COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth ACO Program Development

Provider Data Reports User Guide

Round 1

Summary Report, Medical Claims Extract, and Member Roster

Spring 2016

Summary

This User Guide contains information on three types of reports:

- **Summary Level Report (Part 1):** Provides information on enrollment, quality, and utilization performance for the attributed member population for calendar year 2014. Substance abuse claims are included in this report.

- **Claims Level Extract (Part 2):** Provides three years of claims level detail for the attributed member population. Substance abuse claims are excluded from this extract.

- **Member Roster Report (Part 3):** Provides information on the panel composition.

All reports are based on calendar year 2014 data. All reports are based on an algorithmic attribution using historic member claims and encounters. **This attribution may differ from actual member attribution or assignment under future ACO models, including the ACO Pilot**, and may attribute a different number of members.

READ BEFORE USING – PURPOSE AND KEY LIMITATIONS OF REPORTS: These reports **cannot currently be used to accurately predict ACO targets or to compare performance to statewide benchmarks.**

MassHealth is currently working through the technical and actuarial details of ACO pricing and target-setting. Actual targets for ACOs will be set through a process that incorporates information not available in the claims extract, such as:

- trend factors and program adjustments
- risk adjustment, normalized to a base population
- comparisons to state benchmark performance
- exclusions and adjustments for certain categories of service

The summary report does not include summary-level total cost of care such as per member per month ("PMPM") cost, risk score, or member month information, to avoid providing misleading information. **MassHealth intends to provide a second round of reporting to bidders/applicants in the ACO procurements; this second round will include TCOC summary information and actual PMPM benchmarks for ACOs.**

The claims extract includes MassHealth paid claims (i.e. PCC plan claims and MCO encounters) and behavioral health encounters for an ACO's attributed members, and will therefore support certain TCOC analyses. However, **the ultimate TCOC pricing and target setting methodology for ACO models will have adjustments to the raw claims data.** For example, certain services (e.g., LTSS) that appear in the claims extract will not be included in ACO TCOC targets, and other services (e.g., pharmacy) will be adjusted. Additionally, the claims extract excludes claim-level information on certain services, such as substance abuse treatment, the costs for which will be included in ACO TCOC targets.

These reports **do support the following uses**, which are in line with their intended purposes:

- claims analysis to understand patterns of care for attributed members, to identify opportunities for enhanced coordination
- claims analysis to understand costs associated with types of utilization, to identify opportunities for enhanced efficiency under TCOC models
- review of the member roster and comparison between the included members and provider records to understand how the attribution methodology is attributing members, and recommend revisions or point out discrepancies to MassHealth
- review of the summary report's information on quality performance and utilization patterns to identify opportunities for improvement or areas for more detailed future analysis

KEY FACTS RELATED TO MEMBER COUNTS AND DISTRIBUTION: The summary report does include member panel distribution across PCC and MCO health plans. However, the member counts and distributions in this report are based on the current attribution algorithm, and therefore, may differ from actual member counts under future ACO models, including ACO pilot. Member counts for the ACO pilot will be determined using PCC of record, and not the current attribution methodology for these reports.

IMPORTANT LEGAL NOTICE: The reports are to be used for the purpose of preparing for participation in payment reform and accountable care models. Participants receiving these reports are required to maintain the privacy and security of the information found in the reports in accordance with applicable state and federal laws and regulations and the terms of the Data Use Agreement and Validation, Data Management and Confidentiality Agreement entered into with EOHHS.

TECHNICAL ASSISTANCE: Please email questions and suggestions to EHS.MassHealthReports@State.MA.US.

Part1: Summary Level Report

Overview

This portion of the user guide provides an overview of each section in the Round 1 Provider Summary Level Report. The report is divided into the following sections:

1. Member Characteristics (*without cost data*)
2. Quality Performance
3. Panel Utilization
4. Care Delivery Patterns *(without cost data)*

These four sections are individually discussed in the following sections of the user guide. Immediately below is an overview of the sources of data, population and services that are applicable to all of these sections.

Data Sources

The Round 1 Provider Summary Level Report is based on data from MassHealth's MMIS system (claims) and encounter data from MCOs. Together, these data represent health services rendered to MassHealth members during calendar year (CY) 2014. The time period of CY 2014 was partially chosen to account for claims runout (the time lag between when the service is rendered and when the claim is submitted).

