MACPAC

Advising Congress on
Medicaid and CHIP Policy

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December 30, 2015

The Honorable Orrin G. Hatch
Chairman

The Honorable Ron Wyden
Ranking Member

Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for your interest in the views of the Medicaid and CHIP Payment and Access Commission (MACPAC) on issues of data availability and transparency of payment in the Medicaid program. These are issues of longstanding concern to the Commission and we have devoted multiple chapters of our reports to Congress on the matters outlined in your November 13 letter.

1. What data sources are lacking or should be employed more effectively, updated or better coordinated to facilitate state options, administrative functions, and inform state and federal decisionmaking? Are there specific reporting requirements in the Medicaid program that are duplicative, overlapping or outdated that could be streamlined?

Data on Medicaid and the State Children's Health Insurance Program (CHIP) play a key role in answering policy questions that affect program enrollees, states, the federal government, health care providers, and others—and in ensuring accountability for taxpayer dollars. Such data are necessary to meet the following objectives:

- managing core program operations;
- ensuring program integrity;
- evaluating program effectiveness and performance;
- holding states and the federal government, plans, and providers accountable;
- promoting transparency to consumers about rights, benefits, and providers; and
- facilitating evidence-based decisionmaking about future program changes.

To manage and analyze the Medicaid program, state and federal decisionmakers need data on:

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- the characteristics of state plans, waivers, and demonstrations;
- people served;
- services delivered and payments for those services;
- providers delivering services; the health of the population served; and
- other program and service outcomes.

Federal administrative data on Medicaid and CHIP are meant to provide comparable information across states, which maintain their own disparate data systems. The Centers for Medicare & Medicaid Services (CMS) is taking a number of steps to improve the timeliness, quality, and availability of federal administrative data on the Medicaid and CHIP programs. These initiatives include:

- MACPro, a web-based system designed to collect state plan, waiver, and other programmatic documents in a structured and consistent format;
- the Transformed Medicaid Statistical Information System (T-MSIS), a data source building on existing person-level and claims-level Medicaid Statistical Information System (MSIS) data submitted by states; and
- Medicaid Information Technology Architecture (MITA), which establishes national guidelines and standards for state-operated Medicaid and CHIP data systems that are funded with federal dollars.

The Commission commented on the need for such improvements in its reports to Congress in 2011 and 2013, noting that such improvements require significant investments of federal and state resources and time to implement. MACPro and T-MSIS have been under development for several years and CMS now reports that both are expected to be fully operational by the end of 2016. MITA is an ongoing effort with states, whose data systems are at varying levels of modernization. The recent extension of the 90/10 federal match for enrollment and eligibility systems, supported by the Commission in its comments on the proposed rule in June 2015, will be an important step in ensuring that states have the resources to complete these updates.

The Commission supports CMS's efforts and has encouraged the agency to continue seeking input from states and other stakeholders. Adequate staffing, funding, and support at both the federal and state levels will be critical to ensuring that the best possible information is collected on Medicaid and CHIP and that it is disseminated in an efficient manner—for example, by making use of technology that allows users to generate key indicators and summary reports with minimal need to sift through large volumes of raw data. Given that plans to modernize the agency's Medicaid and CHIP data systems currently rely on a patchwork of program integrity, quality measurement, health information technology, and CHIP reauthorization funds, the Commission has also voiced concerns as to whether available CMS funds will be sufficient for this purpose.

2. As payment methodologies continue to move towards incorporating pay for performance methodologies, the development and use of standard quality indicators will become more prevalent – such as with the Adult and Pediatric Quality Measures Programs. What quality indicators should be required reporting in Medicaid and what steps should be taken to move in this direction?

The Commission supports efforts by the U.S. Department of Health and Human Services (HHS) to improve the quality of care for children and adults in Medicaid and CHIP, and the data that could be used to assess the outcomes of these efforts. In comments to the Congress on the first HHS children's health care quality report in 2011, the Commission commented on the value of broader use of nationally recognized, evidence-based measures to help identify which program characteristics and policies have the greatest impact on health care quality for Medicaid and CHIP enrollees. In particular, the Commission noted the importance of aligning measures across states and other payers in order to facilitate comparison and reduce reporting burden for both payers and providers.

More recently, in comments on the Department's second children's health care quality report and first report on adult health care quality shared with Congress in November 2014, the Commission noted the encouraging progress that HHS has made in expanding its children and adult quality improvement efforts since 2011. At that time, MACPAC made note of its interest in:

- strengthening CMS's capacity to calculate quality measures for states. Because many of the CMS adult and child core quality measures are calculated based on administrative data, CMS could reduce state reporting burden and duplication of effort if it began calculating some core quality measures for states using the claims and encounter data it is collecting through T-MSIS. CMS is now calculating some child core quality measures for all states using data that states report in their Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit reports (Form 416). Accelerating the use of T-MSIS to support state reporting of additional core quality measures would help build on this success without placing greater burdens on states.

