STATE OF MARYLAND

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MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
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To: Commissioners

From: Linda Bartnyska, Director of the Center for Analysis and Information Systems

Date: February 20, 2014

Re: Recommendation for Final Regulations: COMAR 10.25.06, Maryland Medical Care Data Base & Data Collection

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Background

Staff seeks Commission adoption of COMAR 10.25.06: Maryland Medical Care Data Base & Data Collection, as final regulations. After considering staff's analysis of informal comments received on draft regulations, the Commission adopted proposed and emergency regulations on October 17, 2013 and approved the 2013 and 2014 Submission Manuals on November 21, 2013. The proposed permanent regulations were published in the *Maryland Register* on December 2, 2013. At a hearing held on January 9, 2014, the Administrative, Executive, and Legislative Review Committee of the General Assembly approved the regulations as emergency regulations. Written comments were received from the following six organizations by the January 6, 2014 deadline:

America's Health Insurance Plans (AHIP)
CareFirst BlueCross BlueShield of Maryland, Inc. (CareFirst)
Cigna
League of Life and Health Insurers of Maryland (League)
MedChi
United Healthcare (United)

Staff Recommendation

Staff recommends that the proposed regulations be adopted as final regulations with no changes. Staff notes that most of the formal comments overlapped with informal comments received on the draft regulations and were considered by the Commission before adopting the proposed permanent and emergency regulations at its October 2013 meeting. Commission staff's analysis of the informal comments may be found at http://tinyurl.com/nyp7vsp. In the following section, staff analyzes additional comments and includes the rationale for staff's recommendations. A complete set of the written comments is attached.

Summary and Analysis of Additional Public Comments

Section .02 Definitions

Summary of Comments:

AHIP and the League believe that the proposed regulations do not adequately make it clear that excepted benefits are not intended to be included in the reports. They encourage an explicit exclusion of excepted benefits from reporting requirements.

AHIP recommends excluding supplemental insurance products, including Medicare supplemental insurance that provide cash benefits and are not always aligned with medical care that may be reported on claims. AHIP notes that Medicare supplemental insurance providers may not have the necessary information regarding the medical claim (e.g. diagnosis, provider information, etc.) needed for reporting to the MCDB.

Staff Analysis and Recommendation:

Staff agrees that the regulations do not require collection of data regarding excepted benefits and notes that this issue was raised by another commenter in informal comments and addressed by the Commission when it adopted the proposed regulations. As before, staff concludes that the definition of "general health benefit plan" in .02(8) adequately specifies plans included in reports. Staff recommends that no change be made.

Regarding the second point, staff notes that Medicare supplemental insurance is of specific interest to the State of Maryland and that payors have already been submitting this data. The regulations permit a payor who does not have needed information to request a format modification for one or more data elements. For these reasons, no change is recommended.

Section .05 Time Period for Submitting Data Reports

Summary of Comments:

CareFirst requests that reporting be semiannual and not quarterly, while MedChi supports quarterly reporting. CareFirst also would like for the administrative time for report submission following the end of a quarter to be increased to four months from the two months provided in the regulations.

Staff Analysis and Recommendation:

Before adopting the proposed regulations, the Commission considered staff's analysis, which noted that carriers had expressed a preference for a direct transition to quarterly reporting, rather than a transitional year with semiannual reporting. As previously discussed, the increased frequency of reporting is needed to support State priorities, such as the Health Service Cost Review Commission's monitoring of activities for the hospital waiver and the Maryland Insurance Administration's rate review process. Staff recommends that no change be made.

Regarding CareFirst's request for a longer run-out period, staff notes that the run-out period remains for 2013 data, which will still be submitted annually and cover claims *paid* by April 30, 2014 for services *incurred* during calendar year 2013. In contrast, 2014 data submissions require

quarterly submission of *claims paid* in the reporting period, regardless of date incurred. Thus, from 2014 forward, there is no need for a run-out period. Staff notes that the administrative period was not reduced in the proposed regulations. Staff recommends no changes to the regulations.