Populations Included

The populations reflected in the Summary Report include MassHealth members enrolled in the following eligibility groups: Seniors (non-dual eligible), children with disabilities and without disabilities, and adults with disabilities and without disabilities. Members were required to have had at least six months of continuous eligibility and have at least one qualifying claim during calendar year 2014 where a qualifying claim is a wellness visit, evaluation and management code (office visit), or a prescription. The following eligibility groups were excluded: Medicare-Medicaid Enrollees, members receiving temporary eligibility benefits, members receiving third party liability (TPL), members receiving MassHealth Limited benefits, and members in the Emergency Assistance to the Elderly, Disabled and Children (EAEDC) program. For a more detailed description of excluded populations, including specific aid categories, please see the Technical Appendix.

In addition, the Round 1 Provider Summary Level Report excludes members with zero claims.

Comparison to Statewide Population

In addition to providing information on the four areas mentioned above, the Summary Level Report presents information on the statewide population of ACO eligible MassHealth members, to enable comparisons. The statewide population is defined as MassHealth enrollees in the ACO eligible aid categories, with at least six months of continuous eligibility and at least one qualifying claim in calendar year 2014. Throughout the Summary Level Report, "Statewide Performance" is represented in dark gray.

Services Included

The following MassHealth covered services are included in the report: professional services, institutional services, pharmacy, and waiver services associated with long-term care programs. See Technical Appendix for excluded services. The summary report includes substance use claims.

(Please note that due to member privacy protections, claims that follow the substance use exclusion criteria are not included in the claims extract. For the specific substance use exclusion criteria, please see the Claims Extract documentation.)

Attribution Methodology

Information on the provider reports (summary level, claims extract, and member roster) reflects members who have been attributed based on a hierarchal member attribution methodology. This attribution methodology reflects both member choice and historical utilization. Member self-selection is given precedence in attribution, and claims and encounters are used to attribute a provider when a member does not self-select a PCC. Within the claims and encounter attribution, precedence is given to well visit, encounter, and evaluation and management providers over ordering providers found on pharmacy claims. Providers attributed through claims and encounter data must meet eligibility criteria in order to be considered a Primary Care Provider (PCP). See the "Attribution Methodology" document for these criteria. Below are key steps of the attribution methodology:

1) Known Member – Provider Relationships were Leveraged

In the first step of the attribution methodology, if a member in the PCC program had self-selected a provider, then that member was attributed to the self-selected provider. In this step, provider specialty is not used to limit a provider eligible for self-selection. All members included in this report are required to have a qualifying claim (wellness visit, E&M code, or prescription). If a member selected a PCC provider and did not have a qualifying claim with that provider, they are still included in this report. If a member self-selected multiple PCC providers, then the most recent selected PCC provider was chosen for attribution. Members who started in a PCC program and transitioned to an MCO by the end of 2014 were excluded from this step of attribution, and were allowed to be attributed to a PCP through claims or encounters

2) Application of Claims/Encounter – Commercial Attribution Methodology

If a known self-selected PCC provider relationship was not available, each member was attributed to a PCP based on the commercial attribution methodology using a 24 month lookback:

- Using well visit claims and encounter data, members were attributed to providers based on the plurality of services. In the case of a "tie," a member was attributed using the most recent date of service.

- In some instances members had no well visit claims. If well visit claims did not exist, then evaluation and management claims were used for attribution.

- In the final step of the attribution methodology, pharmacy claims are used to identify the attributed provider if well visit claims or evaluation and management claims did not exist. For pharmacy claims, the ordering provider on the claim was

used to identify the eligible provider that ordered the prescription. If the prescription was ordered by a provider not identified as an eligible provider (see appendix), the pharmacy claim was not considered in the attribution methodology

Employing the criteria outlined above, some MassHealth members are eligible for attribution ("attributable members"), while some members do not meet the criteria and are not eligible for attribution. Attributable members must be in one of the included eligibility groups, must have six months of continuous eligibility, and have at least one qualifying claim. Of all attributable members, attribution to a provider requires identifying a member-provider relationship via PCC self-selection, claims, or encounter data. However, some attributable members are not attributed to a provider because a member-provider relationship cannot be determined using one of these methods. Of the attributable population reflected in the Summary Report, 91 percent are attributed to a provider and 9 percent are not attributed to a provider as seen in the table below.

