NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

# *New Jersey Health Care Quality Institute*
# *Medicaid 2.0: 50 State Survey of Publicly Available Medicaid Data*

## Introduction

As part of Medicaid 2.0 Phase II, which has been generously funded by The Nicholson Foundation, we conducted a state by state survey of all publicly available Medicaid data including eligibility and managed care enrollment data as well as data regarding the cost and utilization of medical services. The purpose of the survey was to catalogue each state's efforts and identify those states that had robust and easily accessible data sets. Our assessment considered the ease of access, level of detail available and the timeliness of the data. A complete list of the states and links to the data are provided on Attachment I.

As discussed in the Medicaid 2.0 Blueprint, the lack of available data inhibits state policy makers and researchers from seeing the impact of the policy changes on the cost and use of Medicaid services. It also impedes providers from participating in value based purchasing strategies and inhibits the work of consumer advocates. As our research indicates, this lack of publicly available summary level data is not due to any statutory or regulatory restrictions but generally limited by available resources. States that have made investments in their technology and analytical software provide much better access to their data.

## Summary

### Eligibility and Enrollment

In general, nearly all states include current monthly eligibility and managed care organization (MCO) enrollment data (where applicable) on their websites. Because of the historical linkage of Medicaid eligibility to welfare, some states continue to maintain this data on their welfare organization's website as opposed to their health departments. In general, states that posted their eligibility and MCO enrollment data, provided the data at the county and MCO level.

While this basic eligibility and enrollment level data was common, a few states included detailed reports on eligibility processing providing additional insight into monthly changes – both new additions and terminations-- in caseload as well as performance levels of the entities that are responsible for determining eligibility. These reports provide policymakers with insight regarding the "churn" rate i.e., families losing eligibility only to regain a few months later when they re-apply. These also help identify which counties process applications most efficiently. The public disclosure of each county's performance provides an incentive to underperforming counties to improve their processes and output.

### Cost and Utilization Data

Most states – like New Jersey -- produce annual reports that include varying degrees of summary cost and utilization data. However, only a handful of states maintain detailed cost and utilization data on their websites. Two states, South Carolina and Oklahoma, maintain interactive databases that allow users to browse the use and cost of different services by region and delivery system (managed care versus fee-for-service). These states highlight the potential for state Medicaid programs to provide the data that is essential for policymakers to better understand the programs trends and adjust policy where necessary.

South Carolina Medicaid through its relationship with University of South Carolina Birth Outcomes Initiative which was launched in in 2011 uses the state's cost and utilization data to improve the health of newborns in the Medicaid program. Using results from this initiative the state successfully reduced unwarranted early-elective inductions by 50 percent, reduced neonatal intensive care unit admissions and saved the South Carolina Department of Health and Human Services (SCDHHS) more than $6 million in the first quarter of 2013.[1]

### Data Available By CMS

Historically CMS required all states to submit detailed eligibility and cost and utilization data each quarter. Because much of the data included in these reports was based on paid claims --states that rely on MCOs abandoned this approach because they no longer maintain the paid claims. However, recently approved federal Medicaid managed care rules (42 C.F.R. §438.818 – Enrollee encounter data) require MCO encounter data be submitted by the states to CMS. CMS will make the data available through its Transformed Medicaid Statistical Information System (T-MSIS). In addition, CMS now offers state by state claim level detail for pharmacy services on their website.[2]

The pharmacy data is reported quarterly and distinguishes between payments made by MCOs versus fee-for-service. It includes product name, package size, number of prescriptions and amount paid for each drug and dosage. Notably the amount paid does not include the impact of the manufacturers rebates which when accounted for significantly reduce the net cost of these products. Since 1992 federal statutes require manufacturer's as a condition of having their products covered by Medicaid must provide rebates to ensure Medicaid receives the manufacturers best price

## Best Practices

Below we highlight the best practices we observed from our survey. We believe these best practices can be replicated in New Jersey, improving both performance in eligibility processing and service delivery. It is also important to note that based on our survey, posting summary level information Medicaid cost and utilization data appear to be compliant with the Medicaid statutes and regulations governing the use of such data.

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[1] https://www.scdhhs.gov/press-release/south-carolina-birth-outcomes-initiative-dramatically-improves-infant-health-saves

[2] https://data.medicaid.gov/State-Drug-Utilization/Drug-Utilization-2016-New-Jersey/6dgg-fe5u

## Eligibility and Enrollment

California and Massachusetts maintain two of the best eligibility reporting systems. Each offers current detailed eligibility application data as well as metrics that are used to measure the entities that process the applications.

