# MCDB Payor Meeting

DECEMBER 16, 2015

# Overview

- Welcome and Introductions
- MCDB Use Cases
- Upcoming MCDB Deadlines
- 2016 Data Submission Manual
- Updates on MCDB Portal and ETL Development
- Payor Questions and Discussion
- Future Meetings

# Recent MCDB Use Cases

- **Legislative Reports**
  - Evaluation of Assignment of Benefits Legislation
  - Evaluation of Maryland Patient Referral Law
  - Annual reports on Health Care Spending and Payments for Professional Services
- **State Agency Decision Support**
  - Maryland Insurance Administration – Rate Review and Investigations
  - Maryland Health Benefit Exchange – Reinsurance and Tobacco Rating
- **Demonstration Program:** Maryland Multi-Payor Patient Centered Medical Home Program

# Active/Current MCDB Use Cases

- **Legislative Reports:** As requested and Annual Reports
- **State Agency Decision Support**
  - Health Services Cost Review Commission – Monitoring and Evaluation of Waiver and Total Cost of Care
  - Maryland Insurance Administration – Expand use of MCDB for Rate Review and Investigations
  - Medicaid – Studies of payment parity
- **Transparency Initiatives**
  - Industry Portal – pricing information for procedure codes and providers
  - Public Query Tool / Zip Code Public Use File – quick access to population-level statistics from MCDB
  - Consumer Portal – episode prices to drive consumer choice of providers
  - Provider Portal – testing and imaging prices to drive choice of referrals
  - Pilot of HealthPartners Total Cost of Care Measure – drive referrals and cost-effective care for primary care providers
- **Data Release** to qualified entities for qualified uses (e.g. academic research, evaluations of demonstration programs, hospital payment model support, etc.)

MHCC MARYLAND HEALTH CARE COMMISSION

# Upcoming Deadlines

- Timely (re)submission essential to meet MHCC obligations to legislature, state partners, and other stakeholders
- **Submission Deadlines for MCDB** Eligibility and Claims Files
  - 2015 Q3 – Deadline was November 30, 2015
    - Active review and feedback in progress
    - Timely resubmissions required, if needed
  - 2015 Q4 – Deadline is February 29, 2016
    - Extension and Format Modification deadline is January 31, 2016
- **CRISP Demographic File** for MPI Development – Deadline is January 15, 2016
  - Testing and onboarding is ongoing. Active engagement is essential
  - Ensure that the file submitted to CRISP includes all membership from all eligibility files for 2015
- **Annual Waiver** from reporting (individual files or complete waiver) – Deadline is January 15, 2016

# 2016 Data Submission Manual & MCDB Portal / ETL Update

Adrien Ndikumwami, Social & Scientific Systems

December 16, 2015

# 2016 DSM-Highlights of Changes

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# Eligibility: Changes to File Layout

- **New Fields**
  - Metal Level Plan Indicator – 100% Threshold
    - Indicate plan type under the Affordable Care Act (ACA)
    - Applies to Non-grandfathered Health Plans and Qualified Health Plans (QHPs) under ACA
  - Cost-Sharing Reduction Indicator
    - Indicate cost-sharing reduction under the Affordable Care Act (ACA)
    - Applies to Non-grandfathered Health Plans and Qualified Health Plans (QHPs) under ACA
    - https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-instructions-5-20-14.pdf (pages 8 and 9)

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# Professional Services: Changes to File Layout

- **New Fields**
  - National Drug Code (NDC)
    - 11-digit code.
    - Ensure leading zeroes are not dropped.
    - Expected to be populated when provider-administered drugs are involved in a claim.
  - Drug Quantity
    - Number of units of medication dispensed.
    - Value must be rounded to the nearest unit.
    - Expected to be populated when provider-administered drugs are involved in a claim.
- **Units of Service – Report rounded whole numbers instead of decimals.**

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# Institutional Services: Changes to File Layout

- Previously was claim-level records.
- NEW layout is line-level.
- Only 1 revenue code on each line.
- All diagnosis codes must be repeated across all lines for the same claim.
- Inpatient claims:
  - All procedure codes present on the same claim should be replicated for each line of the same claim.
- Outpatient claims:
  - Each line will have one revenue code or at least one CPT code. If no revenue code is available, the CPT code should be used to identify the claim line.

