

October 2017 APCD Data Release Notes

# Opening Statement

This release contains the following data:

* 2017 Q1 & Q2 Commercial data
* 2017 Q1 & Q2 MaineCare (Medicaid) data
* Q4 2016 Medicare data

**MHDO APCD Data Dictionary**

The MHDO APCD data dictionary has been developed as an interactive tool to assist data users with understanding the content, format and structure of the MHDO All Payer Claims (APCD) data sets. The data dictionary is designed to support users in:

* Improved navigation of the data elements
* Understanding relationships between data elements and which elements are included with each type of data release
* Access to underlying code sets

We are in the final stages of launching this new resource on the MHDO website and will send an announcement to data users by the end of the month (October 2017) announcing the launch.

**Substance Abuse and Mental Health Services Administration (SAMHSA)-Confidentiality of Substance Use Disorder (SUD) Patient Records, 42 CFR Part 2**

The Department of Health and Human Services (HHS) issued the final rule to update and modernize the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The regulations became effective as of March 21, 2017. In general, the 42 CFR Part 2 rule limits data shared about a substance use disorder (SUD) service by a Part 2 Provider as well as other lawful holders of data related to services rendered by Part 2 providers.

The original proposal the MHDO made to the payers (who are considered lawful holders of the data and are the entities that are required to comply with the provisions in Rule 42 Part 2) submitting data to the MHDO was to establish a uniform approach regarding the redaction of substance abuse claims that complies with the requirements in Rule 42 CFR Part 2. CMS/ResDAC has created a filter that identify the claim lines containing SUD related codes which are then suppressed prior to releasing Medicare claims files to the MHDO. A description of the policy and a listing of the codes used for redaction is found here: <https://www.resdac.org/resconnect/articles/203>

Unfortunately, due to the lack of clarity in the Rule and to date no endorsement from SAMSHA on the use of the CMS/RasDAC filter, payers are applying their own set of codes/filter to their data before submitting claims data to the MHDO. In some cases, payers are suppressing data that is not protected under this Rule.

**Impact of SAMHSA** **42 CFR Part 2 on MHDO Historical Claims Data**

The MHDO has applied the CMS/ResDAC filter to our historical claims data, which means we have removed any claim lines that have a code that is included on the redaction list. We leave any portion of a claim that doesn’t have those codes.

The MHDO is working with the National Association of Health Data Organizations and other States across the country to raise these issues and concerns specific to this rule with SAMSHA in hopes for some clarification on how best to proceed.

**Identification of Non-Continuing Self-Funded Groups or Employers**

MHDO data users raised the question about how best to do a trend analysis post Gobeille. While both the mix of self-funded ERISA plans included in the APCD as well as submissions for fully insured claims data varies over time (see the MHDO Payer Index) the Gobeille decision has created a much higher rate of deactivation.

MHDO has produced a file of MHDO Member IDs of individuals who were part of a self-funded ERISA employer group in the 2015/16 MHDO APCD that discontinued submitting claims data to the MHDO after the Gobeille decision. There are 271,002 distinct member IDs included in this file - you can flag these distinct member IDs in your 2015 and 2016 MHDO claims data if you are looking to create a 2015 data set (pre-Gobeille) that looks like 2016 (post Gobeille) data. Please note: The MHDO continues to reach out to self-funded ERISA employer groups to ask that they voluntarily submit their claims data to the MHDO. We are asking that if the employer agrees to voluntarily submit their claims data to the MHDO that they go back to the date their TPA stopped submitting data to the MHDO (in many cases December 31, 2015 was the last submission). As we discussed at the last data user group meeting, the list of member IDs may be a fluid list as self-funded employers decide to voluntarily submit data to the MHDO.

If you would like to obtain this list, please contact the MHDO at Webcontact.MHDO@maine.gov.

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# Documentation Included with This Release

The documentation included in this release:

1. MHDO’s Release Notes (this document)
2. MHDO’s 2017 Q2 Release Report
3. MHDO’s 2017 Q2 Payer Index
4. MHDO’s 2017 Q2 Validation Report
5. MHMC’s Methodology for Removing Duplicate Rx Claims

# Member Match to Eligibility

Overall, the match rate (which represents the percentage of claims that have a matching eligibility record for the member) is high for all claims. Information on these match rates can be found in MHDO’s 2017 Q2 Release Report.

