90-590 MAINE HEALTH DATA ORGANIZATION

CHAPTER 247: UNIFORM REPORTING SYSTEM FOR NON-CLAIMS-BASED PAYMENTS AND OTHER SUPPLEMENTAL HEALTH CARE DATA SETS

SUMMARY: This Chapter contains the provisions for filing supplemental health care data sets, including non-claims-based payments; aggregated, claims-based payments; and prescription drug rebate data ~~information and other supplemental health care data sets~~.

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1. Definitions

Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

A. **Behavioral Health Care**. "Behavioral health care (BH)" means services to address mental health and substance use conditions. 24-A MRSA §6903, sub-§1-A.

B. **Capitation Payments**. "Capitation payments" means per capita payments to providers to provide services needed by designated patients over a defined period.

C. **Care Management/Care Coordination/Population Health Payments**. "Care management/care coordination/population health payments" means payments to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, patient navigators, or nurse care managers) who help providers organize clinics to function better and help patients take charge of their health.

D. **Carrier**. "Carrier" means an insurance company licensed in accordance with 24-A M.R.S., including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to 24-A M.R.S., chapter 81, a preferred provider organization, a fraternal benefit society, or a nonprofit hospital or medical service organization or health plan licensed pursuant to 24 M.R.S. An employer exempted from the applicability of 24-A M.R.S., chapter 56-A under the federal *Employee Retirement Income Security Act of 1974*, 29 *United States Code*, Sections 1001 to 1461 (1988) ("ERISA") is not considered a carrier.

E. **Designee**. "Designee" means an entity with which the MHDO has entered into an agreement under which the entity performs data collection, validation and management functions for the MHDO and is strictly prohibited from releasing information obtained in such a capacity.

F. **Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments**. "Electronic health records/health information technology infrastructure and other data analytics payments" means payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs outside of the electronic health records and/or the cost of a data analyst to support practices.

G. **Global Budget Payments**. “Global budget payments” means payments made to providers for either a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain services such as behavioral health or pharmacy are carved out. Services typically include primary care clinician services, specialty care physician services, inpatient hospital services, and outpatient hospital services, at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.

H. **Medicare Health Plan Sponsor**. “Medicare health plan sponsor” means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

I. **Medication Reconciliation**. “Medication reconciliation” means payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

J. **MHDO**. "MHDO" means the Maine Health Data Organization.

K. **M.R.S.** “M.R.S.” means *Maine Revised Statutes*.

L. **Non-Claims Based Payments.** “Non-claims-based” means payments that are for something other than a fee-for-service claim. These payments include but are not limited to Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions.

M. **Patient-centered Medical Home Payments**. “Patient-centered medical home payments” means Practice-level payments such as payments to Patient-Centered Medical Homes (PCMH), Health Homes for provision of comprehensive services; payments based upon PCMH recognition; or payments for participation in proprietary or other multi-payor medical -home or specialty care practice initiative.

N. **Pay-for-performance Payments**. “Pay-for-performance payments” means payments to reward providers for achieving a set target (absolute, relative, or improvement-based) for quality or efficiency metrics. Payments could include the return of a withhold if not attached to a claim payment.

O. **Pay-for-reporting Payments**. “Pay-for-reporting payments” means payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for future pay-for-performance incentives.

P. **Payor.** "Payor" means a carrier, third-party payor, third-party administrator, Medicare health plan sponsor or Medicaid.

Q. **Pharmacy Benefits Manager**. "Pharmacy benefits manager" means an entity that performs pharmacy benefits management as defined in 24-A M.R.S. §4347, sub-section 17.

R. **Pharmacy Benefits Manager Compensation.** "Pharmacy benefits manager compensation" means the difference between:

i. the value of payments made by a carrier to its pharmacy benefits manager; and

ii. the value of payments made by the pharmacy benefits manager to dispensing pharmacies for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the carrier.

~~R.~~S. **Primary Care**. "Primary care" means regular check-ups, wellness and general health care provided by a provider (see Appendix A) with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

~~S.~~T. **Primary Care and Behavioral Health Integration Payments**: "Primary care and behavioral health integration payments" means payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting), such as: a) substance abuse or depression screening; b) performing assessment, referral, and warm hand-off to a behavioral health clinician; and/or c) supporting health behavior change, such as diet and exercise for managing prediabetes risk). This excludes payments for mental health or substance use counseling.

~~T.~~U. **Prospective Case Rate Payments**. "Prospective case rate payments" means payments received by providers in a given provider organization for a patient receiving a defined set of services for a specific period.

