**90-590 MAINE HEALTH DATA ORGANIZATION**

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

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

**1. Definitions**

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

* 1. **Behavioral Health Care**. "Behavioral health care (BH)" means services to address mental health and substance use conditions. 24-A MRSA §6903, sub-§1-A.
  2. **Capitation Payments**. “Capitation payments” means per capita payments to providers to provide services needed by designated patients over a defined period.
  3. **Care Management/Care Coordination/Population Health Payments**. “Care management/care coordination/population health payments” means payments to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, patient navigators, or nurse care managers) who help providers organize clinics to function better and help patients take charge of their health.
  4. **Carrier**. "Carrier" means an insurance company licensed in accordance with 24-A M.R.S., including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to 24-A M.R.S., chapter 81, a preferred provider organization, a fraternal benefit society, or a nonprofit hospital or medical service organization or health plan licensed pursuant to 24 M.R.S. An employer exempted from the applicability of 24-A M.R.S., chapter 56-A under the federal *Employee Retirement Income Security Act of 1974*, 29 *United States Code*, Sections 1001 to 1461 (1988) (“ERISA”) is not considered a carrier.
  5. **Designee**. "Designee" means an entity with which the MHDO has entered into an agreement under which the entity performs data collection, validation and management functions for the MHDO and is strictly prohibited from releasing information obtained in such a capacity.
  6. **Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments**. “Electronic health records/health information technology infrastructure and other data analytics payments” means payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs outside of the electronic health records and/or the cost of a data analyst to support practices.
  7. **Global Budget Payments**. “Global budget payments” means payments made to providers for either a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain services such as behavioral health or pharmacy are carved out. Services typically include primary care clinician services, specialty care physician services, inpatient hospital services, and outpatient hospital services, at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.
  8. **Medicare Health Plan Sponsor**. “Medicare health plan sponsor” means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.
  9. **Medication Reconciliation**. “Medication reconciliation” means payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.
  10. **MHDO**. "MHDO" means the Maine Health Data Organization.
  11. **M.R.S.** “M.R.S.” means *Maine Revised Statutes*.
  12. **Non-Claims Based Payments.** “Non-claims-based” means payments that are for something other than a fee-for-service claim. These payments include but are not limited to Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions.
  13. **Patient-centered Medical Home Payments**. “Patient-centered medical home payments” means Practice-level payments such as payments to Patient-Centered Medical Homes (PCMH), Health Homes for provision of comprehensive services; payments based upon PCMH recognition; or payments for participation in proprietary or other multi-payor medical -home or specialty care practice initiative.
  14. **Pay-for-performance Payments**. “Pay-for-performance payments” means payments to reward providers for achieving a set target (absolute, relative, or improvement-based) for quality or efficiency metrics. Payments could include the return of a withhold if not attached to a claim payment.
  15. **Pay-for-reporting Payments**. “Pay-for-reporting payments” means payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for future pay-for-performance incentives.
  16. **Payor.**  "Payor" means a carrier, third-party payor, third-party administrator, Medicare health plan sponsor or Medicaid.
  17. **Pharmacy Benefits Manager**. "Pharmacy benefits manager" means an entity that performs pharmacy benefits management as defined in 24-A M.R.S. §4347, sub-section 17.