Section .09 Provider Directory Report Submission

Summary of Comments:

United requests that language be added that explicitly excludes entities that do not contract directly with providers from the requirement to submit a Provider Directory Report.

MedChi would like to have to fields added to address whether new patients are being accepted and the setting where they practice.

Staff Analysis and Recommendation:

Staff understands United's request to refer to Pharmacy Benefit Managers, as noted in UHC's informal comments and considered by the Commission when it adopted the proposed regulations. Staff agrees that such entities would not be required to submit the Provider Directory Report and notes that the submission manuals include a table of the reports that are required for each type of reporting entity. No change is needed.

Regarding MedChi's request, the Board of Physicians regularly collects physician practice information, such as whether a practice is accepting new patients and the setting where they practice. Staff concludes that there is no need to collect this information in the MCDB as well. Staff recommends that no changes be made.

Section .14 Non-Fee-For-Service Medical Expenditures Report

Summary of Comments:

MedChi stated that it supports the collection of this data, but urges caution in defining this report due to the many technical challenges in collection of this data. MedChi would like to participate in the workgroup to define this report.

Staff Analysis and Recommendation:

MedChi was invited to the workgroup meeting held on October 29, 2013 and will be invited to future meetings. Staff recommends no changes to the regulations.

Other Comments: Collection of Race, Ethnicity, and Language Data

Summary of Comments:

Cigna objects to the collection of race, ethnicity, and language (REL) data, as not necessary to its business operation and creating additional risk if data is accidentally released. Cigna notes that members are reluctant to provide such information and may incorrectly assume that the information will inform their premium rates. United requests an opportunity to review and comment on efforts to collect imputed REL data.

Staff Analysis and Recommendation:

As staff noted in October 2013, the collection of this information is a priority for the offices of the Governor and Secretary of Health and Mental Hygiene to be able to conduct analysis of utilization, quality, and costs by race and ethnicity as part of efforts to reduce or eliminate health disparities. Staff convened a race, ethnicity, and language (REL) workgroup and held meetings in October and November of 2013 to discuss these reporting requirements and strategies for fulfilling them. Based on the recommendations of the workgroup, the submission manual was updated to be consistent with race and ethnicity categories collected by the Health Services Cost Review Commission. A payor will also be permitted to submit imputed race and ethnicity data using its existing approach, if direct reported data is not available. Currently, no reporting threshold is in place on the direct reporting of race and ethnicity data. Staff will reconvene the workgroup when future changes are being considered and, as needed, to collaborate with payors on the collection of this data. Staff notes that United participated in the REL workgroup, will be invited to future workgroup meetings, and will be given an opportunity to comment on future changes. Staff recommends that no changes be made to the regulations.

America's Health Insurance Plans

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January 6, 2014

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

Re: COMAR 10.25.06, *Maryland Medical Care Data Base and Data Collection*

Dear Mr. Sridhara,

I write today on behalf of America's Health Insurance Plans (AHIP) regarding proposed amendments to COMAR 10.25.06, *Maryland Medical Care Data Base and Data Collection,* which would expand the types of information and the types of entities required to submit data to the Maryland Medical Care Data Base. AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

As Maryland considers amendments to COMAR 10.25.06, AHIP encourages the Maryland Health Care Commission to explicitly exclude supplemental health insurance products, commonly referred to as "HIPAA-excepted benefits" under federal law[1], from the claims reporting requirements and clarify that the data reporting requirements are limited to comprehensive, major medical insurance.

Supplemental health insurance products are usually fixed-payment products that pay cash directly to consumers, and benefits are paid without coordination of benefits with other insurance coverage. The consumer is able to use the cash for whatever expenses they deem appropriate, and often these benefits are not used to pay directly for medical expenses. These products offer financial security to individuals and families by ensuring that consumers have the extra financial resources needed to address unexpected expenses associated with a serious illness or injury.

