



**MARYLAND HEALTH CARE COMMISSION**

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**MEMORANDUM**

**TO:** Commissioners

**FROM:** Linda Bartnyska *LMB*  
Director, Center for Analysis & Information Systems

**DATE:** October 10, 2013

**RE:** **Action on Proposed Permanent and Emergency Regulations:  
COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection**

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On September 13, 2013, Commission staff released for informal public comment a draft replacement of COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection. At the same time, staff also sought informal comments on a draft 2013 Medical Care Data Base (MCDB) Submission Manual. The informal public comment period ended on October 4, 2013. Comments were received from eight organizations. Attached are the following documents for your consideration:

1. **Analysis of Informal Public Comments and Staff Recommendations – Draft COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection; and Draft MCDB Submission Manual.** Comments received are grouped by category, followed by Staff's analysis and recommendation. Section II contains staff's analysis of comments regarding the regulations; Section III contains staff's analysis of comments on the draft 2013 MCDB Submission manual. Copies of the original comments are attached in Section IV.

2. **COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection.** Staff will recommend that the Commission adopt these regulations to replace the Commission's current regulations concerning data collection and the Maryland Medical Care Data Base.

At the October 17 Commission meeting, Staff will make a presentation regarding the comments received and Staff's recommendations, and will ask the Commission to adopt COMAR 10.25.06 as proposed permanent and emergency regulations.



**Analysis of Informal Public Comments and Staff Recommendations**

**COMAR 10.26.06:**

**Maryland Medical Care Data Base  
& Data Collection;**

**and**

**Draft 2013 MCDB Submission Manual**

October 17, 2013

## **I. Introduction**

With the advent of health care reform, there is an increased need in the State of Maryland and nationally for detailed information on health care utilization, the relationship between health care utilization and health plan benefit design, and quality of care. In response to the need for more information and to support other State agencies, such as the Maryland Insurance Administration and the Maryland Health Benefit Exchange, Commission, staff has developed needed revisions to its data collection rules for the Maryland Medical Care Data Base (COMAR 10.25.06).

Commission staff has worked collaboratively with stakeholders to develop and review the proposed regulations. On April 15, 2013 payors were alerted of the need for changes and notified of upcoming opportunities to engage in the process. A plan for expansion of the MCDB, explaining the rationale for the changes, was distributed to payors on June 24, 2013 and reviewed at a meeting of payors held on June 26, 2013.

On September 13, 2013, Commission staff released draft MCDB regulations for informal public comment. Staff also sought comments on a draft 2013 MCDB Submission Manual. The informal comment period closed on October 4, 2013. Staff considered the written comments and also held meetings with various payors and organizations that requested meetings in response to staff's offer to discuss the draft MCDB regulations and draft 2013 Manual. After considering the informal public comments, staff has made changes to the regulations and will be making changes in both the 2013 and the 2014 MCDB Submission Manuals. Staff will discuss and seek Commission approval of changes to the Manuals at the Commission's November meeting. Written comments were received from the following organizations:

- Alliance of Maryland Dental Plans (Alliance)
- CareFirst BlueCross BlueShield of Maryland, Inc. (CareFirst)
- Cigna
- DentaQuest
- Maryland Medical Assistance Program (Medicaid), Department of Health & Mental Hygiene
- Maryland Hospital Association (MHA)
- Mega Life and Health Insurance Company (Mega)
- United Healthcare (United)

The remainder of this document provides a summary of the written informal comments received and staff's analysis and recommendations. A complete set of the written comments is attached in Part IV.

## **II. Summary and Analysis of Informal Public Comments – MCDB Regulations**

### **Section .01 Scope and Purpose**

#### **Summary of Comments:**

The Alliance of Maryland Dental Plans requests clarification whether Maryland residents covered under non-Maryland contracts are to be included in the reports submitted. In addition it asks whether administrators of plans for self-funded businesses are to be included. Cigna raises a question whether requiring reporting on self-insured plans would be a pre-emption of the ERISA law. Cigna notes that it has been voluntarily providing self-insured data in past submissions. The Maryland Hospital Association strongly supported the collection of self-insured data, characterizing the collection of such data as critical.

#### **Staff Analysis and Recommendation:**

In response to the question posed by the Alliance, the reports made by payors will include Maryland residents covered under non-Maryland contracts.

As noted by the MHA, having data on the self-insured market is essential to fully understanding health care costs, utilization, and quality in Maryland. Staff appreciates the cooperation of payors that, like Cigna, previously have voluntarily provided data regarding self-insured plans. Staff believes that requesting data from self-insured plans is not preempted by ERISA. Massachusetts, another state with a history of collecting such information in its all-payer claims database (APCD), also requests self-insured data and has asserted that requiring data submission for self-insured plans is not preempted by ERISA (<http://www.mass.gov/chia/docs/g/chia-ab/1014.pdf>). Staff notes that Maine, another state with an APCD, also collects data from all health plans, including self-insured plans and third party administrators.

### **Section .02 Definitions**

#### **Summary of Comments:**

The Alliance of Maryland Dental Plans, CareFirst, DentaQuest, and United request clarification regarding in the definition of “general health benefit plan” in .02B. They note that, under the definition of “payor”, only dental plans and vision plans sold on the Health Benefit Exchange are required to submit data to the MCDB. DentaQuest and the Alliance request clarification on the definition of “payors” that are required to submit data. In particular, they seek clarification on whether excepted benefits are intended to be included.

#### **Staff Analysis and Recommendation:**

Staff agrees with the need for clarification of the definition of “general health benefit plan” and recommends revision to the renumbered definition as follows (underline indicates new language):

- .02B(8)(d): A vision plan certified by the Maryland Health Benefit Exchange; or
- .02B(8)(e): A dental plan certified by the Maryland Health Benefit Exchange.

Staff understands the question regarding excepted benefits to be related to limited-scope dental or vision plans. As noted in the revised definition of “general health benefit plan,” only dental or vision plans certified by, and sold on, the Maryland Health Benefit Exchange are required to report.

### **Section .03 Persons Designated to Provide Data to the Commission**

#### **Summary of Comments:**

The Alliance of Maryland Dental Plans, DentaQuest, and United request clarification whether Third Party Administrators (TPAs), Pharmacy Benefit Managers (PBMs), Qualified Dental Plans (QDPs), and Qualified Vision Plans (QVPs) would be required to report separately when such reports will be contained in the submission of another payor.

#### **Staff Analysis and Recommendation:**

Staff agrees with the commenters that a payor whose data is contained in another payor’s submission should not be required to submit data separately. To clarify this, staff recommends changing .03B as follows (underline indicates new language; ~~strike through~~ indicates deleted language):

- B. Data ~~Already~~ Otherwise Collected by the Commission from ~~Providers and Payors~~ or Providers.  
 (1) A payor’s reports are considered submitted to the Commission if they are contained within the submission of another payor.  
 (2) For the purpose of supplementing the MCDB, the Commission may include information that the Commission has otherwise received regarding providers and services.”

### **Section .04 Process for Collecting Data**

#### **Summary of Comments:**

Medicaid notes that the MCDB will not contain complete information on its enrollees, given that only Medicaid Managed Care Organization (MCO) data and not fee-for-service (FFS) data is cited in .04C. Medicaid recommends inclusion of FFS data.

#### **Staff Analysis and Recommendation:**

Staff agrees that FFS data is necessary to get a complete picture of the services rendered to Medicaid enrollees. As discussed with Medicaid, staff’s intent was that Medicaid would add FFS data to the MCO data and include its Eligibility Data Report and Provider Directory Report.

Staff recommends the following change to .04C to note that Medicaid will be providing additional data along with the MCO data:

- C. An MCO shall provide each required report to the Commission through the Maryland Medical Assistance Program (~~Medicaid~~), which will provide the MCO reports and related information to the Commission.