~~U.~~V. **Prospective Episode-based Payments.** "Prospective episode-based payments" means payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers, including providers, or care for a specific condition over a specific time.

~~V.~~W. **Provider**. "Provider" means a health care facility, health care practitioner, health product manufacturer or health product vendor but does not include a retail pharmacy.

X. **Provider Salary Payments**. "Provider salary payments" means payments for salaries of providers who provide care. This category may only be applicable for closed health systems.

~~W.~~Y. **Rebate**. "Rebate" means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point-of-sale, as part of retrospective financial reconciliations (including reconciliations that also reflect other contractual arrangements), or by any other method. "Rebate" does not mean a "bona fide service fee", as such term is defined in Section 447.502 of Title 42 of the Code of Federal Regulations, published October 1, 2019.

~~X.~~Z. **Recoveries**. "Recoveries" means payments received by a provider from a payor and then later recouped due to a review, audit, or investigation. Recoveries not reported in claims payments should be netted out of the total non-claims-based payments reported.

~~Y. **Redacted Payments**. "Redacted payments" mean payments in which an entire claim or some portion of a claim that would normally be part of the payor's medical or pharmacy claims submission to the MHDO was removed or altered prior to submission to conform to the requirements of 42 CFR Part 2.~~

~~Z.~~AA. **Retrospective/Prospective Incentive Payments**. "Retrospective/prospective incentive payments" means payments to reward providers for achieving quality and/or efficiency goals. The two main subcategories of incentive payments are pay-for-performance and pay-for-reporting.

~~AA.~~BB. **Risk-based Payments**. "Risk-based payments" means payments received by providers (or recouped from providers) based on performance relative to a defined spending target. Risk-based payment methodologies can be applied to different types of budgets, including but not limited to episode of care and total cost of care. The two main subcategories of risk-based payments are shared savings and shared risk.

~~BB.~~CC. **Shared-risk Recoupments**. "Shared-risk recoupments" means payments payors recoup from providers if costs of services are above a predetermined, risk-adjusted target. Shared-risk arrangements are typically calculated on a total cost of care basis and typically exclude high-cost outliers. Recoupment should be netted out of the total non-claims-based payments reported.

DD. **Shared-savings Distributions**. "Shared-savings distributions" means payments received by providers if costs of services are below a predetermined and risk-adjusted target. The amount of savings the provider can receive is often linked to performance on quality measures.

~~CC.~~EE. Substance Use Disorder (SUD). "SUD means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal, excluding tobacco/nicotine or caffeine use.

~~DD.~~FF. **Supplemental Health Care Data Sets**. "Supplemental health care data sets" means data files specific to payments for primary care, behavioral health or other health care services. Supplemental health care data sets may include aggregated, non-claims-based payment information, or aggregated or non-aggregated, ~~redacted~~ SUD claims-based payment information.

~~EE.~~GG. **Third-party Administrator.** "Third-party administrator" means any person licensed by the Maine Bureau of Insurance under 24-A M.R.S., chapter 18 who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service

organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State.

~~FF.~~HH. **Third-party Payor**. "Third-party payor" means a state agency that pays for health care services or a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization, or managed care organization licensed in the State.

2. Non-Claims-Based Payments and Other Supplemental Health Care Data Set Filing Description

A. **General Requirements**

(1) Payors that: ~~a~~i) provide medical benefits to Maine residents; and ~~b~~ii) are not excluded from submitting health care claims data sets under 90-590 Chapter 243 Sec 2(A)(9)(a-b); and iii~~c~~) reimburse providers by means other than a Fee-for-Service model shall submit to the MHDO or its designee the following complete data sets, if applicable.

(2) Types and descriptions of data sets and supporting information files

a) Non-claims-based (NC) data sets consist of aggregated NC payment information regarding payments from payors to providers for the prior calendar year, which is defined as the performance period. NC files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out. Payors shall report NC payments for Medicare and non-Medicare Advantage (commercially insured) populations separately, combining plans as needed within those populations. It may be necessary to estimate portions of NC payments by population if amounts are paid to provider systems for plans that include both populations. Population counts encompass all eligible members, not just those associated with providers who received NC payments.

b) Aggregated, SUD-claims-based (AC) data sets consist of AC payment information regarding payments from payors to providers. The performance period is retrospective and defined to include claims incurred during the prior calendar year (no limitation on paid date). AC files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out. Payors shall aggregate SUD claims payments by the product codes identified in Section 2(B), data element AC003 and report totals for each product code. The total members and total member months in the AC file include all members eligible for the product code in the performance period, not just those with SUD claims.

