchanges look like maybe on the surface it's more of a Department of Insurance thing or for somebody else, most of the places where we've gone, Medicaid seems to own it or own most of the responsibility with the requirement that they subsidize premiums up to 400 percent of FPL. I mean, Medicaid is going to be constructing huge data warehouses and databases to track people. So it just makes the work you're doing even that much more important. I'm hoping they'll listen anyway, but that's even more reason to.

CHAIR ROWLAND: I think another thing that ought to really be looked at in our data analysis is the timeliness of data, what do we need in real time versus what we want to be able to retrospectively go back and evaluate how something has worked or whatever. And I think that gets to time lags on both administrative data and survey data, and it really speaks to Sara's point about if you can pull stuff of and extract it quickly, then you get it in a different time frame. But some of the policy questions that we are going to try to answer or that Congress and the administration and

states are trying to answer requires data that's not from 2005 or even from 2010 but is from 2011 because we know how dynamic the program is. And what we gain sometimes from survey data is things that change slower over time and where we want to be able to do more tracking. And I think that's the other issue of where do we want just point-of-time data and where do we want to be able to look at trends and to be able to identify for especially our early-warning system it's going to require us to look at how tight the time frame is between when we get data and not. You know, an early-warning system based on five-year-old data is not going to work either.

So I think that theme has to be part of what we look at in the data, sort of when it is available as well as what do we need to answer in what kind of timeframe.

VICE CHAIR SUNDWALL: [Off microphone] The whoops data. We get it five years later. Whoops, we did that wrong.

CHAIR ROWLAND: Are there other comments for guidance in restructuring this chapter from the Commission members?

COMMISSIONER RILEY: Have we done any outreach to the states about this? Because I'd like to hear from the Medicaid directors. They may have some specific ideas about more incremental reforms, but I'm concerned that we engage them.

EXECUTIVE DIRECTOR ZAWISTOWICH: We've talked to the Medicaid directors very briefly about the chapter, but we have not specifically engaged them in a work group discussion or anything like that.

CHAIR ROWLAND: That might be very useful, I think.

EXECUTIVE DIRECTOR ZAWISTOWICH: And I think we can do that as part of our consultation process.

CHAIR ROWLAND: I think that will be a good way to find out what's being asked for that's not being used and how much harder to answer some questions would be than others. I mean, what's the easy way to get an answer versus what would take a lot of redoing of data systems?

I'm sensing that we're also not at a point right now ready to jump in and make a decision on any of these recommendations, so what I think we should do is take these comments into a revision of the draft chapter to get that chapter back out, and in that process see if we can reformulate around this discussion some of those recommendations for us to take up and consider. Is that agreeable with the Commission members? Okay.

Well, then, let's take this discussion on in the next iteration, and we will now open the discussion here to any public comments that we may have from people in the public on this issue or any of the other issues that are before the Commission in its work.

PUBLIC COMMENT

[No response.]

CHAIR ROWLAND: We've wowed you with our data discussion.

[Laughter.]

CHAIR ROWLAND: Well, we then will adjourn the meeting and then reconvene in executive session after a break. What I would also like to thank the public for is your understanding yesterday of the weather conditions that prohibited us from conducting the full meeting, so we appreciate you getting out in the remaining ice and snow to be with us today. We'll be having our next meeting in February, February 25th, and look forward to being able at that time to review the entire March report that we are planning for Congress and to go through the final discussion of that. So we will continue to work and the staff will continue to work very hard in the interim.

Thank you.

[Whereupon, at 11:27 a.m., the meeting was adjourned.]