1. **Pharmacy Benefits Manager Compensation.** “Pharmacy benefits manager compensation” means the difference between:
   1. the value of payments made by a carrier to its pharmacy benefits manager; and
   2. the value of payments made by the pharmacy benefits manager to dispensing pharmacies for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the carrier.
2. **Primary Care**. "Primary care" means regular check-ups, wellness and general health care provided by a provider (see Appendix A) with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.
3. **Primary Care and Behavioral Health Integration Payments**: “Primary care and behavioral health integration payments” means payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting), such as: a) substance abuse or depression screening; b) performing assessment, referral, and warm hand-off to a behavioral health clinician; and/or c) supporting health behavior change, such as diet and exercise for managing prediabetes risk). This excludes payments for mental health or substance use counseling.
4. **Prospective Case Rate Payments**. “Prospective case rate payments” means payments received by providers in a given provider organization for a patient receiving a defined set of services for a specific period.
5. **Prospective Episode-based Payments.** “Prospective episode-based payments” means payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers, including providers, or care for a specific condition over a specific time.
6. Provider.  "Provider" means a health care facility, health care practitioner, health product manufacturer or health product vendor but does not include a retail pharmacy.
7. **Provider Salary Payments**. “Provider salary payments” means payments for salaries of providers who provide care. This category may only be applicable for closed health systems.
8. **Rebate**. “Rebate” means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point-of-sale, as part of retrospective financial reconciliations (including reconciliations that also reflect other contractual arrangements), or by any other method. “Rebate” does not mean a “bona fide service fee”, as such term is defined in Section 447.502 of Title 42 of the Code of Federal Regulations, published October 1, 2019.
9. **Recoveries**. “Recoveries” means payments received by a provider from a payor and then later recouped due to a review, audit, or investigation. Recoveries not reported in claims payments should be netted out of the total non-claims-based payments reported.
10. **Retrospective/Prospective Incentive Payments**. “Retrospective/prospective incentive payments” means payments to reward providers for achieving quality and/or efficiency goals. The two main subcategories of incentive payments are pay-for-performance and pay-for-reporting.
11. **Risk-based Payments**. “Risk-based payments” means payments received by providers (or recouped from providers) based on performance relative to a defined spending target. Risk-based payment methodologies can be applied to different types of budgets, including but not limited to episode of care and total cost of care. The two main subcategories of risk-based payments are shared savings and shared risk.
12. **Shared-risk Recoupments**. “Shared-risk recoupments” means payments payors recoup from providers if costs of services are above a predetermined, risk-adjusted target. Shared-risk arrangements are typically calculated on a total cost of care basis and typically exclude high-cost outliers. Recoupment should be netted out of the total non-claims-based payments reported.
13. **Shared-savings Distributions**. “Shared-savings distributions” means payments received by providers if costs of services are below a predetermined and risk-adjusted target. The amount of savings the provider can receive is often linked to performance on quality measures.
14. **Substance Use Disorder (SUD)**. “SUD means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal, excluding tobacco/nicotine or caffeine use.
15. **Supplemental Health Care Data Sets**. “Supplemental health care data sets” means data files specific to payments for primary care, behavioral health, or other health care services. Supplemental health care data sets may include aggregated, non-claims-based payment information, or aggregated or non-aggregated, SUD claims-based payment information.
16. **Third-party Administrator.** “Third-party administrator” means any person licensed by the Maine Bureau of Insurance under 24-A M.R.S., chapter 18 who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State.
17. Third-party Payor. "Third-party payor" means a state agency that pays for health care services or a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization, or managed care organization licensed in the State.