c) Prescription drug rebate (DR) data sets consist of aggregated prescription drug payment and rebate information. The performance period is retrospective and defined to include claims incurred during the prior calendar year with no limitation on paid date or rebate received date. DR files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out.

d) NC and AC data set types shall be accompanied by the appropriate supporting information file. Samples are found at https://mhdo.maine.gov/portal.

i. The supporting information file for an NC payment data set must describe the methods used to reimburse behavioral health care providers.

ii. The supporting information file for an AC payment data set must detail the methods used to identify the substance use disorder claims, the specific

code lists that are used for procedure codes, revenue codes and diagnosis codes, provider types and any other detail on the claim that is required to select the substance use disorder claim.

(3) The payors specified in section (1) shall indicate the data set types that are applicable to all plans or certify that these are not applicable via the annual registration update at https://mhdo.maine.gov/portal by February 28th of each year. It is the responsibility of the payor to amend the information, as needed, and to have an authorized user electronically sign to confirm/attest that the information provided is complete and accurate.

(4) The payor(s) that administer(s) health insurance for State of Maine employees and the Maine Education Association Benefits Trust to pay for behavioral health care shall also submit separate data sets and supporting information for these two groups.

(5) Each payor is responsible for the submission of all applicable data sets and supporting information made by any sub-contractor on its behalf.

(6) Any self-funded employee benefit plan regulated by ERISA that submits claims data under 90-590 CMR Chapter 243 Section 5 shall submit completed, applicable data sets for Maine residents and supporting information in accordance with the provisions of this rule. Any such data shall be subject to the same laws and regulations as other MHDO data.

~~(1) Payors that: a) provide medical benefits to Maine residents; and b) are not excluded from submitting health care claims data sets under 90-590 Chapter 243 Sec 2(A)(9)(a-b); and c) reimburse providers by means other than a Fee-for-Service model shall submit to the MHDO or its designee complete non-claims-based (NC) payment data and/or aggregated, redacted claims-based (AC) payment data, if applicable, and each data set type must be accompanied by the appropriate supporting information file in accordance with the requirements of this section. NC and AC payments are payments from payors to providers based on the definitions above. The supporting information file for an NC payment data set must describe the methods used to reimburse behavioral health care providers. The supporting information file for an AC payment data set must detail the methods used to redact the substance use disorder claims, the specific code lists that are used for procedure codes, revenue codes and diagnosis codes, provider types and any other detail on the claim that is required to select the substance use disorder redacted claim. See https://mhdo.maine.gov/portal for sample NC and AC supporting information files.~~

~~The above payors shall report NC and AC payments for all plans or certify that these are not applicable via the annual registration update at https://mhdo.maine.gov/portal by February 28th of each year. The payor(s) that administer(s) health insurance for State of Maine employees and the Maine Education Association Benefits Trust to pay for behavioral health care shall also submit separate data sets and supporting information for these two groups. It is the responsibility of the payor to amend the information, as needed, and to have an authorized user electronically sign to confirm/attest that the information provided is complete and accurate.~~

~~(2) Payors shall report NC payments for Medicare and non-Medicare Advantage (commercially insured) populations separately, combining plans as needed within those populations. It may be necessary to estimate portions of NC payments by population if amounts are paid to provider systems for plans that include both populations. Population counts encompass all~~

~~eligible members, not just those associated with providers who received Non-Claims-Based Payments. Payors shall aggregate redacted claims (AC) payments by the product code identified in AC003 and report totals for each product code. The total members and total member months in the AC file include all members eligible for the product code in the performance period, not just those with redacted claims.~~

~~(3) Each payor is responsible for the submission of all information related to NC and AC payments and applicable supporting information made by any sub-contractor on its behalf.~~

~~Any self-funded employee benefit plan regulated by ERISA that submits claims data under 90-590 CMR Chapter 243 Section 5, may voluntarily submit completed data sets for Maine residents regarding NC and AC payments and applicable supporting information in accordance with the provisions of this rule. Any such data shall be subject to the same laws and regulations as other MHDO data.~~

~~(4) Payors shall prepare the NC and AC files for the prior calendar year, using the most recent information available at the time of file generation with a minimum of 3 months of run-out. For the NC file, the performance period is defined to include payments made to providers in the prior calendar year. For the AC file, the performance period is retrospective and defined to include claims incurred during the prior calendar year (no limitation on paid date).~~

B. **Data Elements and Attributes by Header Record, Trailer Record and File Type**

Header Record (for All File Types)

