114.5 CMR 23.00: PAYER REPORTING OF TOTAL MEDICAL EXPENSES AND RELATIVE PRICES

Section

23.01: General Provisions

(1) Scope and Purpose. 114.5 CMR 23.00 governs the methodology and filing requirements for health care payers to calculate and report Health Status Adjusted Total Medical Expenses and Relative Prices to the Division of Health Care Finance and Policy.

(2) Authority. 114.5 CMR 23.00 is adopted pursuant to M.G.L. c. 118G, § 6.

(3) Effective Date. 114.5 CMR 23.00 is effective on April 1, 2011.

23.02: Definitions

The following terms as used in 114.5 CMR 23.00 have the following meanings, except where the context clearly indicates otherwise:

Allowed Claims. Paid medical claims plus related Member liabilities, including, but not limited to, co-pays, co-insurance, and deductibles.

Ancillary Services. Non-routine services for which charges are customarily made in addition to routine charges, that include, but are not limited to, laboratory, diagnostic and therapeutic radiology, surgical services, and physical, occupational, or speech-language therapy.

Calendar Year. The period beginning January 1st and ending December 31st.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy.

Data Specification Manual. The Data Specification Manual contains data submission requirements, including, but not limited to, required fields, file layouts, file components, edit specifications, and other technical specifications.

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

Health Care Payer (Payer). A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, a Third Party Administrator, and a self-insured health plan.

Health Care Services. Supplies, care and services of medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive, or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services, services provided by a community health center or by a sanatorium, as included in the definition of "hospital" in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

Health Status Adjusted Total Medical Expenses (TME). The total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a Per Member Per Month basis, as calculated under 114.5 CMR 23.04.

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Hospital. A hospital licensed by the Department of Public Health in accordance with the provisions of M.G.L. c. 111.

Member. A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.

Member Months. The number of Members participating in a plan over a specified period of time expressed in months of membership.

Non-claims Related Payments. Payments made to providers not directly related to a medical claim including, but not limited to, pay for performance, care management payments, infrastructure payments, grants, surplus payments, lump sum settlements, capitation settlements, signing bonuses, governmental payer shortfall payments, infrastructure, medical director, and health information technology payments.

Payments Subject to Surcharge. Payments subject to the surcharge established by M.G.L. c. 118G, § 38, including payments defined under 114.6 CMR 14.05(1)(b) and excluding payments defined under 114.6 CMR 14.05(1)(c).

Pediatric Physician Practice. A physician group practice in which at least 75% of its patients are children up to the age of 18.

Per Member Per Month (PMPM). An adjustment made by dividing an annual amount by Member Months.

Physician Group. A medical practice comprised of two or more physicians organized to provide patient care services (regardless of its legal form or ownership).

Physician Local Practice Group. A geographically organized subgroup of a Physician Group that provides primary care.

Private Health Care Payer. A carrier authorized to transact accident and health insurance under M.G.L. c. 175, a nonprofit hospital service corporation licensed under M.G.L. c. 176A, a nonprofit medical service corporation licensed under M.G.L. c. 176B, a dental service corporation organized under M.G.L. c. 176E, an optometric service corporation organized under M.G.L. c. 176F, a self-insured plan, a third party administrator, or a health maintenance organization licensed under M.G.L. c. 176G. Private Health Care Payers include any carrier or Third Party Administrator that contracts with the office of Medicaid, the Commonwealth Health Insurance Connector, or the Group Insurance Commission to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XVIII, XIX, or XXI, under the Commonwealth Care Health Insurance program, Medicaid managed care organizations, or under the Group Insurance Commission.

Provider. Any person, corporation partnership, governmental unit, state institution or any other entity qualified under the laws of the Commonwealth to perform or provide health care services.

Public Health Care Payer. The Medicaid program established in M.G.L. c. 118E and any city or town with a population of more than 60,000 that has adopted M.G.L. c. 32B.

Relative Prices. The contractually negotiated amounts paid to Massachusetts providers by each Private and Public Payer for health care services, including Non-Claims Related Payments and expressed in the aggregate relative to the payer's network wide average amount paid to providers, as calculated under 114.5 CMR 23.05.

Routine Services. The regular room and board services, daily nursing care, minor medical and surgical supplies, and the use of equipment and facilities.

Surcharge. The surcharge on payments made to Hospitals and Ambulatory Surgical Centers established by M.G.L. c. 118G, § 38 and 114.6 CMR 14.00.

