

Management Tools for Medicaid and State Children's Health Insurance Program (SCHIP)

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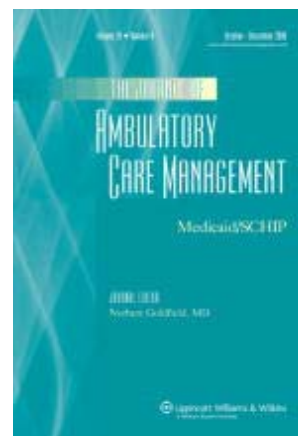
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Abstract

Medicaid and the State Children's Health Insurance Program need analytic tools to manage their programs. Drawing upon extensive discussions with experts in states, this article describes the state of the art in tool use, making several observations: (1) Several states have linked Medicaid/State Children's Health Insurance Program administrative data to other data (eg, birth and death records) to measure access to care. (2) Several states use managed care encounter data to set payment rates. (3) The analysis of pharmacy claims data appears widespread. The article also describes "lessons learned" regarding building capacity and

improving data to support the implementation of management tools.

MEDICAID is the nation's largest public health insurance program for low-income Americans. In 2003, federal and state governments spent \$275.5 billion on Medicaid (Sommers et al., 2005). Medicaid insures 1 in 4 children, and is the single largest payer for long-term care and mental health services (Kelly, 2005; Mark et al., 2005). In 1997, Congress created the State Children's Health Insurance Program (SCHIP, Title XXI) to address the growing problem of children without health insurance. The federal funding available for SCHIP is fixed, with a maximum of \$40 billion allocated to the program over the first 10 years, which ends in 2007.

Controlling costs while ensuring that Medicaid and SCHIP enrollees have access to high-quality medical care is a continuing challenge. Although there are broad federal requirements, states have a wide degree of latitude in the design and operation of their programs (Kelly, 2005; Mark et al., 2005).

States' ability to use administrative data to monitor their Medicaid and SCHIP programs and their proficiency in using management tools varies considerably. This holds true for both managed care and fee-for-service programs. For example, a 2001 survey indicated that 35 states (92% of respondents) reported collecting encounter data (ie, records of healthcare visits and other services) from health plans, but fewer than half reported using the data to produce specific access or quality measures (Landon et al., 2004). Similarly, the large majority of Medicaid primary care case management programs are not using quality measurement, feedback, and improvement strategies (Schneider et al., 2004).

This article gleans lessons from innovative Medicaid and SCHIP agencies that use their data to oversee their programs. While administrative data are frequently used to monitor healthcare quality and guide payment (Agency for Healthcare Research and Quality, 2005; Pope et al., 2004), state Medicaid and SCHIP agencies have not uniformly availed themselves of management tools that transform their data into information. States that have already implemented management tools can serve as models for other states. This article looks at the factors that led to their success in using administrative data, and identifies strategies for building capacity for using management tools and improving the quality of their data.

Describing the state of the art in the states, this article is designed to take advantage of Internet technology. References to Web sites enable the reader to drill down to the specifics in state reports, which serve as potential models. Obtaining reports was very difficult 10 years ago; now (in certain environments), it requires only a point-and-click.*

METHODS

We collected information via 3 methods: (1) a review of the informal (eg, gray) literature available on the Internet, (2) case studies of 5 states, and (3) discussions with experts outside of these states, including meetings with a technical advisory panel.