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
HD001	**Record Type**	Text	2	HD
HD002	**Submitter**	Text	8	MHDO-assigned identifier of payor submitting data. Do not leave blank.
HD003	**Payor**	Text	8	MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage
HD004	**Type of File**	Text	2	AC Aggregated, ~~Redacted~~ SUD Claims-Based Payments DR Prescription Drug Rebates NC Non-Claims-Based Payments
HD005	**Period Beginning Date**	Text	6	CCYYMM Beginning of paid period for payments
HD006	**Period Ending Date**	Text	6	CCYYMM

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
				End of paid period
HD007	**Record Count**	Number	10	Total number of records submitted in this file Exclude header record in count
HD008	**Comments**	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Trailer Record (for All File Types)

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
TR001	**Record Type**	Text	2	TR
TR002	**Submitter**	Text	8	MHDO-assigned identifier of payor submitting data. Do not leave blank.
TR003	**Payor**	Text	8	MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage
TR004	**Type of File**	Text	2	AC Aggregated, ~~Redacted~~ SUD Claims-Based Payments DR Prescription Drug Rebates NC Non-Claims-Based Payments
TR005	**Period Beginning Date**	Text	6	CCYYMM Beginning of paid period for payments
TR006	**Period Ending Date**	Text	6	CCYYMM End of paid period
TR007	**Data Processed**	Text	8	CCYYMMDD Date file was created

File Type NC – Non-Claims-Based Payments

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
NC001	**Submitter**	Text	8	MHDO-assigned identifier of payor submitting data. Do not leave blank.
NC002	**Payor**	Text	8	MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage
NC003	~~**Insurance Type/Product Code**~~ **Placeholder**	~~Text~~ N/A	~~2~~ 0	~~**Do not code as part of this data extract AND leave blank.** Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes:~~ ~~HN Medicare Part C~~ ~~MD Medicare Part D~~ ~~Retired. Leave Blank.~~ .
NC004	**Performance Period Start Date**	Text	6	CCYYMM Effective date of performance period. Performance period refers to payment date.
NC005	**Performance Period End Date**	Text	6	CCYYMM End date of performance period. Performance period refers to payment date.
NC006	**Total Number of Members**	Number	10	The count of individual members with any eligibility in the performance period in the population identified in NC012. No decimal places; round to nearest integer Example: 12345
NC007	**Total Member Months**	Number	10	The total number of member months of eligibility in the performance period in the population identified in NC012. No decimal places; round to nearest integer Example: 12345
NC008	**Total Dollars Non-Claims-Based Payments**	Number	10	Do not code decimal point. Two decimal places implied.

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
NC009	**Total Dollars Non-Claims-Based Payments (Primary Care Only Portion)**	Number	10	Do not code decimal point. Two decimal places implied. See definition of Primary Care above (1Q) for reporting Primary Care Only.
NC010	**Total Dollars Non-Claims-Based Payments (BH/SUD Only Portion)**	Number	10	Do not code decimal point. Two decimal places implied. See definition of Behavioral Health/Substance Use Disorder above (1A) and Appendix C for reporting BH/SUD Only.
NC011	**Total Dollars Non-Claims-Based Payments (non-PC/non-BH/SUD)**	Number	10	Do not code decimal point. Two decimal points implied.
NC012	**Population**	Text	2	Population to which the payments apply. CI Commercially Insured (non-Medicare Advantage) MA Medicare Advantage MC MaineCare
NC013	**Payor Notes**	Text	320	Clarification about the population to which the payments apply, limitations in ability to report the measure, and/or explanation of why the data is not reported.

Note: 8/23/2024-Based on payor feedback, the NC numbering scheme has reverted to the previous version. This technical change is identified above in orange in Track Changes. This technical correction was added after formal adoption and will be incorporated into the rule when it is reopened for revision.