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

1. **General Requirements**
2. Payors that: i) provide medical and pharmacy benefits to Maine residents; and ii) are not excluded from submitting health care claims data sets under 90-590 C.M.R. Chapter 243 Sec 2(A)(9)(a-b); and iii) reimburse providers by means other than a Fee-for-Service model shall submit to the MHDO or its designee the following complete data sets, if applicable.
3. Types and descriptions of data sets and supporting information files
   1. Non-claims-based (NC) data sets consist of aggregated NC payment information regarding payments from payors to providers for the prior calendar year, which is defined as the performance period. NC files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out. Payors shall report NC payments for Medicare and non-Medicare Advantage (commercially insured) populations separately, combining plans as needed within those populations.  It may be necessary to estimate portions of NC payments by population if amounts are paid to provider systems for plans that include both populations.  Population counts encompass all eligible members, not just those associated with providers who received NC payments.
   2. Aggregated, SUD claims-based (AC) data sets consist of AC payment information regarding payments from payors to providers. The performance period is retrospective and defined to include claims incurred during the prior calendar year (no limitation on paid date). AC files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out. Payors shall aggregate SUD claims payments by the product codes identified in Section 2(B), data element AC003 and report totals for each product code.  The total members and total member months in the AC file include all members eligible for the product code in the performance period, not just those with SUD claims.
   3. Prescription drug rebate (DR) data sets consist of aggregated prescription drug payment and rebate information. The performance period is retrospective and defined to include claims incurred during the prior calendar year with no limitation on paid date or rebate received date. DR files must contain the most recent information available at the time of file generation with a minimum of 3 months of run-out.
   4. NC and AC data set types shall be accompanied by the appropriate supporting information file. Samples are found at <https://mhdo.maine.gov/portal>.
      1. The supporting information file for an NC payment data set must describe the methods used to reimburse behavioral health care providers.
      2. The supporting information file for an AC payment data set must detail the methods used to identify the substance use disorder claims, the specific code lists that are used for procedure codes, revenue codes and diagnosis codes, provider types and any other detail on the claim that is required to select the substance use disorder claim.
4. The payors specified in section (1) shall indicate the data set types that are applicable to all plans or certify that these are not applicable via the annual registration update at <https://mhdo.maine.gov/portal> by February 28th of each year. It is the responsibility of the payor to amend the information, as needed, and to have an authorized user electronically sign to confirm/attest that the information provided is complete and accurate.
5. The payor(s) that administer(s) health insurance for State of Maine employees and the Maine Education Association Benefits Trust to pay for behavioral health care shall also submit separate data sets and supporting information for these two groups.
6. Each payor is responsible for the submission of all applicable data sets and supporting information made by any sub-contractor on its behalf.
7. Any self-funded employee benefit plan regulated by ERISA that submits claims data under 90-590 C.M.R. Chapter 243 Section 5 shall submit completed, applicable data sets for Maine residents and supporting information in accordance with the provisions of this rule.  Any such data shall be subject to the same laws and regulations as other MHDO data.
8. **Data Elements and Attributes by Header Record, Trailer Record and File Type**

**Header Record (for All File Types)**

| **Data**  **Element**  **#** | **Data**  **Element**  **Name** |  | **Type** | **Maximum**  **Length** | **Definition/Description** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **HD001** | **Record Type** |  | Text | 2 | HD |
|  |  |  |  |  |  |
| **HD002** | **Submitter** |  | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
|  |  |  |  |  |  |
| **HD003** | **Payor** |  | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
|  |  |  |  |  |  |
| **HD004** | **Type of File** |  | Text | 2 | AC Aggregated, SUD Claims-Based Payments  DR Prescription Drug Rebates  NC Non-Claims-Based Payments |
|  |  |  |  |  |  |
| **HD005** | **Period Beginning Date** |  | Text | 6 | CCYYMM |
|  |  |  |  |  | Beginning of paid period for payments |
|  |  |  |  |  |  |
| **HD006** | **Period Ending Date** |  | Text | 6 | CCYYMM |
|  |  |  |  |  | End of paid period |
|  |  |  |  |  |  |
| **HD007** | **Record Count** |  | Number | 10 | Total number of records submitted in this file |
|  |  |  |  |  | Exclude header record in count |
|  |  |  |  |  |  |
| **HD008** | **Comments** |  | Text | 80 | Submitter may use to document this submission by assigning a filename,  system source, etc. |