## **Section .05 Time Period for Submitting Data Reports**

### **Summary of Comments:**

United recommends that the Commission provide a testing period for new submitters in advance of the routine submission timeline in order to establish appropriate data protocols. Medicaid noted that it permits at least six months of run-out for encounter submission, and perhaps longer for certain inpatient and higher-end services and, thus, recommend a six month run-out. CareFirst and the Maryland Hospital Association suggests that the regulation should use claims paid in the reporting period, regardless of service date. CareFirst noted that the timing of the 2013 annual submission and the 2014 first quarter submission would present challenges. In addition, CareFirst indicated that it favors defining quarters based solely on the claim payment date, rather than on the date of service.

### **Staff Analysis and Recommendation:**

Staff agrees with United that a testing period would be helpful in ensuring that new submitters correctly make submissions in accordance with the MCDB regulations and the MCDB Submission Manual. Subject to availability of funds, staff intends to explore testing opportunities for new submitters.

Staff agrees with the suggestions by CareFirst and MHA that, beginning with quarterly submission in 2014, the requirement not be based on services rendered in the quarter but, instead, be based on claims paid during the quarter, regardless of service date. Thus, beginning with 2014 quarterly reports, there would no longer be a need for a run-out period, and identifying claims for reporting would be simplified for payors. In addition to address the concern of the overlapping due dates for the 2013 annual and 2014 first quarter submissions, the 2014 Submission Manual will specify that the first and second quarter submission be submitted simultaneously by August 31, 2014. The deadline for the 2013 annual submission will remain as June 30, 2013. For these reasons, staff recommends the following changes to Section .05:

- A. For services rendered in calendar year 2013:
  - (1) Only those reporting entities designated under Regulation .03A(1) shall submit to the Commission a complete set of the entity's data for that period in the form and format described in Regulations .07 - .14 of this chapter by June 30, 2014.
  - (2) The submission shall consist of all claims for services provided in 2013 that are adjudicated between January 1, 2013 and April 30, 2014, four months after the end of the reporting period.

B. For services rendered in calendar year 2014 and thereafter, each reporting entity shall submit to the Commission a complete set of the entity's data for claims paid during each quarter in the form and manner described in Regulations .07 – .14 of this chapter within 42 months of the last day in the applicable quarter, unless a less frequent submission is specified by the Commission, with notice to reporting entities that includes a dated posting on the Commission's website.

~~C. Each submission shall consist of all claims for services provided in the previous reporting period that are adjudicated between the first day of the reporting period for which the submission is due through three months after the end of that reporting period.~~

## **Section .06 Protection of Confidential Information**

### **Summary of Comments:**

United requests a clarification of the process by which a payor submits data to the State-Designated HIE for the creation of a Master Patient Index (MPI). United requests that, if carriers are expected to maintain this encrypted data, a timeline be specified and further details be given regarding the expected role of the carrier. Medicaid states that it must approve any release of Medicaid data and that such data releases are subject to approval by DHMH's IRB. Medicaid also suggests that the Commission should seek statutory changes that would permit the MHCC to collect patient identifying information for limited purposes. It notes that if the Commission had this ability, the burden on reporting entities would be reduced because the intermediate step of submitting data to the State-Designated HIE would be eliminated.

### **Staff Analysis and Recommendation:**

Staff agrees that clarification is needed. There are different types of patient identifiers described: a payor-generated and encrypted patient identifier; a universally unique identifier (UUID) generated and encrypted using an algorithm provided by MHCC; and an MPI to be assigned by the state-designated Health Information Exchange, which is the Chesapeake Regional Information System for our Patients (CRISP). The payor-generated identifier has been reported in the past and will continue to be reported. The UUID has been reported in the past and will continue to be reported until the MPI is consistently reported. The MPI is expected to be reported in all later submissions.

The process for creating and reporting the MPI will be detailed in the 2014 MCDB Submission Manual. In brief, payors must submit limited demographic data to CRISP, who will attach MPI identifiers, and return the cross-walk with the payer-generated ID to the payors. Payors will then include the MPI in the Eligibility File submitted to MHCC. The timeline for these transactions will coincide with the submission timeline and will be detailed in the MCDB Submission Manual. In order to clarify the submission requirements regarding MPI, staff recommends the following changes to .06A(2)(b):

- (b) Beginning with 2014 submissions, direct each reporting entity to:
  - (i) Provide ~~provide~~ selected data to the State-Designated HIE for the creation and encryption of a Master Patient Index; and

(ii) Include Master Patient Index identifiers received from the State-Designated HIE in its eligibility data report, as provided in Regulation .11.

Staff acknowledges the validity of Medicaid's concerns regarding its control over any requests for Medicaid data, including the need for approval by the DHMH IRB. Staff notes that COMAR 10.25.11.01, which is referenced in the draft regulation, permits the Commission to use other recognized IRBs to consider requests for encounter level data. The Commission will use the DHMH IRB for requests for Medicaid data. Staff recommends the following changes to Regulation .06C to acknowledge Medicaid's authority over the release of Medicaid data:

- C. Disclosure of Data for Research Use.  
To ensure that confidential or privileged patient information is kept confidential, prior to any disclosure of data that contains "directly or indirectly identifiable health information", as defined in HIPAA:  
(1) A review shall be conducted by the Commission's an appropriate Institutional Review Board, as provided in COMAR 10.25.11;  
(2) The Maryland Medical Assistance Program (Medicaid) shall review and approve any request for the release of Medicaid data.

Regarding Medicaid's suggestion that statutory changes be sought that would permit the Commission to collect patient identifying information for limited purposes, Commission staff notes that the MHCC cannot currently collect these fields because of existing law, Health-General Article §19-133(d)(3). Commission staff believes that Medicaid's suggestion of a statutory amendment has merit.

### **Section .09 Provider Directory Report Submission**

#### **Summary of Comments:**

United requests confirmation that Pharmacy Benefit Managers, who submit stand-alone pharmacy data, are not expected to submit a Provider Directory Report. Medicaid notes that it already submits a provider directory to CRISP.

#### **Staff Analysis and Recommendation:**

Staff confirms United's understanding of the regulation. Staff understands Medicaid's concern, but notes that the provider directory is required in the MCDB for appropriate patient attribution to practitioners. Staff recommends no changes.

### **Section .15 Report Submission Methods**

#### **Summary of Comments:**

United requests that updates to the MCDB Submission Manual be limited to semiannual and that six months lead time be provided to make necessary changes.

### **Staff Analysis and Recommendation:**

Staff expects that it will only be making annual updates to the Manual. While multiple changes are being made for the 2014 submissions, staff anticipates that any changes other than the annual update will concern incomplete or incorrect information in the Manual. Staff recommends the following changes to .15B to clarify this intention:

- B. The MCDB Data Submission Manual shall contain technical specifications, encryption algorithms, layouts, required reports, and definitions for each reporting entity.
  - (1) The Commission shall provide an annual MCDB Submission Manual by November 15 ~~21~~ of each year to be used for the reporting periods in the subsequent year.
  - (2) The Commission may ~~provide quarterly updates to correct incomplete or erroneous information in the MCDB Submission Manual, as necessary at least 3 months prior to each submission due date and provide notice of each correction on the Commission website and by email to the contact persons designated by payors.~~ provide quarterly updates to correct incomplete or erroneous information in the MCDB Submission Manual, as necessary at least 3 months prior to each submission due date and provide notice of each correction on the Commission website and by email to the contact persons designated by payors.
  - (3) The Commission shall timely post the annual MCDB Data Submission Manual ~~and each update to the Manual~~ on the Commission website and provide notice in the Maryland Register.

### **Section .16 Request for an Extension of Time**

#### **Summary of Comments:**

United requests that the possible extension time revert to the 60-day period in the current regulations, rather than change to 30 days. In addition, it is concerned with the requirement to show “extraordinary circumstances” to receive an extension.