- expanding the use of core quality measures in state quality improvement efforts. Now that the Medicaid and CHIP child and adult core measures have been established, states and CMS should consider opportunities to improve the use of core quality measures in state quality improvement initiatives, such as managed care external quality review organization activities. The child and adult core quality measures were initially designed to be used by managed care organizations and providers. However, CMS currently only collects core quality measure data at the state level, and there is limited evidence that these measures are being widely used in state managed care oversight and provider incentive programs. Before requiring the use of any particular core quality measure, CMS should consider the usefulness of the measure and ensure that it will actively use the measure in its oversight process.

- improving quality measures for individuals with disabilities. In MACPAC's March 2012 report to Congress, the Commission recommended that HHS, in partnership with the states, update and improve quality assessment for Medicaid enrollees with disabilities. The adult core quality measures do not currently include measures specific to individuals with disabilities, and HHS reports to Congress have been largely silent about efforts to measure and improve care provided to this population. Quality measurement for Medicaid enrollees with disabilities continues to be a priority area of consideration for the Commission, and MACPAC encourages HHS to devote more attention to this issue.

- continuing funding for the adult and child quality measures programs. The Commission supports continued, dedicated funding to support state and CMS quality measurement efforts. While funding for pediatric quality

measures has been extended through FY 2017, dedicated funding for adult measures expired in FY 2014, raising concerns about how continued measurement activities will be supported. The needed investments in quality measurement are small compared to total spending in the Medicaid program, but they are important investments in the program, both on behalf of those whose care is financed by Medicaid and taxpayers.

3. At present, gaps in the information collected at the federal level related to Medicaid provider payment amounts make it difficult to determine how much providers are paid. To obtain more current and comprehensive information about how Medicaid dollars are spent, and how providers and others are paid, what role should the federal government play in requiring additional, or streamlining existing, state reporting of Medicaid provider payments. Should individual provider payments be made more transparent? Should states be required to report DSH and non-DSH supplemental payments at the individual provider level, and if so, should this be reported into T-MSIS? Should these types of payments be audited or auditable? Should states be required to report the amount paid in provider taxes, certified public expenditures, or intergovernmental transfers or increase transparency of these payment sources?

There are several compelling reasons that data on both disproportionate share hospital (DSH) and non-DSH supplemental payments should be reported at the provider level. First, provider-specific data are necessary for assessing whether state payment methods and rates are consistent with the federal statute. While states have considerable flexibility in setting rates and methods, Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization. But information on the base Medicaid payments that providers receive – that is, the per case or per diem payment associated with delivery of specific services to specific Medicaid beneficiaries – may provide only a partial picture of how much Medicaid is paying a given provider.

To assess payment fully, policymakers need to know the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures.

The level of payment, or payment rate, can be considered the most basic measure of economy and is essential to an assessment of payment efficiency, a measure of value that compares what is spent (economy) to what is obtained (quality, access, utilization). Typically, an analysis of whether a health care payment is economical includes comparison to the cost to provide a given service and comparison to what other payers pay for a comparable service in a given geographic area.

Other health care payers, including Medicare, commonly conduct such assessments. In Medicaid, however, federal policymakers and program administrators do not have the complete data necessary to make such assessments and therefore to ensure that payments are consistent with delivery of quality, appropriate care to beneficiaries.

The second reason for collecting provider-level data is that Medicaid spending for supplemental payments is substantial and growing. In fiscal year (FY) 2014, states reported making $24.2 billion in non-DSH supplemental

payments to hospitals, more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states. The amount of funds raised through providers and local government contributions is also significant and increasing. As such, the federal government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee states' use of Medicaid funds.

In light of these concerns, in March 2014, MACPAC recommended that the Secretary of HHS collect and report data on non-DSH supplemental payments at the provider level. And in October 2015, in deliberations on a report on disproportionate share hospital payments that is due to Congress on February 1, 2016, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-federal share (e.g., provider taxes, certified public expenditures, and intergovernmental transfers). Specifically, MACPAC recommends that the Secretary collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Commission recommends that the Secretary collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

In its recommendations, MACPAC has not spelled out the mode of data collection, rather calling on the Secretary of HHS to develop the appropriate methods. In doing so, the Secretary must balance the interest in collecting specific information from all states in a timely manner against the burden this task would create for state and federal program administrators as well as providers serving Medicaid beneficiaries. In the Commission's view, it makes sense to build upon existing data collection efforts to the extent possible. Below we describe different approaches to data collection and their strengths and limitations.

Currently, most provider-level payment data are reported through the MSIS. While MSIS appears to be capable of receiving and reporting supplemental payment data, our analysis finds that most states do not currently report them. The specifications for T-MSIS also include fields for the collection of supplemental payments, although it is not clear whether or to what extent these elements will be required.