	Percent
Percent of attributable members that are attributed to a provider	91%
Percent of attributable members not attributed to a provider	9%

Cell Size Suppression

This report follows the CMS guidelines regarding cell size suppression, which states that cells calculated using 10 or fewer observations may not be displayed. This applies to admissions, patients, etc. as well as percentages or other formulas if the result is calculated from 10 or fewer observations. When one reporting field is suppressed, on some occasions, it would be possible to calculate that field by subtracting from the "Total" column. When this is the case, the next lowest value is also suppressed. Suppressed fields are indicated by an "*".

Summary Report Organization

The Round 1 Provider Summary Report is organized into three pages and four sections, by topical area. In many of the tables, data points on the provider's member population (labeled "Your Performance") are compared against the statewide member population (labeled "Statewide Performance"). Data points on the member panel are colored orange, while the data on the statewide member population are colored dark grey.

Page 1, Section 1: Member Characteristics

This section provides demographic, member eligibility, and utilization information for the member panel. Where applicable, the member panel characteristics are compared against the statewide MassHealth population.

Table 1.1 – Demographic Distribution

Demographic Distribution displays the distribution of members by gender, age group, and eligibility group. Extracted from the MMIS eligibility file, member demographics are provided for the provider's panel, and compared against the statewide MassHealth population. Key fields include:

Characteristic	Description
Gender	Percentage distribution of members by gender. Gender information is extracted from MMIS eligibility file.
Age Range	Percentage distribution of members by age range. Age range includes Under 21, 21-64, and 65+. Ranges were selected to align with age-related eligible requirements of Medicaid, CHIP, and Medicare. Age information is extracted from MMIS eligibility file.
Eligibility Group	Percentage distribution of members by eligibility group. The population is broken down in to five eligibility groups: Adults with Disabilities, Adults without Disabilities, Children with Disabilities, Children without Disabilities, Non-Medicare Seniors, and Other. Other is comprised of members who changed eligibility during CY 2014. These members had at least six months of continuous eligibility and then became ineligible for ACO enrollment at the end of the year. Eligibility group is based on aid category, and is extracted from MMIS eligibility file. In addition, the percentage of members with Serious Mental Illness (SMI) is included. SMI is defined as members with claims indicating the following conditions: Schizophrenia, Major Depressive, Bipolar, Paranoid Disorder, and Reactive and Unspecified Psychosis.

Table 1.2 - Member Panel Distribution Across PCC & MCO Health Plans

This table displays the percentage distribution of Primary Care Clinician Plan (PCC), other MassHealth members, and Managed Care Organization (MCO) enrollment for the attributed member population. This reflects the distribution as of the end of calendar year 2014. These member counts are based on the current attribution algorithm and may differ from actual member counts under future ACO models, including the ACO pilot. Member counts for the ACO pilot will be determined using PCC of record, and not the current attribution methodology for these reports.

Table 1.3 - Utilization Metrics by Member Cost Category

This table displays information detailing the utilization patterns of the member panel, broken out into three subgroups: the subgroup of members in the top 5% of total cost, the subgroup of the members in the next top 10% of total cost, and the subgroup of members in the remaining 85% of total cost. For each of these subgroups, the following information is presented:

Characteristic	Description
ED Visits Per 1,000	Number of Emergency Department visits per subgroup, per 1,000 members.
Inpatient Admissions Per 1,000	Number of inpatient admissions for subgroup, per 1,000 members.
30-day All Cause Readmission Rate	The 30-day readmission rate for patients discharged from the hospital.
Percent of Members With Behavioral Health Disorder	Percent of members identified as having a behavioral health disorder.
Percent of Members with Disability	Percent of subgroup identified as having a disability.

Page 2, Section 2: Quality Performance

Table 2.1 - Claims-Based Quality Measures

This table reflects performance on quality measures for which ACOs may be held accountable compared to statewide performance and to the 90th percentile of New England HEDIS® 2015 benchmarks. Note that two measures are not compared against these benchmarks: Avoidable ED Visit Rate is not a HEDIS measure, and the Plan All-Cause Readmission HEDIS measure does not have a benchmark for Medicaid. In addition, these two measures are categorized as "Lower is Better," meaning that a lower value, corresponding to fewer avoidable ED visits, for example, is preferable to a higher rate that corresponds to a greater number of visits. These measures may be changed in future reports beyond Round 1.

Table 2.1 presents the provider's "observed adherence rate" for each of the following measures.