We searched the Internet for state reports that used Medicaid and/or SCHIP administrative data. The Web sites of all 50 states and the District of Columbia were examined, focusing on state Medicaid agencies, public health departments, and the state legislative auditing offices. We also searched the sites of federal agencies, private organizations (eg, research organizations), and national associations for documents that would shed light on states' use of Medicaid and/or SCHIP administrative data and management tools. This process yielded more than 250 reports published between 1997 and 2004, most of which were issued by states. States vary quite substantially on the number of available reports, as well as on the quality of these reports. A database of these reports can be accessed at http://www.hpm.umn.edu.floyd.lib.umn.edu/ambul_db/index.asp.†

Second, we conducted case studies of 5 states that effectively used administrative data to manage their Medicaid and SCHIP programs: Arizona, Michigan, Ohio, South Carolina, and Utah. To select the states, we examined Web sites and publications to determine whether a state Medicaid or SCHIP program had (1) query tools based on administrative data accessible on public Web sites; (2) significant experience collecting encounter data in addition to claims data; (3) conducted extensive data linkages across administrative databases from both internal and external data systems; (4) exported management information tools to other states; and (5) utilized management information tools to assess program effectiveness and efficiency. Based on these selection criteria and with a preference for regional diversity, the above 5 states were selected. Extensive discussions were held (usually via phone) with experts, many of whom were managing Medicaid/SCHIP programs but some of whom were executives of health plans or other contractors (eg, researchers).

Finally, we had extensive discussions with experts outside of these states. Some of these discussions involved an advisory committee that included representatives of state Medicaid programs, state policy and planning agencies, and several federal agencies. Other discussions involved researchers and contractors who study and/or assist states with their Medicaid and SCHIP data and analyses, as well as several staff members of the Center for Medicare & Medicaid Services (CMS).

Our findings are based—in addition to the above formal methods—on the professional experiences of the authors, 2 of whom have worked as state health data agency officials and another 2 of whom have served as consultants either on data tools or on management tools for a number of states.

STATE OF THE ART

Even among the 5 case study states, there was variation in states' capacity to use administrative data and advanced analytic applications. Barriers to advancing the Medicaid/ SCHIP analytic agenda are common; thus, data and analytic tools are generally underutilized by state Medicaid/SCHIP programs. There are, however, management tools that the case study states commonly used. This section describes 5 uses of administrative data to manage Medicaid and SCHIP programs, ordered roughly from simple to complex analytic tools.

Query tools quickly provide basic statistics

Query tools, perhaps the most widely used of all management tools, enable users without programming skills to access program information online. In contrast to their predecessor technology (printed tables), query tools make program statistics available in a matter of seconds. This is accomplished by aggregation of data ahead of time, rather than performing calculations on large databases at the time a user makes the request for information.

Typically, online queries are used to take a quick “sounding” of a particular population during a period. A series of queries can be used to create a simple tracking report for program management. These tools are most often used to meet quick turnaround deadlines and reports for legislatures and program administrators.

Utah's Indicator-Based Information System for Public Health (IBIS-PH) is one of the most extensive publicly available query systems (IBIS, 2005). One can run Medicaid/SCHIP queries in such domains as hospital and emergency department use, health surveys, and cancer registries. For instance, one can obtain the number of asthma-related admissions from the emergency department for people enrolled in Medicaid or SCHIP (together or separately).

Other query tools of note are South Carolina's Analysis of Emergency Room Discharges by Selected Characteristics (ORS, 2005) and CMS' State Summary Datamart. The latter is based on Medicaid enrollment and utilization data submitted by the states. Users of the latter query tool can disaggregate metrics such as claims count and dollars spent by such categories as state, age group, and Medicaid vs SCHIP status.*

Linked data used to measure access to care

Although Medicaid/SCHIP programs can usually (but not always) link their own administrative files to each other (eg, hospital and enrollment files), linking Medicaid files to other data within state government is more challenging. However, once linkage at the individual level has occurred, analyses can be used to monitor the quality of care delivered.

Typically, Medicaid data are linked to data in 1 of 3 categories:

- * Public health dataAdministrative data (eg, immunization and blood lead testing)Survey data (eg, behavioral risk factor surveys)
- * Vital statistics (ie, birth and death records)
- * Administrative data from other social service programs (eg, Temporary Assistance for Needy Families and Medicare)

Note that each category of data is usually housed in a different section of state government, often within the health department. The following 2 examples demonstrate how states have used data linkages to produce analytic reports.

