Draft Work Plan for Expanding the Content and Use of Maryland's *Medical Care Data Base (MCDB)* to Address New Information Needs

Maryland Health Care Commission (MHCC)

Center for Analysis and Information Services (CAIS)

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Introduction

With the advent of health care reform, there is an increased need for detailed information on health care utilization, the relationship between health care utilization and health plan benefit design, and quality of care. In response to the need for more information and new reporting requirements placed on the MHCC by the Maryland Legislature and other state agencies, such as the Maryland Insurance Administration (MIA) and the Maryland Health Benefit Exchange (HBE), the MHCC has developed a draft work plan for a new MCDB that ties new information/data needs to: revisions of the data collection rules including *expansion of the data submitted* to the MCDB and *frequency of data submissions*, and access to data/information contained in the MCDB. This report outlines the MHCC's proposed changes to data collection and data access in response to increased needs for information on health care access and utilization.

Background on Maryland's All-Payer Claims Database

In 1993, the Maryland General Assembly enacted health care reform legislation that included the creation of the Maryland Medical Care Data Base (MCDB), a data base of health care practitioner services obtained from health care insurance carriers and HMOs (payers) doing business in Maryland and who collect more than $1 million in health insurance premiums. It was intended that information on payments and services derived from the MCDB could be used to support the development of cost containment strategies and assist payers, policymakers, practitioners, and the public in health care decision-making. Details regarding the data elements to be submitted (and the submission formats) were to be determined by the Maryland Health Care Commission (MHCC, Commission) in data regulations. In response to the dramatic increase in prescription drug spending in the 1990s, these regulations were revised in October 1999 to include information on privately insured prescription drug spending and utilization, as permitted under the original legislation.

In 2007, the General Assembly passed House Bill 800 (HB 800), Maryland Health Care Commission – Program Evaluation, (2007 Laws of Maryland, Chapter 627), which reauthorized the Commission and its programs. The law expanded the types of information that could be collected as part of the Medical Care Data Base to enable the MHCC to provide a more complete picture of health care spending by private insurers. The MHCC created new regulations for the MCDB, which required payers to submit data on insurance eligibility, facility services (primarily hospital inpatient and outpatient information) and insurance product design. The MHCC has delayed the definition and submission of an insurance product design file in order to learn from the plan description requirements placed on carriers by the federal government under the ACA.

The MHCC has obtained Medicare data files for inclusion in the MCDB every year since 1995, when private payers began submitting their data. The research identifiable files (RIF) Medicare files contain beneficiary level protected health information (PHI). Requests for RIF data require a Data Use Agreement (DUA) and are reviewed by CMS's Privacy Board to ensure that the beneficiary's privacy is protected and the need for identifiable data is justified. The MHCC's current Medicare DUA is a research DUA and does not permit the MHCC to use the data for purposes other than those listed in our DUA or to share the data with other researchers.

Proposed Revisions of Data Collection Rules

X. Information Need(s) / *Barrier(s) / Proposed Solution*

A. Ability to assess the impact of the Assignment of Benefits legislation on patients, payers, and hospital-based and on-call physician specialties.

Barrier(s)

Currently the information submitted by carriers to the MCDB does not include information on whether or not the patient assigned benefits to the servicing physician for an out-of-network service. The absence of this information makes it impossible to determine the impact of assignment of benefits (AOB) for hospital-based physician services provided in hospitals on patients, payers, and the affected physician specialties, as required by the Maryland Legislature (due 12/2014).

Proposed Solution

1) Have private carriers submit a flag on professional service claims for out-of-network providers that will designate whether or not the patient assigned benefits to the out-of-network physician for this particular service. ***Needed in 2013 claims data.***

B. Complete information on spending for and utilization of health services covered by private insurance.

Barrier(s)

If a carrier makes payments to PCMH-based or ACO-based providers through lump sum payments rather than increased reimbursement for specific services attributable to unique patients, then the MCDB data will not fully reflect the amount of health care spending for services rendered by these providers.