#### **Staff Analysis and Recommendation:**

Staff recommends no change to the regulation. With the move to quarterly submissions, staff notes that the current possible 60-day extensions, while appropriate for annual submission, could result in a cascading impact on quarterly submissions. The requirement to show extraordinary circumstances justifying an extension means merely that the need for the extension should be caused by events outside the payor’s control. Staff notes that the urgency for timely data for State priorities, as well as the quarterly submissions, requires a stricter standard.

### **Section .17 Request for an Annual Waiver or Format Modification.**

#### **Summary of Comments:**

The Maryland Hospital Association raises concerns about the validity of data if waivers or format modifications are permitted. The MHA encourages strict adherence to the established reporting standards.

### **Staff Analysis and Recommendation:**

Staff understands MHA’s concern and expects to grant an annual waiver request or format modification request infrequently, in the case of a situation beyond the control of a payor. It may occasionally be necessary, albeit rarely, to grant request for an annual waiver of the submission of a data report or a format modification request. Staff notes that, in making a request for a waiver or format modification, the payor must detail extraordinary circumstances that lead it to make the request. Such requests can be expected due to the great variation across carriers in data platforms and the variety of products sold. Staff intends to insist on compliance with the regulations’ reporting requirements except when necessary due to the reporting entity’s inability to provide a report or to “submit values for a specific data element....”

### **Section .19 Summaries and Compilations**

#### **Summary of Comments:**

United raise concerns about the potential use of MCDB data, especially payment rates to providers, for collusion or anti-competitive activities. While United supports more open information being available to consumers, it recommends a transparent and standardized data release policy that will account for these considerations. CareFirst concurs with this position. United proposes the addition of the following language to Regulation .19: “Any public disclosure or use of data made available to the public shall not facilitate collusion or anti-competitive conduct and is not expected to increase the cost of healthcare.”

#### **Staff Analysis and Recommendation:**

Staff shares United and CareFirst’s interest in protecting MCDB data and only releasing data for appropriate uses and to qualified users. The Commission has a long history of protecting confidential information, and has had a detailed review process for release of the MCDB data, including IRB review. Staff notes that a workgroup is planned to identify sensitive fields in MCDB data products. Payors will be invited to participate in this workgroup and inform the development of data products and data release policy. Because current draft .19 provides that such summaries and compilations be made “in compliance with all applicable federal and State law and regulations, staff concludes that the stated concerns regarding collusion or anti-competitive activities are addressed. For this reason, staff recommends no changes.

### **Other Comments**

#### **Comments regarding encounter payment amounts:**

Medicaid notes that MCOs do not currently submit encounter payment amounts, but that this data will be available after the launch of MMIS 3, which is expected to be operational in 2015, at the earliest. In the interim, Medicaid will provide estimates of encounter payment amounts.

Medicaid would also like to be involved in any definition of reports that are relevant to the Medicaid data submission.

**Staff Analysis and Recommendation:**

Commission staff appreciates Medicaid’s efforts to provide estimates in lieu of payments in advance of direct reporting of payments from MCOs in MMIS 3. Staff invites Medicaid to review and comment on the MCDB Submission Manual, which provides specifications for each of the existing data reports. Staff also notes that a pilot test to map Medicaid MCO data to MCDB data is underway. Medicaid will continue to be included in all MCDB workgroups.

**Comments regarding the MCDB Submission Manual**

Cigna is concerned that moving data specifications to the MCDB Submission Manual provides too broad an authority regarding policy making to Commission staff. Cigna fears that this may permit policy changes without adequate review of stakeholders.

**Staff Analysis and Recommendation:**

Staff appreciates Cigna’s concern and notes that the Commission has a long history of engaging stakeholders in making policy changes. The changes recommended by staff to the MCDB regulations and Manual have been presented and discussed at Commission meetings, carrier meetings, and workgroup meetings over the last six months. The motivation behind moving data specifications solely to the submission manual is primarily a practical issue. As delivery and payment systems change, policy needs arise, or errors are found, it is burdensome to change regulations each time a modification to field specification is necessary. Staff will always engage all stakeholders whenever changes are made to the Manual, and will seek approval of the Commission before finalizing changes.

**General Comments**

Most commenters supported the overall goals of MCDB expansion and the need to revise regulations to permit such expansion. Several commenters specifically noted their appreciation of the opportunity to be involved in the process and expressed their hope to continue such engagement.

**Staff Analysis:**

Staff is appreciative of the active involvement of stakeholders and will continue to partner with them in the expansion of the MCDB.

### **III. Summary and Analysis of Informal Public Comments – Draft 2013 MCDB Submission Manual**

#### **Data Submission Documentation and Data Summary Worksheets**

##### **Summary of Comments:**

CareFirst and United note that the documentation requirements create an additional administrative burden, which will be exacerbated by the move to quarterly reporting.

##### **Staff Analysis and Recommendation:**

Commission staff understands the concerns about administrative burdens. The goal of the documentation and worksheets is to ensure that the appropriate data is received and to support data cleaning and auditing. That said, the Commission is embarking on an effort to build an automated Extraction, Transfer, and Loading (ETL) system, wherein most of these documentation items will not be needed. Work on this effort will begin by July 2014. In the interim, staff has reviewed the documentation and worksheet items. Staff anticipates it will remove the following items from the required documentation:

- Page 15: Professional Services File Control Total Verification – SOURCE COMPANY
- Page 16-19: All tables to be removed
- Page 22: National Drug Code (NDC)
- Page 23: Institutional Services File Control Total Verification – TYPE OF FACILITY
- Page 25: Institutional Services File – RECORD STATUS
- Page 26-28: All tables to be removed
- Page 29: Eligibility File Control Total Verification – POLICY TYPE
- Page 30-37: All tables to be removed

All other data submission documentation and data summary worksheets will remain in place. Pending review, modifications of existing documentation and worksheets may be made. Staff hopes this substantial reduction in requested documentation tables will alleviate administrative burdens for payors.

#### **New and Modified Field Specifications**

##### **Summary of Comments:**

Mega Life and Health Insurance, Medicaid, and United note that their ability to report on certain fields (e.g., Assignment of Benefits, CPT II codes, Zip Code + 4, NPI) are dependent on whether providers submit such information, and whether these fields are part of their claims databases.

### **Staff Analysis and Recommendation:**

Staff notes that Section .17B details the process for a format modification request, wherein providers may request variances for specific fields with a written request 30 days before the applicable submission date. Staff will review requests on a case-by-case basis, consistent with past submissions.

### **Professional Services Data Report**

#### **Summary of Comments:**

DentaQuest and the Alliance of Maryland Dental Plans note that dental specific fields, such as tooth number or surface, are missing from the Professional Services Data Report.

#### **Staff Analysis and Recommendation:**

Dental Plans will not be required to report until 2014. For this reason, the draft 2013 Submission Manual circulated along with the draft regulations intentionally does not include the dental specific fields. The 2014 MCDB Submission Manual will include the Dental Data Report, which is a modified version of the Professional Services Data Report and will include dental specific fields. Staff will send the Dental Data Report to dental plans to provide feedback before publication of the 2014 Manual.

### **Race and Ethnicity Thresholds**

#### **Summary of Comments:**

United requests that the threshold for Source of Enrollee Race/Ethnicity Information be reduced from 95% to 3%. It states that it currently has between 2-3% direct assignment of race and ethnicity for its commercial plans. CareFirst requests that there be no threshold on Race and Ethnicity data.

