OK. Good morning, everyone.

We’re going to go ahead and get started.

Thank you all for being here.

We have a really special treat for you today.

So Prior to joining the

by Doctor Kathy Bradley,

who is Professor and Dean of the

Colorado School of Public Health as

well as the Deputy Director of the

University of Colorado Cancer Center,

where she also holds the Paul

Bunn Chair in Cancer Research.

So Prior to joining the
University of Colorado Dean, Bradley was the founding Chair of the Department of Healthcare. She’s a health economist and received her PhD and MPA from the University of North Carolina, Chapel Hill. She has served on the National Academies of Science, Engineering and Medicine’s National Cancer Forum and formerly served on the National Advisory Committee to HRQ. She currently serves on the Methodology Committee for Pacori. Doctor Bradley has received numerous awards.
and honors including the Women in Science, Dentistry and Medicine Professional Achievement Award and Leadership, and she maintains an active resource portfolio of NIH and Foundation funded grants where she leads research related to cancer disparities and outcomes, financial burden, and labor market outcomes of cancer survivors. Please join me in welcoming Dean Bradley.

Good morning, everyone and thank you for that introduction and thank you for the opportunity to be here. I’m so fortunate to have had
two beautiful days in New Haven. It’s just been fantastic.
I’m happy to report that I did get to try the pizza.
Everyone, when I tell them I was given a talk here, they were saying make sure you get out and try the pizza.
So yesterday morning, that’s what I had for breakfast.
So and this is not my first time being in New Haven and giving grand rounds at Yale.
The first time I did it was probably 20 years ago.
I was an assistant professor at Michigan State University and Doctor Ruth McCorkle,
who was a professor in nursing, invited me out and the room was entirely different. And I was telling Michaela about it, that it was in this room that was like a well that looked down where they used to do the old grand rounds with the patient down below. And it had to be probably one of the most intimidating things I’ve ever done, being there as an assistant professor and then sort of in that particular setting. But it is fantastic to be back. I titled my presentation The Winding Path between Medicaid and...
Cancer Health Disparities.

And that’s because nothing with Medicaid is straightforward and certainly nothing with cancer is straightforward. That too tends to be quite circuitous.

Before launching into the presentation, I want to go ahead and do the spoiler alert and talk about the three things that I think are takeaways. The 1st is just the complexity of the problem, and I think as researchers, especially if you’re doing disparities, we like a good problem, you know. So this one is a particularly good problem. That is something with lots of facets.
it's hard not to talk about Medicaid and Medicaid coverage. It's probably our best hope for narrowing disparities that just seem to be widening no matter what we do. But it does provide coverage to a population that so desperately needs it. And so understanding the program is pretty critical.

And in places that haven't expanded Medicaid or really maligned against the Affordable Care Act, one of the arguments you frequently hear is substandard care. It's just terrible healthcare.
And we whether that’s true or not, it’s something that is said frequently and it’s up to us to figure that out. And if it is substandard in some places, where are those places and how do we improve it in our policies. So that’s the first area is to really think about this problem. The second thing is around data. And we all need data to do our research. But but you know, secretly we hate data because it’s so hard to acquire. And once we finally got it, we get it from these agencies that are...
holding data that aren’t met for research.

We take it and we’re clever.

We’re going to merge it with different data sets and stuff.

But now what do we have in front of us?

And it’s understanding that data and the importance of doing so.

And then the final take away is really all about the data infrastructure.

And by not having a good infrastructure because our health system in the United States is so incredibly fragmented.

that we don’t have a comprehensive data infrastructure that we can just pull down and understand what’s
happening with the quality of care, especially with those who most need it.

So at the end of the presentation, I leave time for questions. So please be thinking about those questions.

I really love that part. And being able to have a discussion, I think that’s the most interesting thing.

So going forward, first I’d like to just acknowledge the wonderful people I have the pleasure to work with.

Marcelo, Rich, Sarah and Faye All from Colorado. Lindsay Sabick, University of Pittsburgh always love working with her and then our colleagues.
00:05:37.035 --> 00:05:39.167 at the cancer registry and civic
00:05:39.167 --> 00:05:41.719 who holds the all payer claims data.
00:05:41.720 --> 00:05:44.939 Colorado is one of the few states that
00:05:44.939 --> 00:05:48.250 have an all payer claims database that’s
00:05:48.340 --> 00:05:51.304 available for research and they have
00:05:51.304 --> 00:05:53.512 been wonderful about working with us,
00:05:53.520 --> 00:05:54.520 but they are not cheap.
00:05:57.040 --> 00:05:58.920 The agenda for the talk,
00:05:58.920 --> 00:06:00.720 just an overview of Medicaid
00:06:00.720 --> 00:06:03.319 getting us all on the same page,
00:06:03.320 --> 00:06:06.720 factors that affect cancer outcomes,
00:06:06.720 --> 00:06:09.320 specific factors about Medicaid and
00:06:09.320 --> 00:06:11.816 that enrollment that can affect what
00:06:11.816 --> 00:06:14.000 happens to you once you’re diagnosed,
00:06:14.000 --> 00:06:17.156 treated and become a cancer survivor.
Then the factors that affect research, the incomplete data we might have, the nuances of our data and the importance of understanding it.