It is also important to note that many of the data elements which are at the core of APCD data collection efforts are not gathered as part of a supplemental product claim (e.g. procedure codes,

[1] See 42 U.S.C. 300gg-91(c) for the federal definition of "excepted benefits" which includes, but is not limited to: hospital indemnity or other fixed indemnity insurance, accident-only coverage, specified disease or illness policies, disability income insurance, and Medicare Supplement products.

provider billed charges or negotiated rates, referral information, provider quality information) because such information is irrelevant to a supplemental claim.

Although Medicare Supplement products are more closely aligned with actual medical claims (paying the 20% of a claim that the Medicare program will not cover), we note that inclusion of Medicare Supplement products in claims database reporting requirements distorts the data that will be used by the state because payments for these products represents incomplete data sets on a small portion of the actual claims costs incurred by the Medicare patient. Medicare Supplement carriers receive very limited data from CMS and are not able to obtain additional information to give the APCD the complete data set needed to understand what has occurred with each claim episode for which it is paying the supplemental amount. For example, Medicare Supplement data will not contain important claims details such as diagnosis codes, provider quality information, etc.

Data reported by supplemental carriers will duplicate or skew data reported by comprehensive major medical carriers. We note that many other states have specifically created this exemption for HIPAA-excepted benefit products, and some states (e.g. Vermont) noted the unfortunate effect on their data efforts of including supplemental products, and have since excluded them.

For these reasons, it is important that supplemental health insurance products be clearly exempted from the reporting requirements in the Maryland Medical Care Data Base and Data Collection rules. If you have any questions regarding these comments or would like additional information, please do not hesitate to contact me directly (gtrujillo@ahip.org, 202-778-1149).

Sincerely,

gtrujillo

Geralyn Trujillo, MPP
Regional Director

Deborah R. Rivkin
Vice President, Government Affairs - Maryland

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January 6, 2014

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

Re: 10.25.06 Maryland Medical Care Data Base and Data Collections

Dear Mr. Sridhara:

I write on behalf of CareFirst BlueCross BlueShield ("CareFirst") and in response to the proposed regulations 10.25.06 Maryland Medical Care Data Base and Data Collections published in the Maryland Register on December 2, 2013. As expressed in our previous discussions and correspondence dated October 9, 2013 (see attached), we are still concerned with the following:

- Proposed regulation .05B maintains the quarterly reporting requirement that was in the informally proposed draft rather than moving it to semi-annually or annually as discussed. The proposed regulation actually accelerates the reporting obligation and provides that the quarterly reports need to be improved within 2 months of the last day of the applicable quarter. The informal comments had provided that they needed to be provided within 4 months.
- Proposed regulation .07 appears to keep the requirement that reports be about paid and incurred claims instead of only paid claims as discussed with MHCC staff.
- The proposed regulations do not address a delayed implementation date as requested.
- Proposed regulation .19 regarding summaries and compilations also did not change from the informally proposed regulations and, therefore, could still be interpreted to allow the manipulation of summaries to reveal confidential and proprietary information and carrier rates with providers. CareFirst respectfully 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."

As our comments above are not reflected in the proposed regulations, despite our raising these substantive issues, we respectfully request a meeting to discuss the outstanding concerns before the regulations are finalized. I look forward to working with you and can be reached at 410-528-7054.

Sincerely,

Deborah R. Rivkin

Marla Harris Tildon
Senior Vice President
Public Policy and Community Affairs

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CareFirst

October 9, 2013

VIA EMAIL (srinivas.sridhara@maryland.gov)
Srinivas Sridaha
Acting Chief, Cost and Quality Analysis
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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,

Maria Harris Tildon

Patrick M. Gillespie
Director,
State Government Affairs

Law & Public Affairs

VIA FACSIMILE AND ELECTRONIC MAIL

January 6, 2014

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

Dear Chief Sridhara:

Thank you for the opportunity to comment on the proposed rules cited as COMAR 10.25.06 regarding "Maryland Medical Care Data Base and Data Collection." Cigna has significant concerns and opposes these proposed rules in their current form. A fundamental issue posed by these proposed rules is balancing the need for transparency in the marketplace and the lack of a compelling business case for the Commission to collect this additional data.