NQF	Measure	Description
N/A	**Avoidable Emergency Department (ED) Visit Rate**	The percentage of ED visits identified as avoidable using an adapted version of the NYU Emergency Department visit classification algorithm.[1] In the adaptation, "non-emergent" and "emergent/primary care treatable" are assigned a probability score for being avoidable. When that probability is greater than 80%, the ED visit is categorized as avoidable. For this measure, a lower score represents higher performance.
1768	**Plan All-Cause Readmission Rate**	Calculates the rate of unplanned, acute readmissions for any diagnosis within 30 days of discharge from a hospital (for members aged 18 and older). The measure will result in a single readmission rate. For this measure, a lower score represents higher performance.
N/A	**Adolescent Well-Care Visits**	Measures the percentage of members 12 to 21 years old who had at least one comprehensive well-care visit with a primary care or OB/GYN practitioner over the course of the year that included all of the following: A health and developmental history, a physical exam, and health education/anticipatory guidance.
0004	**Initiation & Engagement of Alcohol and Other Drug Dependence Treatment – Engagement Total**	Percentage of members who engaged treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.
0004	**Initiation & Engagement of Alcohol and Other Drug Dependence Treatment – Initiation Total**	Percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.
1799	**Medication Management for People with Asthma**	Percentage of members ages 5 to 64 who were identified as having persistent asthma and dispensed an appropriate asthma controller medication that they remained on the medication for at least 75% of their treatment period.

Page 2, Section 3: Panel Utilization

Section 3, Panel Utilization, is a comparative snapshot of utilization by service category.

Table 3.1 - Member Panel Utilization (per 1,000 member years)

The purpose of this table is to provide a snapshot of levels of utilization of across different types of services: Professional Visits, Inpatient Admissions, Hospital Clinic Visits, Emergency

[1] Background and the methodology of the NYU Avoidable ED Visit measure can be found at http://wagner.nyu.edu/faculty/billings/nyued-background

Department Visits, and Pharmacy scripts. The utilization metrics are shown on a percentile scale. The percentiles are based on statewide provider-level performance for this population. The bars show the provider and statewide utilization rates relative to the 25th, 50th, 75th, 90th percentile values.

Utilization measures are calculated by counting the number of events (i.e. the numerator which includes the number of inpatient admissions, pharmacy claims, ED visits, etc.) and dividing by the total member months (denominator). The rate is then multiplied by 12,000 to arrive at the "per 1,000" member years figure in the denominator.

Page 3, Section 4: Care Delivery Patterns

Table 4.1 – Top 5 Providers by Member Counts and Category of Care

This table provides insight as to which specific providers or institutions are delivering care most frequently to the member panel. The table includes provider name and the number of members served by the provider across four service areas: Hospital Inpatient, Hospital Outpatient, Behavioral Health, Emergency Department, and Specialty Physicians. For each of these service areas, the top five providers or institutions with the highest number of members receiving care from them are displayed. Each row in Table 4.1 represents a different provider record using the MassHealth Master Provider Identifier (MPI). Apparent duplicates of the provider name may occur, indicating more than one provider ID for that provider.

Table 4.2 – Percent of Your Members by Count of ED Visits

Table 4.2 is a histogram that shows the distribution of the member panel by count of ED visits per year. Each vertical bar represents the count of panel members with the number of ED visits labeled on the x-axis. The line graph overlaying the histogram represents the cumulative percentage of your panel as number of ED visits increases. Note: members with zero ED visits, non-utilizers, are not included in this table.

Table 4.3 – Prevalence of Top Ten Conditions by Members' Cost Group

This table shows the prevalence of the ten common Hierarchical Clinical Classification (HCC) conditions across MassHealth. This table presents three subgroups: members with total costs in the top 5%, members with total costs in the top 10%, and the remaining 85% of members. For each subgroup, the table displays the prevalence of these ten conditions in descending order. The ten conditions included in this table are the same regardless of ACO or subgroup. The ten conditions are listed below.

Ten HCC Conditions	
Hypertension	Diabetes (with or without complications)
Major Depressive, Bipolar, Paranoid	Disorders of the Vertebrae/Spinal Discs
Asthma	Attention Deficit Disorder
Drug/Alcohol Abuse (with or without dependence)	Chronic Obstructive Pulmonary Disease
Depression	Osteoporosis and Other Bone/Cartilage

Technical Appendix

The following Appendix provides more detailed information on the methodology and assumptions behind the Round 1 Provider Summary Level Report.