And then just to get a sense from all of you, the disparities between Medicaid and other forms of insurance are what is going on there? Is it inadequate care? What do we do about it? And then wrapping up with some future directions, nothing really to disclose except that this grant was funded by the National Cancer Institute and Marcelo and I are Co principal investigators.
So why this is such an interesting problem? And I have the puzzle pieces there because I’m guessing like me, many of you enjoy a good puzzle, right? Figure things out. So what we want to understand is Medicaid, is it a safety net savior or this malign purveyor of inadequate care? Which one is it? So many years ago when I was here presenting, I was actually presenting about Medicaid and cancer, sort of the very first research I did in this area and was trying to really understand things.
And you know, I was young and and and stupid and many employees and working with the state health department around getting their Medicaid data and merging it with cancer. And it was really a complicated process and they didn’t want to let go of their data. And I have found that these individuals insured by Medicaid were had worse survival. And I said something along the lines of it’s a safety net just above the grave, which did not make the Medicaid people want to give me their data anymore. And that wasn’t a way to form the relationship.
So an important lesson learned at that time, but it formed kind of the basis really of understanding why is it that people who are insured by Medicaid did so much worse and was it the insurance, as it something about them? You know, that they had tons of comorbidities, got in late but kind of led to this circuitous journey. So the next point of enroll too late and lack of continuous coverage. If you come in once you’re diagnosed, you probably have later stage
disease and probably have other problems that aren’t being cared for. So what’s the right comparison group? Is it people have had insurance all along or people have Medicaid insurance all along. So anyway, thinking about that reimbursement, we know Medicaid reimbursed at a much lower rate even for people who are diagnosed through the CDCS National Cancer or breast and cervical cancer early detection program that once they’re enrolled in Medicaid for treatment of their cancer,
that care is reimbursed in some states at an even lower rate than a normal Medicaid patient. So there’s all kinds of things that we do around reimbursement that prohibits access and then data complexity. Medicaid data is a mess. People come into Medicaid, they drop off the next month. We don’t know what happens to them. And it’s trying to understand how they got into Medicaid. And because Medicaid is the pair of absolute last resort,
you may be missing claims if they have any other type of health insurance. So Medicaid is the largest insurance program in the United States and for most states it is larger now than their education program. So it is just a huge program across the country and in every state it is ministered differently. Large provider of people of color protects against major financial consequences, which is what insurance is supposed to do, to give you that insurance. And then this huge variability. And the graph that I show is the proportion
NOTE Confidence: 0.956897123181818
00:10:31.362 --> 00:10:33.776 of people by different racial ethnic
NOTE Confidence: 0.956897123181818
00:10:33.776 --> 00:10:35.960 groups that are covered by Medicaid
NOTE Confidence: 0.913549963333333
00:10:38.720 --> 00:10:39.944 under the ACA.
NOTE Confidence: 0.913549963333333
00:10:39.944 --> 00:10:42.392 We were supposed to expand Medicaid,
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00:10:42.400 --> 00:10:44.848 but then it was left up to the
NOTE Confidence: 0.913549963333333
00:10:44.848 --> 00:10:47.344 states to do so. At this point,
NOTE Confidence: 0.913549963333333
00:10:47.344 --> 00:10:50.480 10 states have still not expanded Medicaid.
NOTE Confidence: 0.913549963333333
00:10:50.480 --> 00:10:54.368 North Carolina is set to begin was set
NOTE Confidence: 0.913549963333333
00:10:54.368 --> 00:10:57.080 to begin in the beginning of December
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00:10:57.080 --> 00:11:00.399 if they are able to launch the program.
NOTE Confidence: 0.913549963333333
00:11:00.400 --> 00:11:03.625 So still some important holdouts
NOTE Confidence: 0.913549963333333
00:11:03.625 --> 00:11:06.506 with Medicaid expansion and
NOTE Confidence: 0.913549963333333
00:11:06.506 --> 00:11:09.678 in those particular states,
NOTE Confidence: 0.913549963333333
00:11:09.680 --> 00:11:11.780 the threshold for Medicaid to
NOTE Confidence: 0.913549963333333
00:11:11.780 --> 00:11:14.240 qualify for Medicaid is quite low.
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So one of the things we used to say in Virginia was you really could not cut grass and still qualify for Medicaid. The level was 13% of the federal poverty line, pretty astounding right? As Medicaid expanded, we do know that it provided a lot of good to a lot of people. It did increase access to care. We observed improvements in some health outcomes and it contributed to reductions in racial disparities in healthcare coverage. So by and large it seemed to be doing some of the things that we had hoped that it would.
We’ve started to see improvements both in access and in some health outcomes. In expansion states, cancer survivors had greater access to doctors and non compared to non expansion states, women had a lower odds of receiving recommended mammograms or Pap smears, and expansion was associated with earlier detection and appropriate cancer treatment and in reduced mortality for those who were able to receive Medicaid coverage. So this is some of the work that Lindsay Sabek and I and
her colleagues were able to do, showing pre and post expansion and these differences that it made. So it does seem to be better than not having insurance and having to go through the traditional safety net of showing up at a safety net hospital. Despite these improvements though, we know that there’s some variability that the same benefit was not seen across the board. So we have here some evidence that newly diagnosed patients there was improved 2 years survival. But in cancer sites such as urologic malignancies,
there was no change in stage at presentation. And that the thyroid cancer showed that Medicaid patients were still likely to be diagnosed at an advanced stage and less likely to receive a guideline from coordinate care. So the pictures not really complete. We have evidence and that’s a lot of what we do as researchers. We build a body of evidence and doesn’t always agree with each other. It’s the body of evidence and we try to make the most out of the studies we have and to understand the validity, the credibility that they do everything.
right and how does this body of evidence build in One Direction or other.