In the late 1990's California embarked on an intensive effort to consolidate the various county-based eligibility systems and created the Statewide Automated Welfare System (SAWS). SAWS provides a host of eligibility and enrollment data but also includes key data points that measure each county's performance. For instance, a weekly report is issued that tracks how many Medi-Cal applications have been pending for longer than the 45 days required under federal regulations by county.[3]

They also actively monitor renewals at the counties to ensure families are receiving and submitting their renewal notices as well as how many of the renewal applications result in a renewal. This last metric is extremely useful in determining the areas where enrollment fraud may be occurring and where renewal requirements/efforts are most effective.[4] For example, based upon these reports many smaller counties renew more than 95% of the applicants for coverage while some larger counties renew between 70 and 80%. The statewide average in October 2016 was 88%. This variation in eligibility retention between counties should result in policy makers adjusting processing techniques that bring the lower performing counties closer to the statewide average.

Massachusetts tracks and reports quarterly new case additions, terminations and cases that were reinstated within 90 days of termination. This data allows the state to measure program churn; i.e. cases are being terminated that ultimately should not have been because there was no change in their financial status. They also track and report how many new applications are missing critical data. Missing information is the leading cause of delays in processing applications.[5] This data is used to the modify the application process by identifying the biggest challenges to applicants, i.e. submitting paystubs, birth certificates and proof of residence and then finding solutions to improve the process.

## Cost and Utilization

There is a wide variation among the states in the availability of Medicaid cost and utilization data. This variability is attributable to several factors including the size of the program, available state resources and relationships with state universities. The available data can be grouped as follows:

**Annual Reports** – Most states produce an annual report that includes their most recent year's cost and utilization data. However, there is a wide variation in the level of depth of the data. Most include summary level data tables while a few others like Oklahoma produce extensive annual reports with multiples levels of detail.

**Historical trend data links** – many states provide select data through links to Excel tables that provide limited historical data with varying degrees of detail. In this context, most states that were not using managed care as their primary delivery system produced more detailed reports than their counterparts.

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[3] http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/CFSW/TotalIndividualsOnApplicationsPending45Days.pdf

[4] http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/CFSW/MCRenewalsCounty_Oct16.pdf

[5] http://www.mass.gov/eohhs/docs/masshealth/research/masshealth-dashboard-report-2.pdf

***Highlights: Oklahoma and Texas***

Texas produces and publishes detailed cost and utilization reports by county and by MCO using self-reported data prepared by health plans under the terms and conditions of the Uniformed Managed Care Contract. In addition, the same data is used to produce targeted utilization trend reports on key topics such as deliveries, pharmacy and behavioral health.[6]

The Oklahoma Health Authority maintains an interactive data dashboard in addition to select in depth reports on the cost and use of key services including deliveries, dental, behavioral health, pharmacy and emergency department visits.[7]

**University Based Research Centers** - Some states share responsibility for the use of their Medicaid data with their state universities. These organizations, which at times function as a gatekeeper of the data for researchers, use the data to provide in depth research and analysis of topics of interest to stakeholders and the public at large.

***University based Medicaid Research Centers and Institutes***

- University of South Carolina's Institute for Families in Society, Division of Policy and Research on Medicaid and Medicare
- Center for Health Policy and Research, UMass Medical School
- *Center for State Health Policy, Rutgers University*
- University of Southern Maine - Cutler Institute for Health and Social Policy, Muskie School of Public Service
- Georgia Health Policy Center, Georgia State University
- The Hilltop Institute, University of Maryland, Baltimore County (UMBC)
- California Medicaid Research Institute (CAMRI) at UCSF
- The Ohio Colleges of Medicine Government Resources Center
- University of Wisconsin Population Health Institute
- Virginia Commonwealth University Department of Healthcare Policy and Research

**Highlight: South Carolina**

The Medicaid Policy and Research at the University of South Carolina Institute for Families in Society provides an interactive user-friendly tool to access its Medicaid utilization data through its ***SC HealthViz.*** SC HealthViz was developed as a project of the SC Department of Health and Human Services through a contract with the University of South Carolina's Institute for Families in Society, Division of Policy and Research on Medicaid and Medicare.