The CMS requires that children enrolled in Medicaid receive a blood lead test at 12 months and 24 months of age. To measure its progress toward meeting this public health goal, Michigan linked Medicaid enrollment data with its blood lead testing database to determine the number of Medicaid children tested. It discovered that managed care enrollees have much higher rates of testing than do fee-for-service enrollees (52% vs 38%), and that the percentage of Medicaid enrollees tested by the third birthday increased from 40% in December 2003 to 50% in July 2005 (Michigan Department of Community Health, 2005).

The second example involves birth certificates, which typically have a wealth of information on pregnancy and delivery, such as birth weight, trimester in which prenatal care began, weight gain during pregnancy, and whether there was alcohol or tobacco use during pregnancy. Connecticut linked birth certificates with enrollment files for its Medicaid managed care program (Connecticut Voices for Children, 2005). It found that 73% of mothers in Medicaid had adequate prenatal care (as measured in terms of early start and number of visits) compared to 87% of other mothers. Among Medicaid plans, the figures ranged from 68% to 77%.*

Data linkages face several barriers, including expense, confidentiality issues, and lack of trained staff. Many of the data linkages that have been accomplished were funded by specific federal or foundation programs. Even after technical obstacles to linkage are overcome, the cost of maintaining the linkage is an impediment. More often than not, when outside funding was no longer available these projects did not continue.

Encounter data used to set payment rates and measure clinical performance

Most states are able to use enrollment files and fee-for-service claims data to track program expenditures for a variety of purposes, including budget monitoring and rate- and fee-setting. Many states, however, are just beginning to use encounter data from managed care organizations for these financial activities.

States face several barriers to the use of encounter data for financial activities, including actuarial inexperience with encounter data; the lack of data on charge/cost; and nonsubmission by the managed care organization of encounter data for services (eg, mental health services or pharmacy) that the managed care organization may have subcontracted to another entity. However, a number of states, typically those with a greater proportion of their Medicaid population in managed care, have worked on this problem over the years and now have useable data (Verdier et al., 2002; Verdier & Hurley, 2004). For example, Arizona and Minnesota use the diagnosis codes on encounter data to adjust payment to health plans (Gifford et al., 2004-2005).

For monitoring clinical performance of their managed care plans, states typically require plans to analyze their own encounter data. The most commonly used clinical performance measures are Health Plan Employer Data and Information Set (HEDIS®), the standardized measurement set published by the National Committee for Quality Assurance. States such as Arizona (Arizona Health Care Cost Containment System, 2005), Minnesota (Minnesota Department of Human Services, 2003), and New York (New York State Department of Health, 2003) publicly report plan-specific results.

A few states have created a database of encounters in all their Medicaid plans and use it to measure clinical performance. For instance, Rhode Island (Rhode Island Department of Human Services, 2003) has monitored asthma care, reporting the distribution of asthma prescriptions by therapeutic category. Wisconsin (Wisconsin Department of Health and Family Services, 2003) profiles health plans in terms of immunizations and lead testing, reporting statistically significant differences among plans. Ohio (2004) reports plan-specific results for a range of measures, such as the percentage of children who received blood lead screening.

Analysts sometimes implicitly envision a managed care database that has all the information of a traditional fee-for-service database and that can answer a wide range of questions. Designing a database to answer a limited set of questions can be advantageous. For instance, Minnesota's restricting of the data elements to those needed for risk adjustment accelerated the collection of data (Gifford et al., 2004-2005).

Pharmacy costs managed through tool use

Pharmacy costs are one of the fastest growing components of Medicaid spending. Each of 4 policies—prior authorization, generic substitution, cost sharing, and quantity limits—have been implemented by a majority of states in an effort to reduce expenditures without impeding access to care (Morden & Sullivan, 2005). Management tools are used in conjunction with these policies to guide their implementation and monitor their impact.

