

2016 APCD Data Release Notes

# Opening Statement

This release contains the following data:

* Calendar year 2016 (Q1 – Q4) Commercial data
* Q2 – Q4 2016 MaineCare (Medicaid) data
* Q3–Q4 2015 Medicare data.

**Impact on Data Volume Post Gobeille**

In a comparison of 2016 vs. 2015 data MHDO has maintained over 80% of the volume of medical, pharmacy and eligibility records. For each payer submitting data to the MHDO, we have produced a comparison of record counts for their 2016 data vs. their 2015 data found in MHDO’s 2016 Release Report. If a historical volume validation issue was triggered on submission of the data, we have included the payer’s rationale supporting their request.

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

Several data users have raised the question about how best to do an accurate 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 our activation/deactivation report) the Gobeille decision has created a much higher rate of deactivation. MHDO is evaluating the feasibility of providing information on members in the historical data that are associated with groups or plans that elected not to submit data post-Gobeille. Whether this information would take the form of new analytic datasets for trend analysis or member ID crosswalks has not yet been determined. MHDO will be discussing this issue with the APCD subcommittee of the Data User Group and will provide an update on this issue including next steps in May 2017.

**ICD-9 to ICD-10 Transition**

This release is the first major release of ICD-10 claims data. The Healthcare Cost and Utilization Project (HCUP) has published a Brief Into to ICD-10-CM/PCS Codes document that users may find helpful. The document is available here: <https://www.hcup-us.ahrq.gov/datainnovations/BriefIntrotoICD-10Codes041117.pdf>

**Default Values**

In compliance with MHDO Rule Chapter 120 by default, data releases will include county to identify the patients’ home addresses and age unless the additional data elements of city, state, zip code, and date of birth are specifically requested and approved by the MHDO.

**Payer Index**

This release includes a new MHDO Payer Index as defined by our data user group. Previously, with each release we included a Payer Activation/Deactivation Report that summarized basic information collected in our registration system but it only included those payers with recent activity. The Payer Index expands this information to include information for all payers.

Additionally, at the request of the data user group, the payer fields have been filled in with the name of the submitter when the payer name is not populated.

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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 2016 Release Report
3. MHDO’s 2016 Payer Index
4. MHDO’s 2016 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 this document: MHDO’s 2016 Release Report.

Note: These submitters represent less than 1% of dental and pharmacy volume.

**Medical Claims File**

The overall match rate for the medical claims file is 97.9%.

**Dental Claims File**

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

Union Security Insurance Company (C0182), CoreSource Inc (T0052), and Patient Advocates LLC (T0164) have a low match rate for records and claim counts (less than 50%). As of this release these payers are inactive.

**Pharmacy Claims File**

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

American Health Care Administrative Services Inc. (T0527) has a low matched record and claim counts (less than 50%). As of this release this payer is inactive.

# 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 does not yet have this additional indicator added. In order to make this information available to data users, the MHDO will be issuing a ME912\_MHDO\_PRODUCT crosswalk along with the next data release that will provide the new enhanced product code along with the following fields: ME910\_MHDO\_MEMBERID, ME004\_YEAR, ME005\_MONTH. This should allow data users to link the new information to eligibility information they have already received. The crosswalk will cover Medicare eligibility from Q1 2013 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 (001) and/or submitter (002) fields for eligibility, medical and/or pharmacy files submitted by Martin’s Point (C0549) and its PBM/TPA CaremarkPCS (T0005) for 2016 paid dates were replaced with payer code C0744.

**C0010 & C0011 – Aetna**

Pharmacy Claims: As of 1/6/2016 MHDO was formally notified that Aetna’s Pharmacy provider had inadvertently not submitted any of their pharmacy claims data for the 2015 Q1 and Q2 release. These data have been submitted and are included as part of this release.

Aetna is reporting ICD codes to the MHDO but not exactly as they appear on the incoming claims. Aetna has made every attempt to populate the ICD fields as accurately as possible. They are 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 the interim solution being used.

* 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 thru 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 thru 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

We have not created a Missing Data Report for this release as there are only two active payers (one a mandated and one a voluntary submitter) missing 2016 data (see below). Please consult the Payer Index for more information about deactivations and data end dates. As a reminder of our release policy, we typically don’t release a month of claims data if the supporting eligibility file was not submitted for that month.

**Medical Claims File**

Voluntary Submitter:

Geisinger Indemnity Insurance Company (T0552) did not submit Q4 2016 Medical Claims data. We are working with them to determine if they will continue to submit data to the MHDO on a voluntary basis.

**Dental Claims File**

None.

**Pharmacy Claims File**

Voluntary Submitter:

Geisinger Indemnity Insurance Company (T0552) did not submit Q4 2016 Pharmacy Claims data. We are working with them to determine if they will continue to submit data to the MHDO on a voluntary basis.

Mandated Submitter:

All 2016 pharmacy and eligibility claims for C0025F submitted by CIGNA HealthSpring (C0567) on behalf of CHLIC (C0025) are missing. A letter from the Attorney General’s office has been sent to CHLIC and HealthSpring requesting compliance with the MHDO law by June 1, 2017.

# 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. New to this release is a tab with a comparison of each submitter’s 2016 data vs. their 2015 data. If a historical volume validation issue was triggered on submission of the data, we have included the payer’s rationale supporting their request.

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.