#### **Staff Analysis and Recommendation:**

Staff understands the concerns regarding thresholds regarding direct reporting of race and ethnicity. The draft 2013 MCDB Submission Manual has a threshold for the *source* of data and not for the race and ethnicity assignment itself. If race and ethnicity data is not available, a payor may report either that it did not ask the enrollee, or that the enrollee was asked but refused to report it. Staff recommends no changes to the threshold for the Source of Enrollee Race/Ethnicity Information field.

It should also be noted that the ability to conduct analysis of utilization, quality, and costs by race and ethnicity is a priority for the offices of the Governor and the Secretary of Health and Mental Hygiene. To that end, proactive efforts from carriers are needed to make progress. Staff will be convening a workgroup on race and ethnicity reporting to the MCDB on October 22, 2013 to which payors have been invited. Alternate options and strategies for improving

reporting, such as indirect race and ethnicity assignment, leveraging other data sources, and education programs, will be discussed.

### **Provider Directory Report**

#### **Summary of Comments:**

United seeks clarification regarding reporting on out-of-state providers to enrollees included in the data submission. It proposes including information on all practitioners who provide services to eligible enrollees.

#### **Staff Analysis and Recommendation:**

Staff confirms that this is the intention of the section of the Manual. For out-of-state services, only practitioners who serve eligible enrollees need to be included in the data submission.

#### **IV. Informal Comments Received**



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October 4, 2013

Srinivas Sridhara  
 Acting Chief, Cost and Quality Analysis  
 Maryland Health Care Commission  
 4160 Patterson Avenue  
 Baltimore, Maryland 21215

Re: Draft Medical Cost Data Base and Data Collection Regulations

Dear Mr. Sridhara:

On behalf of the Alliance of Maryland Dental Plans, thank you for the opportunity to comment on the Commission’s draft Maryland Medical Cost Data Base and Data Collection regulations. The Alliance represents many of Maryland’s dental insurers and dental plan organizations. We have reviewed the draft regulations and offer the following comments.

Comment #1- Scope of the Regulations

Please clarify the scope of the regulations with respect to out of state plans and self funded plans. Regulation .01 indicates that they apply to “health care services provided under a Maryland contract or to Maryland residents.” A Maryland resident may not be covered by a Maryland contract. Do the regulations require reporting on an health services provided to an individual who is covered by a contract sitused in another state but administered by a Maryland carrier or Third Parry Administrator? Additionally, do the regulations apply to self-funded business administered by a Third Party Administrator who is registered with the State? In clarifying the scope of reporting for Third Parry Administrators, it would also be helpful to clarify when a Third Party Administrator is not required to report because the data has been separately reported by another entity.

Comment #2- Regulation .02 Definitions

There are a few definitions that we believe require revision and clarification. Specifically, the definition of “general health benefit plan” includes dental and vision plans within its definition. It is our understanding that the regulation is intended to only capture data from qualified dental plans and qualified vision plans. If that is in fact the case, the definition of “general health benefit plan” is overbroad. Additionally, the definition of “Payor” does not encompass all dental benefit providers as it does not include dental plan organizations. It is not clear if the exclusion of dental plan organizations is intention or if it is an oversight. Further, if the intention is not to include HIPAA excepted benefits within the reporting, the use of the term “health insurance” in the definition of “Payor” may need to be revised. Generally speaking, the term health insurance is a broad term and

includes products such as dental, vision, disability, specified disease within its parameters. These products are not typically included in the reporting under claims payment databases and do not seem to be the intended targets of the reporting under these regulations.

Comment #3- Regulation .03 Persons Designated to Provide Data to the Commission

As previously noted, we understand the intention of the regulation to be to only include those dental and vision benefits that are provided through qualified dental plans and qualified vision plans on the Maryland Health Benefit Exchange. If this is true, we believe that the language in Regulation .03 should be revised to better reflect this intended scope. As written today, based on the definition of “general health benefit plan,” all dental and vision plans seem to fall within the reporting requirements.

Comment #4- Professional Services Submission Data Report

The Professional Services submission does not appear to account for tooth number or surface. It is common to have the same procedure done on multiple teeth in the same encounter. Without collecting this information it is possible these services would be seen as duplicates to anyone reviewing the submitted data. We believe that appropriate changes to reflect tooth number or surface should be made.

Again, thank you the opportunity to provide comments. Should you have any questions on these comments, please do not hesitate to contact me.

Very truly yours,



Kimberly Y. Robinson



**Maria Harris Tildon**  
Senior Vice President  
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October 9, 2013

VIA EMAIL (srinivas.sridhara@maryland.gov)

Srinivas Sridaha  
Acting Chief, Cost and Quality Analysis  
Maryland Health Care Commission  
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Dear Mr. Sridhara:

I write on behalf of CareFirst BlueCross Blue Shield (“CareFirst”) and in response to the Maryland Health Care Commission’s (“MHCC”) proposed regulations Subtitle 10, Chapter 25 Maryland Medical Care Data Base and Data Collection and 2013 draft Submission Manual circulated for informal public comments. CareFirst appreciates the opportunity to provide feedback to the MHCC on some of the operational concerns CareFirst has with the proposed regulations. As you are aware, Ben Steffen agreed that CareFirst could first discuss its concerns and thoughts on the proposed regulations with MHCC staff prior to submitting written comments even if that delayed the submission of comments to the MHCC. CareFirst and MHCC staff spoke on October 8, 2013 and this letter summarizes the concerns raised during that conversation.

1. Race/Ethnicity Data. The 2013 draft Submission Manual provides for a threshold of 95% for the Source of Enrollee Race/Ethnicity Information. CareFirst appreciates the MHCC’s and the State’s efforts to focus on health disparities in the State and to utilize data to foster policy discussions on how to address such disparities. However, as consumers are not required to and cannot be compelled to report their race/ethnicity when applying for health insurance, CareFirst believes such a high reporting threshold is not only impractical but infeasible. We therefore appreciate the MHCC clarifying during our conversation that the MHCC does not interpret the threshold to be a requirement on a carrier to report the race/ethnicity of 95% of its enrollees but merely report data in the race/ethnicity field 95% of the time where such data could reflect an enrollee’s race/ethnicity, that such information is unknown, or that the enrollee refused to provide the information.

Nevertheless, as the State moves to encourage carriers to indirectly assign an enrollee’s race/ethnicity where it has not been provided, CareFirst recommends that the MHCC develop indirect assignment algorithms that can be uniformly applied across carriers to ensure consistency in reporting.

2. Reporting Frequency. Proposed regulation .05B would require carriers to quarterly submit to the MHCC a complete set of the carriers' data. As CareFirst expressed yesterday to the MHCC, quarterly reports pose a great resource challenge particularly where the data MHCC requests be submitted may be changed throughout the year. As CareFirst requires a minimum of 120 days' prior notice of any changes in the data to be provided to operationalize the requirement.

During our call, the MHCC acknowledged carriers' programming and operational concerns in changing reporting requirements. CareFirst understood the MHCC as confirming that it will not change the data reporting requirements more frequently than annually. CareFirst also understood that the MHCC would be modifying the reporting requirement from the current paid and incurred methodology to only a paid methodology. If these understandings are correct, CareFirst believes a quarterly report is feasible. If these understandings are incorrect, CareFirst has strong objections to the new requirement and recommends that data reports be submitted to the MHCC semi-annually rather than quarterly.

3. Manual/Worksheets. We appreciate the MHCC sharing on the call that it intends to remove certain portions of the existing worksheets that are antiquated or cumbersome for carriers to fill out. Nevertheless, CareFirst is concerned that future additions or changes to the Submission Manual or required worksheets may be burdensome or unnecessary. CareFirst therefore recommends that the MHCC establish a formal carrier engagement process prior to any changes to the Manual or worksheet requirements. Carrier involvement in the Manual and worksheet requirements is particularly important if the Maryland Insurance Administration is to use worksheets and data reports for rate setting purposes.

