

**Chapter 241: Uniform Reporting System for Hospital Inpatient Data Sets and Hospital Outpatient Data Sets (*routine technical*)**

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**Section I. Basis Statement.**

The Maine Health Data Organization is authorized by statute to collect health care data. This chapter governs the provisions for filing hospital inpatient data sets and hospital data outpatient data service sets. The provisions include identification of the organizations required to report; requirements for the content, form, medium, and time for filing the data; standards for the data reported; and compliance provisions.

The proposed changes contain clarifications, additions and deletions that will improve the content and value of the MHDO hospital encounter data for authorized data users. MHDO is aware of the challenges created for hospitals when changes are made to the MHDO file layout. Therefore, we have minimized the disruption of the proposed changes in the layout by ensuring that most of the changes occur at the end of a record type. Lastly, several of the proposed changes align with updates to the national standards and the MHDO’s new data submission portal.

A public hearing was held on July 13, 2017 and comments were accepted until July 24, 2017 at 5:00 p.m.

**Section II. Names of Individuals that Submitted Comments.**

The following is a list of individuals and affiliations that submitted written comments to the Maine Health Data Organization (MHDO) regarding the proposed rule changes:

1. David Winslow, Vice-President of Financial Policy, Maine Hospital Association
2. Lisa Harvey-McPherson, Vice-President Government Relations, Eastern Maine Healthcare Systems
3. Andrew E. Smith, State Toxicologist and Manager of Maine CDC’s Environmental and Occupational Health Programs, Maine Center for Disease Control and Prevention

**Section III. Summary of Comments Received by Submitter with Proposed Agency Response & Action.**

Below is a summary of the comments received by each submitter and the proposed Agency Response:

**1. The Maine Hospital Association submitted the following comments**:

**Comment 1:**

*Many of the changes in this proposed rule are technical in nature and we have no objections to. There are three changes, however, which we believe are unnecessary and unwise. The proposed changes to Definitions Sections E and G and Section 3 E of the Submission Requirements.*

**Definition Section E** *adds parent entity to the definition of a hospital. Hospitals are already clearly defined in Title 22 and that definition is already referenced in this section. The proposed definition of parent entity is confusing at best, but we assume it is intended to mean an entity such as MaineHealth or Eastern Maine Health Systems. These Health Systems are not hospitals; they don’t provide direct healthcare to patients and they don’t create or collect hospital claims data. We are in favor of transparency but it is difficult for us to see exactly what such a “parent entity” would submit to MHDO for hospital claims data. To the extent that an inpatient or outpatient service is provided in a hospital or affiliated physician practice, these claims already have to be submitted under the existing hospital definition and requirements. For these reasons, we ask that the Board reject this proposed change.*

**MHDO Staff Response:**

The rationale for the proposed change is based on hospitals data submitters suggesting that physician practices (primary and specialty care) are being acquired by health systems. It was our understanding that in order to continue to collect data for physician practices that are being acquired by a health system we should include the language as stated below in 1. E.2.

**1. E. Hospital**. "Hospital" means:

* + - * 1. any acute care institution required to be licensed pursuant to 22 M.R.S.A., chapter 405;~~.~~
				2. and/or a Parent Entity, which means the person, organization or corporation that has control, directly or indirectly through majority ownership, affiliation, contract or membership of a hospital and/or any affiliated health care facility.  A parent entity may be an individual hospital or, as a parent of a health care facility, may be considered a health care facility.

**MHDO Staff Recommendation:** Based on the comments provided by the Maine Hospital Association MHDO staff recommends that the MHDO board reject the proposed change in

1. E. 2. as follows:

**1. E. Hospital.** "Hospital" meansany acute care institution required to be licensed pursuant to 22 M.R.S.A., chapter 405.

* + - 1. ~~and/or a Parent Entity, which means the person, organization or corporation that has control, directly or indirectly through majority ownership, affiliation, contract or membership of a hospital and/or any affiliated health care facility.  A parent entity may be an individual hospital or, as a parent of a health care facility, may
			be considered a health care facility.~~

**MHDO Board Action:** Approved.

**Comment 2:**

**Definition Section G** *may be an improvement over the existing definition but, in its current form, it should be clarified. The sentence that reads: “Hospital Outpatient Data also includes services provided by specialty groups or primary care practices” should be expanded to read: “Hospital Outpatient Data also includes services provided by specialty groups or primary care practices that are departments of the hospital.*

**MHDO Staff Response:**

The reason for the proposed revisions in the definition of Hospital Outpatient Data is to clarify for hospital data submitters and their vendors what hospital outpatient data includes using language that is more in line with how they think about hospital outpatient data. The goal of the revised language is to minimize situations where a hospital excludes their primary care practices from their MHDO data submissions because they do not think of these practices as departments of the hospital but rather an affiliate.

**MHDO Staff Recommendation:**

Revise the language as requested and add the additional clarification regarding affiliation.