Alabama, for instance, has implemented a Preferred Drug List (PDL) and requires prior authorizations for nonpreferred drugs.* Using pharmacy claims data, Alabama generates reports that are used by the Drug Utilization Review Board to help decide which drugs should appear on the PDL.† Alabama also uses the claims data to produce estimates of PDL-related savings.

All case study states described various analytic work with pharmacy claims data, whether it was done by their own staff, contractors such as pharmacy benefits managers (PBMs), or university pharmacists. Arizona, for example, uses its pharmacy data for diabetes and asthma management, to monitor behavioral health and contraindicated medications. While some uses of these management tools can be labor intensive, the standardized pharmacy codes across the country have allowed adoption of many

pharmacy management tools with minimal additional programming costs for states. States' capacity to analyze individual use of pharmaceuticals combined with provider prescribing patterns is dependent upon their ability to compile large volumes of claims data, analytic skill in handling the data, and political sensitivity with providers.

Standardized pharmacy data create an opportunity for establishing a benchmarking tool, that is, a tool that allows states to compare their pharmacy utilization and expenditures with those of others. The CMS has created such a tool—Statistical Compendium: Medicaid Pharmacy Benefit Use and Reimbursement (CMS, 2004). The tool can be used to compare average state expenditures, for instance, for central nervous system drugs (the therapeutic category with the highest expenditures). Unfortunately, the most recent data available on the CMS site is from 1999, which limits states' ability to use it for management purposes.

Decision support tools used to manage care

The term "decision support tools" is often used to mean a range of sophisticated analyses. Ohio's Enhancement Care Management (ECM) Program, Phase I of which was implemented in October 2004, illustrates how a number of tools can be used together (Ohio, 2005a).

The ECM Program provides case management services to aged, blind, and disabled Medicaid beneficiaries, who constitute a much greater proportion of Medicaid's acute care spending than do the more numerous children and pregnant women. The program covers chronic diseases such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease. As these are classic conditions for disease management programs, ECM can be seen as a disease management program. Clinical performance measures are set for each condition.

Ohio contracts with one ECM plan for each county in the program. These plans are a diverse group, ranging in sophistication from a physician-hospital organization to a national case/disease management firm. If an ECM plan does not meet performance standards, it must refund a portion of its payment. Beneficiaries select a primary care physician (PCP) to coordinate their care. Each PCP is paid \$3 dollars per member per month plus an additional incentive amount linked to clinical performance.

The ECM Program has a number of the decision support tools, several of which provide the functionality necessary for any disease management program (Villagra, 2004). First, the ECM Program uses predictive modeling to identify beneficiaries with conditions that it covers. In particular, it uses MedStat's Episode Grouper, which links inpatient, outpatient, and drug experience to construct episodes of care and measure severity of illness (Ohio, 2005b). Second, it uses software to track the utilization of ECM members. Output is sent to PCPs to facilitate their encouraging members to obtain needed care. Third, it plans to conduct "provider profiling," by calculating performance by PCP and ECM plan. Feedback to providers indicates on which measures a provider needs to improve. Finally, the ECM Program plans to combine these clinical performance measures with performance standards (ie, target levels) to serve as the basis of a pay-for-performance program.

ECM has only recently been implemented in one county (as measured by a participation rate of at least 50%). It is, therefore, premature to judge the effectiveness of the various decision support tools.

SUCCESS FACTORS

What made the case study states successful in using administrative data to help manage their Medicaid and SCHIP programs? We found that the primary factors were identified with the adoption of management tools: the presence of leadership and a statewide data culture.

Political and administrative leadership is key

A strong leader with a vision of how data can be used for program and policy decisions can have a major impact on infrastructure development and the development of management information tools. An evidence-based leadership style can persuade others of the investment necessary for a robust data and information system.

Leadership can help overcome barriers, such as limited financial resources, to the development of advanced data systems. Despite a relatively poor constituency, South Carolina's governor supported investments in data infrastructure and decision support tools for Medicaid and public health, resulting in the development of a sophisticated care management tool. Other states with greater resources also benefit from leadership. In Michigan, for example, the governor pushed for interagency data sharing to monitor lead levels in the blood.

