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State Health Access Data Assistance Center

Assessing State Administrative Data to Monitor Health Care Reform

U.S. Department of Health and Human Services

Data Council - September 9, 2012

Funded by the Assistant Secretary for Planning and Evaluation

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Overview of Presentation

- ASPE-Funded Project "*Assessing the Potential of State Administrative Data to Monitor Health Care Reform*"
- Complementary Activities
  - Robert Wood Johnson Foundation (RWJF) State Health Reform Access Network - State Network
  - SHADAC's work funded by the California Health Foundation to develop an evaluation framework for the state of California

Purpose of the ASPE Project

(1) Develop a framework for state-level data required for evaluation of the Affordable Care Act (ACA)

(2) Collect examples of specific administrative data that will be needed for annual reporting and evaluation

(3) Model language for proposal (RFP) or eventual contract language for the implementation of state-based Exchanges.

Background and Focus

- Selection of 8 states across the country
  - Actively pursuing Health Insurance Exchange and Medicaid Expansion
  - Document review, select state interviews, small group convening
- Review of ACA language for data collection and reporting requirements
  - Initial focus on statutory language
  - Rules and guidance when promulgated

Focus of Review

- Federal requirements…*but also*…
- Focus on States' needs for monitoring and evaluation – both policy and program needs
  - Highlight administrative/process concerns to allow for course corrections
  - Provide information on effectiveness of state-based reform
  - Provide information on newly insured – where they access coverage (Exchange/Medicaid) and levels of subsidy

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Selection the study states

Criteria

- Actively pursuing state- based Health Insurance Exchange and Medicaid expansion
- At least one from each of the four Census Regions (NE, W, MW and South)
- Has some data infrastructure (*assessed by SHADAC historical knowledge*)

State-Based Health Exchange Activity

as of August 24, 2012

- State-based Exchange via legislation
- State-based Exchange via executive order
- Partnership Exchange
- Federally-facilitated Exchange
- Unclear/Undecided

Source: Center on Budget and Policy Priorities, http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf

Census Region	State	Rate of Uninsured (%)	Exchange Implementation Enabling Authority	Estimated Change in Medicaid Enrollment (%)	Exchange Implementation rant
NE	Connecticut	9.0	Legislation	32.2	Yes ($6,687,933)
	New York	**11.9**	**Executive Order**	**13.4**	**Yes ($59,249,717)**
	Vermont	**7.8**	**Legislation**	**9.1**	**Yes ($18,090,369)**
MW	Illinois	13.9	Legislation Not Passed	26.3	Yes ($37,917,831)
	Indiana	14.9	Executive Order	31.6	Yes ($6,895,126)
	Minnesota	**8.9**	**Executive Order**	**20.0**	**Yes ($30,317,000)**
SO	Alabama	14.6	Legislation Not Passed	29.3	Yes ($8,592,139)
	Georgia	19.6	Legislation Not Passed	38.1	No
	Maryland	**11.3**	**Legislation**	**29.2**	**Yes ($27,186,749)**
	West Virginia	14.6	Legislation	32.1	Yes ($9,667,694)
W	**California**	**18.4**	**Legislation**	**25.4**	**Yes ($39,421,383)**
	Colorado	**15.6**	**Legislation**	**33.2**	**Yes ($17,951,000)**
	Hawaii	7.5	Legislation	24.0	Yes ($14,440,144)
	Nevada	22.5	Legislation	38.4	Yes ($23,738,273)
	Oregon	**17.0**	**Legislation**	**41.2**	**Yes ($15,652,301)**
	Washington	14.1	Legislation	20.1	Yes ($150,794,727)

The Robert Wood Johnson State Health Reform Access Network (State Network)

- TA program to provide 10 states with essential resources to implement the expansion provisions of the ACA
- SHADAC is one of 5+ contracted TA providers available to the 10 states
- Variety of models for expanding coverage through a shared learning environment