**Trailer Record (for All File Types)**

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

**File Type NC – Non-Claims-Based Payments**

| **Data**  **Element**  **#** | **Data**  **Element**  **Name** |  | **Type** | **Maximum**  **Length** | **Definition/Description** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **NC001** | **Submitter** |  | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
|  |  |  |  |  |  |
| **NC002** | **Payor** |  | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
|  |  |  |  |  |  |
| **NC003** | **Performance Period Start Date** |  | Text | 6 | CCYYMM  Effective date of performance period. Performance period refers to payment date. |
|  |  |  |  |  |  |
| **NC004** | **Performance Period End Date** |  | Text | 6 | CCYYMM  End date of performance period. Performance period refers to payment date. |
|  |  |  |  |  |  |
| **NC005** | **Total Number of Members** |  | Number | 10 | The count of individual members with any eligibility in the performance period in the population identified in NC012.  No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **NC006** | **Total Member Months** |  | Number | 10 | The total number of member months of eligibility in the performance period in the population identified in NC012.  No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **NC007** | **Total Dollars Non-Claims-Based Payments** |  | Number | 10 | No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **NC008** | **Total Dollars Non-Claims-Based Payments (Primary Care Only Portion)** |  | Number | 10 | No decimal places; round to nearest integer. Example: 12345 See definition of Primary Care above (1Q) for reporting Primary Care Only. |
| **NC009** | **Total Dollars Non-Claims-Based Payments (BH/SUD Only Portion)** |  | Number | 10 | No decimal places; round to nearest integer. Example: 12345 See definition of Behavioral Health/Substance Use Disorder above (1A) and Appendix C for reporting BH/SUD Only. |
|  |  |  |  |  |  |
| **NC010** | **Total Dollars Non-Claims-Based Payments (non-PC/non-BH/SUD)** |  | Number | 10 | No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **NC011** | **Population** |  | Text | 2 | Population to which the payments apply.  CI Commercially Insured (non-Medicare Advantage)  MA Medicare Advantage  MC MaineCare |
| **NC012** | **Payor Notes** |  | Text | 320 | Clarification about the population to which the payments apply, limitations in ability to report the measure, and/or explanation of why the data is not reported. |
|  |  |  |  |  |  |

**File Type AC – Aggregated SUD Claims-Based Payments**

| **Data**  **Element**  **#** | **Data**  **Element**  **Name** |  | **Type** | **Maximum**  **Length** | **Definition/Description** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **AC001** | **Submitter** |  | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
|  |  |  |  |  |  |
| **AC002** | **Payor** |  | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
| **AC003** | **Insurance Type/Product Code** |  | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Rule Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes:  HN Medicare Part C  MD Medicare Part D |
|  |  |  |  |  |  |
| **AC004** | **Performance Period Start Date** |  | Text | 6 | CCYYMM  Effective date of performance period for reported Insurance Type/Product Code. Performance period refers to incurred date on redacted claims. |
|  |  |  |  |  |  |
| **AC005** | **Performance Period End Date** |  | Text | 6 | CCYYMM  End date of performance period for reported Insurance Type/Product Code. Performance period refers to incurred date on redacted claims. |
|  |  |  |  |  |  |
| **AC006** | **Total Number of Members** |  | Number | 10 | The count of individual members with any eligibility in the performance period in the product code identified in AC003.  No decimal places; round to nearest integer Example: 12345 |
|  |  |  |  |  |  |
| **AC007** | **Total Member Months** |  | Number | 10 | The total number of member months of eligibility in the performance period in the product code identified in AC003.  No decimal places; round to nearest integer Example: 12345 |
|  |  |  |  |  |  |
| **AC008** | **Total Plan-Paid Dollars SUD Claims-Based Payments Not Reported to MHDO** |  | Number | 10 | The amount on claims that were not submitted to the MHDO under MHDO Rule Chapter 243. No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **AC009** | **Total Plan-Paid Dollars on Claims/Claim Lines Sent to MHDO where SUD Codes Were Removed** |  | Number | 10 | Indicates the amount paid on claims where SUD codes were removed before the claims were submitted to MHDO under MHDO Rule Chapter 243. No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **AC010** | **Total Plan-Paid Dollars SUD Claims-Based Payments Related to Primary Care** |  | Number | 10 | No decimal places; round to nearest integer. Example: 12345 |
| **AC011** | **Coverage Type** |  | Text | 2 | Type of coverage with which payments are associated.  01 Medical  02 Pharmacy |
| **AC012** | **Payor Notes** |  | Text | 320 | Clarification about the population to which the payments apply, limitations in ability to report the measure, and/or explanation of why the data is not reported. |