And what we see with cancer and Medicaid, it’s not initially a clear story, but there’s a signal and I think it’s a reasonably strong signal that Medicaid is beneficial. So this is where I coming back to when I gave the talk here long ago, I looked at Medicaid merged with our state cancer registry. We also merged in Medicare data as well, one of the first states to do that and my long term colleague who is still around had lots and lots of experience in working with data sets.
Very patient person, good contrast to me, especially at that time in my life. And he said the reason we’re doing this is because we don’t have a meat grinder to put our hand in. And so it was kind of an interesting way to think about having to go out and get this data from the state agency who had never used it for research purposes and was in a completely different part of the state agency where the cancer registry was held. And we were just very fortunate that they were all
willing to work together and do this and create this resource. And what we found there is that among people who were insured by Medicaid. So we have only Medicaid. The differences between black and white women and mortality disappeared when they received the same kind of treatment. And that at the time, that’s my most cited paper, interestingly enough, and it was when I first published it. Most of the papers that cited it was pointing out that’s not the case, that there are important racial differences. And now in recent years the citations are,
00:15:36.680 --> 00:15:39.008 you know that is probably the case that
NOTE Confidence: 0.905944137142857
00:15:39.008 --> 00:15:41.438 if you do treat everybody the same,
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00:15:41.440 --> 00:15:42.970 you’re probably going to get the
NOTE Confidence: 0.905944137142857
00:15:42.970 --> 00:15:43.480 same outcome.
NOTE Confidence: 0.905944137142857
00:15:43.480 --> 00:15:45.760 The differences aren’t that great.
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00:15:45.760 --> 00:15:48.440 So it was an interesting study and a
NOTE Confidence: 0.905944137142857
00:15:48.440 --> 00:15:50.670 place that where having Medicaid data
NOTE Confidence: 0.905944137142857
00:15:50.670 --> 00:15:53.895 and being able to look at people that
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00:15:53.895 --> 00:15:56.673 are about the same socioeconomic status,
NOTE Confidence: 0.905944137142857
00:15:56.680 --> 00:15:58.640 being able to see if there are differences.
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00:16:05.720 --> 00:16:09.822 So sorry, it looks like something has
NOTE Confidence: 0.9370623
00:16:09.822 --> 00:16:12.237 got out of order and apologies for that.
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00:16:12.240 --> 00:16:13.640 So we’re going to start
NOTE Confidence: 0.9370623
00:16:13.640 --> 00:16:15.040 with the enroll too late.
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00:16:15.040 --> 00:16:19.352 So why is it that despite being able
NOTE Confidence: 0.9370623
00:16:19.352 --> 00:16:23.005 to show that there are promising,
NOTE Confidence: 0.9370623
00:16:23.005 --> 00:16:25.905 there’s promising evidence towards
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00:16:25.905 --> 00:16:28.384 Medicaid being a beneficial
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00:16:28.384 --> 00:16:29.920 expansion for individuals?
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00:16:29.920 --> 00:16:32.454 Why is it that some of the
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00:16:32.454 --> 00:16:34.200 disparities continue to persist?
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00:16:34.200 --> 00:16:36.248 And this is a study that I did
NOTE Confidence: 0.9370623
00:16:36.248 --> 00:16:38.608 with the National Cancer Institute
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00:16:38.608 --> 00:16:40.850 colleagues where we actually
NOTE Confidence: 0.9370623
00:16:40.850 --> 00:16:43.600 took national RCR Medicare group,
NOTE Confidence: 0.9370623
00:16:43.600 --> 00:16:45.525 was interested in expanding to
NOTE Confidence: 0.9370623
00:16:45.525 --> 00:16:48.213 CR Medicaid and we merged the two
NOTE Confidence: 0.9370623
00:16:48.213 --> 00:16:50.277 and started looking at the data.
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00:16:50.280 --> 00:16:54.158 And what you find that many people
NOTE Confidence: 0.9370623
00:16:54.160 --> 00:16:56.266 don’t get into Medicaid until after
NOTE Confidence: 0.9370623
00:16:56.266 --> 00:16:58.120 they’ve been diagnosed with cancer.
And by many people, I mean more than 1/3 or so really don’t show up into the system until they’re diagnosed. So they go to an emergency department somewhere, sometimes for something else, sometimes it’s for symptoms. Some tests get done, find out there’s cancer and there’s a social worker financial person at with associated the hospital who really whose job is to make sure they get paid. They figure out that the person’s eligible.
Medicaid and they get them enrolled. Medicaid then becomes a retrospective coverage going back and picks up the claims that occurred from diagnosis forward. When they come in at that point, it’s because they’re symptomatic and they’re having problems. So of course, Medicaid doesn’t have much of a chance to really provide them the kind of care where you’re going to see the same mortality outcome even if they have screening. So the breast and cervical cancer program is an interesting one that we were able to look at ’cause
we could see how people came into the Medicaid program. So the CD CS program has been around a long time and it provides site specific care. So free screening to women who do not have insurance coverage or who are underinsured but they don’t qualify for Medicaid can get free screening. So they have a little bit more money income resources than your typical Medicaid insured person. So if they go through, get the screening, they are then enrolled in Medicaid for their care. And you might ask, well,
Gee, you know, they have a higher income status. They don’t qualify for Medicaid. They might be better off and we’d expect them to do better than say, the person who’s been enrolled in Medicaid all along. What we did in this study is we looked at women who came in through the CD CS program. We looked at women who’ve been insured by Medicaid all along and those who came in after diagnosis. And we’re able to show that the board that those who enrolled in Medicaid all along did better.
00:19:19.932 --> 00:19:21.600 came in through the CDC.
00:19:21.600 --> 00:19:24.300 Those who came in after diagnosis and Medicaid,
00:19:24.300 --> 00:19:25.780 while not the same as privately insured and we showed that here that they are still doing much, much better.
00:19:34.640 --> 00:19:35.684 much, much better.
00:19:35.684 --> 00:19:37.076 And in cervical cancer,
00:19:37.080 --> 00:19:39.190 those who were continuously enrolled in Medicaid actually did better than women who were privately insured.
00:19:41.755 --> 00:19:43.720 So we are seeing a difference that doesn’t the outcomes are not the same in terms of detection and mortality as private insurance.
They’re just not. I mean, these are individuals with other kinds of problems and other challenges, but if they have continuous coverage, they do better. It’s the fact that Medicaid is picking them up when it’s already fairly late in their disease process. And if we think of it as a public insurance program, is that the best way to spend our money? We’re not going to have the best outcomes. It is expensive care. At this point, isn’t it better to have them in a program continuously covered,
getting screening,
getting less expensive care and having much,
more better outcomes over time.
We also looked at Medicaid and and
found across different cancer sites
in Michigan that people enrolled
in Medicaid after diagnosis had
an 8 year lower survival rate.
So big big difference that compared
to Medicaid enrolled continuously
and non Medicaid patients.
There are other studies that have
been done both in North Carolina and
Missouri that has similar findings
and that they attributed also to
the timing of enrollment and we’re able to see this survival gap. The next question about the problem is can they see a doctor, Is it these low reimbursement rates that hinder accessing care, So you give them care and they can’t get in. And this was a study by one of your colleagues, Victoria Marks here that did a fascinating study of calling and trying to get paid an appointment and found that they could not get in that many people just simply didn’t accept Medicaid or in some safety net institutions what they
do and they did this at VCU, which was a large safety net institution.