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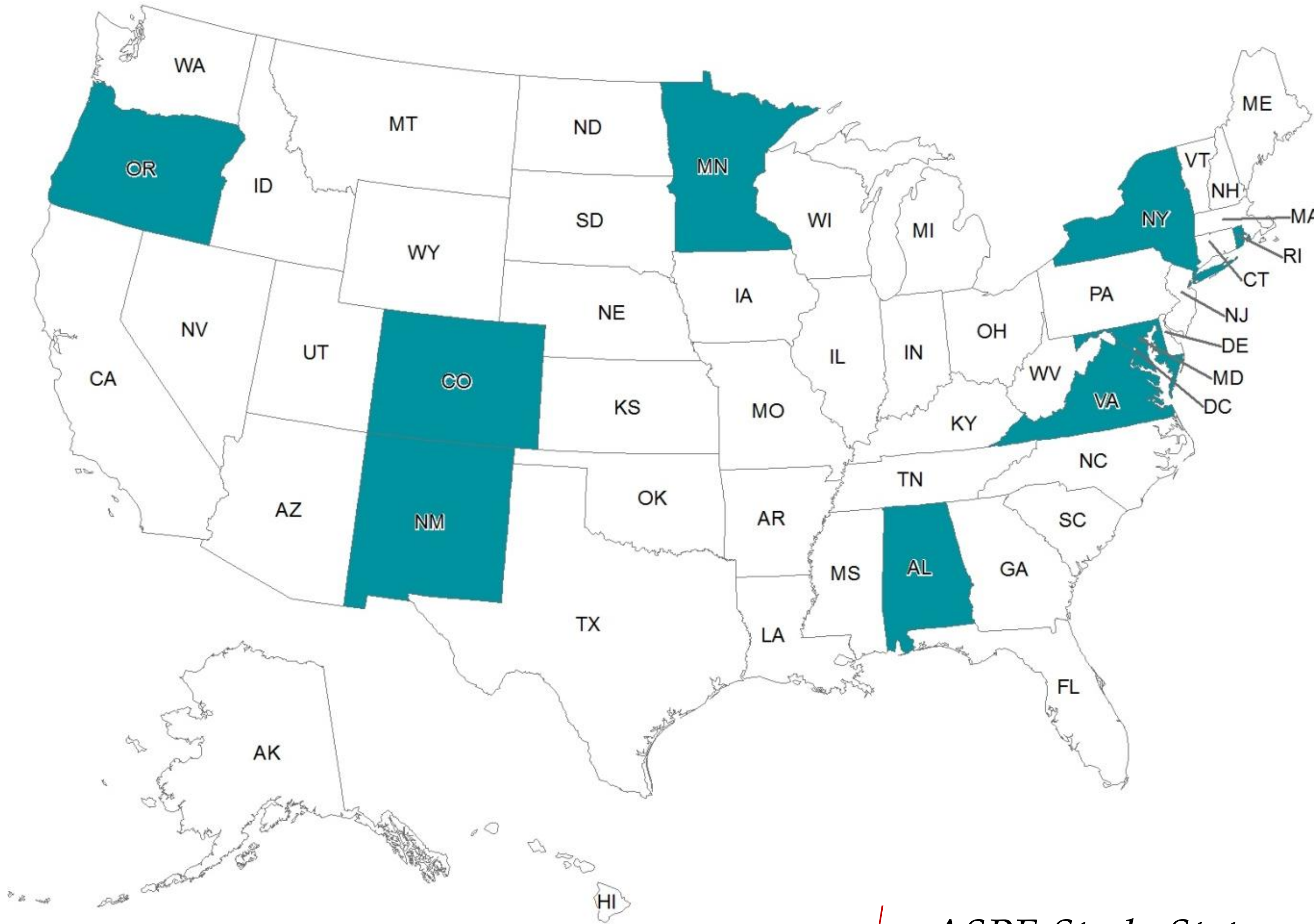
RWJF State Network States