**File Type DR – Prescription Drug Rebates**

| **Data**  **Element**  **#** | **Data**  **Element**  **Name** |  | **Type** | **Maximum**  **Length** | **Definition/Description** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **DR001** | **Submitter** |  | Text | 8 | MHDO-assigned identifier of payor submitting data. Do not leave blank. |
|  |  |  |  |  |  |
| **DR002** | **Payor** |  | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
|  |  |  |  |  |  |
| **DR003** | **Insurance Type/ Product Code** |  | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix B for standard code list. Coding should match MHDO Rule Chapter 243 Data Element ME003. In addition, MHDO uses the following non-standard codes:  HN Medicare Part C  MD Medicare Part D |
|  |  |  |  |  |  |
| **DR004A** | **Performance Period Start Date** |  | Text | 6 | CCYYMM  Effective date of performance period. Performance period refers to date of fill. |
| **DR004B** | **Performance Period End Date** |  | Text | 6 | CCYYMM  Effective date of performance period. Performance period refers to date of fill. |
|  |  |  |  |  |  |
| **DR005** | **Drug Code** |  | Text | 11 | NDC Code |
|  |  |  |  |  |  |
| **DR006** | **Drug Name** |  | Text | 80 | Text name of drug |
|  |  |  |  |  |  |
| **DR007** | **Generic Drug Indicator** |  | Text | 1 | N No, branded drug  Y Yes, generic drug |
|  |  |  |  |  |  |
| **DR008** | **Specialty Drug Indicator** |  | Text | 1 | Drug defined as a specialty drug under the terms of a payor’s contract with its PBM.  N No  Y Yes |
|  |  |  |  |  |  |
| **DR009** | **Total Count of Prescriptions Filled** |  | Number | 15 | Total count of all prescriptions filled by members.  No decimal places; round to nearest integer Example: 12345 |
|  |  |  |  |  |  |
| **DR010** | **Total Quantity Dispensed** |  | Number | 15 | Total Number of metric units of medication dispensed.  No decimal places; round to nearest integer Example: 12345 |
| **DR011** | **Total Pharmacy Expenditure Amount** |  | Number | 15 | The sum of all incurred claim allowed payment amounts to pharmacies for the drug as defined by the payor’s prescription drug benefit. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers).  (Allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates or pharmacy benefit manager compensation in any way).  No decimal places; round to nearest integer Example: 12345 |
|  |  |  |  |  |  |
| **DR012** | **Total Manufacturer Prescription Drug Rebates** |  | Number | 15 | Total prescription drug rebates remitted by or on behalf of a pharmaceutical manufacturer, directly or indirectly, to a payor, or to a pharmacy benefits manager under contract with a payor. The total manufacturer prescription drug rebate amount should not be included in the total pharmacy expenditure amount.  No decimal places; round to nearest integer Example: 12345 |
|  |  |  |  |  |  |
| **DR013** | **Total Pharmacy Prescription Drug Rebates** |  | Number | 15 | Total prescription drug rebates (including direct or indirect remuneration) remitted by or on behalf of a pharmacy, directly or indirectly, to a payor, or to a pharmacy benefits manager under contract with a payor. The total pharmacy prescription drug rebate amount should not be included in the total pharmacy expenditure amount.  No decimal places; round to nearest integer Example: 12345 |
| **DR014** | **Percent Rebate Retained by PBM** |  | Number | 5 | The percent of total prescription drug rebates retained by a pharmacy benefits manager under contract with a payor.  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DR015** | **Total PBM Compensation Amount** |  | Number | 15 | The total value of payments made by the payor to its pharmacy benefits manager that is not paid to the pharmacy. The pharmacy benefits manager compensation amount should not be included in the total pharmacy expenditure amount. PBM compensation does not include any compensation paid by a manufacturer, developer, or labeler for the performance of services.  No decimal places; round to nearest integer. Example: 12345 |
|  |  |  |  |  |  |
| **DR016** | **Payor Notes** |  | Text | 1000 | Additional information related to the data submitted for this drug product. |

1. **File-Level Specifications**
2. **File Formats**.
   * + 1. Each data file submission shall be an encrypted (AES-256) ASCII file, variable field length, and asterisk delimited. It shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. Each record shall be terminated with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).
       2. Each supporting information file shall be a Microsoft Excel®-compatible spreadsheet.
3. **Filled Fields**. All required fields shall be filled where applicable. Non-requiredtext and number fields shall be left blank when unavailable.
4. **Position**. All text fields are to be left justified. All numeric fields are to be right justified.
5. **Signs**. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields.