They booked four people who had Medicaid insurance for the same slot that would come in because they anticipated no shows difficulty getting there, so incredible wait times. So really fascinating problem that if you don’t at least get reimbursement up to the point of Medicare may be difficult getting in managed care programs. A lot of states have Medicaid managed care as their approach to Medicaid delivery to try to offset some of that to bring in a more managed program.
Savick and colleagues dug a little bit deeper in this and found that a mostly positive impact on breast and cervical cancer screening with increased physician payments and under a fee for service managed care plan reimbursement had less of an impact. Says that those kind of delivery plans had already was doing some things to manage and get people in. They had agreed to take on Medicaid They had agreed to take on Medicaid patients to begin with and so the reimbursement did not matter as much as you would expect. So I’ll take a little breather at this point. And are there disparities,
what do you think it are there disparities in the way that people are treated on Medicaid insurance compared to other forms of insurance? So disparities there not there, seen a lot of nods. Yep, there's still disparities. Do you think it’s mostly because of the timing of enrollment, reimbursement, there are lots of nods on the reimbursement or is it just they do provide a poor quality of care and this is a difficult to treat population. Is it something endogenous?
In other words, there’s not a lot of people buying that particular argument. Often times, providers, clinicians, they don’t know what kind of insurance their patient has when they get in front of them. By the time they’re there, the same kind of treatment is provided, and it’s once they are there, I don’t think those who actually treat them and lay hands on them really at that point know what kind of health insurance. They may know at some point the...
treatment trajectory as they go forward around reimbursement rates and things.

But initially that cares that no. OK.

So let’s understand the data that we’re working with the research so far.

To just recap,

Medicaid is an important safety net,

but it does appear to have some holes.

There’s a problem with enrollment and continuous care.

People who qualify for Medicaid aren’t enrolled in the program.

They just don’t realize they are certainly in Colorado.

We see a lot of people coming
in who qualify for Medicaid,

but they’re worried about their citizenship status and Colorado has a don’t ask policy and we just bring them in.

It tends to be more general, but they don’t want to approach the health system because of that.

Various other reasons that we see that people are shying away, but they qualify none the less.

So we have a problem there with continuous coverage, and then we need to understand once again and what is really happening.

And our team then began to wonder,
what if the data are not telling
the complete story?
What if there’s something inherently
wrong with being able to look
because most of the research,
because as my colleague said about
having a meat grinder to put
our hands in to get all this data.
It’s complicated and it’s costly
and it takes years of forming those
relationships and being incredibly
patient to get all of those pieces in place.
As a result,
many people use cancer registry.
They use the CR data,
which they can be able to pull easy or NCDB, other kinds of cancer registry data that they can get their hands on. And the question we began to ask well, what if those data are not right? turning to this part of the study is from a paper that just recently got published in JAMA Health Forum. And there we started to, we took the all pair claims data, merged it with our state cancer registry. And for the first time I was able to actually compare to private insurance and to be able to do lots of controls in the data to
get an equivalent control group.

So it’s pretty exciting to be able to do this.

We started off with the question of are there treatment disparities and radiation and hormonal therapy compared to private insurance.

We were trying to figure out where the step of our research project, this wasn’t what we intended to start to, was really our validation.
data good and where might some holes be.

And this is the step we all do in our data.

And we think, OK,

Nobody's going to be interesting,

but that ended up being the story,

our research question,

we knew that there the literature was

filled with papers that women insured by

Medicaid did not get radiation therapy.

They were not put on hormonal

therapy relative to women of

other forms of health insurance.

So we started there and we thought,

OK,

OK,

we're going to compare to private
insurance because this is a group that were picked women who were younger than age 65. Then we were going to go through and just do this toughest comparison private insurance where they should be getting the best care compared to a public insurance program. And there’s some nuances about Colorado’s Medicaid that I’ll get back to, but this was the setup for our study and here are some of the other studies that showed under use of adjuvant radiation therapy and post breast conserving surgery.
in North Carolina and in Georgia
we see the same sort of thing.
A Missouri study showed a delay
in treatment and increased risk
of death and related it all
to differences in treatment.
We link the cancer registry
with all payer claims data.
Did not take long to do the linkage.
It took about a year and
a half to get the data,
getting everybody to agree,
yes, you can have the data.
And just as we were about to get it,
the privacy officer at the state decided,
you know what,
we’re only going to give you year of death, not and year of diagnosis, not month and year.