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Surcharge Payer. An individual or entity that:

(a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and

(b) meets the criteria set forth in 114.6 CMR 14.05(1)(a).

Third Party Administrator. An entity who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions, or premiums for, or adjusts or settles claims on or for residents of the Commonwealth. Third Party Administrators shall also include pharmacy benefit managers and any other entity with claims data, eligibility data, provider files, and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth except that Third Party Administrators shall not include an entity that administers only claims data, eligibility data, provider files, and other information for its own employees and dependents.

Total Medical Claims. Total allowed claims for all categories of medical expenses including, but not limited to, hospital inpatient, hospital outpatient, sub-acute such as skilled nursing and rehabilitation, professional, pharmacy, mental health and behavioral health and substance abuse, home health, durable medical equipment, laboratory, diagnostic imaging and alternative care such as chiropractic and acupuncture claims, incurred under all fully insured and self-insured plans.

23.03: General Reporting Requirements

(1) Annual Reports.

(a) Each Payer shall file annually its TME by Physician Group, Physician Local Practice Group, and Member Zip Code, and its Relative Prices for Hospitals, Physicians, and Other Providers in accordance with the requirements of 114.5 CMR 23.04 and 23.05.

(b) A Private Health Care Payer is subject to the reporting requirements in 114.5 CMR 23.00 if:

1. The Payer is a Surcharge Payer and the Payer's Payments Subject to Surcharge placed the Payer at the company level within the top 12 Surcharge Payers for the period October 1, 2009 through September 30, 2010 as determined by the Division and posted on the Division's website; or

2. The Payer contracts with the office of Medicaid, the Commonwealth Health Insurance Connector, or the Group Insurance Commission to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XVIII, XIX, or XXI, under the Commonwealth Care Health Insurance program, Medicaid managed care organizations, or under the Group Insurance Commission.

3. If a Private Health Care Payer subject to the reporting requirements of 114.5 CMR 23.00 makes separate surcharge payments under 114.6 CMR 14.00 for individual plans or clients the Payer shall file the required data for all of its plans or clients.

(c) Public Health Care Payers may provide data to the Division pursuant to an interagency service agreement.

(2) Data Submission Requirements.

(a) Each Payer shall submit data directly to the Division in electronic format. Data submissions must conform with edit specifications as set forth in the Data Specification Manual. The Division will notify a Payer whether the submission has been accepted or rejected. Payers must correct and resubmit rejected data until notified that the submission has been accepted.

(b) Each Payer's chief executive officer or chief financial officer shall certify under pains and penalties of perjury that all reports and records filed with the Division are true, correct and accurate.

(c) The Division may request that a Payer submit additional documentation of reported TME and Relative Prices. Payers must submit documentation requested by the Division within 15 business days from the date of the request, unless the Division specifies a different date. The Division may, for cause, extend the filing date of the requested information, in response to a written request for an extension of time.

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(d) The Division may amend data specifications and filing deadlines by Administrative Bulletin.

(3) Penalties.

(a) If a Payer fails to submit required data to the Division on a timely basis, or fails to correct submissions rejected because of errors, the Division shall provide written notice to the Payer. If the Payer fails to provide the required information within two weeks following receipt of said written notice, the Division will take all necessary steps to enforce this provision to the fullest extent of the law.

(b) Private Health Care Payers that do not comply with the reporting requirements of 114.5 CMR 21.00 are subject to a penalty of up to $1,000 per week for each week that the Payer fails to provide the required data, up to a maximum of $50,000 in accordance with M.G.L. c. 118G, § 6.

(c) The Division will notify the Attorney General's Office to enforce the provisions of 114.5 CMR 23.03(3)(a) and (b).

23.04: Health Status Adjusted Total Medical Expenses

(1) TME by Physician Group and Physician Local Practice Group.

(a) Reporting Requirements.

1. Payers shall report TME by Physician Group and Physician Local Practice Group for Massachusetts Members required to select a primary care physician.

2. Payers shall report TME for Physician Groups and Physician Local Practice Groups Physician Local Practice Groups with at least 36,000 Member Months for the calendar year.