If a self-insured employer carves out the pharmacy coverage or the behavioral health coverage from the medical services, then there is incomplete information on service use in the MCDB, which impacts other objectives in this work plan, including practitioner performance measurement. However, there needs to be a common patient identifier for the medical services and the carved out services in order for the services to be combined at the patient level.

Proposed Solutions

2) A new report/data file in the MCDB submission by carriers/payers with information on lump sum payments from carriers to providers as part of the carriers' compensation to the providers for non-claim-based services. This compensation would include non-claims-based payments to the providers for patient volume, care quality, and shared savings metrics.
   - ***WORK GROUP for Payer Reporting of Total Medical Expenses***
     The MHCC is forming a workgroup comprised of participants from carriers/payers, the Maryland Insurance Administration, the Maryland Health Benefit Exchange, etc., that will define this report/file. The starting point for this will be the "total medical expenses reporting" definition currently in use by Massachusetts. http://www.mass.gov/chia/researcher/hcf-data-resources/apcd/submitting-data-to-the-apcd.html
3) Obtain pharmacy claims for Maryland beneficiaries in self-insured employer plans from pharmacy benefit managers (PBMs) used by self-insured employers.
4) Obtain behavioral health claims for Maryland beneficiaries in self-insured employer plans from behavioral health companies used by self-insured employers.
5) Have private carriers submit demographic information on enrollees in fully-insured and self-insured plans to CRISP, which will create a Master Patient Index for each enrollee so that pharmacy and

behavioral health claims for each enrollee in a self-insured employer plan can be matched to that enrollee's claims for professional and institutional care and claims for any enrollee who changes private plans during the year can be combined.

C. Information on per enrollee health services use and spending for plans sold in and outside the Health Benefit Exchange for use by the Maryland Insurance Administration (MIA), the Health Benefit Exchange (HBE), and the MHCC in its role as monitor of annual changes in health care utilization.

Barrier(s)

Without a way to identify enrollees in private plans sold in the Exchange, there will be no way to segment the services and enrollees associated with the individual and small group plans purchased through the Exchange. Also, some small insurers that will sell insurance through the Exchange will not be required to submit data to the MCDB because they are not covered by current regulations.

Proposed Solutions

6) Require all carriers that sell insurance through the Exchange to submit data for these enrollees to the MCDB.
7) Require all carriers and co-op plans who submit data to the MCDB to include information on whether the plan was sold through the Exchange.

D. Timely and accurate information on per enrollee health services use and spending by enrollee demographics, insurance market, type of plan (benefit design), and geographic locations (sub-county if possible) for use by the Maryland Insurance Administration (MIA), the Health Benefit Exchange (HBE), and the MHCC in its role as monitor of annual changes in health care utilization. **Information on pricing transparency. Information on coverage transitions from Medicaid to private insurance (and vice-a-versa).**

Barrier(s)

Where data is concerned, there is generally a tradeoff between accuracy and speed. However, there has been a lag of almost two years in reporting per person annual health care spending among the privately insured by the MHCC due in part to problems with carrier submissions to the MCDB: identifying problems; correcting the data has taken up to a year. Because the MHCC's Medical Care Data Base (MCDB) will serve as the data collection mechanism for both the MIA and the HBE, their desire for quarterly utilization information underscores a need for more frequent and streamlined data processing.

Although the MHCC has the authority to collect information on insurance product design, staff has delayed the definition and submission of this file in order to make the definition of this file align with the plan description requirements placed on carriers by the federal government under the ACA. Because there is no common enrollee identifier across the insurance plans, there is no way to track when an enrollee makes coverage transitions from Medicaid to private coverage or vice-a-versa.

Currently there are pricing transparency tools that group payments for all services provided during a medical "event" into stages of care/provider source. While these tools use just a limited set of summary information, they typically require revenue codes, which currently are not included in the MCDB institutional file.

With regard to demographic characteristics of interest, the smallest geographic area for which utilization can be calculated with the MCDB is by zip code; Medicare data includes the four digit extension which breaks the zip code into smaller geographic regions. The desire to compare

utilization by race/ethnicity is thwarted by the absence of this demographic information on the eligibility file.