File Type AC – Aggregated~~, Redacted~~ SUD Claims-Based Payments

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
AC001	**Submitter**	Text	8	MHDO-assigned identifier of payor submitting data. Do not leave blank.
AC002	**Payor**	Text	8	MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
				in the case of self-funded coverage
AC003	**Insurance Type/Product Code**	Text	2	Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes: HN Medicare Part C MD Medicare Part D
AC004	**Performance Period Start Date**	Text	6	CCYYMM Effective date of performance period for reported Insurance Type/Product Code. Performance period refers to incurred date on redacted claims.
AC005	**Performance Period End Date**	Text	6	CCYYMM End date of performance period for reported Insurance Type/Product Code. Performance period refers to incurred date on redacted claims.
AC006	**Total Number of Members**	Number	10	The count of individual members with any eligibility in the performance period in the product code identified in AC003. No decimal places; round to nearest integer Example: 12345
AC007	**Total Member Months**	Number	10	The total number of member months of eligibility in the performance period in the product code identified in AC003. No decimal places; round to nearest integer Example: 12345
AC008	**Total Plan-Paid Dollars SUD Claims-Based Payments Not Reported to MHDO**	Number	10	The amount on claims that were not submitted to the MHDO under MHDO Rule Ch. 243. Do not code decimal point. Two decimal places implied.
AC009	**Total Plan-Paid Dollars on Claims/Claim Lines Sent to MHDO**	Number	10	Indicates the amount paid on claims where SUD codes were removed before the claims were submitted to MHDO under MHDO Rule Ch. 243.

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
	where SUD Codes Were Removed			Do not code decimal point. Two decimal places implied.
AC010	**Coverage Type**	Text	2	Type of coverage with which payments are associated. 01 Medical 02 Pharmacy
AC011	**Payor Notes**	Text	320	Clarification about the population to which the payments apply, limitations in ability to report the measure, and/or explanation of why the data is not reported.
AC012	**Total Plan-Paid Dollars SUD Claims- Based Payments Related to Primary Care**	Number	10	Do not code decimal point. Two decimal places implied.

Note: 8/23/2024-Based on payor feedback, the AC numbering scheme has reverted to the previous version. This technical change is identified above in orange in Track Changes. This technical correction was added after formal adoption and will be incorporated into the rule when it is reopened for revision.

File Type DR – Prescription Drug Rebates

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
DR001	**Submitter**	Text	8	MHDO-assigned identifier of payor submitting data. Do not leave blank.
DR002	**Payor**	Text	8	MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
DR003	Insurance Type/ Product Code	Text	2	Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes: HN Medicare Part C MD Medicare Part D
DR004	Performance Period Start Date	Text	6	CCYYMM Effective date of performance period. Performance period refers to date of fill.
DR004	Performance Period End Date	Text	6	CCYYMM Effective date of performance period. Performance period refers to date of fill.
DR005	Drug Code	Text	11	NDC Code
DR006	Drug Name	Text	80	Text name of drug
DR007	Generic Drug Indicator	Text	1	N No, branded drug Y Yes, generic drug
DR008	Specialty Drug Indicator	Text	1	Drug defined as a specialty drug under the terms of a payer's contract with its PBM. N No Y Yes
DR009	Total Count of Prescriptions Filled	Number	15	Total count of all prescriptions filled by members. No decimal places; round to nearest integer Example: 12345
DR010	Total Quantity Dispensed	Number	15	Total Number of metric units of medication dispensed. No decimal places; round to nearest integer Example: 12345

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
DR011	Total Pharmacy Expenditure Amount	Number	15	The sum of all incurred claim allowed payment amounts to pharmacies for the drug as defined by the payor's prescription drug benefit. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). (Allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates or pharmacy benefit manager compensation in any way). No decimal places; round to nearest integer Example: 12345
DR012	Total Manufacturer Prescription Drug Rebates	Number	15	Total prescription drug rebates remitted by or on behalf of a pharmaceutical manufacturer, directly or indirectly, to a payor, or to a pharmacy benefits manager under contract with a payor. The total manufacturer prescription drug rebate amount should not be included in the total pharmacy expenditure amount. No decimal places; round to nearest integer Example: 12345
DR013	Total Pharmacy Prescription Drug Rebates	Number	15	Total prescription drug rebates (including direct or indirect remuneration) remitted by or on behalf of a pharmacy, directly or indirectly, to a payor, or to a pharmacy benefits manager under contract with a payor. The total pharmacy prescription drug rebate amount should not be included in the total pharmacy expenditure amount. No decimal places; round to nearest integer Example: 12345

Data Element #	Data Element Name	Type	Maximum Length	Definition/Description
DR014	Percent Rebate Retained by PBM	Number	10	The percent of total prescription drug rebates retained by a pharmacy benefits manager under contract with a payor. Do not code decimal point. Two decimal places implied.
DR015	Total PBM Compensation Amount	Number	15	The total value of payments made by the payor to its pharmacy benefits manager that is not paid to the pharmacy. The pharmacy benefits manager compensation amount should not be included in the total pharmacy expenditure amount. No decimal places; round to nearest integer Example: 12345
DR016	Payor Notes	Text	1000	Additional information related to the data submitted for this drug product.

