

Claims Data Submission Rule Harmonization Issues
(please refer to associated Contrasted Comparison table)
(Decisions/Agreements from 3/24/08 conference call presented below)

Color Code

Orange – Coding Issues and Errors

These differences appear to be the result of errors in drafting or some communications problems as the draft rules were shared among the four states.

- a. The differences associated with MC030 and MC036 seem to be errors and can be easily corrected.
- b. It is unclear why the Insurance Type/Product Codes are so different between MA/NH and ME/VT. This will require some discussion but I believe most of these differences can be eliminated.

Decisions/Agreements:

- The Insurance Type/Product Codes for ME003, MC003, and PC003 should be reconciled among all of the states data collection rules (where appropriate) such that the code list is the most expansive. A separate Excel table has been created listing the codes for the three data elements and should be referenced when each of the states next amend their rules.
- All states should expand the field length of MC030 to 60 characters when their rules are next amended (NB - this modification is also included in the Data Alignment Table because it impacts the total length of the Medical Claims file).
- All states with the typographical error should correct the codes for MC036 when their rules are next amended.

Red – Interstate Operability

The differences within this category will have the greatest impact when creating a multi-state claims database (or when attempting to compare the data of one state with another) and may lead to additional administrative costs for the states and MHDPC.

- a. Although at first glance it appears that NH, by including members covered by a policy issued in NH and not NH residents per se, is not in alignment with the other three states, the differences may be more semantic than actual. It is true

that by including all members covered by the policy NH has MA, ME, and VT residents (as well as others from around the country) in their database. If the NH data are to be used collectively or in an interstate comparison, the eligibility files would need to be unduplicated. NH may consider creating a subset of the claims data in their possession that includes only NH residents. However, it is unclear that NH is lacking any large numbers of commercially covered lives by not requiring the policies to be associated with NH residents. NH will have difficulty legally compelling a MA licensed carrier to submit data related to NH residents covered by a fully insured product offered by a MA employer. This is true for a ME resident covered by a NH carrier, a VT resident covered by a NY licensed carrier, etc. ME is currently receiving the Anthem NH data for covered ME residents on a voluntary basis. We should discuss how the data might be shared in a similar fashion to the RAPHIC states by the larger national/regional carriers. Although VT is required by state law to collect claims data on all non-VT residents, it will be legally and technologically difficult to do.

b. ME is the only state utilizing the older SSN encryptor. If there is a need to follow individuals who move across state boundaries, this will create a problem. More importantly, it creates additional costs for the data providers if they must run to encryptors. ME has begun utilizing the new encryptor and will map the first version to the newer version for the SSN's collected in prior years.

c. Currently, there is no uniform coding system to identify payers submitting data to each state. Although licensed carriers do have NAIC codes (which is used as primary identifier at the MHDPC), TPA's do not. In addition, the larger carriers have multiple components with multiple NAIC codes. In order to minimize confusion, reduce costs, and to allow for greater accuracy in a multi-state database, the RAPHIC states need to agree upon a consistent and uniform system for identifying the data submitters.

Decisions/Agreements:

- If NH and VT (or any other states) are collecting claims data for non-residents, it is desirable to create for public use a claims database with the non-residents removed to prevent duplicative data when regional databases are created or when interstate comparisons are made. It was also agreed that an effort be made to ask the large out of state carriers to voluntarily provide claims data to a particular state for residents covered by policies issued in other states (e.g. – ME residents covered by Anthem NH or NH residents covered by MA BC/BS).
- ME will begin utilizing the newer SSN encryptor and map the numbers in the historical data to the new so that it will be uniform and comparable.
- NAIC Codes will be used by all states to identify the carriers submitting data to the MHDPC (or to other data processors). MHDO staff (with the

MHDPC) will create a unique identifier for all third-party administrators (TPA's) and pharmacy benefits managers (PBM's). Each state needs to submit a list of licensed or registered TPA's and PBM's (when available) to the MHDO so that the unique identifier can be assigned.

Blue – Interstate Comparability

While the issues associated with this category may not necessarily increase costs or impact the accuracy of the databases, they will render the data less comparable, complete, and, in some respects, less valuable.

a. From its inception, ME had envisioned the claims database to include as many commercial and governmental payers as legally possible. ME is willing to assist the RAPHIC states to secure CMS approval to add the Medicare and Medicaid data their databases. The other RAPHIC states may also wish to secure the Medicare Part D data directly from the commercial carriers.

b. While states may wish to forgo the collection of dental claims during the initial stages of the construction of a claims database (or may elect to never collect the claims), it would be in the best interests of all states to provide a uniform structure that would allow for the inclusion of dental claims in the future without impacting any of the other files.

c. A discussion needs to occur regarding the merits of including durable medical equipment in the claims databases. Is there a need for the data (policy, research, etc.) and can it be collected accurately?

Decisions/Agreements:

- ME has agreed to assist the other states with preparing data requests to CMS for the integration of the Medicare and Medicaid data with the commercial claims.
- If the other states elect to collect dental claims, it will be done in a consistent manner.
- A discussion of MA's and NH's requirement that payers submit HEDIS/CAHPS did not occur. The pros and cons of this requiring this information need to be discussed soon if ME and VT are to follow MA and NH.
- ME was asked to provide an annual total for commercial durable medical equipment claims. The number is 771,177, or slightly over 2%, for commercial claims. Durable medical equipment claims represent almost 5% of the Medicare claims. If the numbers are significant to MA and NH,

they should consider amending their rules to include durable medical equipment claims.

Green – File Structure

While the RAPHIC states may never come to complete agreement relative to the individual data elements included in a claims database, we should agree on file formats. Failure to do so will result (or may have already resulted) in additional costs to the data submitters. When one state introduces additional data elements and places them in the middle of an existing file sequence (e.g. – NH's addition of the Version Number as MC005A, or MA's Pharmacy Country Name as PC024A) instead of at the end, it forces the data submitters to modify their extraction programs for those states, which may lead to unexpected errors. All new data elements should be placed at the end of the files with some discussion occurring among the RAPHIC states so two or more states do not make simultaneous modifications that end up being contrary to one another. Placing new data elements at the end of the submitted data files does not mean that the end product has information that is out of sequence or context. The data can be reformatted/re-sequenced as the final files are being created after the edits are run and the files are being prepared for the agency or entity holding the data for distribution to the public.

Decisions/Agreements:

- The group agreed that it would be beneficial to the data submitters if we can keep the base file structures identical. To that end, any additional data element that a state wishes to add to a particular file would be located at the end of the file. To avoid creating elements with the same number and location in the file, the parties involved with data collection must coordinate adopting and amending their submission rules. A separate Excel table has been created which provides a layout that will keep the core elements in a consistent array but will allow each state to add additional elements according to their need. The table shows the current location of the problem elements and a proposed location of where they need to be moved (some will remain the same). The data elements in the "Proposed" column will either be actual adopted data elements for a particular state, or place holders, if not currently adopted or not applicable to another state.

Black – Differences of Minimal Impact

These differences will not have a significant (if any) impact with respect to interstate harmonization and do not necessarily need to be modified.

Unless the RAPHIC states agree on some minimum % of the commercial population that should comprise a state's claims database, each state can

determine the number of data submitters vs. number of members it believes it can accommodate in a cost-effective manner.

Decisions/Agreements:

Although some discussion ensued regarding a "minimum" % for commercial claims, it was agreed to not take any action at this time since all states are attempting to collect as much as possible while being cost effective. It was suggested that all states provide estimates of the commercial population covered to those using the data.