4. Implementation Date. A move from an annual submission to a transitional semi-annual submission to ultimately a quarterly submission may be feasible if carriers understand the timeline the MHCC seeks such transition to take place in. Absent a clear timeline, however, CareFirst is concerned about its ability to timely comply with deadlines it is not clearly aware of and the utility of such data to the MHCC. For example, the 2013 annual report is due to the MHCC on June 30, 2014. If CareFirst has to submit a quarterly report to the MHCC beginning in 2014, it would submit the Q1 2014 report by May 31, 2014, before the annual 2013 report is due. CareFirst therefore recommends that the MHCC include in the final regulations a timeline detailing the date by which a carrier must submit a report and the period the report covers. This will facilitate carriers' compliance with the reporting requirements and a thoughtful transition plan.

5. Dental and Vision Plans. Proposed regulation .02B(9) defines a "general health benefit plan" to include a vision plan or a dental plan. The MHCC clarified on our call, however, that the reporting requirements only apply to (a) standalone qualified vision or dental plans sold on the Maryland Health Benefit Exchange or (b) embedded dental or vision benefits in medical plans sold on- or off-Exchange. We recommend that this definition be modified to clarify that the reporting does not apply to off-Exchange standalone dental or vision plans.

6. Summaries and Compilations. CareFirst is concerned that the summaries and compilations the MHCC develops under proposed regulation .19 could be manipulated to reveal confidential and proprietary information about individual carrier rates with providers to carriers'

detriment. CareFirst recommends that regulation .19 be modified to expressly provide at the end that “Any such public-use data, summaries, and compilations shall be developed to prevent and prohibit reverse engineering, decompiling, decoding, decrypting, disassembling, or in any way derive carrier specific rating information.”

Thank you for the opportunity to comment on the above regulations. If you have any questions, please feel free to contact me.

Sincerely,



Handwritten signature of Maria Harris Tildon in blue ink, consisting of stylized initials and a surname.

Maria Harris Tildon

Patrick M. Gillespie  
Director,  
State Government Affairs

Law & Public Affairs



**VIA ELECTRONIC MAIL**

October 4, 2013

The Honorable Srinivas Sridhara  
Acting Chief,  
Cost and Quality Analysis  
Maryland Health Care Commission  
4160 Patterson Avenue,  
Baltimore, Maryland 21215

499 Washington Boulevard  
Jersey City, New Jersey 07310  
Tel 201-533-4538  
Fax 860-298-2395  
patrick.gillespie@cigna.com

Dear Chief Sridhara:

Thank you for the opportunity to comment on the draft rules cited as COMAR 10.25.06 regarding "Maryland Medical Care Data Base and Data Collection." Cigna has concerns and believes that the policy issues presented in this document are significant enough to warrant a delay in publishing these proposed rules until there has been opportunity to discuss further with affected insurance carriers.

Cigna is dedicated to helping the people we serve improve their health, well being and financial security. Cigna offers products and services under the Connecticut General Life Insurance Company (CGLIC) or the Cigna Health and Life Insurance Company (CHLIC). Cigna-HealthSpring, formerly Bravo Health, also offers a variety of Medicare Advantage related products. All of these Cigna companies proudly serve our Maryland customers by providing health care solutions to meet their unique needs.

In general, All Payer Claims Database systems impose a significant administrative burden on carriers when there is increased pressure on carriers to reduce administrative costs. Unique programs in each state, with vastly different reporting requirements, create added challenges for national carriers like Cigna who operate claim platforms across multiple states.

In particular, Cigna is concerned about the construct of the draft rule and interaction with the technical manual. These draft rules would permit the Commission to impose ever more significant reporting requirements and other broad policy changes merely by revising a technical manual. The technical manual should be used solely to provide guidance to implement policies adopted under Maryland's administrative procedure laws. It is entirely inappropriate to use revisions to a technical manual as a vehicle for any policy changes.

Moreover, Cigna is concerned about how these proposed changes would impact Cigna customers for whom Cigna provides Administrative Services Only. The proposed scope of these rules would require including these plans which are governed by federal ERISA laws. While Cigna currently provides claims data on a voluntary basis, the additional requirements contemplated in these rules could undermine the pre-emption of state regulation of these ERISA plans.

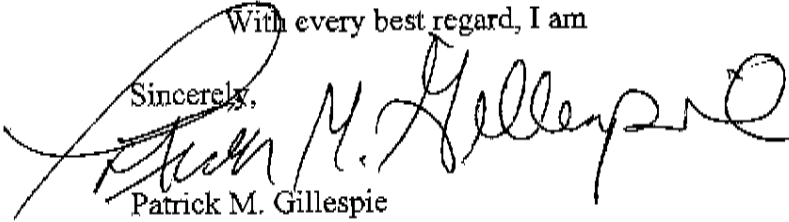
COMAR 10.25.06  
October 4, 2013  
Page 2

While the foregoing issues are major, there are a host of other important issues presented in these draft rules. So, rather than provide an exhaustive list here, Cigna requests a meeting with the Commission to discuss and present our concerns. Cigna also requests that the Commission convene an informal working group of insurance carriers to review the draft rules prior to the publication of a rule proposal. Cigna representatives would be willing to serve on such an informal working group.

Thank you for the opportunity to comment on these issues. If you have any questions or desire additional information please do not hesitate to contact me.

With every best regard, I am

Sincerely,



Patrick M. Gillespie  
Director,  
State Government Affairs

CC: Julia Huggins, President and GM  
Bryson Popham



October 4, 2013

Srinivas Sridhara  
Acting Chief, Cost and Quality Analysis  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

**Re: Comments on COMAR 10.25.06: MARYLAND MEDICAL CARE DATA BASE AND DATA COLLECTION**

Dear Mr. Sridhara:

On behalf of DentaQuest, I write in response to the call for public comment related to COMAR 10.24.06: Maryland Medical Care Data Base and Data Collection. DentaQuest is a dental benefits administrator serving more than 700,000 Marylanders. DentaQuest administers the state Medicaid dental program in addition to offering commercial dental plans via the Maryland health benefits exchange and directly to Maryland individuals and businesses.

Our team reviewed the reporting requirements contained in COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection and identified the following issues for your consideration:

- Clarify definitions of "general health benefit plan" and "payor". Both definitions would be applicable to dental plans but it is unclear if the intent is to include only a Qualified Dental Plan (QDP) or and whether or not the regulation meant to pull in a fee-for-service or dental plan organization. As currently written all lines of dental plans are pulled into these definitions.

Similarly, in section .03, a "payor" is required to provide data to the Commission. This would generally apply to non-exchange entities and normally excludes excepted benefits but again, under the current definition of "payor" excepted benefits would be pulled into this provision. We will need clarification as to whether or not excepted benefits were intended to be pulled into these data requirements.

- Clarification on TPA insured business. The language of the regulation suggests that TPAs are impacted for insured business that is not otherwise reported by a carrier providing data to MHCC. However, this is not explicit. Please provide clarification regarding required reporting for TPAs and the scope of the regulation with regard to the self-funded market.
- The Professional Services submission does not appear to account for tooth number or surface. It is common to have the same procedure done on multiple teeth in the same encounter. Without collecting this information it is possible these services would be seen as duplicates to anyone reviewing the submitted data.

# DentaQuest

- Universally Unique Identifier (UUID). We are unable to access details about the UUID encryption software documentation, source code, and executables. Without details we cannot fully comment on potential concerns related to Security and Compliance.

Thank you for the opportunity to provide comment. Please do not hesitate to contact me with any questions at [kristin.laroche@improvingoralhealth.com](mailto:kristin.laroche@improvingoralhealth.com) or 617-886-1458.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kristin LaRoche".