A statewide data culture facilitates data sharing but necessary privacy restrictions hinder efforts

Management tool users are likely to have a culture that values data and information. This culture often permeates the entire state health system, resulting in robust public health data and the use of administrative data by the Medicaid program. Examples where this is the case include California, Wisconsin, Utah, South Carolina, Michigan, and Rhode Island. These states have historically had strong health data agencies and Medicaid programs that rely on management tools.

A culture of data sharing is somewhat easier to maintain when agencies are co-located. For example, states where the Medicaid program was located within a large umbrella agency were likely to have access to Vital Records and Public Health databases. In many cases, staff transfer between programs and maintain strong ties with their prior unit. These staff connections assist in maintaining the relationships critical to data sharing activities. For example, the Medicaid programs in Wisconsin, Michigan, and Utah were able to collaborate with Public Health and Vital Records on issues such as lead screening, immunizations, and prenatal care as a result of co-location.

An unintended consequence of the privacy provisions of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) has been to complicate state data sharing. While the privacy regulations are necessary to protect personal health information from inappropriate use, state data sharing has been reduced as a result of misinterpretations and overzealous interpretation of the law. Medicaid/ SCHIP access to critical data, such as State Vital Records Birth Reporting System data, is more restricted in some states than in others. The range of interpretation in State Vital Records agencies runs from not allowing any sharing of information with Medicaid to allowing linkages with Medicaid data. Some of the barriers to sharing data are related to HIPAA privacy rule interpretations; others are associated with the complexity of unraveling the relationship between HIPAA and associated state statutes or state administrative rules. Often it is easier to give data requests low priority than it is to share it appropriately.

LESSONS LEARNED

This section summarizes the most important "lessons learned." This summary can be used as a guide for improvement of existing state Medicaid and SCHIP strategies for management information tools. These lessons have been gleaned from leading data programs, both those studied for this project and those observed by the National Association of Health Data Organizations (NAHDO) and others that provide technical assistance to states around data collection, analysis, and dissemination. Applied selectively or collectively, these lessons can provide a roadmap for states as they advance their Medicaid and SCHIP management agenda.

Capacity-building lessons

States must have the technical and analytic capacity to implement and employ management tools. State Medicaid and SCHIP agencies rarely have all the required expertise among their staff, and have used a variety of methods to acquire know-how to support management tools applications.

Build in-house technical expertise and augment as necessary

The build-or-buy question is often posed when large expenditures are proposed. For Medicaid programs, the combination of highly skilled state employees working with technical experts is the approach that is most likely to provide the creativity and stability needed for management information tool development and ongoing reporting. All case study states reported that they had highly skilled and experienced internal staff—they could not rely exclusively on outside expertise. Others have also documented the need for internal staff for system development and maintenance (Howell, 1996).

Case study states tended to rely on a combination of expert contractors and university researchers to supplement their in-house staff. Many of the important Medicaid issues require in-depth advanced actuarial analysis with an ongoing commitment to models for monitoring program efficiency. Other issues also require highly specialized analytical skill sets available in university research centers. For example, cost-effective analytical resources are needed for technical analyses in a variety of areas including pharmacy economic studies, rate setting, risk adjustment, provider performance and quality measurement, evaluations of program initiatives, and policy impact studies. States that have leveraged their academic resources include Michigan, Ohio, Rhode Island, and Utah.

Tap technical expertise in state government

States with well-developed statistical or data centers outside of Medicaid are also sources of technical expertise in areas such as risk adjustment and decision support tools. Public health agencies, state health data organizations, or statistical centers in various state agencies generally have statisticians, epidemiologists, demographers, programmers, and analysts with skills in data

collection, management, data/information dissemination, and statistical and geographic analysis.