Alabama
Colorado √
Maryland √
Michigan
Minnesota √
New Mexico
New York √
Oregon √
Rhode Island
Virginia

√ = *ASPE Study State*

SHADAC role in State Network

- Examples of data assistance/analysis TA
  - ACA analysis of eligible but not enrolled by geographic area – *for outreach purposes*
  - Small-area estimate of uninsurance by state senate district
  - Estimation of non-legal populations and current health insurance coverage – *for safety net planning*
  - SHADAC projection model – *who goes where*
  - Comparative analysis of five forecasting models (lead: Jean Abraham)
  - Development of Evaluation Framework

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SHADAC State Network Small Group Convening on Reporting and Evaluation

- "*Developing an Evaluation Framework for the Affordable Care Act,*"
- Hosted by ASPE and State Network Project
- 8/10 state network states
- Topics
  - Setting benchmarks and goals
  - Identifying data resources and gaps in data
  - Coordinating across agencies
  - Identifying stakeholder interests

Key Findings: Federal Data Requirements

1. Verification of eligibility

2. Reporting on exchange operations

3. Certification of Quality Health Plans

4. Reporting related to Medicaid

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1. Verification of Eligibility

- State is required to report citizenship and income information to the HHS and the Treasury (§§ 1411(c); 1311(d)(4)(H))
- Potential data points:
  - ☑ Date of Birth
  - ☑ Income
  - ☑ Citizenship
  - ☑ Family Size
  - ☑ Tax credits
  - ☑ Individual exemption status

1. Verification of Eligibility—Caveats

- Limitation on what information may be collected from individual consumers
  - "information strictly necessary to authenticate identity, determine eligibility, and determine amount of credit or reduction" (§ 1411(g)(1))
    - Probably not race, etc.
- Start with Federal enrollment form requirements

2. Reporting in Exchange Operations

- States must collect and annually publish information about the Exchange's operations (§§ 1313(a)(1) & 1311(d)(7))
- Potential data points:
  - ☑ Exchange expenditures
  - ☑ Exchange activities
  - ☑ Exchange receipts
  - ☑ Average costs of licensing, regulatory fees, & other payments
  - ☑ Exchange's administrative costs
  - ☑ Monies lost to fraud, waste and abuse

3. Certification of Qualified Health Plans

- State Exchanges must certify the health plans offered through the Exchange – Plans must provide information (§ 1311(e) (3)(A))
- Possible data Points
  - ☑ Claims payment & policies
  - ☑ Periodic financial disclosures
  - ☑ Disenrollment/Enrollment
  - ☑ Claims denied
  - ☑ Rating practices
  - ☑ Cost-sharing
  - ☑ Payments for out of network coverage

4. Reporting Related to Medicaid

- States must report Medicaid related information (§§ 2001(d)(1)(C); 2002(a); 2401; 2701)
  - Annual enrollment and operations
  - Plan for measuring eligibility
  - BHP/home- and community-based services information
  - Annual report of services provided

Key Finding – Exchange Activity

- Range of federal Exchange-related grants from $19.2 million in the CO to $87.7 million NY
- All but two have enabling legislation to proceed with Exchange development
  - Minnesota and New York are operating under an Executive Order from their respective governors
  - Some concern about need for legislation to move forward without legislative support
- All on schedule to submit BluePrint plan

Key Finding - State Data Needs

- States understand the need for data for evaluation and monitoring purposes
  - However, the pace of Exchange design as well as new rules around Medicaid, has pushed data collection and reporting to the back burner.
- States would like to start with a short list of "must haves" to include in Exchange vendor requirements and/or specifications.
  - Meet federal reporting requirements
  - Provide additional reports to the states