A. Included and Excluded Populations Criteria

The following table shows the criteria for each of the included and excluded member populations:

Group	Criteria	Included/Excluded
Temporary Eligibility	cde_aid_category = 'AA'	Excluded
Dual Senior	At least one ind_medicare has a flag and age is over 65	Excluded
Dual Under 65	At least one ind_medicare has a flag and age is under 65	Excluded
Other TPL	Coverage_category not null or partial	Excluded
Limited	cde_pgm_health is 'LIM,' 'LIMCP,' 'LIMHS'	Excluded
Health Safety Net	cde_pgm_health is 'HSN,' 'HSNF,' 'HSNS,' and 'PHSN'	Excluded
EAEDC	cde_pgm_health is 'EAEDC'	Excluded
Premium Assistance/SBI	cde_pgm_health is 'PRA' or 'SBI'	Excluded
MCO Exclusions	Members who are NOT in the following MCOs: 'MBH','BMC','CAR','FLN','HNE','NHP','CHA'	Excluded
Senior, non-Dual	age >= to 65	Included
Disabled Child	age <= 20 and ind_aid_disabled = 'Y'	Included
Disabled Adult	21 <= age <= 64 and ind_aid_disabled = 'Y'	Included
Non-Disabled Child	age <= 20 and ind_aid_disabled = 'N'	Included
Non-Disabled Adult	21 <= age <= 64 and ind_aid_disabled = 'N'	Included

B. Excluded Services Criteria

Services where CDE_DISBURSMENT is equal to "1" or "6" were excluded from the analysis. See the table below for all the value for CDE_DISBURSEMENT.

CDE_DISBURSEMENT	0 - Pay 1 - State Agency 2 - Muni-Med 3 - Non-Billing 4 - EHR Incentive Provider No-Pay 5 – HER Incentive Provider Expenditures Only 6 – Health Safety Net (HSN) N/A Unknown

C. Attribution Methodology

Application of Commercial Attribution Methodology – Claims Selection

In the application of the commercial attribution methodology, the following claims were examined for eligible members and designated providers,

1. Well visits (PROC_CODE between '99381' and '99397' or PROC_CODE between '99201' and '99215' or PROC_CODE between '99221' and '99223')

2. Evaluation and management (PROC_CODE between '99201' and '99499' or PROC_CODE='T1015')

3. Pharmacy claims

Only paid professional claims and encounters are included.

Providers Eligible for Attribution Based on Commercial Attribution Methodology

The following types of providers were included in attribution,

- Primary Care Providers (Family/General Practice, Geriatrics, Obstetrics, Gynecology, Internal Medicine, Pediatrics, Physician Assistant, Nurse Practitioner)

- Hospital Licensed Health Centers

- Community Health Centers

- Acute Outpatient Hospitals

- Group Practice Organizations

Notes:

A master provider table has been created that combines FFS and Encounter provider data and the MassHealth master provider id. This identifier then can then be linked to an ACO. The result is that attribution can happen across both FFS and Encounter claims data.

In the case of multiple individual providers associated with a larger provider entity, such as a group practice, some individual providers may have no members attributed to them as their associated members have been assigned to another entity to avoid double-counting of members.