**1. G**. **Hospital Outpatient Data**. "Hospital outpatient data" pertains to the data generated for any patient visit that is not considered an inpatient admission, at any department of the hospital, regardless of its physical location.  Hospital Outpatient Data also includes services provided by specialty groups or primary care practices that are departments of the hospital and or affiliates of the hospital.~~pertains to information which is associated with patients who receive services in a formally organized ambulatory department, clinic, provider-based practice considered a department of the hospital, and/or other departments of a hospital when those patients are not considered to be inpatients.~~

**MHDO Board Action:** Revise recommended language as follows:

**1. G**. **Hospital Outpatient Data**. "Hospital outpatient data" pertains to the data generated for any patient visit that is not considered an inpatient admission, at any department of the hospital, regardless of its physical location.  Hospital Outpatient Data also includes services provided by specialty groups or primary care practices when the hospital owns the data. ~~that are departments of the hospital and or affiliates of the hospital.pertains to information which is associated with patients who receive services in a formally organized ambulatory department, clinic, provider-based practice considered a department of the hospital, and/or other departments of a hospital when those patients are not considered to be inpatients.~~

**Comment 3:**

**Section 3 Submission Requirements, Subsection E** shortens the filing period for hospital records from the current 90 days to 30 days. *This change is impractical for hospitals to comply with and we believe that it will also lead to an incomplete and inaccurate MHDO hospital data set. In many cases it simply takes hospitals more than 30 days to create the claims and records making it impossible for them to submit the information to the MHDO within that timeframe. There are a myriad of reasons that it could take in excess of 30 days for a hospital to create a claim and record. The rendering provider needs to create the written record noting the services that were provided during the visit to the hospital. Then, the record goes to the Medical Records Department to be coded with the relevant ICD-10 code, HCPC code, CPT code, etc. The record then needs to go back to the rendering provider for signature. Lastly, the record needs to be formatted in the proper way to be submitted to the Insurance Carrier and eventually to the MHDO. For the reasons I have stated, along with the great expense it would take to make the system changes, the 30-day requirement should be rejected and the Board should maintain the 90-day requirement that appears in current law.*

**MHDO Staff Response:**

Releasing data timely is one of the goals of the MHDO transformation effort. In 2016 MHDO launched its new hospital data submission portal which was developed with two primary goals: to reduce the administrative burden on those submitting hospital data and to improve the quality and completeness of the hospital data at the point of submission. By accomplishing these goals we have been able to release to approved users higher quality hospital data more timely. However, based on several requests from hospital data users, the need for even more timely releases has been expressed. That was the rationale behind the proposed change in the filing periods.

**MHDO Staff Recommendation:**

Based on the comments provided by the Maine Hospital Association (MHA) regarding the administrative challenges of implementing the proposed change in the current 90 day filing period requirement to a 30 day requirement; and as described in the MHA’s comments the likely outcome of an incomplete and inaccurate MHDO hospital data submission if the proposed change is implemented, staff recommends that the board modify the proposed change described below as follows:

**3. E**. **Filing Periods**. Each inpatient discharge or outpatient service record must be filed no later than 90 ~~30~~ days following the calendar quarter in which the discharge or service occurred. ~~Each outpatient service record must be filed no later than 90 days following the calendar quarter in which the service occurred.~~

**MHDO Board Action:** Approved.

**2. Eastern Maine Healthcare Systems submitted the following comment**:

**Comment:**

*Our comment and concern with the changes focus on the proposal to change data submission from the current 90 days to 30 days. The 30 day timeframe would create significant challenges in our ability to close out accounts and accommodate necessary communication regarding documentation and coding queries along with other administrative tasks related to creating a clean account. Once the hospital receives the Siemens files they have many manual steps to scrub and correct the data once again requiring significant communication with other departments to address all inquiries related to the data. While the proposed 30 day timeframe is challenging for large and small hospitals, our smaller hospitals simply do not have the staffing to accommodate the increased workload to meet the deadline. For example, at some smaller hospitals only one staff member is dedicated to MHDO data submission activity and when this person is on vacation no MHDO related work occurs. We believe the 30 day timeline for data submission would reduce the quality of our data provided to MHDO requiring ongoing work to address errors in information as information is rejected by MHDO or will require correction after submission. As*

*a user of MHDO data we rely upon the accuracy of the claims information and see no value in implementing a 30 day submission timeline at the risk of data quality. We strongly recommend that the current 90 day standard for data submission be retained in the final rule.*

**MHDO Staff Response:** The rationale for the proposed change in the filing periods is based on the request from MHDO data users that MHDO collect and release hospital data more timely without jeopardizing the quality of the data submissions.