C. **File-Level Specifications**

1) **File Formats**.

(a) Each data file submission shall be an encrypted (AES-256) ASCII file, variable field length, and asterisk delimited. It shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. Each record shall be terminated with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

(b) Each supporting information file shall be a Microsoft Excel®-compatible spreadsheet.

2) **Filled Fields**. All required fields shall be filled where applicable. Non-required text and number fields shall be left blank when unavailable.

3) **Position**. All text fields are to be left justified. All numeric fields are to be right justified.

4) **Signs**. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields.

3. Submission Requirements

A. **File Organization.** Each file shall be submitted to the MHDO or its designee separately.

B. **Filing Method**. Data files and supporting information must be submitted to the MHDO's Payor Data Portal via secure FTP or secure web upload interface at https://mhdo.maine.gov/portal. E-mail attachments shall not be accepted.

C. **Testing of Files**. File testing shall be completed within one hundred and eighty days of the adoption of any changes to the data element content or format of the files described in Section 2(B) or at least sixty days prior to the initial submission of production files.

D. **Rejection of Files**. Failure to conform to the requirements subsections A, B, or C of this Section shall result in the rejection of the applicable data file(s). All rejected files must be resubmitted in the appropriate, corrected form to the MHDO or its designee within 15 days.

E. **Filing Period**. The annual filing for each submission shall cover the previous completed calendar year and shall be due by August 31.

F. **Update/Replacement of Data**. A payor may update or replace a data file submission up to one year after its original due date. Any updates or replacements after this period must be approved by the MHDO.

4. Data Validation; Notification; Response

A. **Attestation**. The MHDO or its designee shall require an authorized user for each payor to electronically sign an attestation that the payor is compliant with the requirements outlined in this rule. The annual attestation shall be due by August 31.

B. **Notification**. Within 15 days, the MHDO or its designee will complete the evaluation of any data file submissions and notify any payors whose data submissions for any filing period do not satisfy the requirements of Section 2(B). This notification will identify the specific file(s) and the data elements within the file(s) that do not satisfy the requirements.

C. **Response**. Each payor notified under subsection 4(B) shall respond in writing within 15 days of notification and make the necessary changes within 30 days to satisfy the requirements.

5. Public Access

Information collected, processed and/or analyzed under this rule shall be subject to release to the public or retained as confidential information in accordance with 22 M.R.S. Chapter 1683 and *Code of Maine Rules* 90-590, Chapter 120, unless prohibited by state or federal law.

6. Extensions or Waivers to Data Submission Requirements

If a payor, due to circumstances beyond its control, is temporarily unable to meet the terms and conditions of this rule, a written request must be made within 30 days of the filing deadline of August 31 to the Compliance Officer of the MHDO. The written request shall include: the specific requirement to be extended or waived; an explanation of the cause; the methodology proposed to eliminate the necessity of the extension or waiver; and the time frame required to come into compliance. If the Compliance Officer does not approve the requested extension or waiver, the payor may submit a written request appealing the decision to the MHDO Board. The appeal shall be heard by the MHDO Board at the next regularly scheduled meeting following receipt of the request at the MHDO.

7. Compliance

The failure to file, report, or correct non-claims-based payment data sets when required under the provisions of this rule may be considered a violation under 22 M.R.S. Sec. 8705-A and Code of Maine Rules 90-590, Chapter 100: *Enforcement Procedures*.

STATUTORY AUTHORITY: 22 M.R.S. §§ 8703(1); 8704(1) & (4); and 24-A M.R.S, §6951

EFFECTIVE DATE: December 12, 2021

AMENDED: December 20, 2022

Appendix A
Primary Care Provider Type Taxonomy Codes and Description

Primary Care	
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary Care Clinic
261QR1300X	Rural Health Clinic
207Q00000X	Physician, Family Medicine
207R00000X	Physician, General Internal Medicine
175F00000X	Naturopathic Medicine
208000000X	Physician, Pediatrics
208D00000X	Physician, General Practice
363L00000X	Nurse Practitioner
363LA2200X	Nurse Practitioner, Adult Health
363LF0000X	Nurse Practitioner, Family
363LP0200X	Nurse Practitioner, Pediatrics
363LP2300X	Nurse Practitioner, Primary Care
363A00000X	Physician Assistants
363AM0700X	Physician Assistants, Medical
207RG0300X	Physician, Geriatric Medicine
207QG0300X	Family Practice Geriatrics
207QA0505X	Family Practice Adult
207QA0000X	Family Practice Adolescent
175L00000X	Homeopathic Medicine
2083P0500X	Physician, Preventive Medicine
364S00000X	Certified Clinical Nurse Specialist
163W00000X	Registered Nurse, Non-Practitioner
OB/GYN Codes	
207V00000X	Physician, Obstetrics and Gynecology
207VG0400X	Physician, Gynecology
363LW0102X	Nurse Practitioner, Women’s Health
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology

Appendix B
Maine Health Data Organization
Source Codes

Accredited Standards Committee (ASC)

ASC X12 Directories
(MHDO Data Element: NC003)

SOURCE: Complete ASC X12 005010 Standard

AVAILABLE FROM:
https://www.nex12.org/
Data Interchange Standards Association, Inc. (DISA)
7600 Leesburg Pike Ste 430
Falls Church, VA 22043

ABSTRACT: The complete standard includes design rules and guidelines, control standards, transaction set tables, data element dictionary, segment directory and code sources. The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

Several Definitions are adapted from the Milbank Memorial Fund Report, available from:

https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf

National Uniform Claim Committee

Healthcare Provider Taxonomy Code Set
(MHDO Data Element: NC010; Tables in Appendices A and C)

SOURCE: https://taxonomy.nucc.org/

ABSTRACT: The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions. Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers. The Code Set consists of two sections: Individuals and Groups of Individuals, and Non-Individual.

Appendix C
Behavioral Health Provider Type Taxonomy Codes and Descriptions

Taxonomy Code	Taxonomy Description	
	Classification	**Specialization**
101Y00000X	Behavioral Health & Social Service Providers	Counselor
101YA0400X	Behavioral Health & Social Service Providers	Addiction (Substance Use Disorder)
101YM0800X	Behavioral Health & Social Service Providers	Mental Health
101YP1600X	Behavioral Health & Social Service Providers	Pastoral Behavioral Health & Social Service Providers
101YP2500X	Behavioral Health & Social Service Providers	Professional
101YS0200X	Behavioral Health & Social Service Providers	BH & Social Service Providers, School
103K00000X	Behavioral Health & Social Service Providers	Behavior Analyst
103T00000X	Psychologist, Clinical	Assistant Behavior Analyst
103TA0400X	Psychologist, Clinical	Behavior Technician
103TA0700X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Adult Development & Aging
103TB0200X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Cognitive & Behavioral
103TC0700X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Clinical
103TC1900X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Counseling
103TC2200X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Clinical Child & Adolescent
103TF0000X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Family
103TM1800X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Mental Retardation & Developmental Disabilities
103TP0016X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Prescribing (Medical)
103TP0814X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Psychoanalysis
103TP2701X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, Group Psychotherapy
103TS0200X	Psychologist, Clinical	Behavioral Health & Social Service Providers/Psychologist, School

Taxonomy Code	Taxonomy Description	
	Classification	**Specialization**
104100000X	Behavioral Health & Social Service Providers	Social Worker
1041C0700X	Behavioral Health & Social Service Providers	Behavioral Health & Social Service Providers
1041S0200X	Behavioral Health & Social Service Providers	School
106H00000X	Behavioral Health & Social Service Providers	Marriage and Family Therapist
106S00000X	Behavior Technician	Behavior Technician
133VN1006X	Registered Dietitian or Nutrition Professional	Dietary & Nutritional Service Providers/Dietician, Registered, Nutrition, Metabolic
163WA0400X	Registered Nurse	Addiction (Substance Use Disorder)
163WP0807X	Registered Nurse	Psychiatric/Mental Health, Child & Adolescent
163WP0808X	Registered Nurse	Psychiatric/Mental Health
163WP0809X	Registered Nurse	Psychiatric/Mental Health, Adult
171M00000X	Case Manager/Care Coordinator	Case Manager/Care Coordinator
171W00000X	Contractor	Contractor
175T00000X	Peer Specialist	Peer Specialist
177F00000X	Other Service Providers	Lodging
207QA0401X	Physician/Addiction Medicine	Allopathic & Osteopathic Physicians/Family Medicine, Addiction Medicine
207ZC0008X	Pathology	Clinical Informatics
2080P0006X	Physician/Pediatric Medicine	Allopathic & Osteopathic Physicians/Pediatrics, Developmental– Behavioral Pediatrics
2084A0401X	Physician/Addiction Medicine	Allopathic & Osteopathic Physicians/Psychiatry & Neurology, Addiction Medicine
2084F0202X	Physician/Neuropsychiatry	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Forensic Psychiatry
2084P0015X	Physician/Neuropsychiatry	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Psychosomatic Medicine
2084P0800X	Physician/Psychiatry	Allopathic & Osteopathic Physicians/Psychiatry
2084P0802X	Physician/Neuropsychiatry	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Addiction Psychiatry
2084P0804X	Physician/Neuropsychiatry	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Child & Adolescent Psychiatry
2084P0805X	Physician/Neuropsychiatry	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry
222Q00000X	Developmental Therapist	Developmental Therapist
225400000X	Rehabilitation Practitioner	Rehabilitation Practitioner
225500000X	Specialist/Technologist	Respiratory, Developmental, Rehabilitative and Restorative Specialist