3. Payers shall report TME separately for Medicaid and Commonwealth Care (combined), Medicare, commercial full-claim, and commercial partial-claim plans. Commercial (self and fully insured) data for physicians' groups or zip codes for which the Payer is able to collect information on all direct medical claims and subcarrier claims shall be reported in the full-claim category. Commercial (self and fully insured) data for physicians' groups or zip codes that do not include all medical and subcarrier claims shall be reported in the partial-claim category. Payers must include the full amount paid for medical claims, including amounts paid under stop-loss or reinsurance agreements, even if the Payer was not directly providing payment for those services. Payers shall not include data for which they are the secondary or tertiary payer such as Medicare Supplement.

4. Payers shall report TME data in the aggregate for all Physician Groups and Physician Local Practice Groups with fewer than 36,000 Member Months for the calendar year.

5. Payers shall attribute Non-claims Payments to a Provider at the Local Practice Group Level and thereafter at the Physician Group Level. If direct attribution is not possible, Payers shall allocate Non-claims Payments by Member Months.

6. Payers must report the risk adjustment tool and version used to report the Health Status Adjustment Score. The Division may specify additional requirements for reporting the Health Status Adjustment Score by Administrative Bulletin or in the Data Specification Manual.

(b) Required Data Elements.

1. DHCFP Provider Number
2. OrgID or Payer's Internal Provider Number
3. Physician Group Name
4. Local Practice Group Name
5. Pediatric Indicator
6. Member Months (annual)
7. Health Status Adjustment Score
8. Normalized Health Status Adjustment Score: the Health Status Adjustment Score divided by the Payer's average health status adjustment score.
9. Total Allowed Medical Claims (annual): the medical claims expenses by the following subcategories: hospital inpatient, hospital outpatient, professional physician, other professional, pharmacy, and other.

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10. Total Non-claims Payments (annual): the non-claims payments by the following subcategories: incentive programs, risk settlements, care management expenses, and other.

(c) Calculation of TME by Physician Group and Physician Local Practice Group. Based upon the data specified in 114.5 CMR 23.04(1)(b) the Division shall calculate TME by Physician Group and Physician Local Practice Group by summing Total Medical Claims and Total Non-claims Payments to obtain Total Payments. PMPM Unadjusted TME will be calculated by dividing Total Payments by Member Months. PMPM Health Status Adjusted TME: will be calculated by dividing PMPM Unadjusted TME by the Health Status Adjustment Score. PMPM Normalized Health Status Adjusted TME will be calculated by dividing PMPM Unadjusted TME by the Normalized Health Status Adjustment Score. Payers will be provided a copy of the calculation.

(2) TME by Zip Code.

(a) Reporting Requirements.

1. Payers shall report TME by zip code for all Massachusetts Members based on the zip code of the Member. The Division shall not publicly report zip code TME data unless aggregated to an amount appropriate to protect patient confidentiality.

2. Payers shall separately report TME for Members whose plans require the selection of a primary care provider and TME for Members not required to select a primary care provider.

3. Payers shall report TME separately for Medicaid and Commonwealth Care (combined), Medicare, commercial full-claim, and commercial partial-claim plans. Commercial (self and fully insured) data for physicians' groups or zip codes for which the Payer is able to collect information on all direct medical claims and subcarrier claims shall be reported in the full-claim category. Commercial (self and fully insured) data for physicians' groups or zip codes that do not include all medical and subcarrier claims shall be reported in the partial-claim category. Payers must include the full amount paid for medical claims, including amounts paid under stop-loss or reinsurance agreements, even if the Payer was not directly providing payment for those services. Payers shall not include data for which they are the secondary or tertiary payer such as Medicare Supplement.

4. Payers shall allocate Non-claims Payments by Member Months.

5. Payers must report the risk adjustment tool and version used to report the Health Status Adjustment Score. The Division may specify additional requirements for reporting the Health Status Adjustment Score by Administrative Bulletin or in the Data Specification Manual.

(b) Required Data Elements.

1. Member Zip Code
2. PCP/No PCP Member Designation
3. Member Months (annual)
4. Health Status Adjustment Score
5. Normalized Health Status Adjustment Score: the Health Status Adjustment Score divided by the Payer's average health status adjustment score.
6. Total Allowed Medical Claims (annual): the sum of medical claims expenses designated into the following subcategories: hospital inpatient, hospital outpatient, professional physician, other professional, pharmacy, and other.
7. Total Non-claims Payments (annual): the sum of non-claims payments.