**Medical Claims File**

The overall match rate for the medical claims file is 99.1%.

**Dental Claims File**

The overall match rate for the dental claims file is 98.8%.

**Pharmacy Claims File**

The overall match rate for the pharmacy claims file is 96.2%.

Cigna Health and Life Insurance Company. (C0025) have low matched record and claim counts (less than 50%). This is due to the missing C0025F data noted in the Missing Data and Other Data Observations section of this document.

Note: This submitter represents less than 2% of pharmacy volume.

# Payer Specific Notes

**G0002 - Medicare**

As mentioned in previous release notes, starting with the 2013 eligibility data, MHDO has been populating the field ME912\_MHDO\_PRODUCT field based on the fields BENE\_MDCR\_ENTLMT\_BUYIN\_IND\_01-12 from CMS. The values provided in this field are Medicare specific and provide detailed information on Part A, Part B, and state buy-in. The values of these indicators are shown below:

* 0 = NOT ENTITLED
* 1 = PART A ONLY
* 2 = PART B ONLY
* 3 = PART A AND PART B
* A = PART A, STATE BUY-IN
* B = PART B, STATE BUY-IN
* C = PARTS A AND B, STATE BUY-IN

These indicators do not differentiate Medicare Advantage from traditional Fee-For-Service eligibility. In order to differentiate, starting with the Q1 2016 Medicare data, MHDO will be concatenating information from the BENE\_HMO\_IND\_01-12 fields to the values derived from the BENEMDCR\_ENTLMT\_BUYIN\_IND fields. This second character will indicate whether a beneficiary was enrolled in a Medicare Advantage plan during the month. The Values of this indicator are shown below:

* 0 = Not a member of an HMO
* 1 = Non-lock-in, CMS to process provider claims
* 2 = Non-lock-in, group health organization (GHO; MA plan) to process in plan Part A and in area Part B claims
* 4 = Fee-for-service participant in case or disease management demonstration project
* 5 = Not in documentation
* A = Lock-in, CMS to process provider claims
* B = Lock-in, GHO to process in plan Part A and in area Part B claims
* C = Lock-in, GHO to process all provider claims

The Medicare data included with this release has this additional indicator added. In order to make this information available to data users, the MHDO issued a ME912\_MHDO\_PRODUCT crosswalk along with the last data release that provided the new enhanced product code along with the following fields: ME910\_MHDO\_MEMBERID, ME004\_YEAR, ME005\_MONTH. This allows data users to link the new information to eligibility information they have already received. The crosswalk covers Medicare eligibility from Q1 2012 to Q4 2015.

**C0549 & C0744 - Martin’s Point**

As of January 1, 2016, Martins Point Generations LLC (C0549) reorganized resulting in a change to both the name of the entity and MHDO-assigned number. Martins Point Generations LLC (C0549) is now Martin's Point Generations Advantage Inc (C0744). All instances of payer code C0549 populating the payer and/or submitter fields for eligibility, medical and/or pharmacy files submitted by Martin’s Point (C0549) and its PBM/TPA CaremarkPCS (T0005) for 2016 and 207 paid dates were replaced with payer code C0744.

**C0010 & C0011 – Aetna**

Aetna is reporting ICD codes to the MHDO but not as they appear on the incoming claims. Aetna is working on a new data store which will allow them to capture the ICD codes and submit to the MHDO as they appear on the incoming claims. This should be completed late 2017/early 2018. The information below details how Aetna is reporting ICD-10 codes in the interim.