SC HealthViz provides a user friendly accessible tool that allows users to obtain data on South Carolina Medicaid enrollment, eligibility, MCO performance and summary service utilization. In addition, the tool is used by Institute evaluate and report key metrics related to the cost and use of

[6] https://hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-financial-statistical-reports
[7] http://www.okhca.org/research.aspx?id=17483

services and access to care. The interactive data currently does not include cost information, but will when the tool is updated later in 2017. Notably some cost data is included in other specific projects such as the birth outcomes initiative. The SC HealthViz tool is used by a wide range of stakeholders including the legislature, MCOs, provider groups, policymakers, researchers and consumers. The Institute partners with the state's contracted to MCOs to produce various quarterly data reports that the MCOs use to track and analyze HEDIS measures and identify high utilizers.

**Actuarial Certifications** – Two states, Oregon and Tennessee, publish their actuarial certification of their MCO capitation rates. These certifications include historical cost and utilization trends for each service – inpatient hospital, pharmacy, etc. – and for each category of Medicaid for which there is a capitation rate –i.e., age, sex and disability level groupings. In setting capitation rates the state's actuaries use historical cost and utilization data from two main sources; MCO encounter data and the MCO financial reports provide a detailed breakdown of costs by rate cell and service type, i.e. physician, hospital, pharmacy, etc. Since the MCO encounter data is reconciled with MCO Financial reports it provides the most accurate picture of historical costs.[8]

## Conclusions

While all states produce basic eligibility and enrollment data, there is wide variation in the type, amount and scope of state Medicaid cost and utilization data. Ranging from annual reports and static monthly snapshots to interactive databases, the available data is used to provide transparency regarding the use of public funds and for stakeholders to better understand the trends in their Medicaid programs.

States that have partnered with their universities are able to critically evaluate the programs performance at an arms-length distance. They serve as an important source of research for state policy makers by assisting the program's management in isolating trends and regional variation. This research provides a basis from which policy makers can develop strategies to address problem areas.

New Jersey policy makers should expand a State University's role to include providing an interactive database that includes aggregate cost and utilization data. State officials should also post the actuarial certifications which offer detailed insights on the cost and use of services.

### State by State Survey Chart

Below is the state by state survey chart. It is important to note the limitations of the data presented. Not all states report their Medicaid data in the same manner which makes true comparisons difficult. Some states for example report their fee-for-services expenditures in detail but group all MCO covered services together while others provide the MCO breakdown. Consequently, the data presented below should be viewed as a sampling of data reporting practices across these states rather than a comprehensive comparison.

[8] https://www.tn.gov/assets/entities/tenncare/attachments/actuarial15.pdf

| | ---------- Eligibility and Enrollment---------- | | | | ----------Cost and Utilization---------- | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **State** | **Eligibles by County** | **Eligibles by Age** | **MCO enrollment** | **Frequency** | **Expenditures by county** | **Expenditures by Type of Beneficiary by County** | **Expenditures by Type of Service** | **Frequency** | **Most recent year available** |
| **Alabama** | X | X | N/A | monthly | X | X | X | annual | 2015 |
| **Alaska** | | X | N/A | annual | | X | X | multi-year | 2014 |
| **Arizona** | X | X | x | monthly | | | X | annual | 2017 |
| **Arkansas** | X | X | N/A | annual | X | | X | annual | 2015 |
| **California** | X | X | X | monthly | | | X | quarterly | 2016 |
| **Colorado** | X | X | X | monthly | | | X | monthly | 2017 |
| **Connecticut** | | X | N/A | monthly | | X | X | annual | 2017 |
| **Delaware** | | | | monthly | | | | N/A | 2016 |
| **Florida** | X | X | X | monthly | | | X | annual | 2017 |
| **Georgia** | | X | X | monthly | | | X | annual | 2017 |
| **Hawaii** | X | X | X | quarterly | | | | annual | 2016 |
| **Idaho** | | | N/A | N/A | | | | N/A | N/A |
| **Illinois** | X | X | X | monthly | | | | N/A | N/A |
| **Indiana** | X | X | X | monthly | | | | N/A | N/A |
| **Iowa** | X | X | X | monthly | X | X | X | quarterly | 2017 |
| **Kansas** | | X | | monthly | | X | X | monthly | 2017 |
| **Kentucky** | X | X | X | monthly | | | | N/A | N/A |
| **Louisiana** | X | X | X | monthly | | | X | monthly | 2017 |
| **Maine** | | | N/A | N/A | | | | N/A | N/A |
| **Massachusetts** | X | X | X | monthly | | | | annual | 2015 |
| **Maryland** | X | X | X | annual | | | | N/A | N/A |
| **Michigan** | X | X | X | monthly | | X | | annual | 2016 |
| **Minnesota** | X | X | X | monthly | X | X | | annual | 2015 |
| **Mississippi** | | X | | monthly | | | X | annual | 2016 |
| **Missouri** | | | | N/A | | | | N/A | N/A |
| **Montana** | X | | N/A | monthly | X | | X | monthly | 2017 |
| **Nebraska** | | X | | monthly | | X | X | annual | 2016 |
| **Nevada** | X | X | X | monthly | | | | N/A | N/A |