# Pharmacy: Changes to File Layout

- **Financial fields changed.**
  - Drop implied decimal format and round to whole numbers.
  - Financials should match format of other claims files.

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# Redundant Fields

- Exist on both eligibility file and claims file layouts.
- Are generally "plan characteristic" fields, not "claim/service" or "patient characteristics" fields.
- No longer required on claims files
  - Field must be included, but can be blank. Do not populate with "*", "N/A", etc.
- **The fields are required on eligibility files**
  - 100% threshold for every field.
- Examples:
  - Date of enrollment
  - Date of disenrollment
  - Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator
  - Coverage Type
  - Product Type
- Refer to the Data Submission Manual for complete list of fields and their required thresholds for each file type.

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# Patient ID Consistency

- Each enrollee should have the same encrypted Patient ID in every file for the same enrollee, across quarters and years.
- If the encryption of the patient ID must change, you must notify MHCC and provide crosswalks between old identifiers and new identifiers for every previously submitted ID.

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# Claims Versioning Fields

- **Helps estimate claim payment status at a certain period of time for analysis purposes.**
- **Located on claims files.**
- **Required starting with the 2015 data submission.**
- **Includes the fields:**
  - Claim adjudication date
  - Claim line number
  - Claim line type (O = original, V = void, R= replacement, B= Back Out, A = Amendment)
  - Former Claim Number – the original claim number previous to the claim number record, for the same exact services (same person, same date, same provider, etc.)
  - Flag for Former Claim Number Use *NEW*
    - 1 = Former claim number not used- claim control number does not change
    - 2 = Former claim number not used- new claim control number is generated
    - 3 = Former claims number used

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# Other Considerations

- **Linkage Between Files**
  - PATIDP and Dates of Service used to link claims and eligibility files.
  - Dates of Service in claim file should fall within coverage period in eligibility file.
  - Fields must link between files for all records.

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# 2016 Submission Schedule

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| 2016 Medical Care Data Base Submission Schedule | | | | |
|---|---|---|---|---|
| **MCDB Data Reporting** | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
| Reporting Period (Based on Paid Date) | 01/01/16 – 03/31/16 | 04/01/16 – 06/30/16 | 07/01/16 – 09/30/16 | 10/01/16– 12/31/16 |
| • Annual Waiver Request Due Date **Standard** | 01/15/2016 | 01/15/2016 | 01/15/2016 | 01/15/2016 |
| • Data Submission Begin Date *NEW* • "Pre-Submission" Format Modifications Request Begin Date | 4/1/2016 | 7/1/2016 | 10/1/2016 | 1/1/2017 |
| • Preliminary Data Submission Due Date *NEW* • "Pre-Submission" Format Modifications Request Due Date • Extension Request Due Date **Standard** | 04/30/2016 | 07/31/2016 | 10/31/2016 | 01/31/2017 |
| • "Post-Submission" Format Modifications Request Due Date *NEW* | 05/15/2016 | 08/15/2016 | 11/15/16 | 02/15/17 |
| • Final Data Submission Due Date **Standard** | **05/31/2016** | **08/31/2016** | **11/30/16** | **02/28/17** |

# MCDB Portal and ETL

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# Timeline of Data Quality Checks

- **Quarterly**
  - Tier 1 – File format and layout
  - Tier 2 – Field fill rate compared to thresholds and format modifications; field format consistency
  - Tier 3 – Cross-field validations, cross-report trends, evaluation by major categories (e.g. market, product, etc.)
- **Annual**
  - Consistency between members reported on eligibility file vs. CRISP demographic file. Added to quarterly checks in 2016.
  - Claims versioning, analysis of incurred volume. Added to quarterly checks in 2016
  - Comparison to benchmarks, e.g. MIA Actuarial Memoranda, MHBE reports, etc.

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# Tier 3 Data Quality Reports

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# Tier 3 Reports - Univariate

- Snapshot of financial and numeric fields (observations, records missing, descriptive statistics, etc…)
- Warnings should be addressed if highlighted fields do not match business expectations.