**3. Submission Requirements**

1. **File Organization.** Each file shall be submitted to the MHDO or its designee separately.
2. **Filing Method**. Data files and supporting information must be submitted to the MHDO’s Payor Data Portal via secure FTP or secure web upload interface at <https://mhdo.maine.gov/portal>. E-mail attachments shall not be accepted.
3. **Testing of Files**. File testing shall be completed within one hundred and eighty days of the adoption of any changes to the data element content or format of the files described in Section 2(B) or at least sixty days prior to the initial submission of production files.
4. **Rejection of Files**. Failure to conform to the requirements subsections   
   A, B, or C of this Section shall result in the rejection of the applicable data file(s). All rejected files must be resubmitted in the appropriate, corrected form to the MHDO or its designee within 15 days.
5. **Filing Period**. The annual filing for each submission shall cover the previous completed calendar year and shall be due by August 31.
6. **Update/Replacement of Data**. A payor may update or replace a data file submission up to one year after its original due date. Any updates or replacements after this period must be approved by the MHDO.

**4. Data Validation; Notification; Response**

1. **Attestation**. The MHDO or its designee shall require an authorized user for each payor to electronically sign an attestation that the payor is compliant with the requirements outlined in this rule. The annual attestation shall be due by August 31.
2. **Notification**. Within 15 days, the MHDO or its designee will complete the evaluation of any data file submissions and notify any payors whose data submissions for any filing period do not satisfy the requirements of Section 2(B). This notification will identify the specific file(s) and the data elements within the file(s) that do not satisfy the requirements.
3. **Response**. Each payor notified under subsection 4(B) shall respond in writing within 15 days of notification and make the necessary changes within 30 days to satisfy the requirements.

**5. Public Access**

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

**6. Extensions or Waivers to Data Submission Requirements**

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

**7. Compliance**

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

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

EFFECTIVE DATE: December 12, 2021

AMENDED:

December 20, 2022

December 17, 2023 – filing 2023-250

**Appendix A**

**Primary Care Provider Type Taxonomy Codes and Description**

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

**Appendix B**

**Maine Health Data Organization**

**Source Codes**

**Accredited Standards Committee (ASC)**

**ASC X12 Directories**

**(MHDO Data Element: NC003)**

SOURCE: Complete ASC X12 005010 Standard

AVAILABLE FROM:

https://www.nex12.org/

Data Interchange Standards Association, Inc. (DISA)

7600 Leesburg Pike Ste 430

Falls Church, VA 22043

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

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

[https://www.milbank.org/wp-content/uploads/2021/04/Measuring\_Non-Claims\_7-1.pdf](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.milbank.org%2Fwp-content%2Fuploads%2F2021%2F04%2FMeasuring_Non-Claims_7-1.pdf&data=04%7C01%7Ckarynlee.harrington%40maine.gov%7C4d7be88dfa00433b2dd608d9a489cfe2%7C413fa8ab207d4b629bcdea1a8f2f864e%7C0%7C0%7C637721734389936185%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=jiVbqZlDhdxEeOGDg6jsAHDpd9yBqsStE1Lg8JtHU1A%3D&reserved=0)