| | ---------- Eligibility and Enrollment---------- | | | | ----------Cost and Utilization---------- | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **State** | **Eligibles by County** | **Eligibles by Age** | **MCO enrollment** | **Frequency** | **Expenditures by county** | **Expenditures by Type of Beneficiary by County** | **Expenditures by Type of Service** | **Frequency** | **Most recent year available** |
| **New Hampshire** | X | X | | monthly | | | X | annual | 2008 |
| **New Jersey** | | X | | monthly | | X | X | annual | 2015 |
| **New Mexico** | X | X | X | monthly | | | | N/A | N/A |
| **New York** | X | X | X | monthly | X | X | X | annual | 2016 |
| **North Carolina** | X | X | N/A | monthly | X | X | X | monthly | 2017 |
| **North Dakota** | | X | N/A | monthly | | | X | quarterly | 2017 |
| **Ohio** | X | X | X | monthly | X | X | | annual | 2017 |
| **Oklahoma** | X | X | N/A | monthly | X | X | X | annual | 2017 |
| **Oregon** | X | X | X | monthly | X | X | X | annual | 2017 |
| **Pennsylvania** | | X | X | monthly | | | | N/A | N/A |
| **Rhode Island** | | X | | annual | X | X | X | annual | 2015 |
| **South Carolina** | X | X | X | monthly | X | X | X | annual | 2016 |
| **South Dakota** | X | X | | monthly | | X | X | monthly | 2017 |
| **Tennessee** | X | X | X | monthly | X | X | X | quarterly | 2016 |
| **Texas** | X | X | X | monthly | X | X | X | monthly | 2016 |
| **Utah** | X | X | | annual | | X | X | annual | 2016 |
| **Virginia** | X | X | | monthly | X | X | X | annual | 2016 |
| **Vermont** | | X | N/A | annual | | X | X | annual | 2016 |
| **Washington** | X | X | X | monthly | X | X | X | annual | 2017 |
| **West Virginia** | | X | X | monthly | | X | X | annual | 2015 |
| **Wisconsin** | X | X | X | monthly | | | | N/A | N/A |
| **Wyoming** | X | X | N/A | monthly | X | X | X | annual | 2016 |

| ***New Jersey Health Care Quality Institute*** | |
|---|---|
| ***Medicaid 2.0*** | ***Attachment I*** |
| ***State Medicaid Data Inventory*** | |
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| **State** | **Web Links** |
| | |
| Alabama | http://medicaid.alabama.gov/content/2.0_Newsroom/2.3_Publications/2.3.1_2015_Report.aspx |
| Alaska | http://dhss.alaska.gov/fms/Documents/MESA/MESA%202014-34_SFY2015.pdf |
| | http://dhss.alaska.gov/HealthyAlaska/Documents/Initiatives/FY2016_Annual_Medicaid_Reform_Report_11152016.pdf |
| Arizona | https://azahcccs.gov/Resources/Reports/federal.html |
| Arkansas | http://humanservices.arkansas.gov/Pages/dhsReports.aspx |
| California | http://www.dhcs.ca.gov/dataandstats/reports/Pages/default.aspx |
| Colorado | https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports |
| Connecticut | https://dnav.cms.gov/Views/Search.aspx |
| Delaware | http://dhss.delaware.gov/dhss/dmma/info_stats.html |
| Florida | http://www.fdhc.state.fl.us/Medicaid/index.shtml |
| Georgia | https://dch.georgia.gov/budget-performance |
| Hawaii | http://www.med-quest.us/ManagedCare/CmsReport.html |
| Idaho | http://healthandwelfare.idaho.gov/Default.aspx?TabId=123 |
| Illinois | https://www.illinois.gov/hfs/info/Pages/default.aspx |
| Indiana | http://in.gov/fssa/ompp/4881.htm |
| Iowa | https://dhs.iowa.gov/ime/about/performance-data |
| Kansas | http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2017.pdf |
| | http://www.kdheks.gov/hcf/data_consortium/data_consortium_health_indicators/default.htm |
| Kentucky | http://www.chfs.ky.gov/dms/stats.htm |
| Louisana | http://ldh.louisiana.gov/assets/medicaid/forecast/17_6ForecastReport_March2017.pdf |
| | http://ldh.louisiana.gov/assets/medicaid/MedicaidEnrollmentReports/EnrollmentTrends/EnrollmentTrends-4.17.pdf |
| Maine | http://www.maine.gov/dhhs/oms/index.shtml |
| Massachusetts | http://www.mass.gov/eohhs/researcher/ |
| | http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf |
| | http://www.mass.gov/eohhs/researcher/insurance/masshealth-reports/masshealth-measures.html |
| Maryland | https://mmcp.health.maryland.gov/Pages/home.aspx |
| Michigan | http://www.michigan.gov/documents/mdhhs/2016_Annual_State_Summary_544176_7.pdf |
| Minnesota | https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp |
| Mississippi | https://medicaid.ms.gov/resources/ |