Proposed Solutions

8) The annual carrier submission of data to the MCDB will be replaced with quarterly data submissions. This will permit the MCDB contractor to identify problems in privately insured data submissions sooner and enable the carriers to resolve data problems prior to completing the calendar year submission. There will be a transition from annual to semi-annual to quarterly submission deadlines. The costs and benefits of quarterly data submissions will be assessed over a three-year period.
9) A new carrier report/data file will be submitted to the MCDB on plan benefit design, with information on plan-specific service benefits, restrictions, and patient out-of-pocket obligations.
   - ***WORK GROUP for Plan Benefit Design Report***
     The MHCC is forming a workgroup comprised of participants from carriers/payers, the Maryland Insurance Administration, the Maryland Health Benefit Exchange, etc., that will define this report/file. The starting point for this will be the "product file submission guide" currently in use by Massachusetts. http://www.mass.gov/chia/researcher/hcf-data-resources/apcd/submitting-data-to-the-apcd.html
10) Add revenue codes to the institutional record for inpatient services.
11) Add the four digit zip code extension to the information submitted by carriers.
12) Obtain Medicaid MCO claim, enrollment, and plan benefit data from the Medicaid Administration, including the four digit zip code for enrollee residence.
13) Establish mechanisms by which carriers will provide information on race/ethnicity that are appropriate for use in estimation of differences in utilization patterns.
   - ***WORK GROUP for reporting utilization by race/ethnicity***
     The MHCC is forming a workgroup comprised of participants from carriers and other stakeholders to study use of secondary information sources to assign race and ethnicity categories and for which purposes this secondary data could be used/not used.
14) Have Medicaid submit demographic information on enrollees in MCOs to CRISP, which will create a Master Patient Index for each enrollee so that enrollee transitions from private plans to Medicaid and vice-a-versa can be tracked.

E. Information on Practitioner Performance

Barrier(s)

Accurate measurement of practitioner performance, whether quality of care or the typical level of resources used (cost) to treat a condition, requires information on all the patients treated by the practitioner over a 24 month period to have a sufficient sample size and because treatment duration may cross over calendar years. In order to identify all the patients treated by a practitioner, the practitioner identifier must be consistent across all payers and the specialty of the practitioner must also be consistent across payers. There is a national practitioner identifier, known as the National Provider Identifier (NPI), however, some of the private payers that submit data to the MCDB do not provide the servicing practitioner NPI on many of their claims. The specialty code designation for a practitioner can vary by payer, and the current list of specialty codes in the MCDB data is limited.

It is especially important to include Medicare beneficiaries in the assessment of practitioner performance, since Medicare patients receive a disproportionate share of health care services. However, CMS does not permit Medicare data to be used in performance measurement unless: the

researcher combines the Medicare data with data from other insurers; the performance measures are approved by CMS; and the researcher has been certified by CMS as a Qualified Entity (QE), which obligates the researcher to follow a measurement testing and dissemination process that involves the practitioners being evaluated prior to the measurements being made public. Additionally, if the QE proposes to use a performance measure not currently approved by CMS, the QE must document stakeholder collaboration on definition of the proposed measure and provide test results for the measure to document its utility and reliability.

Proposed Solutions

15) The MHCC will obtain QE certification from CMS.
16) The MHCC will form an on-going Practitioner Performance Measurement Workgroup comprised of knowledgeable stakeholders to determine the performance measures to be generated from the APCD (includes MCDB, MCO, and Medicare data).
17) The MHCC will obtain Medicare claims data and MCO claims data on a quarterly basis, so that the professional service claims for privately insured, Medicare, and Medicaid beneficiaries are available for analysis at roughly the same time.

Increase Access to Data/Information Contained in the MCDB

X. Information Need(s) / *Barrier(s) / Proposed Solution*

F. Improve access to information from the private insurance component of the MCDB

Barrier(s)

The privately insured data component of the MCDB is available to applicants who can meet the significant data security requirements and have the ability to analyze the very large data files using appropriate statistical software. However, many in the non-research public health community who could put information from the MCDB to good use are not prepared to either house or analyze the data.

