PART 2: FEDERAL-STATE ISSUES

- Benefits, challenges, role of Claims-based Databases, including APCDs for Medicare; Status and challenges of sharing Medicare data with Claims-based Databases, including APCDs;
- **Benefits, challenges, roles, uses of Claims-based Databases, including APCDs for Medicaid Agencies; Status of sharing Medicaid data with Claims-based Databases, including APCDs**
- Legislative issues with Claims-based Databases, including APCDs, including lack of consistency across state laws, requirements, data collection standards, reporting
- ERISA considerations regarding Claims-based Databases and APCDs; opportunities and challenges moving forward
- SAMHSA / 42 CFR Part 2 issues and Claims-based Databases, including APCDs
- OPM and Claims-based Database efforts

Thank you for inviting me to speak to the second item, specifically on how APCDs are used to support the Medicaid Program as implemented by states.

From a CMS oversight perspective, Medicaid participation in APCDs is not required. States can choose to participate and share their Medicaid claims/encounter data if they determine that doing so would address business needs such as access to all payer data for planning needs related to cost, efficiency, quality of care, system utilization, patterns of care, and geographic differences. In some cases, it is the state itself that hosts the APCD, which dramatically increases the likelihood of Medicaid participation (ex. Utah, Kansas or Tennessee). There are some excellent examples of how states have used the data in APCDs to pinpoint key issues at: https://www.apcdshowcase.org/case-studies?field_category_tid=7

Federal matching funds are available for some of the costs associated with Medicaid participation in an APCD.

For example, if a state does not have an APCD but wants to build one, such as what is occurring in NY state, the Medicaid program may be eligible for ninety-percent matching funds for their share of the costs for the build, assuming they can justify that the APCD will meet Medicaid functional business requirements that would have had to be met through a technological solution one way or the other. In this instance, the state could also receive a seventy-five percent federal match for the Medicaid Program's share of on-going maintenance and operational costs of the APCD.

Another example is if an APCD already exists, Medicaid can receive the ninety percent match for the costs incurred in building the interface between the state's claims/encounter data warehouse and the APCD. However, in this scenario, the costs for the Medicaid agency's on-going participation in the APCD is only matched at fifty percent federal funding. That is because the APCD is a desired interface but is not part of the Medicaid Program's IT enterprise solution.

What this highlights is that the federal funding for Medicaid participation in an APCD is variable based upon how it is used by the Medicaid program. CMS works with each state Medicaid agency individually on their proposal and request for matching funds.

Another challenge to Medicaid's use/participation in APCDs is claims/encounter data quality and lag times. The value of the APCD is greatly diminished if the data is stale and/or represents disparate data models and semantic definitions and/or has significant gaps. CMS has been working with states on the Transformed Medicaid Statistical Information System (T-MSIS) for several years to bring about a standardized data set with a consistent data dictionary, data formats and data quality checks that includes Medicaid and the Children's Health Insurance Program (CHIP) data on beneficiaries, providers, claims, encounters, managed care plans and third party liability. In our work with states on T-MSIS, we have a much clearer perspective on data quality issues and the very real issues of inconsistency, gaps and invalid values in states' claims and encounter data.

There are two additional areas that may limit the value of APCDs for the Medicaid Program. The first is that many states desire the layering of clinical data and claims data to have a more fulsome view of both the utilization, cost and impact of Medicaid coverage. In many cases, states may find participation in an APCD to only answer some of their questions and have to also work with health information exchange entities for the clinical data to complete the picture. That can cause operational inefficiencies and obstacles with person matching, link keys, etc. If it is not already occurring, expanding the vision of APCDs to include functional linkages to health information exchange with proper privacy protections would perhaps obfuscate the need for state Medicaid Programs to build their own separate data pathways.

Secondly, the Medicaid and CHIP Programs in most states are integrated with human services programs such as SNAP and TANF. Understanding just healthcare services utilization underestimates the social determinants of healthcare utilization, cost and outcomes. Many states have a vision to better understand how their common beneficiaries in these programs are accessing services, defining "provider" in a much more expansive manner and adopting a data analytic approach that is no longer exclusive to healthcare claims.

In general, we are open to states' proposals and negotiate the availability of federal matching funds on a state-by-state basis within the context of the state Medicaid Program's overall data analytics roadmap.

Thank you.