



August 11, 2014

Chairman Ron Wyden and Senator Charles Grassley
United States Senate Committee on Finance
Washington, DC 20510-6200

Dear Chairman Wyden and Senator Grassley:

Thank you for the opportunity to share suggestions for improving the accessibility and usefulness of health care data. The Georgetown University Center for Children and Families is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families.

With your leadership, Medicare has made great strides in increasing the availability of detailed data on its operations. In the past few years, progress has been made to improve the reporting of data related to other publicly-supported health coverage programs, as well, but more attention is needed. Medicaid, the Children's Health Insurance Program (CHIP), and Marketplace coverage receive hundreds of billions of dollars annually in investments from federal and state taxpayers, yet the robustness and timeliness of data reporting makes it difficult to assess the performance of these key public coverage programs in real time. Federal efforts to improve health care data transparency should pay particular attention to our public insurance affordability programs. Greater transparency regarding how individuals are applying for and enrolling in coverage as well as the quality of care they receive should be top priorities. In addition, all-payer claims databases are a vital means to aggregate and share health care data; their development and connection should be incentivized by the federal government.

Eligibility and Enrollment Performance Indicators

Implementing the Affordable Care Act has brought many changes and many challenges to CMS, state Medicaid and CHIP agencies, and state marketplaces. Continuous improvement in enrolling eligible individuals will require close monitoring of the performance of all of the interrelated systems that play a role in connecting people to the right coverage at the right time. Federal investments have already aided states in upgrading their eligibility systems and one important benefit of these investments (as is a condition of the enhanced federal funding) should be the availability of timely data.

The federal government should require Medicaid and CHIP agencies, as well as all marketplaces, to report a full suite of data to allow policymakers and the public to

assess their performance in handling the flow of individuals into, during, and out of coverage. This would include timely data on:

- Eligibility determinations, including the transmission, acknowledgement and disposition of transfers between Medicaid, CHIP, and marketplaces;
- Enrollment levels, including demographic and geographic breakdowns and disenrollments over the reporting period;
- Renewal activity, including the retention rate on a monthly and annual basis; and
- Standardized reasons for denials of new applications and disenrollment at renewal that distinguish between eligibility-related reasons and denials or disenrollment for non-eligibility related reasons such as missing documentation or incomplete forms.

Requiring such reports and releasing the data in a timely way would help drive improvements across the country. State agencies and other stakeholders could more easily identify successful strategies and areas for improvement, both within their own states and in others, speeding adoption of best practices nationwide.

Quality Indicators

Across the health care sector, the need for reliable measures of quality has been broadly recognized. Yet while Medicaid enrolls more people than any other single source of coverage in the nation, consistent and timely data on the quality of coverage it delivers can be scarce. Because it covers so many varied populations and is operated by states, consistent quality data will require strong federal leadership. Likewise, CHIP and marketplace quality data will be most useful if the measures and reporting requirements are standardized on a national level.

Federal legislation has already encouraged the collection and reporting of some quality measures in Medicaid and CHIP—this progress should be both accelerated and deepened. HHS has developed core sets of quality measures for children in a range of coverage sources and for adults in Medicaid. State Medicaid and CHIP agencies have voluntarily reported on some, though far from all, of these measures. State Medicaid and CHIP agencies should be required to develop and submit plans to achieve full reporting of all of the core measures for both children and adults. Offering technical assistance and incentives, similar to the Medicaid performance bonus, for states that do a good job of reporting and showing improvement on key quality indicators would go a long way to accelerate the use of data in enhancing the performance of our public programs.

Plans for collecting and reporting quality measures in Medicaid and CHIP must address an important drawback of past efforts: inconsistent measurement between managed care organizations and Medicaid/CHIP benefits delivered through fee-for-service. State-level reports must present data that are comparable for all enrollees in a state, regardless of the delivery system that manages their care. Nonetheless, it

is important to track quality by managed care organization in order to assess their performance.

Federal law already provides for a quality rating system (QRS) for qualified health plans and HHS has taken prudent steps to ensure that its measures align with those already in use or developed for Medicaid and CHIP. However, implementation of the QRS has been delayed. Congressional attention could help ensure that the QHP quality rating system:

- Reflects the intent of the Affordable Care Act;
- Serves the needs of health care consumers first, not those of health plans or other stakeholders; and
- Is implemented as soon as possible while meeting the system's goals.

For quality, as well as eligibility and enrollment performance indicators, the federal government should seek to report measures at the national, state, and county or regional levels to allow more accurate and actionable research. Currently, data are primarily aggregated and reported only at the state and national levels. Given the variety of health and demographics within a state, state-level reports are often insufficient for making policy-relevant conclusions. County- or regional-level data could provide the needed insight to better address disparities and learn from communities that are experiencing success in improving health care access, quality, and cost.

All-Payer Claims Database

Tracking, compiling and analyzing claims is a powerful way to understand how health care is delivered and whether it is meeting the goals set out by government, consumers, purchasers, providers, and other stakeholders. The fragmentation of claims data across many private payers and the multiple public programs inhibits the system-wide understanding of health care utilization, costs, and quality that is needed to make systemic improvements, including identifying the most effective services.

Several states have already pioneered the development of all-payer claims databases to integrate collection of claims information from private payers and public programs. Congress should set the goal of ensuring a high-functioning all-payer claims database that uses a standardized format for data collection in every state. The federal government should provide incentives for states to meet this goal in a reasonable timeframe. While the sale of data from such databases to health care industry customers (with appropriate privacy and security controls) can help offset some of their ongoing costs, detailed data must also be available to researchers and the public at little to no cost. Allowing researchers and the public access to information on paid and denied claims will provide a vital element of transparency into the cost and quality of the health care services that taxpayers help to fund and can help to drive improvements in care.

Again, thank you for the opportunity to provide comments as the Committee on Finance considers ways to improve the availability and usefulness of health care data. To discuss further any of the recommendations above, please contact Joe Touschner at jdt38@georgetown.edu.

Sincerely,

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