Cigna supports the broad transparency goals expressed in section III of the proposed rules. In terms of creating transparency tools for our members, Cigna has been a leader in this space. In 2012, Cigna's online health care cost and quality tools were recognized as one of the top ten technology innovations of the year by *Information Week*. Cigna's customer website, myCigna.com features physician and health facility quality and pricing information that is personalized to an individual's health plan. These price estimates cover more than 200 common procedures-from delivering babies to knee replacement surgery-that represent 80 percent of Cigna's medical claims. A tour of our web applications is available by clicking on "Site Benefits" at myCigna.com. Cigna also provides mobile applications for wireless devices and a customer service hotline that operates 24 hours a day, 365 days a year. By connecting with each customer and providing actionable information, how and when they want it, we enable each individual to improve their health, financial security and ultimately their quality of life. Cigna views these tools as a competitive differentiator in the marketplace.

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. Claim systems are designed to process claims and are ill-equipped to meet the cross functional reporting requirements contemplated in these proposed rules. The assumptions and estimates of economic impact of the proposed rules do not accurately estimate the staff and programming time associated with preparing these reports.

Cigna is concerned about the construct of the draft rule and interaction with the technical manual. These 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 by the Commission under Maryland's administrative procedure laws. Cigna believes it is inappropriate to use revisions to a technical manual to implement policy changes. The proposed rules would permit that and unfortunately could deprive the public of adequate notice and the opportunity to be heard under the rulemaking process. Please amend section .15 of the proposed rules to narrow the scope of the technical manual.

Among the proposed new data requirements, Cigna is particularly concerned about the required collection and submission of each member's race and ethnic information as contemplated in sections .11 and .15 of the proposed rules. Cigna understands that customers, due to legitimate privacy concerns, are increasingly reluctant to furnish such personal information. Moreover, customers could incorrectly infer that Cigna or other carriers are collecting such data in order to rate their policies. Also, requiring that carriers collect such data elements significantly increases the level of risk associated with any accidental release of personal data. Cigna treats the collection and retention of a customer's information seriously and only collects data that is absolutely necessary to our business operations. This information is already collected and made readily available by the United States Census Bureau.

Cigna is concerned about the potential disclosure of negotiated reimbursement rates among carriers and providers. The language in part III, sections e, f of the proposed rules suggests it is the Commission's intention to disclose such discounts. The proposed rules should clarify that information available to members on carrier websites, such as the one that Cigna currently maintains be exempt from public disclosure. The broad public disclosure of information regarding negotiated discounts is anti-competitive; it would create a "price floor" and could result in steep cost increases for Maryland consumers. Prior to adopting these rules, Cigna respectfully suggests that the Commission consult with the U.S. Department of Justice and the Federal Trade Commission to ensure that these proposed rules do not violate the agencies joint "Statements of Anti-trust Enforcement Policy in Healthcare."

Finally, the proposed rules should be amended to allow additional time for carriers requesting an extension in section .16. There could be significant programming issues, as previously stated, presented in preparing these reports and a 30 day extension may not be adequate. Cigna suggests that the Commission allow for a 90 day extension of time. This additional time would afford carriers the opportunity to run internal checks on data prior to submission and ultimately provide the Commission with information that is as accurate as possible.

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

The
League
of
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Health
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of
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410-269-1554

January 6, 2014

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

RE: COMAR 10.25.06

Dear Mr. Sridhara:

Thank you for the opportunity to provide comments on behalf of the League of Life and Health Insurers of Maryland, Inc (League). The League is the trade association for the life and health insurance industry in the State of Maryland. Many of the League's member companies are national carriers who are working to manage vastly different reporting requirements from state to state. Managing the administrative burden placed upon carriers by such all payor claims databases is of paramount concern. To that end, we offer the following comments and concerns:

MCDB Data Submission Manual
The proposed regulations remove a great deal of specificity from the previous regulations and yield those details to the Manual. As a result, by changing the Manual, new requirements not specified in the regulations and not subject to a public review process may be added. Policy decisions should be made through amendment to the Manual. The regulations should limit the Manual's use to providing implementation guidance only. While we appreciate that the proposal commits to updating the Manual only annually, we believe it will be important that the MHCC create a process to engage with carriers on proposed amendments to the Manual well in advance on the annual November release date.