Kristin LaRoche  
Manager, Government Affairs & Policy



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor — Anthony G. Brown, Lt. Governor — Joshua M. Sharfstein, M.D., Secretary

October 4, 2013

Srinivas Sridhara, PhD.  
Acting Chief, Cost and Quality Analysis  
Maryland Health Care Commission  
4160 Patterson Ave.  
Baltimore, MD 21215

**Subject: Comments on Draft COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection**

Dear Dr. Sridhara:

The Maryland Medicaid Program respectfully submits this letter of comment on the draft regulations issued by the Maryland Health Care Commission (MHCC) on September 13, 2013.

**Master Patient Index Encryption**

The Medicaid Program has an overarching concern about the requirement in 10.25.06.06A to submit data to the Health Information Exchange (HIE) for the creation and encryption of a Master Patient Index. MHCC advises that it does not have the statutory authority to request patient identifying information because of Health General Article §19-133(d)(3) (requiring that certain health records be filed “in a manner that does not disclose the identity of the person protected”). But MHCC is tasked under the Centers for Medicare and Medicaid Services Qualified Entity Program with communicating with doctors about their own patients and how their patient data is being used to calculate physician performance measures. When it does so, MHCC will use the HIE’s Master Patient Index that masks patient names with an encryption code. To examine information relating to their patient, therefore, the doctor must decipher the code in order to obtain the necessary information, which is a significant burden. The encryption process is proposed merely as a work-around for the above statutory limitation. Accordingly, we recommend that MHCC work on a statutory change that permits MHCC to collect patient identifying information for limited purposes. This would reduce the administrative burden on reporting entities by eliminating the intermediate step of submitting data to the HIE. This recommendation would also improve the Medical Care Data Base, increase MHCC’s reporting capabilities, and facilitate physician use of data regarding their own patients.

### **Run-Out for Encounter Submission**

10.25.06.05B requires each reporting entity to submit a complete set of data for each quarter within four months of the last day of the applicable quarter, unless a less frequent submission is specified by MHCC. The Medicaid Program typically allows at least six months of run-out for encounter submission before considering the data complete. Submission of encounter data for inpatient and higher-end services may take even longer than six months. If MHCC needs the data to be as complete as possible, we recommend extending the requirement to at least six months.

### **Institutional Review Board**

10.25.06.06C requires the MHCC Institutional Review Board to review requests for the disclosure of patient information. The Medicaid Program is the custodian of and charged with safeguarding Medicaid information. Accordingly, the Medicaid Program must approve the release of any such information to third parties. We require that the Department of Health and Mental Hygiene Institutional Review Board approve all third party requests for Medicaid patient information. This is similar to Medicare requirements. This must be reflected in the regulations.

### **Carve-Out Services**

The draft regulations designate Medicaid managed care organizations (MCOs) as reporting entities. It should be noted that MCO reporting would not capture services that are carved out of the MCO benefit package and offered on a fee-for-service (FFS) basis. Carve-out services include: specialty mental health services, dental services, therapy services for children, personal care services, long-term care services after the first 30 days of care, certain HIV/AIDS services, and HIV/AIDS and mental health prescriptions. Substance abuse services will also be carved out in the future. Therefore, comparisons between Medicaid and commercial plans may not be possible using the Medical Care Data Base as proposed.

### **Provider Directory Report**

10.25.06.04B(3) requires reporting entities to submit provider directory reports. These submissions appear to duplicate the reports that the Medicaid Program is already submitting to CRISP.

### **Encounter Payments**

The MCOs currently do not submit payment amounts with their encounters. The Medicaid Program is in the process of procuring the Medicaid Management Information System 3 (MMIS3). It is anticipated that this new system will collect encounter payments. The MMIS3, however, will not be operational until at least 2015. Until the MMIS3 is operational, we can work with MHCC to provide estimated prices for the MCO encounters.


### **Medical Care Data Base Submission Manual**

10.25.06.07 through 14 direct reporting entities to submit data in the form and manner specified in the annual Medical Care Data Base Submission Manual. The Medicaid Program would like to

be included in the discussions on the development of this manual related to MCO submission requirements, such as benefit design reporting.

We thank you for the opportunity to comment at this time and appreciate your consideration of these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Tricia Roddy".

Tricia Roddy  
Director, Planning Administration  
Health Care Financing

cc: Charles J. Milligan, Jr.



MHA  
6820 Deerpath Road  
Elkridge, Maryland 21075-6234  
Tel: 410-379-6200  
Fax: 410-379-8239

October 4, 2013

Srinivas Sridhara  
Acting Chief, Cost and Quality Analysis  
Maryland Health Care Commission  
41060 Patterson Avenue  
Baltimore, MD 21215

RE: COMAR 10.25.06 Maryland Medical Care Data Base and Data Collection

Dear Mr. Sridhara:

On behalf of our 66 member hospitals, the Maryland Hospital Association (MHA) appreciates the opportunity to provide informal comments on the draft regulatory changes to COMAR 10.25.06 Maryland Medical Care Data Base (MCDB) and Data Collection. We support the MHCC's plans to make the data base more complete and more current. Overall we are pleased with the language but would like to recommend several revisions that would ensure all possible data resources are identified, clarify the data submission requirements, and strengthen payor compliance.

We are pleased to see that the proposed language will require reporting by payors that exceed 1,000 total covered lives, as opposed to the existing policy, which only requires those payors with more than \$1 million in health insurance premium collections to report. It is also reassuring to see Medicaid MCOs included in the reporting requirements. However, it is unclear whether Medicaid fee-for-service data will be also collected. Additionally, the language is silent on whether self insured health plans will be required to submit data. In 2010, 33 percent of Maryland employers offered self insured plans, which enrolled 62.5 percent of employed Marylanders.<sup>1</sup> With such a high rate of Marylanders enrolled in self insured plans, it is critical that the data base include data from self insured plans.

We are also supportive of the change in the reporting timeline. By requiring quarterly data submissions, beginning in calendar year 2014, the database will more timely and useful as the state and providers seek to better understand healthcare cost and utilization. However, we would like to understand why only claims with dates of service from the previous period are required to be submitted. We would like to suggest that the language in section .05 be revised to read that the submission should consist of claims for services provided in a prior reporting period, rather than the previous reporting period, thus all the data is based on adjudicated claims regardless of when the service is provided.

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<sup>1</sup> Spotlight on Maryland: A Profile of Maryland's Self-Insured Small Group Health Insurance Market, Maryland Health Care Commission, Center for Information Services and Analysis, May 2012.

Finally, we are concerned that the language in section .17, Request for an Annual Waiver or Format Modification, could be used to needlessly alter data submissions. It is critical that the MCDB contain consistent and valid data. Giving payors an opportunity to change the submission format jeopardizes the validity of the data contained in the MCDB. We would recommend that language in this particular section be strengthened to prevent data format modifications.

Again, thank you for the opportunity to comment on the proposed regulatory changes. If you have any questions, I can be reached at 410-540-5081.

Sincerely,



Anne Hubbard  
Assistant Vice President, Financial Policy & Advocacy

**FW: COMAR 10.24.06: Maryland Medical Care Data Base and Data Collection**

StateReporting NonFinancial <StateReportingNonFin@healthmarkets.com> Thu, Oct 3, 2013 at 10:57 AM

To: "srinivas.sridhara@maryland.gov" <srinivas.sridhara@maryland.gov>

Cc: "DeTuro, Virginia" <virginia.deturo@healthmarkets.com>, "Robledo, AnaLisa" <analisa.robledo@healthmarkets.com>, "Sharp, Courtney" <courtney.sharp@healthmarkets.com>

Hello,

We have reviewed the draft regulations and Data Base Submission Manual and will comply with the quarterly request for the data submission.

If the providers will provide us with the information for the following categories we will be able to comply. The 4 digit add-on to the zip code is not always included from the members or the providers.