Taxonomy Code	Taxonomy Description	
	Classification	**Specialization**
225600000X	Dance Therapist	Dance Therapist
225XM0800X	Occupational Therapist in Private Practice	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist, Mental Health
235500000X	Specialist/Technologist	Speech, Language and Hearing Specialist/Technologist
2355S0801X	Specialist/Technologist	Speech-Language Assistant
235Z00000X	Speech Language Pathologist	Speech, Language and Hearing Service Providers
251300000X	Local Education Agency (LEA)	Local Education Agency (LEA)
251C00000X	Day Training, Developmentally Disabled Services	Day Training, Developmentally Disabled Services
251J00000X	Nursing Care	Nursing Care
251S00000X	Agencies	Community/Behavioral Health
251V00000X	Voluntary Health or Charitable Agency	Agencies/Voluntary or Charitable
252Y00000X	Early Intervention Provider Agency	Early Intervention Provider Agency
253J00000X	Foster Care Agency	Foster Care Agency
261QD1600X	Clinic/Center	Developmental Disabilities
261QG0250X	Clinic/Center	Genetics
261QM0801X	Community Mental Health Center	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
261QM0850X	Ambulatory Health Care Facilities	Adult Mental Health
261QM0855X	Ambulatory Health Care Facilities	Adolescent And Children Mental Health Care Facilities
261QM2800X	Clinic/Center	Methadone
261QR0405X	Clinic/Center	Rehabilitation, Substance Use Disorder
276400000X	Hospital Units	Rehabilitation, Substance Use Disorder Unit
283Q00000X	Hospital-Psychiatric (PPS excluded)	Hospitals/Psychiatric Hospital
305R00000X	Preferred Provider Organization	Managed Care Organization PPO
3104A0625X	Assisted Living Facility	Assisted Living, Mental Illness
310500000X	Nursing & Custodial Care Facilities	Intermediate Care Facility, Mental Illness
311Z00000X	Custodial Care Facility	Custodial Care Facility
311ZA0620X	Custodial Care Facility	Adult Care Home
315P00000X	Nursing and Custodial Care Facilities	Intermediate Care Facility, Mentally Retarded
320600000X	Residential Treatment Facilities	Residential Treatment Facility, Mental Retardation And/Or Developmental Disabilities
320700000X	Residential Treatment Facility, Physical Disabilities	Residential Treatment Facility, Physical Disabilities
320800000X	Residential Treatment Facilities	Community Based Mental Illness
320900000X	Residential Treatment Facilities	Community Based Residential Treatment Facility,

Taxonomy Code	Taxonomy Description	
	Classification	**Specialization**
		Mental Retardation And/Or Developmental Disabilities
322D00000X	Residential Treatment Facilities	Residential Treatment Facility, Emotionally Disturbed Children
323P00000X	Residential Treatment Facilities	Psychiatric Residential Treatment Facility
324500000X	Residential Treatment Facilities	Substance Abuse Rehabilitation Facility
3245S0500X	Residential Treatment Facilities	Substance Abuse Treatment, Children
343800000X	Secured Medical Transport (VAN)	Secured Medical Transport (VAN)
363LP0808X	Nurse Practitioner	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Psychiatric/Mental Health
364S00000X	Certified Clinical Nurse Specialist	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
364SP0807X	Certified Clinical Nurse Specialist	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
364SP0808X	Certified Clinical Nurse Specialist	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health
364SP0809X	Certified Clinical Nurse Specialist	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
364SP0810X	Certified Clinical Nurse Specialist	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
372600000X	Adult Companion	Adult Companion
373H00000X	Nursing Service-Related Providers	Day Training/Habilitation Specialist
3747A0650X	Technician	Attendant Care Provider
374U00000X	Home Health Aide	Home Health Aide
376J00000X	Homemaker	Homemaker
385H00000X	Respite Care	Respite Care
405300000X	Prevention Professional	Prevention Professional