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# Tier 3 Reports - Univariate

| Source System | Source Company | Field Name | N | Missing | Minimum | P1 | P5 | P25 | Mean | Median | P75 | P9 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | HMO | Billed Charge | 47,571 | 0 | 0 | 2 | 10 | 42 | 218.22 | 100 | 180 | |
| A | HMO | Allowed Amount | 47,571 | 0 | 0 | 0 | 0 | 0 | 73.75 | 19 | 75 | |
| A | HMO | Reimbursement Amount | 47,571 | 0 | 0 | 0 | 0 | 0 | 53.25 | 0 | 33 | |
| A | HMO | Patient Coinsurance or Patient Co-payment | 47,571 | 0 | 0 | 0 | 0 | 0 | 4.18 | 0 | 0 | |
| A | HMO | Patient Deductible | 47,571 | 0 | 0 | 0 | 0 | 0 | 15.75 | 0 | 2 | |
| A | HMO | Other Patient Obligations | 47,571 | 0 | 0 | 0 | 0 | 0 | 0.57 | 0 | 0 | |
| A | HMO | Patient Liability = (Deductible + Copay + Other Obligations) | 47,571 | 0 | 0 | 0 | 0 | 0 | 20.50 | 0 | 20 | |
| A | HMO | Payment Amount = (Reimbursement + Patient Liability) | 47,571 | 0 | 0 | 0 | 0 | 0 | 73.75 | 19 | 75 | |
| A | HMO | Patient Age as of 12/31 of the submission year, Non-Rounded | 47,571 | 0 | 0.33 | 1.00 | 6.41 | 29.75 | 42.27 | 46.50 | 56.84 | |
| A | HMO | Length of service | 47,571 | 0 | 1 | 1 | 1 | 1 | 1.00 | 1 | 1 | |
| A | HMO | Units of Service | 47,571 | 0 | 0 | 0 | 0 | 0 | 1.29 | 1 | 1 | |
| A | Non-HMO | Billed Charge | 47,562 | 0 | 0 | 0 | 10 | 43 | 218.03 | 100 | 182 | |
| A | Non-HMO | Allowed Amount | 47,562 | 0 | 0 | 0 | 0 | 2 | 78.93 | 21 | 80 | |
| A | Non-HMO | Reimbursement Amount | 47,562 | 0 | 0 | 0 | 0 | 0 | 54.02 | 0 | 33 | |

# Tier 3 Reports – Data Summary Worksheet

- Comparison of values reported in fields between current year and previous year.
- Compares number of users, unique services, and total payments.

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# Tier 3 Reports – Data Summary Worksheet (cont'd)

| Source System | Category | Subcategory | Number of Users (Unique Patient Keys) | | | | Number of Services (Claim Records) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Q2 2014 | Q2 2015 | % Change Q2 2014 to Q2 2015 | Status | Q2 2014 | Q2 2015 | % Change Q2 2014 to Q2 2015 | Status |
| A | Coverage Type | 1. Medicare Supplemental (i.e., Individual, Group, WRAP) | | | N/A | | | | N/A | |
| | | 2. Medicare Advantage Plan | 4,072 | 3,797 | -6.75% | | 64,869 | 55,331 | -14.70% | Warning |
| | | 3. Individual Market (not MHIP; not sold in MHBE) | 2,026 | 312 | -84.60% | Warning | 16,136 | 2,690 | -83.33% | Warning |
| | | 4. Maryland Health Insurance Plan (MHIP) | | | N/A | | | | N/A | |
| | | 5. Private Employer Sponsored or Other Group (i.e. union or association plans) | 136,528 | 138,166 | 1.20% | | 1,251,904 | 1,206,526 | -3.62% | |
| | | 6. Public Employee – Federal (FEHBP) | 3,883 | 3,985 | 2.63% | | 31,014 | 32,798 | 5.75% | |
| | | 7. Public Employee – Other (state, county, local/municipal government and public school systems) | 36,175 | 28,399 | -21.50% | Warning | 352,386 | 275,634 | -21.78% | Warning |
| | | 8. Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] | 10,034 | 4,664 | -53.52% | Warning | 95,120 | 40,226 | -57.71% | Warning |
| | | 9. Health Insurance Partnership (HIP) | | | N/A | | | | N/A | |
| | | A. Student Health Plan | | | N/A | | | | N/A | |
| | | B. Individual Market sold in MHBE | | | N/A | | | | N/A | |
| | | C. Small Business Options Program (SHOP) sold in MHBE | 1,762 | 3,736 | 112.03% | Warning | 16,785 | 29,932 | 78.33% | Warning |
| | | X. Other | | | N/A | | | | N/A | |
| | | Z. Unknown | | | N/A | | | | N/A | |
| | Consumer Directed Health Plan Indicator | 0. No | 172,078 | 160,445 | -6.76% | | 1,632,817 | 1,452,000 | -11.07% | Warning |
| | | 1. Yes | 22,479 | 22,679 | 0.89% | | 195,397 | 191,137 | -2.18% | |
| | | X. Other | | | N/A | | | | N/A | |
| | Participating Provider Status | X. Other | 194,480 | 183,059 | -5.87% | | 1,828,214 | 1,643,137 | -10.12% | Warning |
| | Plan Liability | 1. Risk (under Maryland contract) | 24,587 | 21,364 | -13.11% | Warning | 248,506 | 199,482 | -19.73% | Warning |
| | | 2. Risk (under non-Maryland contract) | 18,355 | 20,330 | 10.76% | Warning | 168,014 | 180,028 | 7.15% | |
| | | 3. ASO (employer self-insured, under Maryland contract) | 151,721 | 141,471 | -6.76% | | 1,411,694 | 1,263,627 | -10.49% | Warning |
| | | 4. ASO (employer self-insured, under non-Maryland contract) | | | N/A | | | | N/A | |
| | | X. Other | | | N/A | | | | N/A | |
| | [illegible] | [illegible] | | | [illegible] | | | | | |