- **New!** The **CPT Category II** codes (Current Procedure Terminology II) field has been added to the Professional Services file. The CPT Category II codes will facilitate data collection about the quality of care rendered and for purposes of performance measurement.
- **New!** The **Diagnosis Code Indicator** field has been added to the Professional Services file. This field indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.
- **Modified!** The **Patient/Enrollee Zip Code** field on the Professional Services, Pharmacy, Institutional Services, and Eligibility files has been expanded to include the 5-digit US Postal Service code plus the 4-digit add-on code and hyphen (e.g., 21215-2299).
- **Modified!** The **Service Location Zip Code** field on the Professional Services file and **Pharmacy Zip Code** field on the Pharmacy file have been expanded to include the 5-digit US Postal Service code plus the 4-digit add-on code and hyphen (e.g., 21215-2299).
- **Modified!** The **Place of Service** field on the Professional Services file has been updated to include **“Place of Employment-Worksite”** (code #18). This value aligns the MCDB categories with the CMS Place of Service code set.

We will need to do further research for these categories:

- **New!** The **Revenue Codes** field has been added to the Institutional Services file. Please provide the codes used to identify specific service, location, accommodation and/or ancillary charges. This field will improve identification of services provided in hospitals, for use in practitioner performance measurement system, and for pricing of procedures and treatment of chronic conditions.
- **Modified!** A new value has been added to the **Participating Provider Status** flag on the Professional Services file. **“No network for this plan”** (code #9) is an additional response option.

Please let us know if you have any questions or concerns.

Regards,

**Tyrah Rodriguez**  
**Regulatory Affairs Analyst II**  
**Corporate Compliance**  
**HealthMarkets®**

9151 Boulevard 26 • North Richland Hills • TX 76180

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Colleen C. Cohan  
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October 4, 2013

Srinivas Sridhara  
Acting Chief, Cost and Quality Analysis  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

**Re: Draft MCDB Regulation and Draft 2013 MCDB Submission Manual**

Dear Mr. Sridhara,

On behalf of UnitedHealthcare and its affiliated companies, we appreciate the opportunity to comment on the draft MCDB regulations and draft 2013 MCDB Submission Manual. We further appreciate you and other members of the Commission staff taking the time on October 1, 2013 to speak with us regarding questions and concerns we have regarding both documents.

**Draft MCDB Regulation Comments**

**Comment 1: Section .02 Definition of General Health Benefit Plan**

As we discussed during our October 1, 2013 conference call, we understand that the definition of General health benefit plan does not include basic vision plans nor does it include dental plans except for those sold on the Exchange. We respectfully request that those clarifications be included in the definition of General health benefit plan.

**Comment 2: Section .05 Timeframe for Submitting Data Reports**

Section .05 Timeframe for Submitting Data Reports does not include a notation regarding test data submission for entities that become subject to the regulation after its initial implementation. We ask that the State include language in the regulation outlining the timing of test and production data similar to the following:

Reporting entities that become subject to this regulation after January 15, 1996 shall submit to the Commission one month of eligibility, provider, medical claim and pharmacy claim data for determining compliance with the standards for data submission no later than 180 days after the first date of becoming subject to the regulation. Within 90 days of the Commission's acceptance of the test files, Reporting entities will submit historical data which will encompass the month they first became subject to the regulation through the current quarter.

### **Comment 3: Section .06 A – Filing Data Using Encryption**

We ask that the Commission discuss with the reporting entities its planned process for directing each reporting entity to provide selected data to the State-Designated HIE for the creation and encryption of a Master Patient Index (MPI). We want to confirm whether or not reporting entities will be expected to receive, maintain and then submit information from the MPI regarding its respective enrollee. If this is the case, we will want to work with the Commission in outlining appropriate timeframes for the receipt and submission of data from the MPI. An example of appropriate timeframes are fifteen days for the vendor to assign the unique identifier and thirty days for the Reporting entities to incorporate the unique identifier into their data and submit the data. In addition, we ask that a quality control process be built into the vendor's assignment of the unique identifiers as part of the creation of the MPI.

### **Comment 4: Section .09 Provider Directory Report Submission**

As we discussed during our call, please include clarifying language in the regulation to indicate that Pharmacy Benefit Managers who submit stand-alone pharmacy data are not required to submit a Provider Directory Report.

### **Comment 5: Section .15 Report Submission Methods**

This section includes a provision for the Commission to make quarterly updates to the MCDB Submission Manual with three months for the Reporting entities to implement the changes. We respectfully request that the Commission limit changes to the manual to no more frequently than every six months and allow for 180 days for Reporting entities to implement those changes as more frequent changes will be unduly burdensome on the Reporting entities.

### **Comment 6: Section .16 Request for an Extension of Time**

The revised regulation reduces the amount of time from 60 to 30 days that reporting entities can request for an extension to provide data. We respectfully request that the Commission reinstate the 60 day extension option to provide data.

We also note that the Commission will now require that extension requests include the "extraordinary circumstance necessitating the extension request", and while we believe the intent of the Commission is to understand more fully why an extension is being requested, we hope the Commission will not use this new standard to make it harder for payers to receive legitimate extensions of time to provide data.

### **Comment 7: Section .19 Summaries and Compilations**

We note that the draft revised regulation includes existing language and high level direction about the re-release of data to the public.

One critical area that the Commission should consider as more APCD States are implementing price transparency reports and tools concerns the instances in which the

release of data to certain entities identifying specific rates of payment to providers by health plans could lead to anti-competitive activities. While the intent of the Commission's Disclosure of Data to the public is to promote open information to Maryland consumers, this activity could lead to adverse effects on overall market competition that is not in the interest of consumers and will threaten the state's efforts to achieve the health care cost benchmarks it most likely wants to accomplish.

The Commission's APCD Disclosure for Public Use Data Section should include a provision that provides it with discretion to protect against the potential for anti-competitive activities by certain entities that may request APCD data that identifies specific rates of payment by health plan name to providers.

At a federal level, antitrust regulators have recognized the tension between facilitating better information for consumers while limiting the potential for anticompetitive behavior. Under the Sherman Anti-Trust Act, the primary purpose of limited anticompetitive behavior, including collusion to depress prices or artificially inflate prices, is to benefit consumers. As an example, in response to proposed California legislation regarding price transparency, the Department of Justice (DOJ) and Federal Trade Commission (FTC) (the entities that enforce antitrust actions or violations) jointly noted, "Whenever competitors know the actual prices charged by other firms, tacit collusion – and thus higher prices – may be more likely."

The Commission's Disclosure for Public Use language for permitting access to data to consumers should follow and meet the methodological requirements outlined by the DOJ and FTC (see Attached DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care – Statement 6). The DOJ/FTC policy on health care antitrust enforcement states, that without appropriate safeguards or protections, the exchange or release of proprietary or confidential information could facilitate collusion, reduce competition and increase prices and the availability of health care services, all to the detriment of consumers – the patients. Disclosure of a health plan's proprietary or confidential information in its raw form runs counter to the DOJ/FTC policy statement and would not be in the public's interest. Instead it would have the opposite effect, creating potential and serious anti-trust violations and undermine the goals of the Commission's APCD Disclosure for Public Use Data Section.

Given these serious potential issues, we ask that the Commission review data requests for APCD disclosure to the public to determine whether the release or use of data will not result in collusion or anti-competitive conduct, and is not expected to increase the cost of health care for consumers in Maryland by releasing a health plan's identifiable proprietary or confidential information. With that, we propose the following language be included in the Summaries and Compilations Section:

#### **.19 Summaries and Compilations**

The Commission shall develop public-use data, summaries, and compilations for public disclosure, pursuant to Health-General Article §§19-103(c)(3), 19-109(a)(6), and 19-134, Annotated Code of Maryland, in compliance with all applicable federal and State laws and regulations. **Any public disclosure or use of data made available to the**

**public shall not facilitate collusion or anti-competitive conduct and is not expected to increase the cost of healthcare.**

Alternatively, if the Commission would like to implement data disclosure language that has been adopted by another APCD state, we recommend consideration of the following data release language adopted by Rhode Island.

