

Data User Feedback: Data Elements/Structure

MHDO has received data user feedback and recommendations from a variety of sources. This document provides a high-level summarization of this feedback with the goal of prioritizing the issues that have been raised and what additional information is needed to allow MHDO to determine future changes or enhancements that would help address these concerns. No attempt has been made to resolve any inherent contradictions between items that may arise and no judgment has been made on the relative merit of the various issues.

A summary of the key issues raised and potential questions appears below. This is followed by a table listing all of the summary feedback items and source of each.

# Data Elements/Structure

These feedback items involve recommendations to add, remove or change the current required data elements or data file(s) structure/format.

## Key Issues

* Need for consistent set of data elements and formats between states
* Need to restrict collection to only elements required to pay claims; other information would be better gathered from other sources; only require submitters to pass through non-payment-related fields
* Need to produce prioritized list of data elements
* Lack of NPI and inconsistent provider name format makes identifying physicians difficult; the use of NPIs other than the servicing provider or inaccurate NPIs
* Paid amounts for Medicaid data not reflecting true costs due to prospective payments
* Lack of claim or service level cost information for capitated HMO services and other special payment arrangements such as bundled or DRG payments.
* Lack of race/ethnicity, patient lifestyle and behavior information
* Lack of clinical outcome measures, lab results, radiology results, CPT Category II codes
* Changes necessary for ICD-10 and HIPAA 5010 initiatives
* Need for metadata
* Problems with maintaining the integrity of IDNs between feeds for Medicaid claims
* Inconsistent bundling of Medicaid and commercial data

## Questions

* What metadata would end users find most valuable; what formats would they find most useful

# Feedback Summary Table

| Category | Description | Source |
| --- | --- | --- |
| Data Elements/ Structure | Lack of NPIs for easily identifying physicians. We had to go through a painful mapping process using physician names. The provider name data is also not consistently and accurately in the format of first, middle, and last name and is sometimes written as last name, first name and other formats.  | Amy Marr and Michael Boyd, MaineHealth |
| Data Elements/ Structure | Paid amounts on the Medicaid data in 2011 and 2012 are impacted by prospective interim payments. True costs then needed to be imputed in order to use the data. | Amy Marr and Michael Boyd, MaineHealth |
| Data Elements/ Structure | No or limited outcome data (lab results, radiology results, or CPT Category II code) for clinical outcome measures | Deloitte Report |
| Data Elements/ Structure | No or limited race/ethnicity information for disparity study | Deloitte Report |
| Data Elements/ Structure | No or limited patient lifestyle or behavior data like smoking, drinking, exercising, etc.  | Deloitte Report |
| Data Elements/ Structure | Lack of cost data at claim/service level for capitated HMO services | Deloitte Report |
| Data Elements/ Structure | Premium cost is not available in claims data | Deloitte Report |
| Data Elements/ Structure | Another issue that is impacting all the stakeholders pertains to National Provider Identifier (NPI) not available for servicing providers on all the claims. This impacts the overall analysis of claims data.  | Deloitte Report |
| Data Elements/ Structure | Being ready for ICD-10 and HIPAA 5010 initiative. | Deloitte Report |
| Data Elements/ Structure | There is also no metadata repository being maintained. | Deloitte Report |
| Data Elements/ Structure | IDN field is the unique record number in the MHDO claims data feeds. However, in the historical Medicaid data feeds (prior to the newest batch covering quarterly periods from 1/1/2011 to 12/31/2012) we observed different IDNs being used for the exact records, which caused problems in our de-duplication process. IDNs weren't kept unique for some of the Medicaid claim records. | Gokhan Cakmakci, MaineHealth |
| Data Elements/ Structure | Sporadically having Medicaid Data bundled with Commercial data, and sometimes as standalone files. This is causing processing efficiency issues on our side (in addition to duplicates stated in number one above). | Gokhan Cakmakci, MaineHealth |
| Data Elements/ Structure | Limited outcomes data such as labs and radiology results. | LD 1818 Work Group Report |
| Data Elements/ Structure | Lack of costs data at the claims/service level for capitated services or other special payment arrangements such as bundled payments or DRG payments.  | LD 1818 Work Group Report |
| Data Elements/ Structure | NPI issues – NPI not available for all servicing providers on claims, NPI “confusion” between individual practitioners and billing practices, inaccurate NPIs on claims. Carriers may not need an NPI.  | LD 1818 Work Group Report |
| Data Elements/ Structure | Support broad based agreement among the states on a consistent set of data elements and formats for collection. Greater harmonization will enable increased automation through system programming increasing timeliness and efficiency. From a research and data integrity perspective, it also allows better comparisons across states, regions and populations. | LD 1818 Work Group Report |
| Data Elements/ Structure | Data submissions from carriers should be limited to those elements utilized by carriers for the payment of claims. Seek out the best access point for additional data. For example, carriers do not typically need the middle initial of a provider’s name in order to pay claims. It makes more sense to collect this information directly from providers. For non-payment essential fields, submitters should be only required to pass through what the provider submits and not be required to interpret, correct or enhance provider submitted fields.  | LD 1818 Work Group Report |
| Data Elements/ Structure | Maine should consider whether there are some data elements that are more important than others. Prioritizing data elements would help the parties focus on those that are most important. Health information is needed by different constituents and different delivery rates. Patient data most frequent, analytical/financial data less frequently | LD 1818 Work Group Report |