**MHDO Staff Recommendation**:

Based on the comments provided by Eastern Maine Healthcare Systems (EMHS) regarding the administrative challenges of implementing the proposed change in the current 90 day filing period requirement to a 30 day requirement; and as described in the EMHS’s comments the likely risk to the quality of the hospital data submissions if the proposed change is implemented, staff recommends that the board modify the proposed change described below as follows:

**3. E**. **Filing Periods**. Each inpatient discharge or outpatient service record must be filed
no later than 90 ~~30~~ days following the calendar quarter in which the discharge or service occurred. ~~Each outpatient service record must be filed no later than 90 days following the calendar quarter in which the service occurred.~~

**MHDO Board Action:** Approved.

**3. Maine Center for Disease Control and Prevention submitted the following comments:**

**Comment 1:**

*Overall, we are supportive of all proposed changes to this rule. In particular, we would like to express strong support for two sets of changes. Proposed changes to Section 3: Submission Requirements, Subsection E, would stipulate that records must be filed no later than 30 days* *following the calendar quarter in which the discharge or service occurred – a decrease from the current requirement of 90 days. A lack of timeliness in MHDO’s yearly data is one of the most significant challenges we face when we use and disseminate these data, although we recognize that this lack of timeliness is due to other factors besides the time it takes for hospitals to submit data to MHDO. Waiting times for receipt of final MHDO datasets have ranged in the past from approximately two years to more than four years, and our ability to target, conduct, or evaluate public health interventions based on these data is therefore severely limited. We also routinely hear from current and potential end users of this data that two- to three-year-old data are much less useful than data that are only one year old. In consideration of these challenges, we support any effort by MHDO or its data partners that would significantly improve the timeliness of the product. If a 30-day filing window is deemed unachievable by hospitals, we would be supportive any efforts by MHDO or its partners that could result in the production of final data sets in less time than the current standard.*

**MHDO Staff Response:**

Releasing data timely is one of the goals of the MHDO transformation effort. In 2016 MHDO launched its new hospital data submission portal which was developed with two primary goals: to reduce the administrative burden on those submitting hospital data and to improve the quality and completeness of the hospital data at the point of submission. By accomplishing these goals we have been able to release to approved users higher quality hospital data more timely. However, based on several requests from hospital data users, the need for even more timely releases has been expressed. Quarterly data is currently submitted 90 days following the close of the quarter and then the MHDO has needed 90 days to follow up with hospitals on specific data issues and to turn the raw data into clean and transformed data (calculating DRG’s, Geocodes etc) that can be released to approved data users. MHDO is working with its vendor to compress our processing time from 90 days to 45 days in an effort to release hospital data more timely. MHDO plans to make hospital inpatient data (beginning with Q12017 data) available on a quarterly basis to approved data users. If MHDO is successful with compressing our processing time down to 45 days, the quarterly releases should be available approximately 4.5 months after the close of the quarter. We are planning to release Q12017 hospital data in September 2017. Q22017 hospital inpatient data should be the first quarterly release that is available 4.5 months after the close of the quarter.

**MHDO Staff Recommendation:**

No action required in the proposed rule change.

**MHDO Board Action:** Approved.

**Comment 2:**

*The second change for which we would like to express strong support is the addition, in Appendices B-1, B-2, C-1, and C-2, of patient name and address as required data elements. Access to these data would allow us to better identify and track patients through the health care system, and in specific would give us the ability to de-duplicate multiple records for patient visits to different facilities in the process of a transfer of care. Currently, encrypted medical record numbers used to identify patients are unique only within a facility, meaning that we have no way to reliably track patients between facilities. Measures we create and use for acute myocardial infarction visits, in particular, require the de-duplication of these transfers, and access to patient identifiers would make this de-duplication process more accurate and less time-consuming. Furthermore, address information allows us to relate patients to other important geographic units, such as census tracts, which can then be linked to neighborhood demographics or risk factors. Address information can also be used to identify point locations, allowing detailed analysis of spatial patterns, residential-specific assessment of exposures, or analysis of access to care (by drive time, for example). In addition, having patient name and address would allow us to link hospital discharge data to other datasets, such as cancer registry data, birth certificate data, and death certificate data. This would allow us to examine health outcomes and associated risks, such as neonatal re-admissions; maternal morbidity, and neonatal abstinence syndrome. These linkages would also assist in monitoring data quality by comparing conditions across data systems.*

**MHDO Staff Response:**

The primary reason for this proposed change is because the Medical Record Number (MRN) used to identify patients is not consistently being assigned within facilities. The MHDO assigned Medical Record Number (MRN) is a de-identified version of the MRN that is submitted by facilities to uniquely identify patients. The MRN is generally used by the hospital data system to tie information about a particular encounter to a patient's medical history and care information. It has come to the MHDO’s attention that some hospitals assign different MRN’s for the same patient who accesses both their inpatient and outpatient services.  Because of this, MHDO is not always able to create a unique patient identifier within and across facilities. This proposed rule change addresses this issue and will allow the MHDO to create a de-identified master patient index.

**MHDO Staff Recommendation:**

No action required in the proposed rule change.

**MHDO Board Action:** Approved.