(c) Calculation of TME by Zip Code. Based upon the data specified in 114.5 CMR 23.04(2)(b) the Division shall calculate TME by Zip Code by summing Total Medical Claims and Total Non-claims Payments to obtain Total Payments. PMPM Unadjusted TME will be calculated by dividing Total Payments by Member Months. PMPM Health Status Adjusted TME will be calculated by dividing PMPM Unadjusted TME by the Health Status Adjustment Score. PMPM Normalized Health Status Adjusted TME will be calculated by dividing PMPM Unadjusted TME by the Normalized Health Status Adjustment Score. Payers will be provided a copy of the calculation.

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(3) Due Dates.

(a) Annual Reports. Beginning in 2012, annually on June 1st Payers must submit preliminary TME reports for the prior Calendar Year and final TME reports for the Calendar Year ending 17 months prior.

(b) Initial Filing. For Calendar Year 2009, Payers must submit the required reports by March 31, 2011. Payers must submit preliminary Calendar Year 2010 TME data by June 1, 2011.

23.05: Methodology for Reporting Relative Prices

(1) Relative Prices for Hospitals.

(a) Payers must report Relative Price data separately by Medicare, Medicaid, Commonwealth Care, and commercial (fully-insured and self-insured).

(b) Payers shall report hospital categories separately for inpatient and outpatient.

(c) Payers must report Relative Price data separately by hospital category for acute hospitals, chronic hospitals, rehabilitation hospitals, and psychiatric hospitals.

(d) Notwithstanding 114.5 CMR 23.05(1)(c), Payers shall report additional behavioral health-only Relative Price data for acute hospitals with psychiatric or substance abuse units with the psychiatric hospital file. Payers must develop a standard definition of behavioral health services to be used for all acute hospitals impacted by this subsection.

(e) Required Data Elements - Hospital Inpatient.

1. DHCFP Provider Number
2. OrgID or Payer's Internal Provider Number
3. Name of Hospital
4. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
5. Product Type (HMO, PPO, Indemnity, POS, other)
6. Hospital-specific Base Rate: the negotiated rate per discharge, excluding any adjustments for case mix or severity of illness. Payers must note when Hospital-Specific Base Rates are derived from payment data.
    a. For acute hospitals that are not paid on diagnostic-related group (DRG) model, the Payer must calculate a hospital-specific base rate equivalent. Payers who are able to demonstrate significant hardship in developing acute hospital DRG base rates and obtaining DRG software may apply to the Division for a waiver to use a standard per unit rate.
    b. For chronic, rehabilitation, or psychiatric hospitals, Payers may use a per unit rate so long as a uniform unit is applied within each hospital category.
7. Network Average Base Rate: the simple average of the Hospital-specific Base Rate for all hospitals within a Payer's network.
8. Total Non-claims Payments: the sum of all Non-Claims Related Payments. The allocation method for non-claims payments is outlined in the Data Specifications Manual.
9. Total Payments: the sum of all medical claims payments.
10. Case Mix: the Payer's case mix index for the provider including all cases.
11. Number of Discharges: the total number of discharges associated with a provider.
12. Hospital-specific Product Mix: the proportion of the hospital's inpatient payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.
13. Network-wide Product Mix: the proportion of the Payer's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.
14. DRG version and group number used in calculation.

(f) Calculation of Relative Prices - Hospital Inpatient. Based upon the data specified in 114.5 CMR 23.05(1)(e) the Division shall calculate Hospital Inpatient Relative Prices by dividing Total Payments by the product of Case Mix and Number of Discharges to derive an Adjusted Base Rate. The sum of the products of the Adjusted Base Rate by the Network-wide Product Mix will produce the Hospital Product Adjusted Base Rate. The Hospital's Product Adjusted Base Rate divided by Payer's Network Average Product Adjusted Base Rate shall result in the Hospital's Inpatient Relative Price. Payers will be provided a copy of the calculation.

(g) Required Data Elements - Hospital Outpatient.

1. DHCFP Provider Number
2. OrgID or Payer's Internal Provider Number

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3. Name of Hospital
4. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
5. Product Type (HMO, PPO, Indemnity, POS, other)
6. Hospital-specific Service Multipliers: the negotiated fee schedule multipliers for each hospital, for each fee schedule category as determined by the Payer, for each product. For hospitals paid on a non-fee schedule basis, multipliers shall be derived by dividing payments for a service category by the amount that would have been paid if the hospital was paid at a standard fee schedule or base rate for that service category. Payers must note when Hospital-specific Service Multipliers are derived from payment data.
7. Total Claims-based Payments: the sum of all medical claims payments.
8. Total Non-claims Payments: the sum of all Non-Claims Related Payments. The allocation method for non-claims payments is outlined in the Data Specifications Manual.
9. Hospital-specific Service Mix: the proportion of the hospital's revenue for outpatient categories established by the Payer in 114.5 CMR 23.05(1)(g)6.
10. Network-wide Service Mix: the proportion of the Payer's payments for outpatient categories established by the Payer in 114.5 CMR 23.05(1)(g)6.
11. Hospital-specific Product Mix: the proportion of the hospital's outpatient payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.
12. Network-wide Product Mix: the proportion of the Payer's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.