CMS currently collects some supplemental payment data as part of its oversight activities. Beginning in 2014, CMS began requiring states to submit annual non-DSH supplemental data for certain providers. These data are being collected by CMS regional offices and are meant to allow the agency to assure compliance with federal statute and upper payment limit (UPL) regulations, and may provide an improved understanding of total Medicaid payments at the provider level. A solicitation for contractor support issued by CMS in 2014 indicated the agency's interest in compiling a database of DSH and non-DSH supplemental payment data, analyzing payments at state and provider-specific levels, and assessing the utility of data from the T-MSIS for oversight and analysis of DSH payments and state UPL submissions. However, data now being collected are not required to be submitted in a standardized format, nor are they publicly available.

CMS also collects non-DSH supplemental payment data through its DSH audit reports, but these data include only about half of U.S. hospitals. While audit requirements could be expanded to include all hospitals that receive Medicaid payments, the burden on states and hospitals of conducting such audits should be carefully weighed against other alternatives. In addition, reliance on audits alone raises concerns about timeliness, particularly given that the most current DSH audit data are five years old. Given the rapid evolution of the health care system and

frequent changes in state Medicaid payment policy, submission of complete payment data on a more timely basis is desirable.

4. How should federal databases be used to facilitate sharing of information across states that are interested implementing state-specific models or demonstration programs, or to facilitate academic research? Are there certain kinds of multi-state reports or evaluations that would be helpful, for example, reports on spending and utilization for dual eligible individuals, or for certain high-risk populations? Are there other reports or evaluations related to specific demonstrations? What kind of process would be most helpful to ensure maximum usefulness of such reports to relevant stakeholders?

The Commission has commented on several occasions on the need to make evaluations of state innovations, whether conducted through state plan or demonstration authorities, to be more widely available. For example, in its June 2015 report to Congress, the Commission noted the importance of having an independent assessment of delivery system reform improvement program (DSRIP) waivers. Given the potential of these programs to transform care delivery, evaluating the success of DSRIP program should go beyond whether or not providers achieved their particular milestones and whether budget neutrality is maintained. In particular, it is critical to learn whether the quality and access improvement achieved through DSRIP waivers are sustainable in the long term without DSRIP payments. Although each state is required to evaluate its own program, measures should also be aligned across states wherever possible to promote cross-state comparison. A cross-state synthesis of DSRIP outcomes would be a valuable addition to state specific findings. The Commission has also repeatedly expressed interest in early findings from evaluation of the Financial Alignment Initiative demonstrations. And most recently, in discussing its comments on the first HHS report on implementation of new Section 1115 demonstration transparency requirements, Commissioners commented on the desirability of CMS sharing evaluation reports in real-time to facilitate learning among stakeholders and across states. (A letter with the Commission's formal comments on this report was sent to you today under separate cover.)

5. A key issue with many types of Medicaid data is the lag time in reporting and delayed access to timely, quality data. What changes could be made at the Federal and state level to improve the timeliness of the submission and availability of Medicaid data?

T-MSIS is expected to address several longstanding concerns about federal administrative data sources. Specifically, T-MSIS will improve:

- timeliness by moving states from quarterly to monthly data submissions and replacing manual reviews with automated quality checks that provide states with real-time feedback;
- reliability by working with states to document their source data and processes for each data element; and
- completeness by increasing the number of data elements and ensuring that encounter data from managed care plans are reported.

The Commission previously commented on how these developments could also facilitate activities by CMS to support states. For example:

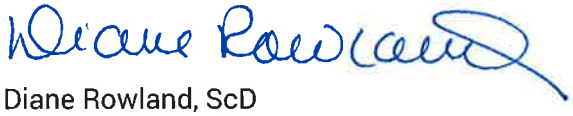
- As noted above, CMS could reduce reporting burdens by directly calculating certain measures reported elsewhere by states. These might include statistics on the EPSDT services provided to children on the CMS-416 form as well as certain child and adult quality measures.
- Encounter data could be used to make national and cross-state comparisons of the care received by Medicaid and CHIP enrollees whose benefits are delivered through fee for service versus managed care.
- Complete enrollment and claims data for enrollees in separate CHIP program could be used to understand the effectiveness of enrollment strategies such as Express Lane eligibility, program transitions, and payment variation by state.
- More timely data would give administrators and policymakers a clearer picture of the programs as they operate now, rather than as they did several years ago. Given the dynamic nature of the Medicaid program and the fast moving policy environment, the availability of current program information is more important now than at any time in the program's history.

6. To what extent is T-MSIS addressing these timeliness issues and what else could be done? Are there any other programs or requirements that you think should be considered as part of our review of reporting requirements at the state and Federal level?

Although progress on T-MSIS has been slower than CMS originally anticipated, the Commission is encouraged by the agency's recent progress. We will be monitoring its implementation over the course of the coming year and will share any relevant concerns with Congress as they occur.

Thank you for your interest in the work of the Medicaid and CHIP Payment and Access Commission. We look forward to continuing to work with you in ensuring that relevant, timely and accurate data are available to ensure that the Medicaid program fulfills its mission of providing high-quality, appropriate services to its beneficiaries while also ensuring prudent use of taxpayer dollars.

Sincerely,



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