Proposed Solutions

- ***WORK GROUP to define Resident Summary Utilization Files***

  The MHCC has formed a workgroup comprised of a variety of stakeholders who are in the process of defining items 18 and 19 below.

18) Define and create summary utilization records for all enrollees in private insurance by patient and insurance characteristics and for all private insurance enrollees. Eventually include records for enrollees in Medicaid MCOs.
19) Define and create summary annual utilization data for sub-county areas by summing the per enrollee records (across all payers) for the enrollees residing in each zip code + four digit extension. The summarization will enable identification of neighborhoods with high utilization levels while protecting the privacy of individuals.

G. Promote use of the privately insured data by researchers and State agencies able to protect and analyze the data.

Barrier(s)

The privately insured data component of the MCDB is available to applicants who can meet the stringent data security requirements and can demonstrate a need for sensitive information fields contained in the MCDB. However, since data requests have been infrequent, the requests have been evaluated on an individual basis with different security, reporting, and data retention rules. With increased interest in information from the MCDB, this distribution system is inconsistent and personnel intensive. Recipients of the data are likely to need help in selecting variables for their studies for a variety of reasons, including the very large number of variables and records in the data files.

Proposed Solutions

20) Revise existing MCDB data distribution rules to incorporate what other states providing access to their APCDs have learned and to promote standardization across states. Limit researcher justification to a limited set of sensitive variables. Tighten IRB function. Require benefit for Maryland residents. Make rules available on website. Recoup costs for application review and construction and delivery of files.
    - ***WORK GROUP to determine sensitive fields in the privately insured data.***
      The MHCC will form a workgroup comprised of carriers and other stakeholders, including consumer representatives, to propose a list of confidential fields in the data that could be obtained by a researcher, but only with a favorable assessment by the IRB/MHCC review team.
21) Establish a help desk for users of the privately insured data funded by users.
22) Explore establishing secure data repositories at 2-4 universities able and willing to protect the data, control access (supported by data access rules/implementation), produce research of value to the residents of Maryland, and offer access to researchers from other Maryland colleges/universities.

H. Sharing of Medicare data files with other state agencies in Maryland.

Barrier(s)

The MHCC's current Medicare DUA is a research DUA and does not permit the MHCC to use the data for purposes other than those listed in our DUA or to share the data with other state agencies.

Proposed Solutions

23) The MHCC will apply to have their research DUA redefined as a State Agency DUA.
24) The MHCC will work with stakeholders to create a sustainable business model.
    - ***WORK GROUP to discuss the state agency function.***

    The MHCC will form a workgroup of representatives to discuss how the MHCC will function in this role as data protector, reporter of use cases/who has the data to CMS quarterly. ResDAC is expected to serve as the help desk for state agencies using the data.

I. Collaboration with other states with APCDs

Barrier(s)

All states created their APCDs at different times with different submission criteria.

Proposed Solution

25) The MHCC will invite states with fully developed APCDs to jointly participate in projects to collaborate in testing a common measure set for use by state Insurance Administrations and a common measure set for expenditures among the privately insured.

TIMELINE: (* = subject to available funding)

2013

July – October: Use **workgroups** to determine:

- *Plan Benefit Design Report*
- *Reporting utilization by race/ethnicity*
- *Payer Reporting of Total Medical Expenses*
- *Sensitive fields in the privately insured data*
- *MHCC role as state agency for Medicare Data*

November: MHCC provides payers with data submission manuals for both 2013 and 2014 data.

2014

June 30: Submission deadline for submitters of 2013 annual calendar year data. *New variable for AOB to be included.* Data will have *4-month claims run-out* – all paid services for 2013 as of April 30th.

August: *All submitters of 2014 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during Jan. 1–June 30, 2014, for assignment of Master Patient Index (MPI) encrypted numbers.

October 31: Due date for submitters of 2014 data for services, enrollment, plan benefits, total medical expenses report for period Jan. 1–June 30; data will have a *3-month claims run-out* – all paid services for Jan. 1–June 30, 2014 as of September 30th. *Submissions will include MPI on eligibility records.

November: MHCC provides payers with data submission manual for 2015 data.