(h) Calculation of Relative Prices - Hospital Outpatient. Hospital Outpatient Relative Prices shall be calculated by the Division by summing the products of the Hospital-specific Service Multiplier for each product type by the Network-wide Service Mix for that product type to derive a Base Service Weighted Multiplier. The sum of the products of the Base Service Weighted Multiplier for each product type and the Network-wide Product Mix shall produce the Base Service and Product Adjusted Multiplier. The Division shall derive a Non-Claims Multiplier of each product for each hospital by dividing non-claims payments by total claims payments and multiplying the result by the Base Service Weighted Multiplier. The sum of the products of the Non-claims Multiplier and the Network Average Product Mix shall produce the Product-adjusted Non-claims Multiplier. The sum of the Product-adjusted Non-claims Multiplier and the Base Service and Product Adjusted Multiplier divided by the Network Average Hospital Outpatient Multiplier shall result in the Hospital's Outpatient Relative Price. Payers will be provided a copy of the calculation.

(2) Physician Groups

(a) Payers must separately identify and report Relative Price data for physician groups who received 3% or more of a Payer's payments to Massachusetts physician group practices.

(b) Payers shall report aggregate Relative Price data for all physician groups who received less than 3% of a Payer's physician group payments in the relevant reporting period but were not paid on the Payer's standard fee schedule. The Division may request additional information on such providers.

(c) Payers shall report aggregate Relative Price data for all physician groups who received less than 3% of a Payer's physician group payments in the relevant reporting period and were paid on the Payer's standard fee schedule. The Division may request additional information on such providers.

(d) Required Data Elements.

1. DHCFP Provider Number
2. OrgID or Payer's Internal Provider Number
3. Name of Physician Group Practice
4. Name of Local Practice Group
5. Pediatric Indicator
6. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
7. Product Type (HMO, PPO, Indemnity, POS, other)

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8. Physician Group-specific Service Multipliers: the negotiated fee schedule multipliers for each physician group, for each fee schedule category as determined by the Payer, for each product. For physician groups paid on a non-fee schedule basis, multipliers shall be derived by dividing payments for a service category by the amount that would have been paid if the physician group was paid at a standard fee schedule or base rate for that service category. Payers must note when Physician Group-specific Service Multipliers are derived from payment data.

9. Physician Group-specific Service Mix: the proportion of the physician group's revenue for service categories established by the Payer in 114.5 CMR 23.05(2)(d)8.

10. Network-wide Service Mix: the proportion of the Payer's payments to physician groups for service categories established by the Payer in 114.5 CMR 23.05(2)(d)8.

11. Physician Group-specific Product Mix: the proportion of the physician group's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.

12. Network-wide Product Mix: the proportion of the Payer's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.

13. Total Claims-based Payments: the sum of all medical claims payments.

14. Total Non-Claims Payments: the sum of all Non-Claims Related Payments. The allocation method for non-claims payments is outlined in the Data Specifications Manual.

(e) Calculation of Relative Prices - Physician Groups. Physician Group Relative Prices shall be calculated by the Division by summing the products of the Physician Group-Specific Service Multiplier for each product type by the Network-wide Service Mix for that product type to derive a Base Service Weighted Multiplier. The sum of the products of the Base Service Weighted Multiplier for each product type and the Network-wide Product Mix shall produce the Base Service and Product Adjusted Multiplier. The Division shall derive a Non-claims Multiplier for each physician group by dividing non-claims payments by total claims payments and multiplying the result by the Base Service Weighted Multiplier. The sum of the products of the Non-claims Multiplier and the Network Average Product Mix shall produce the Product-adjusted Non-claims Multiplier. The sum of the Product-adjusted Non-claims Multiplier and the Base Service and Product Adjusted Multiplier divided by the Network Average Physician Group Multiplier shall result in the Physician Group's Relative Price. Payers will be provided a copy of the calculation.

(3) Other Providers.