And we’re saying how exactly are we going to do survival analysis if we only have the year and ended up in another big discussion of trying to convince the privacy officer that we could indeed have the both month and the year and that delayed our project by another, I don’t know eight months or so. And we had to get everybody at every level involved and eventually they ended up changing the regulation for
the state because we had one privacy
de officer after everybody agreed
after we'd received the funding,
So I'm going to be really cautious today.
So all of these things just to make
it happen and with secondary data
you think it's going to be easier
but it can be quite difficult.
We this is our five year linkage.
We've actually updated it now and
we have it through 2021 incredibly
high quality and with Medicaid
this was 93% overall,
but Medicaid it was 98%.
They were our best data and then we
found that the APCD was reliable with treatment and insurance status. When we went through and really tried to look at the quality of the APCD data, we were new to this. If we had used the cancer registry alone, we know that there are going to be problems and all of you know as well that they collect data of individuals diagnosed with cancer including patient and tumor level diagnosis at date at both date and stage. The outpatient treatment includes oral agents we know are under reported in cancer registries.
It’s just tough to get that data. Registries record the first course of cancer directed treatment, and Medicaid and rural residence treatment data appear to be incomplete. And it’s funny. Our beautiful state of Colorado, most of the populations kind of in Denver through what’s called the Front Range, Denver up through Fort Collins. And then there’s the Rocky Mountains and the rest of the state, which is pretty far-flung. And so the state is mostly rural and frontier. And when we think about Colorado,
we think Aspen and Vail.
And by the way,
they're rural counties as well,
really different outcomes than
your typical rural county,
as you might imagine.
And those particular places.
And then the rest of the state
being very rural except for Denver,
and we're the only comprehensive
Cancer Center and getting to us
can be quite complicated.
And you have to sort of think
through all of those things.
When you use our particular cancer registry,
we know insurance data are incomplete
and in fact it’s overwritten in
the hospitals that record it.
So you get the insurance at the time of
when it’s reported, which can change.
You can come in uninsured,
get Medicaid, pick it up or privately
insured and lose your insurance.
And we know that it’s more
than two years old,
whereas APC data is getting
pretty real time claims data in
it’s able to overcome some
of these limitations because
you get all medical claims,
pharmacy claims, dental claims,
NOTE Confidence: 0.868853958571428
00:32:20.880 --> 00:32:22.470 eligibility and provider
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00:32:22.470 --> 00:32:25.198 files and you can link them.
NOTE Confidence: 0.868853958571428
00:32:25.200 --> 00:32:27.720 You get you get a unique identifier.
NOTE Confidence: 0.868853958571428
00:32:27.720 --> 00:32:30.856 So I know when someone moves from
NOTE Confidence: 0.868853958571428
00:32:30.856 --> 00:32:33.148 private to Medicaid or the other
NOTE Confidence: 0.868853958571428
00:32:33.148 --> 00:32:35.360 way around and you’ll be able to
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00:32:35.438 --> 00:32:38.020 tell all payer claims data is
NOTE Confidence: 0.868853958571428
00:32:38.020 --> 00:32:40.200 really some claims of some payers.
NOTE Confidence: 0.868853958571428
00:32:40.200 --> 00:32:42.248 To be completely honest,
NOTE Confidence: 0.868853958571428
00:32:42.248 --> 00:32:45.320 not all payers are in there.
NOTE Confidence: 0.868853958571428
00:32:45.320 --> 00:32:48.128 Payers covered under ARISA are not
NOTE Confidence: 0.868853958571428
00:32:48.128 --> 00:32:50.742 required to submit claims and that’s
NOTE Confidence: 0.868853958571428
00:32:50.742 --> 00:32:53.339 about 30% of payers oddly enough in
NOTE Confidence: 0.868853958571428
00:32:53.339 --> 00:32:55.879 Colorado most of them voluntarily do so.
NOTE Confidence: 0.868853958571428
00:32:55.880 --> 00:32:58.305 So we having somewhat neat
NOTE Confidence: 0.868853958571428
near complete data,
we can look at a cross and in our state it includes 36 commercial payers.
Our main managed care payer happens to be Kaiser and Medicaid and Medicare.
Our cohort or women ages 21 to 63, we wanted to get them before they aged into Medicare and to see this cleanest Co group,
the cleanest sample we could find,
the CR summary stage of local or regional breast cancer,
enrolled in Medicaid or private insurance at the time of diagnosis,
had continual coverage within three months of diagnosis and continuously enrolled in nine months.
So I intentionally wanted to get those who’ve been in Medicaid sometime prior to diagnosis. We already know there’s a problem with those who come in late. Let’s look at the continuous coverage people now and compare them to our gold standard, hopefully of privately insured individuals and see what happens. So able to control for this and then for those who were supposed to receive radiation therapy, they had breast conserving surgery and for hormonal therapy it was women who had surgery and also...
had estrogen receptor positive or progesterone receptor positive cancer.

Our methods, what is descriptive statistics the standard of what you would expect. We used a follow up time of nine months following the month of last surgery as our observation period. In this data set, 93% of all surgeries regardless of insurance occurred within three months of diagnosis and that gave us a total follow up time of 12 months to look at whether or not they received these therapies, estimated logistic regression and reported marginals for ease of interpretation.
And then we compared what we saw if we used registry alone, if we used APCD or if we use them both what kinds of treatments they got and did a sensitivity analysis because one of the arguments is that those insured by Medicaid takes longer for them to get their surgeries, they can’t get in complicated lives, all those things. So we increased our follow up time to make sure, but we still saw no statistically significant differences. And then we looked at poverty quartile.
and variables for clinician of whether the clinician was in a rural area, whether they practice there. And that ended up being really an important variable because if you’re in Aspen or Vail, chances are you’re going to figure out how to get to Denver and get your healthcare. But if the clinician treating you is in a rural area means that you are, you are a person who can’t get to Denver and is your care going to be different. So that ended up being a really interesting part of our analysis as well.
there are big differences now and
the reporting between Medicaid
and private to the registry,
the registry actually doesn’t
pick up nearly the amount of
data that you see with the APCD.
The APCD is adding a big chunk
of claims that the registry never
sees on treatment that’s coming in.
So people who are Medicaid providers
aren’t reporting as much of the registry.
They’re either in places that don’t
have systems in place or that they
don’t have the resources to be
able to get it to the registry.
But there’s not the kind of support that you get in the Denver and our University Hospital to the registry so huge under reporting that that we initially see that could lead you to a very different conclusion. If we used our cancer registry alone, we saw that women insured by Medicaid were four percentage points less likely to receive radiation therapy than privately insured women. When we add APCD data in, there are no differences.
And now I’ve got this group of people who are continuously insured. I’ve got a state with some geographical challenges to say the least, and I’m not seeing differences when I’m using claims data. Hormonal therapy would do the same thing, 10 percentage point difference in Medicaid. Insured women less likely to receive hormonal therapy. But when we bring in our claims data and can look at the actual pharmacy claims, there’s no difference. They’re still getting the same treatment as our privately.
insured cohort once they get in.