Data Release Review Board. The Department shall establish a review board for the purposes of reviewing predetermined analytic files to be made available on the Department's website, additional requests for public use data, and requests for public use of restricted release files.

The Board will review predetermined analytic files to be made available on the Department's website, additional requests for public use data, and requests for public use of restricted release files to ensure that members, patients and payer-specific claims payment amounts cannot be identified in any product of the proposed work to be made available.

The Board shall provide a non-binding recommendation to the Director that shall be based upon the application criteria set forth in § #.# of these Regulations.

The Board and Director, as part of their review of whether member, patient and payer-specific claims payment amounts are safeguarded shall also consider if any other data available to the applicant or public that the Board or Director is aware of or reasonably should be aware of could be used to re-identify the member, patient or payer-specific claims payment amounts.

The Director may approve the application for use of restricted release files if he or she is also satisfied that the applicant has demonstrated it is qualified to undertake the study or accomplish the intended use, the applicant requires such files in order to undertake the study or accomplish the intended use; and the applicant has demonstrated appropriate privacy and security controls for access to and storage of restricted release files.

#### **Comment 8: Use of Defined Terms throughout Regulation**

We have noted that defined terms, for example Payor and Third Party Administrator, are capitalized in the definition section but not capitalized throughout the MCDB regulation or MCDB Submission Manual. We ask the Commission to format all defined terms throughout the MCDB regulation and MCDB Submission Manual in the same format as is used in Section .02 Definitions of the regulation.

#### **Draft 2013 MCDB Submission Manual Comments**

#### **Comment 1: Data Summary Worksheets**

UnitedHealthcare and Optum data submitters have developed robust and comprehensive data validation quality checks which are based on the transparency of the state's requirements and the vendor's expectations. These quality checks ensure

that the data is passed to the state and/or their vendor exactly as received from the submitting physician and other providers. UnitedHealthcare and Optum Companies do not critique data elements we receive; instead, we rely on the practitioner to accurately submit the services provided, for the diagnosis, at the appropriate address including spelling of streets, towns, and zip codes.

In addition to this file submission quality check with each file submission, UnitedHealthcare and Optum Companies perform periodic quality checks to ensure that the data is complete and includes all appropriate entities as required by the state. If we find a discrepancy, we report it to a state right away to ensure full compliance with the APCD.

The requirement for all data submitters to complete and submit Data Summary Worksheets is highly complicated and takes more time, rework, effort, and causes a very disproportional burden on us. An example of the extra time and effort associated with the Data Summary Worksheets is the process of submitting the worksheets; some of our data submitters must encrypt, password protect then copy the worksheets onto a CD before mailing the CD to the vendor. The additional burden of creating these reports on a quarterly basis further complicates the submission and extends the timeline needed to prepare and submit the file. We ask that the Commission consider alternative data quality processes in lieu of requiring the submission of Data Summary Worksheets. In each and every one of the other APCD states, there is either a vendor mechanism or a data validation which is systematically built to allow for variance requests and to facilitate the submission of data. In today's Maryland Data Summary Worksheet process, we spend weeks explaining our data, rather than changing the data. The most efficient data quality process we have noted to date is in Colorado, however, Oregon, Utah, Minnesota, Maine, Vermont, New Hampshire, Massachusetts, Kansas could also be contacted to discuss their processes.

#### **Comment 2: New and Modified Specifications - Assignment of Benefits Indicator**

Several of our segments do not capture an assignment of benefits indicator as it is not necessary for us to house an assignment of benefits indicator in order to process claims; thus, we will be requesting variances for this field.

#### **Comment 3: New and Modified Specifications – Zip Code + 4**

For the Professional, Pharmacy Claims, Institutional and Eligibility files, our Medicare Advantage segment does not consistently receive the zip code plus four; thus, we will be requesting a variance to the 99% threshold. We may also have other submitters with limited data in these fields.

#### **Comment 4: Provider Directory Report**

The description of the Provider Directory Report provides for the inclusion of information on all Maryland and out-of-State health care practitioners and suppliers that provided services to applicable enrollees during the reporting period. Please clarify the Commission's expectations regarding the inclusion of information on out-of-State health care practitioners as we have limited information on non-participating providers. Is it

acceptable to run the claims reports, identify the practitioners who provided services to the enrollees and create the Provider Directory Report with available data on those practitioners?

#### **Comment 5: Elimination of Duplication of Reporting**

Based on communication with the Commission, we understand that the Commission does not require Reporting entities that perform certain components of the claims adjudication process for the same enrollees to submit duplicate information. We therefore suggest that the following language be added to the Key Submission Requirements section of the Submission Manual:

Each Reporting entity shall also submit all Medical Claims Data Files, Dental Claims Data Files, Pharmacy Claims Data Files, and associated Provider Files for any claims processed by any sub-contractor on the Reporting entity's behalf.

Reporting entities that are in a contractor/subcontractor arrangement with each other and Reporting entities that perform certain components of the claims adjudication process for the same enrollees under a shared services arrangement shall coordinate with each other to avoid duplicative submissions. Any Reporting entity that administers claims of enrollees as a subcontractor of another Reporting entity or can otherwise demonstrate that its submission of data regarding certain enrollees would result in a duplicative submission may request the Commission to waive its obligation to submit data files for such enrollees.

#### **Comment 6: Race, Ethnicity and Language Data Thresholds**

As the Commission considers the implementation of race, ethnicity and language (REL) data thresholds, and as was discussed with the Commission on September 4, 2013, given that we cannot compel our enrollees to provide REL information, UnitedHealthcare commercial products achieve a threshold of between 2% and 3% on the REL fields. The threshold for the Source of Enrollee Race/Ethnicity Information is 95%. We ask the Commission to consider an initial lower threshold of 3% for the specific REL fields.

#### **Comment 7: NPI Field**

One of our segments only captures and reports Servicing Practitioner NPIs; the Practitioner NPI used for Billing and the Attending Practitioner Individual NPI are unavailable. We will be requesting a variance for those fields.

Thank you, again, for allowing UnitedHealthcare the opportunity to comment on the draft MCDB Regulation and DSG. Please let me know if you have any questions or concerns regarding these comments.

Sincerely,

A handwritten signature in cursive script, appearing to read "Colleen C. Cohan".

Colleen C. Cohan  
Associate General Counsel  
Legal & Regulatory Affairs  
UHC – Mid-Atlantic Health Plan

Attachment

## **6. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDER PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION**

### **Introduction**

Participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Providers can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers can use price survey information to make more informed decisions when buying health care services. Without appropriate safeguards, however, information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services. A collusive restriction on the compensation paid to health care employees, for example, could adversely affect the availability of health care personnel.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among providers that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also briefly describes the Agencies' antitrust analysis of information exchanges that fall outside the antitrust safety zone.

### **A. *Antitrust Safety Zone: Exchanges Of Price And Cost Information Among Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies***

The Agencies will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for health care services, or (b) wages, salaries, or benefits of health care personnel, if the following conditions are satisfied:

1. the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);
2. the information provided by survey participants is based on data more than 3 months old; and
3. there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost

data is not used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing of a provider's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for health care services or compensation for employees.

**B. The Agencies' Analysis of Provider Exchanges Of Information That Fall Outside The Antitrust Safety Zone**

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Depending on the circumstances, public, non-provider initiated surveys may not raise competitive concerns. Such surveys could allow purchasers to have useful information that they can use for procompetitive purposes.

Exchanges of future prices for provider services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing providers of price or cost information results in an agreement among competitors as to the prices for health care services or the wages to be paid to health care employees, that agreement will be considered unlawful per se.