2015

February: *All submitters of 2014 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during July 1–Dec. 31, 2014, for assignment of Master Patient Index (MPI) encrypted numbers.

April 30: Due date for submitters of 2014 data for services, enrollment, plan benefits, total medical expenses report for period July 1–Dec. 31; data will have a *3-month claims run-out* – all paid services for July 1–Dec. 31, 2014 as of March 31, 2015. *Submissions will include MPI on eligibility records.

May: *All submitters of 2015 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during Jan. 1–March 31, 2015, for assignment of Master Patient Index (MPI) encrypted numbers.

July 31: Due date for submitters of 2015 data for services, enrollment, plan benefits, total medical expenses report for period Jan. 1–March 31; data will have a *3-month claims run-out* – all paid services for Jan. 1–March 31, 2015 as of June 30, 2015. *Submissions will include MPI on eligibility records.

August: *All submitters of 2015 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during April 1–June 30, 2015, for assignment of Master Patient Index (MPI) encrypted numbers.

October 31: Due date for submitters of 2015 data for services, enrollment, plan benefits, total medical expenses report for period April 1–June 30; data will have a *3-month claims run-out* – all paid services for April 1–June 30, 2015 as of Sept. 30, 2015. *Submissions will include MPI on eligibility records.

November: *All submitters of 2015 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during July 1–Sept. 30, 2015, for assignment of Master Patient Index (MPI) encrypted numbers.

November: MHCC provides payers with data submission manual for 2016 data.

2016

January 31: Due date for submitters of 2015 data for services, enrollment, plan benefits, total medical expenses report for period July 1–Sept. 30; data will have a *3-month claims run-out* – all paid services for July 1–Sept. 30, 2015 as of December 31, 2015. *Submissions will include MPI on eligibility records.

February: *All submitters of 2015 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during Oct. 1–Dec. 31, 2015, for assignment of Master Patient Index (MPI) encrypted numbers.

April 30: Due date for submitters of 2015 data for services, enrollment, plan benefits, total medical expenses report for period Oct. 1–Dec. 31; data will have a *3-month claims run-out* – all paid services for Oct. 1–Dec. 31, 2015 as of March 31, 2016. *Submissions will include MPI on eligibility records.

May: *All submitters of 2016 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during Jan. 1–March 31, 2016, for assignment of Master Patient Index (MPI) encrypted numbers.

July 31: Due date for submitters of 2016 data for services, enrollment, plan benefits, total medical expenses report for period Jan. 1–March 31; data will have a *3-month claims run-out* – all paid services for Jan. 1–March 31, 2016 as of June 30, 2016. *Submissions will include MPI on eligibility records.

August: *All submitters of 2016 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during April 1–June 30, 2016, for assignment of Master Patient Index (MPI) encrypted numbers.

October 31: Due date for submitters of 2016 data for services, enrollment, plan benefits, total medical expenses report for period April 1–June 30; data will have a *3-month claims run-out* – all paid

services for April 1–June 30, 2016 as of Sept. 30, 2016. *Submissions will include MPI on eligibility records.

November: *All submitters of 2016 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during July 1–Sept. 30, 2016, for assignment of Master Patient Index (MPI) encrypted numbers.

November: MHCC provides payers with data submission manual for 2016 data.

2017

January 31: Due date for submitters of 2016 data for services, enrollment, plan benefits, total medical expenses report for period July 1–Sept. 30; data will have a *3-month claims run-out* – all paid services for July 1–Sept. 30, 2016 as of December 31, 2016. *Submissions will include MPI on eligibility records.

February: *All submitters of 2016 data will provide CRISP with a file of demographic information on all Maryland residents (and non-residents covered by Maryland contracts) enrolled in their products at any time during Oct. 1–Dec. 31, 2016, for assignment of Master Patient Index (MPI) encrypted numbers.

April 30: Due date for submitters of 2016 data for services, enrollment, plan benefits, total medical expenses report for period Oct. 1–Dec. 31; data will have a *3-month claims run-out* – all paid services for Oct. 1–Dec. 31, 2016 as of March 31, 2017. *Submissions will include MPI on eligibility records.