**National Uniform Claim Committee**

**Healthcare Provider Taxonomy Code Set**

**(MHDO Data Element: NC010; Tables in Appendices A and C)**

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

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

**Appendix C**

**Behavioral Health Provider Type Taxonomy Codes and Descriptions**

| **Taxonomy Code** | **Taxonomy Description** | |
| --- | --- | --- |
| **Classification** | **Specialization** |
| 101Y00000X | Behavioral Health & Social Service Providers | Counselor |
| 101YA0400X | Behavioral Health & Social Service Providers | Addiction (Substance Use Disorder) |
| 101YM0800X | Behavioral Health & Social Service Providers | Mental Health |
| 101YP1600X | Behavioral Health & Social Service Providers | Pastoral Behavioral Health & Social Service Providers |
| 101YP2500X | Behavioral Health & Social Service Providers | Professional |
| 101YS0200X | Behavioral Health & Social Service Providers | BH & Social Service Providers, School |
| 103K00000X | Behavioral Health & Social Service Providers | Behavior Analyst |
| 103T00000X | Psychologist, Clinical | Assistant Behavior Analyst |
| 103TA0400X | Psychologist, Clinical | Behavior Technician |
| 103TA0700X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Adult Development & Aging |
| 103TB0200X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Cognitive & Behavioral |
| 103TC0700X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Clinical |
| 103TC1900X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Counseling |
| 103TC2200X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Clinical  Child & Adolescent |
| 103TF0000X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Family |
| 103TM1800X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Mental  Retardation & Developmental Disabilities |
| 103TP0016X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Prescribing (Medical) |
| 103TP0814X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Psychoanalysis |
| 103TP2701X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, Group Psychotherapy |
| 103TS0200X | Psychologist, Clinical | Behavioral Health & Social Service Providers/Psychologist, School |
| 104100000X | Behavioral Health & Social Service Providers | Social Worker |
| 1041C0700X | Behavioral Health & Social Service Providers | Behavioral Health & Social Service Providers |
| 1041S0200X | Behavioral Health & Social Service Providers | School |
| 106H00000X | Behavioral Health & Social Service Providers | Marriage and Family Therapist |
| 106S00000X | Behavior Technician | Behavior Technician |
| 133VN1006X | Registered Dietitian or Nutrition Professional | Dietary & Nutritional Service Providers/Dietician, Registered, Nutrition, Metabolic |
| 163WA0400X | Registered Nurse | Addiction (Substance Use Disorder) |
| 163WP0807X | Registered Nurse | Psychiatric/Mental Health, Child & Adolescent |
| 163WP0808X | Registered Nurse | Psychiatric/Mental Health |
| 163WP0809X | Registered Nurse | Psychiatric/Mental Health, Adult |
| 171M00000X | Case Manager/Care Coordinator | Case Manager/Care Coordinator |
| 171W00000X | Contractor | Contractor |
| 175T00000X | Peer Specialist | Peer Specialist |
| 177F00000X | Other Service Providers | Lodging |
| 207QA0401X | Physician/Addiction Medicine | Allopathic & Osteopathic Physicians/Family Medicine, Addiction Medicine |
| 207ZC0008X | Pathology | Clinical Informatics |
| 2080P0006X | Physician/Pediatric Medicine | Allopathic & Osteopathic Physicians/Pediatrics, Developmental– Behavioral Pediatrics |
| 2084A0401X | Physician/Addiction Medicine | Allopathic & Osteopathic Physicians/Psychiatry & Neurology, Addiction Medicine |
| 2084F0202X | Physician/Neuropsychiatry | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Forensic Psychiatry |
| 2084P0015X | Physician/Neuropsychiatry | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Psychosomatic Medicine |
| 2084P0800X | Physician/Psychiatry | Allopathic & Osteopathic Physicians/Psychiatry |
| 2084P0802X | Physician/Neuropsychiatry | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Addiction Psychiatry |
| 2084P0804X | Physician/Neuropsychiatry | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Child & Adolescent Psychiatry |
| 2084P0805X | Physician/Neuropsychiatry | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry |
| 222Q00000X | Developmental Therapist | Developmental Therapist |