# Tier 3 Reports - Duplicates

- Utilizes duplicate keys to analyze for duplicate records within a file.
- Instances of duplicates can impact claims versioning process.

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# Tier 3 Reports – Duplicates (cont'd)

**Maryland Medical Care Data Base (MCDB)**
**Tier 2 Summary Duplicates Report**

P
2015, Quarter 3 ProfessionalServices

| Source System | Payer | Status | Threshold | Number of Records | Number of Violating Records | Violation Rate |
|---|---|---|---|---|---|---|
| A | P | | 5.00% | 97,112 | 4,267 | 4.39% |

**Tier 2 Professional Services Duplicate Key Details**

| Source System | Payer | Claim Control Number | Claim Paid Date | Service Thru Date | Servicing Practitioner Id | Procedure Code | Diagnosis Code | Billed Charge | Allowed Amount | Reimbursement Amount | Number of Records |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A | | 57 | 7/2/2015 | 5/1/2015 | | | | | | | |
| A | | 38 | 8/21/2015 | 7/1/2015 | | | | | | | |
| A | | 68 | 9/15/2015 | 8/1/2015 | | | | | | | |
| A | | 62 | 7/24/2015 | 6/1/2015 | | | | | | | |
| A | | 31 | 7/22/2015 | 6/1/2015 | | | | | | | |
| A | | 40 | 9/9/2015 | 8/26/2015 | | | | | | | |
| A | | 79 | 7/7/2015 | 3/1/2015 | | | | | | | |
| A | | 80 | 7/7/2015 | 4/1/2015 | | | | | | | |
| A | | 13 | 7/21/2015 | 5/1/2015 | | | | | | | |
| A | | 70 | 7/30/2015 | 7/21/2014 | | | | | | | |
| A | | 03 | 7/30/2015 | 6/1/2015 | | | | | | | |
| A | | 85 | 8/14/2015 | 7/1/2013 | | | | | | | |
| A | | 85 | 8/14/2015 | 7/1/2013 | | | | | | | |
| A | | 49 | 9/28/2015 | 3/27/2014 | | | | | | | |
| A | | 30 | 8/21/2015 | 7/3/2015 | | | | | | | |
| A | | 56 | 8/20/2015 | 4/6/2015 | | | | | | | |
| A | | 56 | 8/20/2015 | 4/6/2015 | | | | | | | |
| A | | 60 | 8/21/2015 | 7/2/2015 | | | | | | | |
| A | | 74 | 8/11/2015 | 6/1/2015 | | | | | | | |
| A | | 52 | 7/14/2015 | 4/1/2015 | | | | | | | |

