114.5 CMR 11.00: CRITERIA AND PROCEDURES FOR THE SUBMISSION OF HEALTH PLAN DATA

Section

11.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.5 CMR 11.00 establishes the data and information that every health insurance plan in the Commonwealth must provide to the Division of Health Care Finance and Policy to be used to create the health plan report card required by St. 2000, c. 141. 114.5 CMR 11.00 is effective September 30, 2001.

(2) Authority. 114.5 CMR 11.00 is adopted pursuant to M.G.L. c. 118G, § 24, as added by St. 2000, c. 141.

11.02: Definitions

Agency for Healthcare Research and Quality (AHRQ): is an agency within the U.S. Department of Health and Human Services that funds and conducts research on healthcare quality which includes maintaining the National CAHPS Benchmarking Database (NCBD).

Bureau of Managed Care: is an office within the Division of Insurance, a state government agency that regulates insurers in Massachusetts. The Bureau of Managed Care is responsible for accrediting managed health insurance plans in Massachusetts pursuant to M.G.L. c.176O, § 2.

Consumer Assessment of Health Plans (CAHPS): is a tool developed under the direction of the Agency for Healthcare Research and Quality, a U.S. Government agency, containing surveys that ask consumers about their experiences with their health plans.

Division. The Division of Health Care Finance and Policy established pursuant to M.G.L. c. 118G.

Health Insurance Plan (HIP) For purposes of 114.5 CMR 11.00, Health Insurance Plan shall be defined as 'carrier' is defined in M.G.L. c.176O, § 1. An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

Health Plan Employer Data and Information Set (HEDIS®) is a compilation of information about American health plans to compare their performance on important dimensions of care and service.

National CAHPS™ Benchmarking Database (NCBD): is a set of information, maintained by AHRQ, that compares health plans based upon consumers' experiences as measured through CAHPS survey instruments.

National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization which assesses and reports on the quality of the nation's managed care plans through an accreditation and performance measurement program, including member satisfaction, quality of care, access, and customer service.

11.02: continued

Office of Patient Protection (OPP): is an office within the Massachusetts Department of Public Health. The OPP's responsibilities include making available to the public a report card on managed care health plans in Massachusetts pursuant to M.G.L. c.111, § 217.

Preferred Provider Organization (PPO): is a HIP that provides a subset of licensed providers from which the PPO's members can choose to seek care without receiving permission from a primary care physician or other clinician.

Quality Compass: is a data product sold by the National Committee on Quality Assurance (NCQA), which contains complete validated HEDIS results for all plans who submit their HEDIS data to NCQA for publication.

11.03: Reporting Requirements

(1) Required Reports and Due Dates. Each health insurance plan (HIP) licensed in Massachusetts shall comply with the following reporting requirements:

(a) Each HIP that collects HEDIS data as of July 1, 2001 shall submit that data to the division.

1. Plans that submit HEDIS data to NCQA for publication in their Quality Compass product will have met their requirement for submission to DHCFP and OPP, as long as NCQA assures each HIP that the Quality Compass product will be available to DHCFP and OPP for use in the report card by August 15 of each year. In any year after 2001 for which the August 15 deadline cannot be assured for Quality Compass availability, those plans submitting to NCQA for Quality Compass publication shall submit their data directly and concurrently to DHCFP and OPP by July 31 of that year using an electronic data file format to be determined by DHCFP or as prescribed by NCQA.

2. Plans that collect HEDIS data but that do not submit to NCQA, or do submit to NCQA but decline publication in Quality Compass, shall submit their data directly and concurrently to DHCFP and OPP beginning with the data submission deadline of July 31, 2002 and by July 31 of each year thereafter, using an electronic data file format to be determined by DHCFP or using the same format as that required by NCQA.

(b) Plans that have CAHPS survey data of their enrollees as of July 1, 2001 shall submit their data by September 30, 2001, and by July 31st of each year thereafter, to the National CAHPS Benchmarking Database (NCBD) maintained by the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health and Human Services. DHCFP and OPP will arrange delivery of relevant reports from the NCBD.

(c) Beginning with the data submission deadline of July 31, 2003, plans that do not collect either HEDIS or CAHPS data will be required to conduct CAHPS surveys of their enrollees and submit their data results to the NCBD. If NCQA expands the types of plans it accredits, for example, if NCQA accredits Preferred Provider Organizations (PPOs), those plans must comply with the requirements set forth in 114.5 CMR 11.03(1)(a) and (b) as applicable. The report card will be careful to make reasonable comparisons between plans.

(d) Each HIP shall file or make available to the Division upon request other information that is or will be routinely collected by health plan accrediting organizations, regulatory agencies and the like, and that is reasonably similar to the types of information already being collected pursuant to 114.5 CMR 11.00. HIPs shall provide the requested information within 15 business days from the date of the request, unless a different time is specified. The Division may, for cause, extend the filing date of the requested information, in response to a written request for an extension of time.

(2) Enforcement of Reporting Requirements. If a HIP fails to meet the reporting requirements of 114.5 CMR 11.00, the Division shall notify both the Bureau of Managed Care within the Division of Insurance and the OPP within the Department of Public Health and shall note the non-compliance in the health plan report card.

11.04: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.5 CMR 11.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.5 CMR 11.00.

11.05: Severability

The provisions of 114.5 CMR 11.00 are severable. If any provision or the application of any provision to any HIP or circumstance is held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provision of 114.5 CMR 11.00 or the application of any such provision to HIPs or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.5 CMR 11.00: M.G.L. c. 118G.

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