| 225400000X | Rehabilitation Practitioner | Rehabilitation Practitioner |
| 225500000X | Specialist/Technologist | Respiratory, Developmental, Rehabilitative and Restorative Specialist |
| 225600000X | Dance Therapist | Dance Therapist |
| 225XM0800X | Occupational Therapist in Private Practice | Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist, Mental Health |
| 235500000X | Specialist/Technologist | Speech, Language and Hearing Specialist/Technologist |
| 2355S0801X | Specialist/Technologist | Speech-Language Assistant |
| 235Z00000X | Speech Language Pathologist | Speech, Language and Hearing Service Providers |
| 251300000X | Local Education Agency (LEA) | Local Education Agency (LEA) |
| 251C00000X | Day Training, Developmentally Disabled Services | Day Training, Developmentally Disabled Services |
| 251J00000X | Nursing Care | Nursing Care |
| 251S00000X | Agencies | Community/Behavioral Health |
| 251V00000X | Voluntary Health or Charitable Agency | Agencies/Voluntary or Charitable |
| 252Y00000X | Early Intervention Provider Agency | Early Intervention Provider Agency |
| 253J00000X | Foster Care Agency | Foster Care Agency |
| 261QD1600X | Clinic/Center | Developmental Disabilities |
| 261QG0250X | Clinic/Center | Genetics |
| 261QM0801X | Community Mental Health Center | Ambulatory Health Care Facilities/Clinic/Center, Mental Health |
| 261QM0850X | Ambulatory Health Care Facilities | Adult Mental Health |
| 261QM0855X | Ambulatory Health Care Facilities | Adolescent And Children Mental Health Care Facilities |
| 261QM2800X | Clinic/Center | Methadone |
| 261QR0405X | Clinic/Center | Rehabilitation, Substance Use Disorder |
| 276400000X | Hospital Units | Rehabilitation, Substance Use Disorder Unit |
| 283Q00000X | Hospital-Psychiatric (PPS excluded) | Hospitals/Psychiatric Hospital |
| 305R00000X | Preferred Provider Organization | Managed Care Organization PPO |
| 3104A0625X | Assisted Living Facility | Assisted Living, Mental Illness |
| 310500000X | Nursing & Custodial Care Facilities | Intermediate Care Facility, Mental Illness |
| 311Z00000X | Custodial Care Facility | Custodial Care Facility |
| 311ZA0620X | Custodial Care Facility | Adult Care Home |
| 315P00000X | Nursing and Custodial Care Facilities | Intermediate Care Facility, Mentally Retarded |
| 320600000X | Residential Treatment Facilities | Residential Treatment Facility, Mental Retardation And/Or Developmental Disabilities |
| 320700000X | Residential Treatment Facility, Physical Disabilities | Residential Treatment Facility, Physical Disabilities |
| 320800000X | Residential Treatment Facilities | Community Based Mental Illness |
| 320900000X | Residential Treatment Facilities | Community Based Residential Treatment Facility, Mental  Retardation And/Or Developmental Disabilities |
| 322D00000X | Residential Treatment Facilities | Residential Treatment Facility, Emotionally Disturbed Children |
| 323P00000X | Residential Treatment Facilities | Psychiatric Residential Treatment Facility |
| 324500000X | Residential Treatment Facilities | Substance Abuse Rehabilitation Facility |
| 3245S0500X | Residential Treatment Facilities | Substance Abuse Treatment, Children |
| 343800000X | Secured Medical Transport (VAN) | Secured Medical Transport (VAN) |
| 363LP0808X | Nurse Practitioner | Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Psychiatric/Mental Health |
| 364S00000X | Certified Clinical Nurse Specialist | Physician Assistants & Advanced Practice Nursing  Providers/Clinical Nurse Specialist |
| 364SP0807X | Certified Clinical Nurse Specialist | Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent |
| 364SP0808X | Certified Clinical Nurse Specialist | Physician Assistants & Advanced Practice Nursing  Providers/Clinical Nurse Specialist, Psychiatric/Mental Health |
| 364SP0809X | Certified Clinical Nurse Specialist | Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Adult |
| 364SP0810X | Certified Clinical Nurse Specialist | Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family |
| 372600000X | Adult Companion | Adult Companion |
| 373H00000X | Nursing Service-Related Providers | Day Training/Habilitation Specialist |
| 3747A0650X | Technician | Attendant Care Provider |
| 374U00000X | Home Health Aide | Home Health Aide |
| 376J00000X | Homemaker | Homemaker |
| 385H00000X | Respite Care | Respite Care |
| 405300000X | Prevention Professional | Prevention Professional |