So now this gives us a different look and a different view about these disparities of and when we can get this data and have a true control group. And these comparisons even after beating up on the data with our sensitivity analysis, we still find the same kind of results. At the end of the day, we end up seeing that despite the fact that there are differences at disease, at the stage of disease at diagnosis, we really are seeing under reportment or reporting of treatment. And we tried to figure out whether that was just the provider,
whether it was the location they were in and in a far-flung part of the state. But there is under reporting and some of the when we cared and compared to the cancer registry, APCD has some under reporting as well, but it was so much less and they were able to pick up these Medicaid claims. So disparities were only observed when using the cancer registry alone. This has serious implications for if you rely on, if you go out. And SEAR is no different. When we did the SEAR Medicaid linkage, we the agreement between whatever SEAR.
had as the insurance was entirely different.

And as some of you may know,

SEAR no longer reports insurance data because it’s so terribly unreliable.

But if those are the kind of data that you’re using to do disparities research,

there’s both incorrect data about what the actual insurance carrier is and the data they have are greatly under reported.

If it’s like what we observed in Colorado,

there are limitations.

Colorado is 1 state and as I said at the beginning,

there are 50 different Medicaid programs.

There is something unique
00:39:50.860 --> 00:39:52.240 about our Medicaid program.
00:39:52.240 --> 00:39:53.717 We are a fee for service state,
00:39:53.720 --> 00:39:55.144 not a managed care,
00:39:55.144 --> 00:39:57.280 which is unusual across the state.
00:39:57.280 --> 00:39:59.576 That made us though feel even more
00:39:59.576 --> 00:40:01.279 comfortable with our claims data
00:40:01.280 --> 00:40:03.996 because it is mostly fee for service.
00:40:04.000 --> 00:40:05.720 The sample and omitted women
00:40:05.720 --> 00:40:07.440 who did not receive surgery,
00:40:07.440 --> 00:40:09.312 although 93% of the women in
00:40:09.312 --> 00:40:10.560 our sample received surgery,
00:40:10.560 --> 00:40:12.480 so there probably wasn’t
00:40:12.480 --> 00:40:14.400 a disparity there either.
00:40:14.400 --> 00:40:17.196 We didn’t look at treatment completion.
00:40:17.200 --> 00:40:19.222 And didn’t measure the amount of
00:40:19.222 --> 00:40:21.360 treatment that would be a next step.
NOTE Confidence: 0.928597327857143
00:40:21.360 --> 00:40:23.117 And then as I also mentioned ERISA,
NOTE Confidence: 0.928597327857143
00:40:23.120 --> 00:40:24.880 cover plans are not required,
NOTE Confidence: 0.928597327857143
00:40:24.880 --> 00:40:27.694 but about half of them do voluntarily
NOTE Confidence: 0.928597327857143
00:40:27.694 --> 00:40:30.200 in Colorado for whatever reason.
NOTE Confidence: 0.928597327857143
00:40:30.200 --> 00:40:32.036 So here’s where we ended up.
NOTE Confidence: 0.928597327857143
00:40:32.040 --> 00:40:34.600 Medicaid does a better job than we think.
NOTE Confidence: 0.928597327857143
00:40:34.600 --> 00:40:37.155 The disparities are not quite as great.
NOTE Confidence: 0.928597327857143
00:40:37.160 --> 00:40:39.584 The evidence does suggest the need
NOTE Confidence: 0.928597327857143
00:40:39.584 --> 00:40:41.772 for continuous coverage and I think
NOTE Confidence: 0.928597327857143
00:40:41.772 --> 00:40:43.716 this last point is pretty important,
NOTE Confidence: 0.928597327857143
00:40:43.720 --> 00:40:46.276 need to support the data infrastructure.
NOTE Confidence: 0.928597327857143
00:40:46.280 --> 00:40:47.880 We are providing the data
NOTE Confidence: 0.928597327857143
00:40:47.880 --> 00:40:49.160 that policy makers use.
NOTE Confidence: 0.928597327857143
00:40:49.160 --> 00:40:51.869 And in some States and I’ve heard
NOTE Confidence: 0.928597327857143
00:40:51.869 --> 00:40:53.799 this state stated in Texas,
the reason they haven’t expanded Medicaid as well. It’s just crappy coverage. We want to do something else, but they don’t really have a good alternative or any alternative to Medicaid and the data don’t really support that conclusion. We don’t provide the continuous coverage. So next steps really is replicate somebody else to do the similar kind of things somewhere else and for us to look at other sites of cancer. If we continue to do this.
None the less we have built a body of evidence that I think supports the policy form of both Medicaid expansion and in fact to have continuous coverage and to increase our data infrastructure so that we provide the right evidence for policy makers to use.

Thank you all.

Thank you for your time, attention and I think we’re at the stage of let’s talk, thank you so much for this really important talk, especially the conclusion that being covered by Medicaid is associated with similar
outcomes as private insurance.

And I'd like to hear you discuss a little bit more how to inform policy changes with Medicaid expansion in some of those states. Like is this data enough or if you show that has to occur in other states as well, how can we get the states that don’t have Medicaid expansion to expand? Yeah. I mean it’s it’s interesting I mean it’s it’s interesting I how there can be an argument at this point against expansion and not being having some care and being able to get into the system is so critically important and to be able to show this.
And our Lieutenant governor and both our Governor and Lieutenant Governor are very much about healthcare and making it affordable. The Lieutenant Governor has the awkwardly named office of saving people money in healthcare. Literally. I mean it’s just like really anyway. But she has this office and really pays attention to this kind of evidence. And she herself is a four time cancer survivor that she says all the time. And she visits our Cancer Center, and she is on our Advisory Board.
00:43:21.400 --> 00:43:23.843 comes in and she is always talking

00:43:23.843 --> 00:43:25.513 about the affordability of healthcare

00:43:25.513 --> 00:43:27.729 and access and for us to be able

00:43:27.794 --> 00:43:28.878 to show this data,

00:43:28.880 --> 00:43:30.765 she was completely on board

00:43:30.765 --> 00:43:32.273 and resonating with it.