For example, Medicaid programs have tapped the analytical and programming expertise that reside elsewhere in state government in Missouri, South Carolina, Utah, Washington, and Wisconsin. More specifically, the South Carolina Medicaid program has in place a contract with the South Carolina Budget and Control Board to develop a Client Information System that will provide Medicaid with a sophisticated management tool for individual case management as well as program-wide management.

Adapt and adopt other states' innovations

Because of the cost involved in establishing large data systems and management tools, some states have looked to case study states to implement their systems. For example, Hawaii and Arizona entered into an agreement to implement the Arizona PMMIS for the State of Hawaii Medicaid Program. This type of arrangement can accelerate states' readiness to use management tools as compared to designing and implementing their own systems.

Eight states and 2 US territories are using the Wisconsin Immunization Registry software, jointly planned by the Wisconsin Medicaid program with the Wisconsin Division of Public Health and funded with federal dollars ([Hopfensperger, 2005](#)). The Wisconsin Immunization Registry was designed to be flexible enough to account for differences in other states, making adoption possible. It was shown to be a successful system and as a result other states signed on to use the same system ([Centers for Disease Control and Prevention, 2005](#)).

For states with lean budgets, looking toward other state's successful systems is one way to acquire management tools that might otherwise not be affordable.

Data lessons

Management tools are only as good as the administrative data supporting them. Thus, states must often work on improving the quality of data that are submitted. This is especially true for encounter data from managed care organizations. Unlike fee-for-service claims data that are the basis for payment, encounter data are frequently not used and suffer from such problems as missing data and erroneous coding. While persistent data editing and standardization are key to improving data, states have used a variety of techniques to improve data quality.

Improve data quality through tool use

Several states are using encounter data to calculate clinical measures for public reporting or adjust payment. They have found that health plans are much more likely to improve the accuracy of their data when it was used.* Public reporting of a plan's performance or modifying its payment can have a major impact on the plan's financial well-being, and as a result health plans have become motivated to work with states on data issues. The 2 primary mechanisms responsible for more accurate encounter data are that (1) plans whose performance is below the mean will scrutinize their data and make corrections and (2) plans will also scrutinize and critique the adjustment methodologies, resulting in improved methods for payment by states.

Supply feedback and create incentives

Feedback to plans and providers on the quality of their data, coupled with incentives, can also influence the quality of submissions. For example, a health plan's Medicaid enrollment can increase substantially if the state assigns to it beneficiaries who fail to choose a plan. Michigan does not assign such beneficiaries to plans that submit poor quality data. A Michigan health plan indicated it had responded to that incentive by building into its system all of the state data edits for the encounter data, thus avoiding submitting data with errors and receiving poor data quality reports and the accompanying penalties.

Build constructive relationships with plans and providers

Adversarial relationships between the state and health plans and providers can be an obstacle to obtaining accurate data. One method to build strong relationships is to establish electronic eligibility tools that speed up payments and reduce nonpayment for care delivered. The goodwill created can be parlayed into cooperation from plans, such as their agreement to running Medicaid data edits on their data prior to submission of the data. This effort cuts down on data errors, the length of the submission period, and the cost of clean-up for the state.

Recognizing the importance of maintaining good relationships with plans and providers, states are being cautious as they proceed with advanced management tools. For instance, states are especially concerned about provider sensitivity to the implementation provider profiling. In particular, there may be disagreement about the severity adjustment method or the quality

of the data used in the profiling system. If they believe the information is inaccurate, providers could react by withdrawing from the Medicaid market. To avert such a situation, states are seeking input from providers on how best to implement the profiling system.

Make long-term investments in data warehouses that can pay off with stakeholder support

Many states begin working with administrative claims data by building Medicaid stand-alone systems. However, the development of a data warehouse—a database that brings together data for the purpose of answering queries and generating reports—allows for a wider range of potential uses (Kimball & Ross, 2002). States with a comprehensive information infrastructure can provide immediate information to legislators and the governor on the impact of program changes, changes in federal reimbursement, pharmacy costs, and quality of care. They are more likely to have political support and less likely to be micromanaged by either the legislative or the executive branch. Furthermore, because they are able to document the impact of policy or legislative proposals, they generally receive more financial support. For example, if a Medicaid program can easily document reduced hospitalizations from improved primary care, they are less likely to have preventive outpatient care delivery cut from their approved services.

