# Available Data: Opportunities and Limitations

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# Types of analyses

- Descriptive and Impact analyses of specific models and interventions
  - Enhanced services (e.g., care coordination)
  - Integrated (or specialized) managed care plans
- Outcomes
  - Enrollment
  - Utilization and spending
  - Met/unmet needs
  - Function, Health, Mortality

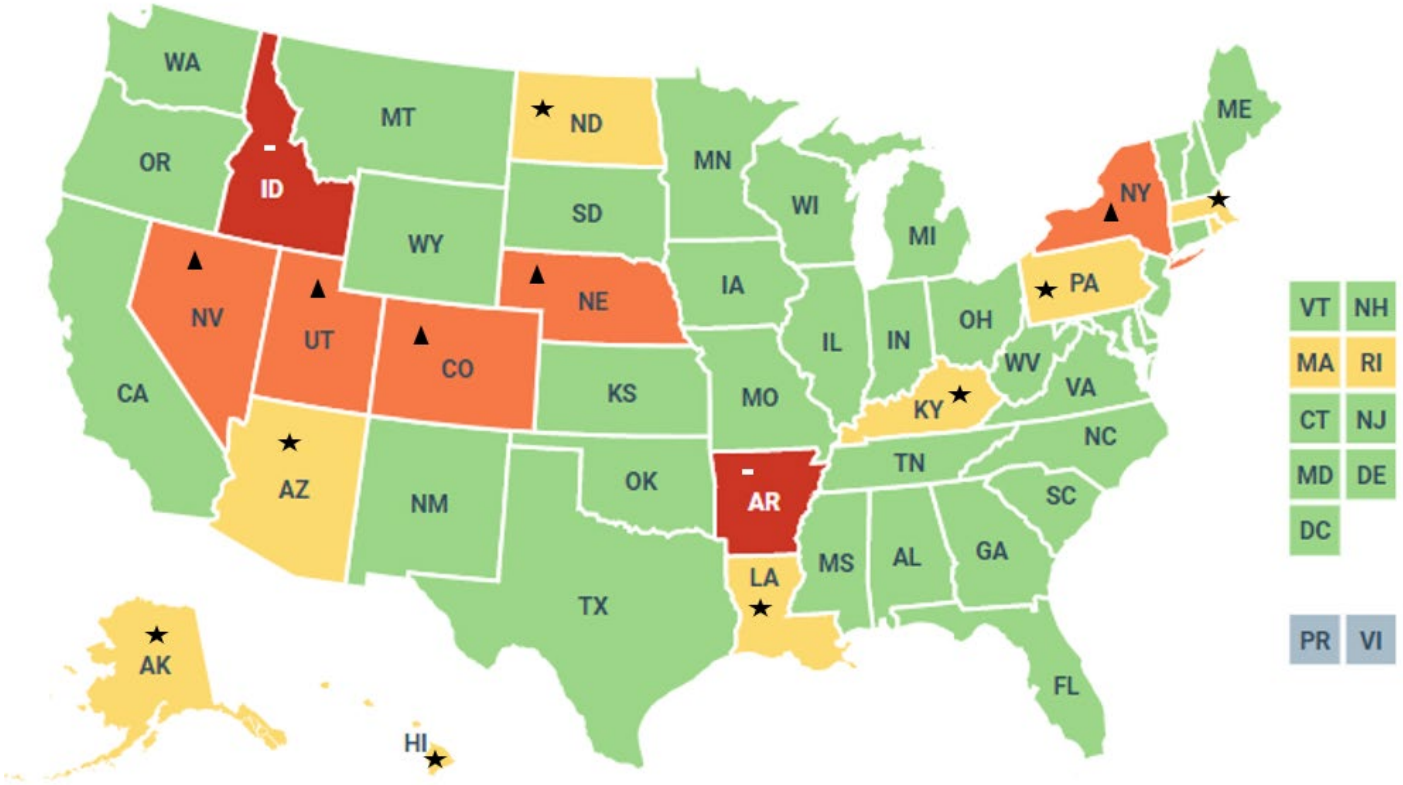
# Types of data for studying duals

- Administrative – utilization and cost
  - Enrollment/denominator
  - Person-level summaries
  - Claims/encounters
- Surveys – social supports, comorbidities, functional limitations
  - List sample frame (e.g., MCBS, NHATS)
  - Population sample frame (e.g., ACS, NHIS, HRS, MEPS)
  - Panels & cross-sections
- Surveys with linked administrative data (e.g., MCBS, HRS, NHATS)
- Linked data from Chronic Conditions Warehouse