| **Data Element** | **Notes** |
| --- | --- |
| MC200  | Will be populated with any ICD-10 code.   |
| MC202 | Will be populated with any ICD-10 code for inpatient facility claims only.  If there is only one ICD-10 code billed by the provider the code can be populated in both the MC200 and the MC202. Unable to distinguish the admitting versus principal diagnosis in our claims system.  |
| MC203 - MC205 (Reason Codes)  | It would be reasonable if Aetna leaves these three fields null in the data. |
| MC206  | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200. |
| MC208 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, or MC206. |
| MC210 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206 or MC208. |
| MC212 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, or MC210. |
| MC214  | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, or MC212. |
| MC216 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, or MC214. |
| MC218  | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, or MC216. |
| MC220  | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, or MC218. |
| MC222 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, or MC220. |
| MC224 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, or MC222. |
| MC226 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, MC222, or MC224.                                             |
| MC228  | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, MC222, MC224, or MC226. |
| MC230 - MC252 | Not available in our data as it does not downstream to our adjudication system. |
| MC254 – MC274 | Other diagnosis fields will be populated with any ICD-10 code that has not already been populated in fields MC200, MC202 or MC206 through MC228.  |

# Missing Data and Other Data Observations

Refer to the MHDO Payer Index for more information about payer submitter deactivations and data end dates. As a reminder of our data release policy, we typically don’t release claims data if the supporting eligibility file was not submitted for a particular reporting period.

## Medical Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) did not submit Q4 2016, Q1, or Q2 2017 Medical Claims data. We are working with them to determine if their self-funded ERISA client will continue to submit data to the MHDO on a voluntary basis. This payer has approximately 17,000 medical members per month which represents less than 3% of commercial medical volume.

Meritain Health (T0385) is missing May 2017 data. The file has been submitted but was not in a passed status in time for this release. It will be part of the Q3 2017 release. This payer has approximately 1,800 medical members per month which represents less than 1% of commercial medical volume.

North America Administrators LP (T0508) is missing April – June 2017 data. The MHDO is working with the payer to determine if future submissions are expected. This payer has approximately 1,300 medical members per month which represents less than 1% of commercial medical volume.

**Mandated Submitters:**

Arcadian Health Plans (C0493) and Humana Insurance Company (C0152), Medicare Advantage claims, are missing February and March 2017 data. The missing files are expected be part of the Q3 2017 release. These payers have approximately 4,800 medical members per month which represents less than 1% of commercial medical volume.

## Dental Claims File

**Voluntary Submitter:**

Meritain Health (T0385) is missing June 2017 data. The file has been submitted but was not in a passed status in time for this release. It will be part of the Q3 2017 release. This payer has approximately 600 dental members per month which represents less than 1% of commercial dental volume.

## Pharmacy Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) did not submit Q4 2016, Q1, or Q2 2017 Pharmacy Claims data. We are working with them to determine if they will continue to submit data to the MHDO on a voluntary basis. This payer has approximately 15,000 pharmacy members per month which represents less than 2% of commercial pharmacy volume.

North America Administrators LP (T0508) is missing April – June 2017 data. This payer has approximately 1,300 pharmacy members per month which represents less than 1% of commercial pharmacy volume.

**Mandated Submitters:**

As previously reported, Cigna Health Spring (C0025F) is missing 2015, 2016 and January – June 2017 Part D Medicare data. All missing data for 2015, 2016, Q1 2017 and Q2 2017 are expected to be part of the Q3 2017 release. This payer has approximately 1,800 pharmacy members per month which represents less than 1% of commercial pharmacy volume.

Envision Insurance Company (C0713) is missing May and June eligibility data: Their Q2 file only contains April records. We are working with the submitter to resubmit. This payer has approximately 4,300 pharmacy members per month which represents less than 2% of commercial pharmacy volume.

# Other Release Reports

1. Release Report

This report provides a summary by payer and file type of all the data included in this release (Release Summary Pivot worksheet). It also contains worksheets by each claim type (DC, PC, and MC) on the match rate to the eligibility file. This report is produced with each quarterly release.

1. Payer Index

This release includes a new Payer Index. Previously, with each release we had included a Payer Activation/Deactivation Report that summarized some information collected in our portal registration system but it only included those payers with recent activity. The Payer Index expands this information to include information for all payers.

1. Validation Report

This report lists all validations that incoming data is checked against, and indicates accuracy by payer (payer codes as defined in the APCD Payer table). This report is produced with each quarterly release.

1. MHMC’s methodology for removing duplicate Rx Claims

This document details one user’s methodology for removing duplicate pharmacy claims.