Key Finding – Role of Consultants

- Consultants are playing a significant role in development of state-based exchanges
  - *Largely because of tight time frame and needed expertise*
- SHADAC reviewed (with Jean Abraham) 5 micro-simulation models to help states understand the data inputs and model assumptions
- SHADAC projection model being adopted in OR is available to 10 State Network states

Key Finding – Evaluation Activities

- Most states recognize the need but have no time to work on formal framework – takes time and energy
- Those states with additional capacity primarily with local health foundation funding (CO, CA) have evaluation planning underway and OR through the RWJF State Network project

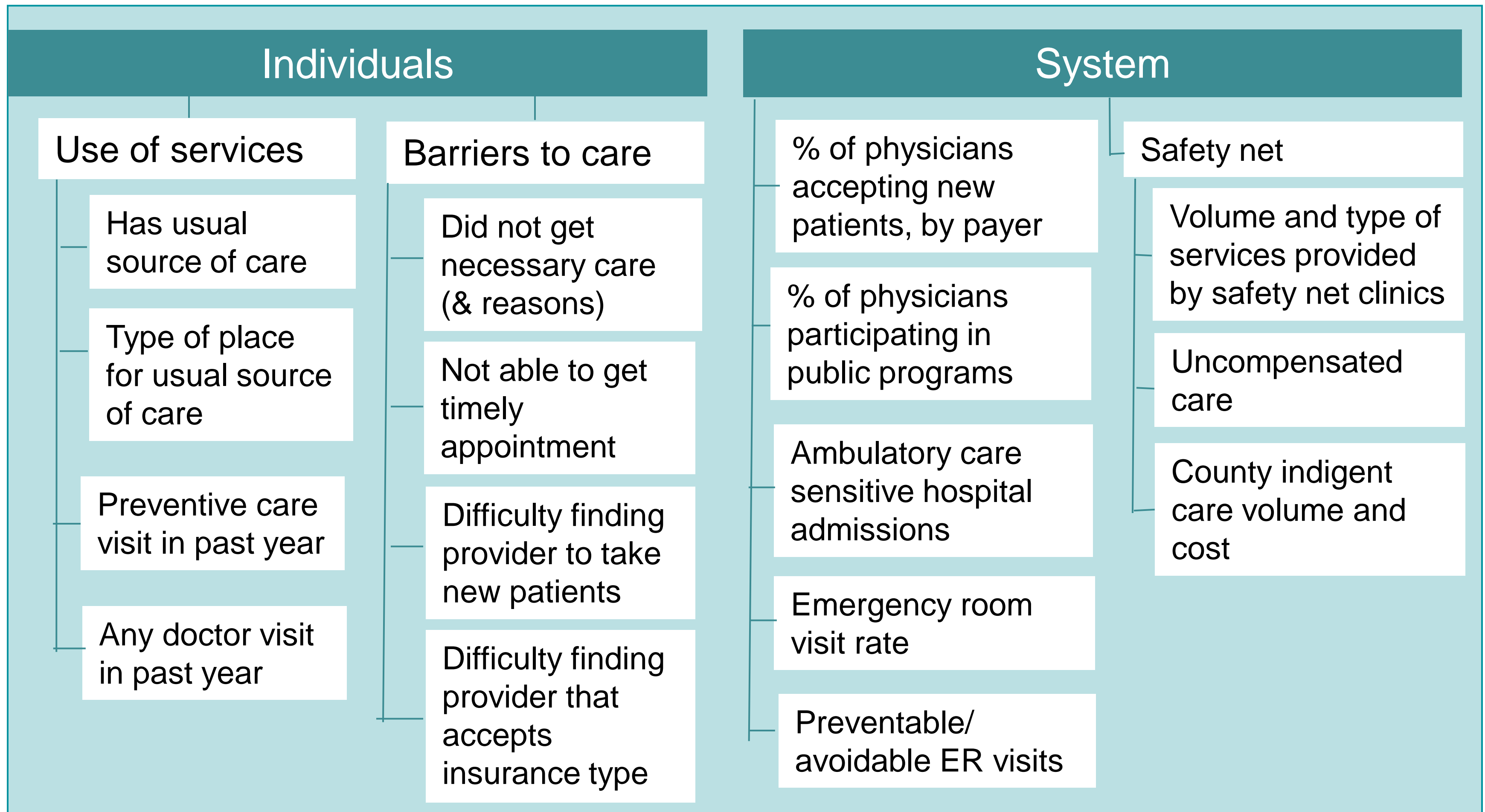
CO Data Advisory Work Group

- Advisory to the Exchange Task Force
- Staffed by CO Health Institute
- Identified over 60 metrics and potential data sources to monitor
- Started with legislation and statutory goals of access, affordability and choice.

California Health Foundation

- Consulted with SHADAC to develop an evaluation framework that identified objectives, metrics and data sources
- Held stakeholder meetings across the state
- Priority Measures:
  – coverage,
  – affordability,
  – comprehensiveness and
  – access to care metrics

CA Example of priority measure: Access to Care



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Priority Measures: Access

Super County Boundaries:
NORTH CENTRAL - Lake, Colusa, Glenn
FOOTHILLS - Amador, Calaveras, Tuolumne, Mariposa
CENTRAL COAST - Monterey, San Benito
NORTH COAST - Humboldt, Del Norte, Mendocino
NORTH - Siskiyou, Tehama, Trinity
NORTH EAST - Lassen, Modoc, Nevada, Sierra, Plumas
EAST CENTRAL - El Dorado, Alpine, Inyo, Mono

Super County

Service Planning Areas (SPA):
SPA 1 - Antelope Valley
SPA 2 - San Fernando Valley
SPA 3 - San Gabriel
SPA 4 - Metro
SPA 5 - West
SPA 6 - South
SPA 7 - East
SPA 8 - South Bay

Los Angeles County
Service Planning Areas (SPA)

Ambulatory care sensitive hospital admissions based on prevention quality indicators (PQIs)

Example:
Short-term Complications of Diabetes (PQI 1) & Uncontrolled Diabetes (PQI 14)

Source: California Office of Statewide Health Planning and Development