# T-MSIS Analytic File (TAF)

- Research Identifiable Files (RIF)
- 2014-2018 (2016 first year with all states)
  - Demographic and Eligibility
  - Claims/Encounters: Inpatient (IP), Long Term Care (LT), Pharmacy (RX), Other Therapy (OT)
    - Monthly, all states
- T-MSIS transition year data released with MAX

# CMS TAF DQAtlas (all Medicaid)




| DQ Assessment | States with specified DQ Assessment |
|---|---|
| Low concern | 35 |
| Medium concern | 9 |
| High concern | 5 |
| Unusable | 2 |
| Unclassified | 2 |

Assessment of TAF dual eligible count relative to Medicare data
Source DQATLAS, 2018 (https://www.medicaid.gov/dq-atlas/welcome)

# Example findings on enrollment (2016 TAF)

- 84% agreement between MBSF and TAF on who is a dual-enrollee
  - But range is wide: 2.4% in AR (nearly all MBSF duals are classified as Medicaid only in TAF) to 98.6% in NE
  - 16 states with <80% agreement
- 86% agreement on full/partial dual & MSP level classification
  - About half of inconsistencies in country are in California
  - 5 states with <80% agreement
  - Rate of inconsistency higher among MMC enrollees

# Example findings on enrollment (2016)

- "Integrated" model participation poorly reported in TAF relative to MBSF
  - 12% of those in MMP, D-SNP, or FIDE-SNP according to MBSF are identified with integrated plan flag in TAF. PACE better, but very low enrollment nationally.
  - Highest agreement in MMP (44%). VERY low in D-SNP (3%) and FIDE-SNP (0%)
  - MMP enrollment either well identified (>95% in OH, MA, VA, NY, TX) or poorly/not identified (MI, RI, SC, CA, IL)
  - D-SNP identification generally poor, but little actual integration with Medicaid among these plans

# Utilization and Spending: Questions

- What difference does integrated care make?
- Does care coordination affect utilization patterns?

# Utilization and Spending: Data

- MBSF good source for ID of duals and annual person-level summary on Medicare side.
- TAF (T-MSIS) does not (yet?) have equivalent of MAX Person Summary file for total annual costs/claims by type of service.
  - Comparisons of MAX totals with CMS Form 64 data showed inconsistencies, sometimes large (though not dual-specific)
  - CMS's DQ analyses show similar issues in T-MSIS.
- Most acute services are best analyzed in Medicare claims
  - But if interested in calculating total cost of care, Medicaid cost-sharing payments may be of interest
- LTC, HCBS and Behavioral Health are more typically Medicaid and a big part of the picture for duals.

# Issues in acute care data

- Cross-over claims
  - Medicare is primary payer, and Medicaid may cover cost-sharing for duals
  - State Medicaid policies vary on how much cost-sharing to reimburse
  - Flags for cross-over claims in Medicaid data are inconsistent, and thus not generally reliable filters
  - Assessing completeness is difficult without a benchmark
- Encounter data
  - Big questions on completeness across and within states
  - Medicare AND Medicaid

# Issues in LTSS data

- Mix of Medicare and Medicaid financing for institutional nursing care
  - SNF (Medicare) vs NF (Medicaid)
  - Data completeness difficult to assess
  - Admission dates, service dates, cross-over flags, per-diem rates?
- HCBS difficult to compare across states
  - Different services offered
  - Different procedure codes for same services
  - Truven HCBS Taxonomy may help, if populated

# Linking Medicare and Medicaid data

- Necessary, in general
- CCW generates unique person level ID across multiple data sources
  - Usable within VRDC
  - Or outside
- Person level matching made easy
- Event level matching can still be a challenge
- Linking MAX to TAF?
  - Be careful

# Non-claims sources

- Surveys likely to provide better picture than administrative data on
  - Demographics
  - Socioeconomic factors
  - Functional Health & Disability
  - Social supports
- Links to Medicare claims for several surveys (MCBS, HRS, NHATS)
- Links to Medicaid available from CCW/VRDC

# Questions?