00:43:34.440 --> 00:43:37.005 the civic they organization that

00:43:37.005 --> 00:43:40.679 manages it and wants it to be used.

00:43:40.680 --> 00:43:42.282 If you’re in a state where

00:43:42.282 --> 00:43:44.040 that’s just not your philosophy,

00:43:44.040 --> 00:43:46.077 you know where you don’t believe data,

00:43:48.480 --> 00:43:50.580 where you don’t trust the data,

00:43:50.580 --> 00:43:53.560 to reduce the public safety net,
it sometimes feel like there's just not enough evidence.

But I think we have to keep trying and that's our job,

to be able to keep putting this out in front.

When we started this part of the project,
it really was that tedious validation component that we all do.

And then it became the story like, wait a minute,

we're not seeing any differences we expected to, but we're not.

And then even when I mentioned this to true believers at the National Cancer Institute that runs the SEER registry,

they said,
well, are you just getting the claims later or do they eventually show up in the Medicaid or in the cancer registry? No, they never showed up. Even when we expanded our linkage out to 2021, the people we saw being diagnosed in the earlier part of our cohort, their claims never made it to the registry. It just doesn’t come in. And providers who are doing care for large Medicaid populations, We don’t have the data infrastructure that’s being reported up.
And when I showed this to our cancer registrar in the state, he said, yeah, that sounds about right. We're, you know, wasn't actually a surprising finding to him. He says, yeah, we're trying to provide more support to these other providers that we know that need it. So the infrastructure is pretty important.

I have a question as a clinician, slightly different perspective. When we, when our patients get Medicaid or free care where we call it here, our team is just ecstatic because now we can actually get reimbursed. We can do the care as we
00:45:35.395 --> 00:45:37.940 would normally have it.
00:45:37.940 --> 00:45:41.216 So I think that that delay
to enrollment certainly resonates,
00:45:41.216 --> 00:45:42.880 but I think that once they get into
our system and then we can start to
hook them up with primary care and
all the things that they haven’t had.
00:45:50.160 --> 00:45:52.460 So that’s my perspective
in terms of that piece of it is
00:45:52.460 --> 00:45:54.980 we’re trying to provide the exact same
care as we do it as our other patients.
00:46:00.464 --> 00:46:03.960 Yeah, I agree with you completely
and I think that is the case in
institutions like ours, right.
You know, if you’re a private provider out in the community, especially way out in the community, you might be more sensitive to how many Medicaid patients you put on your panel. But I think what you described is very much the case. And you know, the key is being able to get them here and get them into these kind of centers where they’re going to get really good care. And they’re and we’ve actually done studies to show that if you go to an NCI designated center or even a COC designated center,
you’re going to get the same care.

Yes. So I first was going to follow up

Melinda’s comment about policy changes.

So I mean I I think what we’re all

agrees with our clinician perspective

is once the patient has Medicaid,

their treatment is similar at

least at a place like this.

So what kind of policy changes do can be

done to deal with that very compelling

data you have that the people who

the pre-existing enrollees do well,

the people who get diagnosed at time

who get insurance at Medicaid at
the time of diagnosis do less well.

What can you do to fix that? You know are states trying not to enroll people as proactively as they can because obviously that increased short term costs or is something we haven’t figured out how to enroll those patients?

Yeah, it varies a lot by state like everything else. So take Massachusetts, it has a very low uninsured baseline in pre ACA it had a very low baseline on insurance rate and they were one of
the first states to expand their Medicaid and offer a way to have insurance if you don’t qualify for Medicaid to be able to get into it. And ACA was modeled after it. So they tended to do a really good job, but they had a low baseline on insurance rates, so it didn’t cost them as much to begin with. If you’re in Alabama where it’s a state you don’t have a lot of resources and much of your population is uninsured, there’s not as aggressive approach to go out and get insurance. And Alabama is one of the states.
that have an expanded Medicaid,
not unsurprising.
So it’s more than I,
I it goes beyond the political philosophy,
but what’s the burden on the state
begin with and this is a state-run program,
those states are not as willing to
go out and be aggressive about it.
So Virginia just expanded not long ago and I,
they are really worried about the
out of the woodwork phenomenon that
if you offer Medicaid now all these
people who now know about the program
00:49:12.636 --> 00:49:15.340 are going to seek it and really
00:49:15.340 --> 00:49:18.040 increase it beyond what they thought.
00:49:18.040 --> 00:49:20.133 I don’t know that states have really
00:49:20.133 --> 00:49:22.159 seen a huge bump in that way.
00:49:22.160 --> 00:49:22.992 Just depends,
00:49:22.992 --> 00:49:26.920 A lot of it is going to be to and
00:49:26.920 --> 00:49:28.880 politically this is so hard to do,
00:49:28.880 --> 00:49:31.580 but it’s the nationalize these programs
00:49:31.580 --> 00:49:34.120 and standardize them across the board.
00:49:36.880 --> 00:49:39.718 Carrie, oh, sorry.
00:49:39.720 --> 00:49:42.918 Thank you so much for your.
00:49:42.920 --> 00:49:45.840 Thank you so much for your for your visit,
00:49:45.840 --> 00:49:49.112 talking for your body of work be assuring
00:49:49.112 --> 00:49:51.640 with regards to the the value of data
00:49:51.705 --> 00:49:53.839 and the importance of Medicaid question.
I just wanted to ask you to take a step back as someone who’s been working in this field typically. Medicaid for quite a while now. It’s just a troubling trend nationwide, 50% of all Medicaid beneficiary nationwide are now covered by a privately insured plan. One of there’s five companies, five 14100 companies or now basically managing their 50% of our many benefits. Yeah. Their revenues of those five companies range from 30 billion in Molinas, over 300 billion for United Healthcare. So just wanted to ask your thoughts about privatization of Medicaid and what’s driving it?
Yeah, I mean, so this comes back to that last slide around Replicate, right, and try to get those differences to see what privatization has actually done in these companies. And that’s a great question to be able to do it. And you know we can start if you get APC DS and registries across several States and be able to make exactly those comparisons because we can identify what insurance company it is and find...
all of that information out around.
I can look at whether they have a high deductible plan or not and be able to make these kind of comparisons and to be able to look at what’s happening in the Medicaid population.
Great question and I’m sorry, I didn’t see that you haven’t.
No, fine.
Thank you so much for all for all of this.
My question comes sort of to as we’ve seen some really impactful advances in, really impactful advances in,
you know, cancer surgery,
immunotherapy, targeted therapy.
What are sort of the methodologic
challenges to taking the same approach to something that maybe actually has a bigger impact on outcomes, but that is not as simple as did you get referred for radiation, but are these things going to be able to be approached from large databases or are you going to need you know more granular work in in single counties or something to address Great question I think and the reason we looked at hormonal therapy is because it’s oral outpatient therapy and we actually was looking at immunotherapy too.
But the sites of it, you know, we’re not a huge state in terms of population. And so when you get out into our rural areas and gets really teeny tiny. But immunotherapies, therapies in these oral treatments are really under reported to registries for obvious reasons. And you’re going to need to get these claims datas from other kinds of sources. So it’s. You’re right. As we make these in advances and they’re doing more and more in
00:52:57.605 --> 00:52:59.228 the outpatient setting. Yeah.

