90-590 Maine Health Data Organization

Public Hearing – August 3, 2023

Basis Statement/Summary of Changes

Chapter 243: Uniform Reporting System for Health Care Claims Data Sets

(Routine Technical Rule)

The Maine Health Data Organization is authorized by statute to collect health care data. This chapter governs the provisions for filing health care claims data sets from all third-party payers, third-party administrators, Medicare health plan sponsors and pharmacy benefits managers. The provisions include identification of the organizations required to report; establishment of requirements for the content, format, method, and time frame for filing health care claims data; establishment of standards for the data reported; and compliance provisions.

This proposed rule adds new fields to collect de-identified substance use disorder (SUD) data, prescription drug rebate data, and additional dental claims information. It modifies fields in the medical claims file to better account for the payment arrangement type at the claim level. It also removes obsolete requirements, definitions, and sources.

The MHDO Board met on February 2, 2023 and authorized the MHDO to initiate rulemaking to Chapter 243. Below is a summary of these rule changes.

1. Add definitions for Pharmacy Benefits Manager Compensation (1(U)), POS (1(X)), Rebate (1(Z)), Substance Use Disorder (1(CC)), and SUD Claims File (1(DD)). [page 3]

   Justification: Additional definitions clarify the new reporting requirements.

2. Add data elements to eligibility (ME) consistent with the APCD Common Data Layout (APCD-CDL™): Grandfathered Plan Indicator (ME116), Metal Tier (ME117), Enrolled Through a Public Health Insurance Exchange (ME118), and Cost-Sharing Reduction Indicator (ME119). [pages 28-29, 32]

   Justification: The new fields in the eligibility file (ME116-ME119) provide researchers with the information needed to understand and report on plan enrollment, cost, and member benefits for those enrolled in a public health insurance exchange.

3. Add Service Line Date – From (MC333), and Service Line Date – Thru (MC334) to the medical claims file. [pages 59, 70]

   Justification: New date fields MC333 and MC334 can be used for reporting claim-line service dates, when available, thereby improving the completeness and accuracy of reported data.

4. Add new data elements Total POS Rebate Amount (PC113), Member POS Rebate Amount (PC114), and PBM Compensation Amount (PC115) to the pharmacy claims file. [pages 76, 79]

   Justification: The collection of pharmacy rebate data improves the transparency and accuracy of prescription drug reporting in the State under 22 MRSA §8736, and validating compliance with 24-A MRSA §§4350-A and 4350-D.

5. Add new data elements consistent with the APCD Common Data Layout (APCD-CDL™) for Oral Cavity (DC112-DC116), Tooth Number(s) or Letter(s) (DC117, DC123, DC129, DC135), and Tooth Surface (DC118-DC122, DC124-DC128, DC130-DC134, DC136-DC140) to the dental claims file. (pages 86-90; 93-94)

   Justification: The Dental Quality Alliance (DQA) has developed several quality indicators that rely on dental data from claims. While the Children's Oral Health Network has only used a measure that requires medical emergency department claims from the DQA measure, CMS is requiring MaineCare to use measures that use these items from the dental claim for reporting on the Children's Health Improvement Program (CHIP).

6. Add new Substance Abuse Disorder Medical Claims File (SM) and Substance Abuse Disorder Pharmacy Claims File (SP) specifications and mappings to national standard formats. [pages 7, 12-18, 95-133]

   Justification: Permit a uniform, complete collection of de-identified SUD data (as opposed to non-uniformly aggregated and redated), which is necessary for accurate reporting of behavioral health care expenditures in Maine, as mandated in PL 2021 c. 603.

7. Modify or clarify data element descriptions, uses, code set values or mappings for Prepaid Amount (MC064), Payment Arrangement Indicator Type (MC331), Paid Amount (PC036), Co-pay Amount (PC040), Coinsurance Amount (PC041), and Deductible Amount (PC042). [pages 39, 58, 59, 74]

Justification: Changes to Payment Arrangement Indicator Type (MC331) and the amount fields provide the clarification necessary for the payors to provide uniform reporting of APC and capitation payment data.

8. Retire data elements for DRG and DRG Version (MC071, MC072; pages 40, 63), APC and APC Version (MC073, MC074; page 40, 41, 63); ICD-9 coding, including Admitting Diagnosis (MC039), E-Code (MC040), Principal Diagnosis (MC041), Other Diagnosis – 1 – 12 (MC042-MC053), and ICD-9-CM Procedure Code (MC058) [pages 37-39, 62]; Payment Arrangement Type Indicator in the pharmacy and dental claims files (PC111; pages 75, 76, 79; DC111; pages 86, 93).

   Justification: Obsolete and unused fields are retired.

9. Delete external sources (Appendix A; pages 14, 15 and 18), the definition of Prepaid Amount (1(~~W~~); page 3), and the general requirement for Prepaid Amount (2(A)(13); page 6).

   Justification: Obsolete or unused external sources, definitions and requirements are deleted.

Statutory Authority: 22 M.R.S.A., §§8703(1), 8704(4), 8708(6-A) and 8712(2)

Effective Date: TBD