(a) Payers must report the data separately for the following provider categories:

1. Ambulatory surgical centers;
2. Community health centers;
3. Community mental health centers;
4. Freestanding clinical labs;
5. Freestanding diagnostic imaging;
6. Home health agencies; and
7. Skilled nursing facilities.
8. The Division may specify additional provider categories for which Payers must submit Relative Prices by Administrative Bulletin.

(b) Payers must separately identify and report Relative Prices for providers who received 3% or more of payments in a given provider category as identified in 114.5 CMR 23.05(2)(a) for the relevant reporting period.

(c) Payers shall report aggregate Relative Price data for all providers who received less than 3% of payments in the relevant reporting period for a given provider category but were not paid on the Payer's standard fee schedule. The Division may request additional information on such providers.

(d) Payers shall report aggregate Relative Price data for all providers who received less than 3% of payments in the relevant reporting period for a given provider category and were paid on the Payer's standard fee schedule. The Division may request additional information on such providers.

(e) Required Data Elements.

1. DHCFP Provider Number
2. OrgID or Payer's Internal Provider Number

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3. Name of Provider
4. Pediatric Indicator
5. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
6. Product Type (HMO, PPO, Indemnity, POS, other)
7. Provider-specific Service Multipliers: the negotiated fee schedule multipliers for each provider, for each fee schedule category as determined by the Payer, for each product. For providers paid on a non-fee schedule basis, multipliers shall be derived by dividing payments for a service category by the amount that would have been paid if the provider was paid at a standard fee schedule or base rate. Payers must note when Provider-specific Service Multipliers are derived from payment data.
8. Provider-specific Service Mix: the proportion of the provider's revenue for service categories established by the Payer in 114.5 CMR 23.05(3)(e)7.
9. Network-wide Service Mix: the proportion of the Payer's payments for service categories established by the Payer in 114.5 CMR 23.05(3)(e)7.
10. Provider-specific Product Mix: the proportion of the provider's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.
11. Network-wide Product Mix: the proportion of the Payer's payments for HMO, PPO, Indemnity, POS, and other Massachusetts provider network products.
12. Total Claims-based Payments: the sum of all medical claims payments.
13. Total Non-claims Payments: the sum of all Non-claims Related Payments. The allocation method for non-claims payments is outlined in the Data Specifications Manual.

(f) Calculation of Relative Prices - Other Providers. Other Provider Relative Prices shall be calculated by the Division by summing the products of the Provider-specific Service Multiplier for each product type by the Network-wide Service Mix for that product type to derive a Base Service Weighted Multiplier. The sum of the products of the Base Service Weighted Multiplier for each product type and the Network-wide Product Mix shall produce the Base Service and Product Adjusted Multiplier. The Division shall derive a Non-claims Multiplier for each provider by dividing non-claims payments by total claims payments and multiplying the result by the Base Service Weighted Multiplier. The sum of the products of the Non-claims Multiplier and the Network Average Product Mix shall produce the Product-adjusted Non-claims Multiplier. The sum of the Product-adjusted Non-claims Multiplier and the Base Service and Product Adjusted Multiplier divided by the Network Average Provider Multiplier shall result in the Provider's Relative Price. Payers will be provided a copy of the calculation.

(4) Due Dates.

(a) Annual Reports.

1. Hospitals. Payers must submit required Relative Price data reports for Hospitals by June 1st each year for the prior Calendar Year.
2. Physician Groups. Payers must submit Relative Price data reports for Physician Groups by June 1st each year for the Calendar Year ending seventeen months prior.
3. Other Providers. Payers must submit required Relative Price data reports for ambulatory surgical centers, community health centers, community mental health centers, freestanding clinical laboratories, freestanding diagnostic imaging centers, home health agencies, and skilled nursing facilities by June 1st each year for the prior Calendar Year.

(b) Initial Filing. Payers must submit hospital Relative Price data for Calendar Years 2009 and 2010, and physician group Relative Price data for Calendar Year 2009 by June 1, 2011. Payers must submit other provider Relative Price data for Calendar Year 2010 by June 30, 2011.

23.06: Other Provisions

(1) Administrative and Technical Information Bulletins. The Division may revise the specifications or other administrative requirements from time to time by notice or administrative bulletin.

23.06: continued

(2) Severability. The provisions of 114.5 CMR 23.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 23.00 or the application of such provisions.

REGULATORY AUTHORITY

114.5 CMR 23.00: M.G.L. c. 118G.