00:52:59.228 --> 00:53:02.276 The data challenges get much greater.

00:53:02.280 --> 00:53:04.134 Yeah. And Tim. Oh, looks like

00:53:04.134 --> 00:53:06.358 we have one on Zoom as well.

00:53:06.360 --> 00:53:08.480 How do you do it?

00:53:08.480 --> 00:53:09.040 I don’t even know.

00:53:09.040 --> 00:53:11.400 Where’s the mouse?

00:53:11.400 --> 00:53:12.000 There it is.

00:53:18.560 --> 00:53:20.312 That’s the only reason why a

00:53:20.312 --> 00:53:21.946 patient with the same socioeconomic

00:53:21.946 --> 00:53:24.394 status would say they will qualify.

00:53:24.400 --> 00:53:27.158 Yes, that with a known cancer diagnosis.

00:53:27.160 --> 00:53:29.680 The only reason. The question is,

00:53:29.680 --> 00:53:32.004 isn’t the key issue that in some

00:53:32.004 --> 00:53:33.812 states they known cancer diagnosis
00:53:33.812 --> 00:53:36.416 is the only reason why the patient 
NOTE Confidence: 0.699103258235294
00:53:36.416 --> 00:53:38.527 with the same socioeconomic status 
NOTE Confidence: 0.699103258235294
00:53:38.527 --> 00:53:41.035 was able to qualify for Medicaid? 
NOTE Confidence: 0.699103258235294
00:53:41.040 --> 00:53:43.614 So, and I don’t know for sure if I’m 
NOTE Confidence: 0.699103258235294
00:53:43.614 --> 00:53:45.360 interpreting your question correctly, 
NOTE Confidence: 0.699103258235294
00:53:45.360 --> 00:53:46.760 but first and foremost, 
NOTE Confidence: 0.699103258235294
00:53:46.760 --> 00:53:48.510 cancer is not a qualifying 
NOTE Confidence: 0.699103258235294
00:53:48.510 --> 00:53:49.679 condition for Medicaid. 
NOTE Confidence: 0.699103258235294
00:53:49.680 --> 00:53:50.895 Unless you’re diagnosed 
NOTE Confidence: 0.699103258235294
00:53:50.895 --> 00:53:52.515 through the CDC program, 
NOTE Confidence: 0.699103258235294
00:53:52.520 --> 00:53:54.158 cancer does not get you on Medicaid. 
NOTE Confidence: 0.699103258235294
00:53:54.160 --> 00:53:56.435 You still have to spend down if 
NOTE Confidence: 0.699103258235294
00:53:56.435 --> 00:53:58.231 you’re above the income requirements 
NOTE Confidence: 0.699103258235294
00:53:58.231 --> 00:54:01.215 to be able to get into the Medicaid 
NOTE Confidence: 0.699103258235294
00:54:01.285 --> 00:54:03.320 program or to have qualified all 
NOTE Confidence: 0.699103258235294
00:54:03.320 --> 00:54:05.120 along just simply not knowing it.
But for many people, there is a spend down period that they have to go through and get on to the program and then they get the coverage that they need. So the the SES, it's the same. If you meet that threshold within a state, you could be similar socioeconomic status but still have to spend down some assets to be able to bring in to the program. And I'm not sure if I answered that question exactly, but I hope so or if not, there's a follow up. Tim, great talk.
It’s more of a philosophical, political question. But with Medicare, you mentioned the importance of maybe having a nationalized program. Medicare, we had a nationalized, but Medicaid we don’t. Do you think there’s any fundamental differences between the programs that have prevented that? Or, you know, is there a path forward to getting a national approach to Medicaid? Yeah, I don’t know. Yeah. With it’s if you think of all the challenges to the ACA that’s already been,
I was a moderator for a panel with a National Cancer Policy Forum where we brought together for the 10 year anniversary of the ACA. And we were talking to Donna Shalala, the people who really were at the table when they crafted the ACA and brought it forward. And the answer was, we would not have compromised that when we ended up because we we compromised on so many places in the...
bill in hopes for bipartisan support.

And when it passed, it went right down party lines, not a single bipartisan vote. So their answer was the reason the ACA isn’t what we wanted it to be is because we compromised. If we did it again, we would not have done that because they were never going to play ball. So you’re going to have to have a different, you know, so it’s it’s a heavy lift. And I think the evidence that we provide and the care that we put in our research is so critical and that we keep just pushing that
we have really valid findings.

We're being more creative with our data.

We're finding this and putting it out there in hopes that there's an audience.

Well, thank you so much. I'd like to take.