Hospital Discharges Per 100,000 Adults

- Low (Bottom 25% - Better)
- Average (Middle 50%)
- High (Top 25% - Worse)

Note: This is the sum of the diabetes short-term complication admission rate and the uncontrolled diabetes admission rate. This is a Healthy People 2010 Indicator.

Minnesota Quality Metrics in Vendor RFP

- Requires development and reporting of quality of care and provider peer grouping
  - 14 measures for physician clinics
  - 50 measures for hospitals and other providers
- Development of "composite" cost and quality information by health care by population and for specific conditions
  - Diabetes, pneumonia, heart failure, total knee replacement, coronary artery disease, and asthma

Key Finding: All Payer Claims Databases

- All of the study states except California have established an all-payer claims database (APCD)
- Maryland has the longest-standing APCD, with data dating to 1998 and expanded data collection enacted 2007.
- The other five states have established their APCDs in recent years and reporting is either new or not yet available.

Mostly now an "intention to use"

- Limited analytic capacity at the state level
- Some limitations by statute
  - MN can only use APCD for peer group reporting
- Potential use for risk adjustment, monitoring costs and trends, comparing systems role by geographic areas
- One of many complex projects states are trying to implement

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Additional Issues

- How to balance need for transparency in terms of collection and use of data and concerns about data privacy and government access to patient-level data.
- Concern about sustainability of exchange and Medicaid expansion
- Need but also difficulty in working across state agencies and across legislative committees

Conclusions

- We have documented a need for assistance in development of a framework for state data collection and exchange reporting
- Phase 2 of this project: working on model exchange vendor language to make sure state and federal reporting functions are built into vendor specifications
- Continue to collect examples and "best practices" – most states will need to work to identify their own goals and objectives

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