| | |
|---|---|
| Missouri | https://dss.mo.gov/mhd/ |
| Montana | http://dphhs.mt.gov/StatisticalInformation |
| **State** | **Web Links** |
| Nebraska | http://dhhs.ne.gov/medicaid/Pages/medicaid_index.aspx |
| Nevada | http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/ |
| New Hampshire | https://www.dhhs.nh.gov/data/index.htm |
| New Jersey | www.state.nj.us/humanservices/dmahs/news/NJ_FamilyCare_2015_Annual_Report.pdf |
| New Mexico | http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx |
| New York | https://www.health.ny.gov/health_care/medicaid/statistics/ |
| | https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2016/docs/health_svs_use_report_2016.pdf |
| North Carolina | https://dma.ncdhhs.gov/nc-medicaid-dashboards#annual |
| | https://www2.ncdhhs.gov/dma/countyreports/2011/AllCounties2011.pdf |
| North Dakota | http://www.nd.gov/dhs/info/pubs/about.html |
| Ohio | http://medicaid.ohio.gov/RESOURCES/ReportsandResearch.aspx |
| Oklahoma | http://www.okhca.org/research.aspx?id=87 |
| Oregon | http://www.oregon.gov/oha/healthplan/Pages/reports.aspx |
| Pennsylvania | http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_213880.pdf |
| Rhode Island | http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/RI_Medicaid_Expend_SFY2015_FINAL2_06082016.pdf |
| South Carolina | http://www.schealthviz.sc.edu/home |
| South Dakota | http://dss.sd.gov/medicaid/ |
| | http://dss.sd.gov/docs/news/reports/2016_medicaid_report.pdf |
| Tennessee | https://www.tn.gov/assets/entities/tenncare/attachments/leg1216.pdf |
| | www.tn.gov/assets/entities/tenncare/attachments/actuarial15.pdf |
| Texas | https://hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-financial-statistical-reports |
| | https://hhs.texas.gov/about-hhs/budget-planning#MonthlyFinancialReports |
| | https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics |
| Utah | https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2014.pdf |
| Virginia | http://www.dmas.virginia.gov/ |
| Vermont | http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Ways%20and%20Means/DVHA%20FY%202017%20Budget%20Book/W~Steven%20Costantino~FY%202017%20Dept%20of%20Vermont%20Health%20Access%20Budget%20Book~2-11-2016.pdf |
| | http://hcr.vermont.gov/library |
| Washington | http://www.ofm.wa.gov/healthcare/dataresources/default.asp |
| West Virginia | http://www.dhhr.wv.gov/bms/BMSPUB/Documents/BMS%20Annual%20Report%202015%20Final%20approved%20version.pdf |
| Wisconsin | https://www.dhs.wisconsin.gov/legislative/data.htm |
| | https://www.dhs.wisconsin.gov/familycare/enrollmentdata.htm |

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|---|---|
| Wyoming | http://health.wyo.gov/wp-content/uploads/2016/02/SFY-2016-Wyoming-Medicaid-Annual-Report.pdf |