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# Tier 3 – Consistency Summary

- **Analyzes fields using established business rules to find violations.**
  - Example 1: Claims paid date reported outside of reporting quarter.
  - Example 2: Coverage start date must be 1 unless it is the first record in the submission quarter.
  - Etc..
- **Detailed consistency reports also available on Portal.**
- **Fields that are analyzed differ between claims files and Eligibility file.**

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# Tier 3 Consistency - Claims

| Source System | Column Description | Status | Rule Description | Min or Max Threshold | Threshold % | # of Obs | # Triggering Rule | Rate % |
|---|---|---|---|---|---|---|---|---|
| A | | | | | | | | |
| | Claim Paid Date | | Claim Paid Date must be in the current quarter only | Min | 100.00% | 3,011,719 | 3,011,719 | 100.00% |
| | Service Thru Date | | % Records with Service End Date in any future quarter cannot be more than 0.1% | Max | 0.10% | 3,011,719 | 0 | 0.00% |
| | Service Thru Date | | % Records with Service End Date in any previous quarter cannot be less 20% | Min | 20.00% | 3,011,719 | 655,850 | 21.78% |
| | Claim Adjudication Date | | Claim Adjudication Date must be in the data submission manual quarter | Min | 100.00% | 3,011,719 | 3,011,719 | 100.00% |
| | Allowed Amount | | % in-network FFS services with Payment > Allowed Amount cannot be more than 5% | Max | 5.00% | 3,011,719 | 0 | 0.00% |
| | Allowed Amount | | % in-network FFS services with allow=0 or missing cannot be more than 1% | Max | 1.00% | 3,011,719 | 0 | 0.00% |
| | Claim Line Type | | Claim Line Type must have an adjustment value(V,R,B,A) for more than 0.1% | Min | 0.10% | 3,011,719 | 94,085 | 3.12% |
| | Claim Line Number | | Claim Line Number must be > 1 for more than 0.1% | Min | 0.10% | 3,011,719 | 1,703,475 | 56.56% |
| | Source System | | Source System in submitted file matches Source System specified by payer for submitted file. | Min | 100.00% | 3,011,719 | 3,011,719 | 100.00% |

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# Tier 3 Consistency - Eligibility

| Source System | Column Description | Status | Rule Description | Min or Max Threshold | Threshold % | # of Obs | # Triggering Rule | Rate % |
|---|---|---|---|---|---|---|---|---|
| A | | | | | | | | |
| | Start Date of Coverage | | Start Date of Coverage Must be Within the current Submission Quarter | Min | 100.00% | 1,507,840 | 1,507,840 | 100.00% |
| | Start Date of Coverage | | Coverage Start Date must be 1 unless it is the first record | Min | 99.90% | 1,507,840 | 1,507,840 | 100.00% |
| | End Date of Coverage | | End Date of Coverage Must be Within the current Sumbmission Quarter | Min | 100.00% | 1,507,840 | 1,507,840 | 100.00% |
| | End Date of Coverage | | Coverage End Date must be the last day of the month unless it is the last record | Min | 99.90% | 1,507,840 | 1,507,840 | 100.00% |
| | Eligdays | | Eligibility day cannot be less than 1 | Max | 0.00% | 1,507,840 | 0 | 0.00% |
| | Eligdays | | Eligibility day cannot be greater than 31 | Max | 0.00% | 1,507,840 | 0 | 0.00% |
| | PATIENT UNIQUE IDP | | Patient ID P must be consistent between quarters | Min | 80.00% | 521,092 | 484,825 | 93.04% |
| | PATIENT UNIQUE IDU | | Patient ID U must be consistent between quarters | Min | 80.00% | 519,343 | 483,542 | 93.11% |
| | Enrollee Identifier-P (Payor encrypted) | | Ratio of Unique Patients (based on the composite key) to Unique Patient ID P must between 0.99 to 1.01 | Range | 99.00% to 101.00% | 521,092 | 521,087 | 100.00% |
| | Source System | | Source System in submitted file matches Source System specified by payer for submitted file. | Min | 100.00% | 1,507,840 | 1,507,840 | 100.00% |

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# Payor Questions and Discussion

# Future Meetings