Part2: Medical Claims Extract

Claims Fields, Specs, and Definitions

Field Name	Type	Length	Definition
ID_UNIQUE	Char	12	Unique de-identified ID assigned to the MassHealth member.
AGE_GROUP	Char	6	Member age group.
CLAIM_ICN	Char	13	De-identified number assigned to a claim processed in the system; used for control purposes.
NUM_DTL	Num	8	The number of the detail line on a claim record.
CDE_PROC	Char	6	CPT or HCPCS Procedure Code used to identify a medical, dental, or DME procedure.
CDE_PROC_MOD	Char	2	First Procedure Modifier is used to further define and add information to the service "procedure" provided.
CDE_PROC_MOD_2	Char	2	Description of the second Procedure Modifier which is used to further define and add information to the service "procedure" provided.
CDE_REVENUE	Num	8	This field identifies the revenue codes submitted on the claims.
QTY_UNITS_BILLED	Num	8	Number of units of service billed at the detail for a claim.
AMT_PAID	Num	8	Amount paid by MassHealth for the services provided. This is a Lewin calculated field that used payment logic developed by MassHealth to determine the total payment for a claim. See Methodology tab for derivation of paid amount.
CDE_DIAG_1	Char	7	The primary diagnosis code that was keyed on the claim.
CDE_DIAG_2	Char	7	The Secondary diagnosis code that was keyed on the claim.
CDE_DIAG_3	Char	7	The Tertiary diagnosis code that was keyed on the claim.
DSC_PLACE_OF_SERVICE	Char	20	Description of place where medical assistance service is performed.
DSC_PATIENT_STATUS	Char	20	Description of the status of the recipient as of the ending service date of the period covered on a UB92 claim.
PX01	Char	7	ICD Procedure Code 1. Code which indicates a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.
PX02	Char	7	ICD Procedure Code 2. Code which indicates a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.
CDE_NDC	Char	11	National Drug Code is a universal product identifier for human drugs in the United States. The code is present on all nonprescription (OTC) and prescription medication packages and inserts in the US. It is 11-digit number in a 5-4-2 format.
CDE_TYPE_OF_BILL	Char	3	The Type of Bill (TOB) is a three digit entry. The first digit is the type of facility, the second digit is the bill classification, and the third digit is the Frequency.
LENTGH_STAY	Num	3	Length of stay (institutional claims only)
SERVICE_DT	Num	4	Year of which services first performed for a recipient.
ADMIT_DT	Num	4	This field specifies the year on which the a patient was admitted for inpatient or outpatient care services.
DISCHARGE_DT	Num	4	Year of Discharge from hospital stay.
SEQUENCE	Num	3	Sequential order of claims for a member based on service date. Sequence restarts each calendar year. See Methodology tab for more detail on how this variable was created.
ID_PROVIDER_BILLING	Char	10	The MassHealth ID given to the provider enrolled with MassHealth for the billing provider on the claim.
PROVIDER_NAME	Char	100	Provider name associated with billing provider ID.

Methodology

Lewin employs the following logic to set the total payment on a claim:
Line = The AMT_PAID field on each line is copied into the new payment field.
Header = After merging header and detail records into a single dataset, the AMT_PAID value is shown only on the first line per claim_icn. All other rows are set to $0.
PAPE = This method utilizes the following steps,

1. Split the data into PAPE detail (cde_price_method = 'PAPE'), PAPE header lines (cde_price_method = 'PAPBDL'), and other.
2. Merge the PAPE detail and PAPE header by claim_icn and show the AMT_PAID value from the header only on the first line per claim_icn. All other rows are set to $0.
3. On Non-PAPE claims, The AMT_PAID field on each line is copied into the new payment field.
4. Combine the PAPE detail and other claims, excluding the PAPE header lines.

For FFS professional claims, the new payment field is set to AMT_ADJUSTED_PCPR if the AMT_PAID = 0 and num_icn and num_dtl match to the supplemental file provided by MassHealth.

The following table shows how each type of claim is processed using the logic above.

Claim Type	Method
Physician, FFS & Encounter	Line
Inpatient, FFS	Header
Inpatient, Encounter	File already merged with detail and accounts for payment logic prior to arrival at Lewin
Long Term Care, FFS	Header
Long Term Care, Encounter	File already merged with detail and accounts for payment logic prior to arrival at Lewin
Outpatient, FFS	PAPE or line for non-PAPE claims
Outpatient, Encounter	Line
Pharmacy, FFS & Encounter	Line
Home Health, FFS only	Line
Dental, FFS & Encounter	Line

Substance Use Exclusions

While individuals that have been diagnosed with a substance use disorder (SUD) are included in the analysis, claims associated with substance use treatment or other sensitive conditions have been excluded. Substance use claims were removed if they met one of the following criteria:

1. Claims where the ICD9/ICD10 admitting or principal diagnosis code is a substance use code, or when the principal procedure is a substance use code
2. Claims lines that have CPT/HCPCS/REVENUE/MODIFIERS with substance use diagnosis codes
3. Pharmacy claims with a therapeutic class or generic name related to substance use

4. Claims that have any of the other substance use criteria (rate ids, provider types, place of service, providers, provider types, encounter types or encounter service category)

Sequence Variable

Sequence is the sequential order of claims for a member in the given calendar year. If an individual member has multiple claims with different service dates, the claims are sorted in ascending order and a number is assigned. In the case of a multi-line claim, Sequence is the same for each line of that claim. For example, if the third claim for a member in that year is a ten line claim, all ten lines will have Sequence = 3. If a member only has one claim, then Sequence is set to 1. Sequence restarts based on service date for each calendar year.

