

February 2018 APCD Data Release Notes

# Opening Statement

This release contains the following data:

* 2017 Q3 Commercial data
* 2017 Q3 MaineCare (Medicaid) data

**MHDO APCD Data Dictionary**

The MHDO APCD data dictionary is 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

The data dictionary is available at <https://mhdo.maine.gov/mhdo-data-dictionary/>

**Note: The next three issues were included in the October 2017 APCD Data Release Notes. We are also including them here due to their critical importance.**

**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 42 CFR 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 42 CFR Part 2. CMS/ResDAC has created a filter that flags and suppresses claim lines containing SUD-related codes prior to releasing Medicare claims files to the MHDO. A description of the policy and a listing of the codes used for redaction are 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/filters 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 issues and concerns specific to this rule with SAMSHA in hope of 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 the mix of claims for self-funded ERISA plans and fully insured included in the APCD 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 an employer agrees to voluntarily submit claims data to the MHDO that it go back to the date its 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, since 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 Q3 Release Report
3. MHDO’s 2017 Q3 Payer Index
4. MHDO’s 2017 Q3 Validation Report
5. MHDO’s APCD FAQ
6. 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 Q3 Release Report.

**Medical Claims File**

The overall match rate for the medical claims file is 98.2%.

**Dental Claims File**

The overall match rate for the dental claims file is 98.7%.

**Pharmacy Claims File**

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

First Health Life & Health Insurance Company (C0177) has a low match rate (less than 75%). This is due to individuals (based on name and DOB) for whom the eligibility contract number and the claim contract number differ. First Health will be resubmitting June – September data for inclusion in the Q4 2017 release. This payer has approximately 2,700 pharmacy members per month, which represents less than 1% of commercial pharmacy volume.

# Payer Specific Notes

**C0065 – Anthem**

Anthem’s supplemental data is being sent correctly as of August 2017, but there are issues in the January 2015 through July 2017 data that needed to be addressed.

1. Medicare Part C and Medicare Part D data not populated accurately beginning in 2015. Medicare Part D is missing from eligibility files, and Part D claim data decreases over the first 11 months of 2015 before dropping off completely in December 2015.
2. ‘SP’ Medicare Supplemental eligibility record volumes ceased as of January 2016, and SP claims volumes ceased as of July 2015.
3. Indemnity, ‘IN’, eligibility volumes increased significantly beginning in January 2016.
4. Medicare Advantage products mapped to product type codes HM or PR.

Anthem has resubmitted supplemental files to fill the reporting gaps and provided logic to recode Medicare Supplemental and Medicare Advantage members in historical files. These issues will be addressed as part of the Q4 2017 release.

**T0005 - Caremark**

September 2017 eligibility is 29.5% lower than average for January-August 2017 and Sept 2017 pharmacy claims are 9.5% lower than average for the same period. Although the drop in membership appears significant, please remember that Caremark may no longer be submitting claims data directly on behalf of payer clients (like Aetna) that have large Maine-based employers likely to opt into submission of their data to Maine’s APCD.

**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) has not submitted Q4 2016, Q1, Q2 or Q3 2017 Medical Claims data. We are working with them to submit self-funded ERISA client data on a voluntary basis. This payer has approximately 17,000 medical members per month, which represents less than 3% of commercial medical volume.

North America Administrators LP (T0508) is missing April – September 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:**

Maine Community Health Options (C0726) is missing July 2017 data. We are working with the submitter to get these data submitted. This payer has approximately 39,000 medical members per month which represents approximately 5% of commercial medical volume.

## Dental Claims File

No missing data.

## Pharmacy Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) did not submit Q4 2016, Q1, Q2 or Q3 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 – September 2017 data. This payer has approximately 1,300 pharmacy members per month, which represents less than 1% of commercial pharmacy volume.

**Mandated Submitters:**

Cigna HealthSpring (C0025F) is missing February – September 2017 Part D Medicare data. All missing data are expected to be part of the Q4 2017 release. This payer has approximately 1,800 pharmacy members per month, which represents less than 1% 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 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. With each previous release, we included a Payer Activation/Deactivation Report that contained select information from our portal registration system but only included payers with recent activity. The Payer Index now contains additional information for all payers.

1. Validation Report

This report lists all validations that incoming data are 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.

1. Frequently Asked Questions

This resource on the MHDO website is available to answer questions about the APCD: [https://mhdo.maine.gov/faqs\_data.html#apcd data](https://mhdo.maine.gov/faqs_data.html%23apcd%20data)