Data warehouses and decision support systems both require a substantial amount of time to build accurate reports. It is therefore critically important to maintain some reporting capacity during the development period to be responsive to major stakeholders' interests.

Take advantage of data standardization and HIPAA-compliant data sharing

The implementation of the Administrative Simplification subtitle of HIPAA has done much to improve the consistency of data across states. The purpose of this subtitle is to encourage the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information, thus improving Medicare, Medicaid, and the overall efficiency of the healthcare system.

While the data elements found in electronic transactions have been standardized, not all Medicaid programs have completely eliminated local codes. Those with remaining local codes are working on eliminating these codes. Unfortunately, the standard coding language for ambulatory data (CPT-4) does not always provide the level of detail necessary for measures of program efficacy. States had developed the local codes in order to better monitor program implementation and outcomes.

Many plans are now capable of using HIPAA-compliant Web-based transaction systems, but some Medicaid programs are staying with older submission systems to accommodate the least sophisticated data submitters. For those plans serving more than Medicaid, this can result in 2 separate billing submission systems—one for Medicaid and the other for their commercial population. Medicaid programs could accept both HIPAA-compliant submissions and submissions to legacy systems.

CONCLUDING COMMENTS

Clearly, there are states that provide models for using management tools with their administrative and public health data to improve oversight of Medicaid and SCHIP programs by monitoring access, quality, and expenditures. Innovator states are willing to share their lessons learned and, if not using proprietary software, their tools. Replication of model reports or applications from one state to another, however, does not occur systematically.

While states want a consistent forum for exchange of information and tools, sporadic attempts by states to arrange such forums have faltered. States that have initiated information exchanges find that competing priorities have slowed or effectually stopped their efforts at information exchange. Resources are limited and often fiscal and program crises intervene; initiating states find that there are just not enough resources to maintain state-to-state forums. Recognizing the need for states to share practices that could improve the quality of care furnished to Medicaid and SCHIP beneficiaries, the CMS is launching a Promising Practices program on its new Medicaid and SCHIP Quality Practices Web site.* The CMS intends to collect information about innovative state practices that address shared problems and meet common goals. This initiative provides an opportunity for states to learn from each other about management tools that use administrative and public health data.

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- *To find similar reports in other states, the reader is advised to use Google's advanced search tool. Identify the Web site for a specific state's Medicaid program and insert the Web site's domain into the domain box. For instance, the domain for Ohio's Medicaid program is <http://jfs.ohio.gov/ohp>. Then type in your search terms. [Context Link]
- †The database is intended for policymakers to get a sense of the type and breadth of reports currently available and identify model uses of administrative and claims data. [Context Link]
- *State Medicaid agencies can obtain access to this query system by emailing a request to miss@cms.gov. [Context Link]
- *Several other states are linking Medicaid files with birth certificates under the Centers for Disease Control and Prevention's Pregnancy Risk Assessment Monitoring System (PRAMS). [Context Link]
- *To access documents on Alabama's pharmacy policies (including its PDL), see www.medicaid.alabama.gov/programs/pharmacy_svcs/pharmacy_services.aspx. [Context Link]
- †The Drug Utilization Review Board often distinguishes among drugs within a therapeutic category, as detailed in publicly available minutes: www.medicaid.alabama.gov/programs/pharmacy_svcs/dur.aspx?tab=4. [Context Link]
- *See URLs cited above in the "Encounter Data" subsection. [Context Link]
- *http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/05_promisingpractices.asp#TopOfPage. [Context Link]

Key words: administrative data; encounter data; Medicaid; SCHIP; vital statistics

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