Medical Claims Extract Sample

ID_UNIQUE	AGE_GROUP	CLAIM_ICN	NUM_DTL	CDE_PROC	CDE_PROC_MOD	CDE_PROC_MOD_2	CDE_REVENUE	QTY_UNITS_BILLED	AMT_PAID	CDE_DIAG_1	CDE_DIAG_2	CDE_DIAG_3	DSC_PLACE_OF_SERVICE	DSC_PATIENT_STATUS	PX01	PX02	CDE_NDC	CDE_TYPE_OF_BILL	LENGTH_STAY	SERVICE_DT	ADMIT_DT	DISCHARGE_DT	SEQUENCE	ID_PROVIDER_BILLING	PROVIDER_NAME
000000000001	41-50	000000000007	1	92508	TM			2	10.86	319			11 -							2014			1	000000867A	James Smith
000000000002	41-50	000000000003	1	92508	TM			2	10.86	319			11 -							2014			1	000000867A	James Smith
000000000003	31-40	000000000006	1	92508	TM			2	10.86	319			11 -							2014			1	000000867A	James Smith
000000000004	31-40	000000000008	1	92508	TM			2	10.86	319			11 -							2014			1	000000867A	James Smith
000000000005	31-40	000000000001	1	92508	TM			2	10.86	319			11 -							2014			1	000000867A	James Smith
000000000005	31-40	000000000002	1				124	1	10605.8	150.9	786.3	276.1		01-DISCHARGED TO HOME OR SELF CARE (ROUTINE	96.36			111	7	2014	2014	2014	2	000000014B	ABC
000000000005	31-40	000000000009	1	99393				1	79.81	V20.2	368.1	V72.19	11 -							2014			3	000000114A	Mary
000000000005	31-40	000000000009	2	S0302				1	9.05	V20.2	368.1	V72.19	11 -							2014			3	000000114A	Mary
000000000005	31-40	000000000009	3	99173				1	18.64	V20.2	368.1	V72.19	11 -							2014			3	000000114A	Mary
000000000005	31-40	000000000009	4	92587				1	5.28	V20.2	368.1	V72.19	11 -							2014			3	000000114A	Mary

Part 3: Member Roster

Member Roster Fields, Specs, and Definitions

Name of Variable	Type	Length	Definition
FIRST_NAME	Char	10	Member first name
LAST_NAME	Char	10	Member last name
DTE_BIRTH	Num	8	Member date of birth
ID_MEDICAID	Char	12	Member unique identifier
CDE_MANAGED_CARE_PLAN	Char	14	Member last plan type in the reporting period
ATTRIBUTION_STEP	Char	7	Step that member was attributed in: Step_0 is member self-selection. Step1 is based on claims. Step1.Well means the member was attributed based on a well visit claim; Step1.E&M means the member was attributed based on an E&M claim; Step1.Rx means the member was attributed based on a pharmacy claim.
MEMBER_MONTHS*	Num	2	Number of months the member was eligible for during the reporting period
ELIG_IND	Char	1	Y or N depending on the eligibility status as of 9/30/15

* Member months in the Member Roster are rounded to whole months.

Member Roster Sample

FIRST_NAME	LAST_NAME	DTE_BIRTH	ID_MEDICAID	CDE_MANAGED_CARE_PLAN	ATTRIBUTION_STEP	MEMBER_MONTHS	ELIG_IND
Floy	Thoma	9/9/197	000000000001	PCC	Step 0	12	Y
Gwyneth	Trickey	6/12/196	000000000002	FFS	Step 1.Well	12	Y
Jettie	Chamerland	6/4/197	000000000003	FFS	Step 1.Well	12	Y
Owen	Markley	8/21/197	000000000004	MCO-MassHealth	Step 1 .Rx	12	Y
Robbin	Newquist	7/29/198	000000000005	FFS	Step 1.Well	12	Y
Leatrice	Brain	7/2/196	000000000006	MCO-MassHealth	Step 1 .E&M	12	Y
Lashawn	Sun	1/15/196	000000000007	PCC	Step 0	12	Y
Sean	Faulkner	4/30/198	000000000008	PCC	Step 0	12	Y
Salina	Griffith	11/28/1980	000000000009	FFS	Step 1.E&M	9	Y
Emiko	Forgey	4/9/198	000000000010	MCO-MassHealth	Step 1.Rx	12	Y

(The names in this roster are fictitious)