Timing of the report-
1. Based on the timing in the regulation, carriers will be providing their report on 2013 services for which payment was made between January 1, 2014 and April 30, 2014 by June 30, 2014 while also reporting their 1st quarter 2014 data by May 31, 2014. The very short timeframe between reports is burdensome and of concern.
2. Regulation .05 requires a report on services rendered in 2013 and paid between January 1, 2014 and April 30, 2014. All other reports for 2014 are based solely on claims paid in the applicable quarter. Are carriers to exclude those payments for 2013 services from the 1st quarter report? If not, the report on paid claims for 1st quarter 2014 could duplicate payment information included in the report on 2013 services.

Summaries and compilations

League members are concerned that the summaries and compilations contemplated under Regulation .19 could be manipulated or otherwise used to reveal proprietary and confidential information regarding provider reimbursement rates paid by a specific carrier. It is important the Commission balance the need for worthwhile public disclosure with the need to avoid disclosure that would lead to anti-competitive consequences. The current language in the proposal is high level, and does not directly address the impact of anti-competitive or collusive behavior. There are a number of ways the Commission could choose to address this issue, including the addition of clear language that such summaries and compilations will be developed in such a way to prevent the revealing or the deriving of any carrier's rate payment information, or the development of a process to ensure that any request for information appropriately safeguards against releasing proprietary and confidential information or information that could lead to an anti-competitive impact on the market. The State can and should meet its goals while providing ample protection to carrier's information.

Data Summary Worksheets-
League members are concerned with the requirement for the continued completion of Data Summary Worksheets. Much like the Manual, we believe there is a critical need for the MHCC to engage with carriers on the format and content of the Worksheets. Moreover, given the tremendous amount of resources required to complete the worksheets, we urge the Commission to consider less burdensome ways to ensure the quality of the data received. We believe there are examples from around the country of efficient data quality processes that could be considered.

HIPAA excepted-benefits
League members are concerned that the regulations do not adequately make clear that HIPAA-excepted benefits products are not be subject to the data reporting requirements. These products may provide some type of medical service but are not akin to the major medical health policies contemplated by the regulations and should be excluded.

Please le me know if you have questions regarding these comments. I would be happy to discuss them with you at your convenience.

Very truly yours,

Kimberly Robinson

Kimberly Y. Robinson, Esq.
Executive Director

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

January 2, 2014

Srinivas Sridhara, Acting Chief
Cost & Quality Analysis
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2222

RE: 10-25.06 - Maryland Medical Care Data Base and Data Collection – Draft Regulations

Sent via email to Srinivas.Sridhara@Maryland.gov

Dear Mr. Sridhara:

On behalf of MedChi, the Maryland State Medical Society, I submit these comments regarding the above-referenced proposed regulations. MedChi understands that the purpose of these regulations is to expand and enhance MHCC's current database to reflect changes in the health care insurance market and delivery system prompted by implementation of the ACA and anticipated changes that may result from the new Medicare Waiver. The regulations predominantly impact carriers and to that end MedChi's comments are focused on the following issues that are particularly relevant to the physician community.

1. Quarterly Reporting: MedChi supports the Commission's proposal to require quarterly reporting by carriers and other required reporting entities. MedChi believes quarterly reporting will result in more timely and relevant data. It also may result in enhanced carrier accountability for timely claims management given a more frequent requirement to claims data submission.

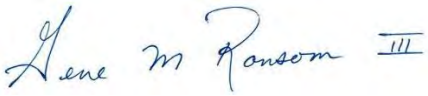
2. Provider Directory Report: MedChi also supports the requirement for reporting entities to submit a provider directory report. MedChi continues to be concerned about network adequacy and the accuracy of current provider directories. To that end, MedChi would encourage the Commission to include: 1) a requirement for reporting entities to reflect whether a provider is accepting new patients, and 2) specification as to whether a provider delivers services in an inpatient setting, a community-based setting or both. The addition of these two additional data elements will enhance the accuracy and usefulness of the provider directory report as a tool to evaluate network adequacy and the location of service delivery.

3. Non-Fee-For-Service Medical Expenses Report: MedChi is cognizant that in order to create a comprehensive medical care data base, non-fee-for-service expenses must be collected. However, MedChi wishes to register its concern about how such expenses will be defined and reported given the lack of specificity on what is to be considered non-fee-for service expenses. The lack of definition is particularly concerning as discussions about "gain-sharing" and other payment mechanisms is commencing through HSCRC Medicare Waiver application and eventual implementation. MedChi is not

opposed to the reporting requirements but urges the Commission to engage stakeholders as it defines what is to be included in this report.

MedChi appreciates the opportunity to comment on the proposed regulations and looks forward to its continued work with the Commission as it seeks to enhance and improve the quality and relevancy of the data it collects.

Sincerely,



Gene M. Ransom, III
Chief Executive Officer

cc: Ben Steffen, Executive Director, MHCC
David Sharp, Director, Center for HIT, MHCC

UnitedHealthcare

Colleen C. Cohan
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Legal & Regulatory Affairs
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January 3, 2014

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

Re: Proposed Modifications to MCDB Regulation

Dear Mr. Sridhara,

On behalf of UnitedHealthcare and its affiliated companies, we appreciate the opportunity to comment on the proposed modifications to the MCDB regulation.

Comments Regarding Proposed Modifications to MCDB Regulation

Comment 1: Section .05 Timeframe for Submitting Data Reports

Section .05 Timeframe for Submitting Data Reports includes a submission timeframe for the first quarter 2014 data that is before the due date for the year 2013 data. We respectfully request a modification to this section such that the first quarter 2014 data submission due date will be after the year 2013 data submission due date. Suggested modified language is as follows in bold, underlined text:

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. **The data for the 1st quarter 2014 will be due within 4 months of the last day of the 1st quarter 2014. The data for the 2nd quarter 2014 and each subsequent quarter will be due** within 2 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.

We also note that with the move to quarterly reporting, data for claims paid during a quarter and not for dates of service during a quarter is required to be submitted. Please confirm that all dates of service prior to January, 2014, will be excluded from the year 2014 quarterly submissions.

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 2: Section .06 A – Filing Data Using Encryption

We ask that the Commission add clarifying language to describe the relationship of the Master Patient Index (MPI) to the MCDB and any effect it will have on submission timeframes of the MCDB data to the MHCC.

Comment 3: Section .09 Provider Directory Report Submission

Please include clarifying language in the regulation to indicate that entities that do not directly contract with providers are not required to submit a Provider Directory Report.

Comment 4: Section .16 Request for an Extension of Time

The proposed changes to the regulation include a reduction in 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 5: Section .19 Summaries and Compilations

We note that the proposed changes to the regulation include 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. We ask the Commission to 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 suggest the MHCC include language similar to the following data disclosure language that has been 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 6: 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.

Comment 7: Imputing Race, Ethnicity, Language Data

Please confirm that, if the MHCC decides to require submitters to impute Race, Ethnicity, and Language data, the MHCC will propose the requirement in a future version of the MCDB rule and permit submitters time to review and comment on the language before finalizing the rule.

2013 MCDB Submission Manual

We understand that the MHCC is finalizing the 2013 MCDB Submission Manual. We would like to reiterate our concern regarding the prior requirements for submitters to send in Data Summary Worksheets. Please reference the following comment which was submitted in October, 2013.

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, and Kansas could also be contacted to discuss their processes.

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

Sincerely,

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