# 956 CMR 13.00: RISK ADJUSTMENT PROCEDURES FOR SMALL AND NON-GROUP MARKET

Section



## 13.01: Purpose and Scope

The purpose of 956 CMR 13.00 is to implement a Risk Adjustment Program as described in 42 U.S.C. § 18063, pursuant to M.G.L. c. 176Q, § 3(v). Risk Adjustment is a permanent risk mitigation provision under the federal Patient Protection and Affordable Care Act. 956 CMR 13.00 applies to all Carriers that offer at least one Risk Adjustment Covered Plan in the Commonwealth.

## 13.02: Definitions

Benefit Year. A calendar year or the applicable portion of a calendar year during which the Risk Adjustment Program is operated.

Carrier. A Carrier, as defined in M.G.L. c. 176M, § 1, that offers at least one Risk Adjustment Covered Plan in the Commonwealth.

CHIA. The Center for Health Information and Analysis established in M.G.L. c. 12C.

Commonwealth. The Commonwealth of Massachusetts.

The Connector. The Commonwealth Health Insurance Connector Authority.

Massachusetts All Payer Claims Database or MA APCD. The All Payer Claims Database maintained by CHIA to which payers are required to submit data under 957 CMR 8.00: *All Payer Claims Database (APCD) and Case Mix and Charge Data Submission*.

Member Month Tracker Report. A report provided by the Connector to each Carrier including calculations of the total member months of enrollment subject to risk adjustment and collected premiums, based on the data submitted to the MA APCD by Carriers for the applicable reporting period.

Final Risk Adjustment Payments and Charges Report. The annual report to be sent by the Connector to Carriers, by June 30th of the year following the applicable Benefit Year, describing charges owed by or payments owed to the Carrier under the Risk Adjustment program, as well as the list of data elements used in creating the risk adjustment data extract, the data extracts themselves, algorithms used to calculate payments and charges, and the output datasets from the algorithms.

Quarterly Simulation Reports. A set of reports provided to each Carrier on a quarterly basis, providing preliminary calculations and data regarding the Carrier's risk adjustment experience. These shall include data quality assessment reports, as well as reports from the Connector regarding the data elements and algorithms used in developing the Risk Adjustment Data Extract and in calculating risk scores and preliminary transfer amounts, based on the data available for the applicable reporting period, and other data relevant to discrepancy resolution.

13.02: continued

Risk Adjustment Covered Plan. Any health insurance coverage offered in the individual or small group market in Massachusetts, as well as any other coverage specified as being subject to the Risk Adjustment Program in the applicable State Payment Notice, with the exception of: grandfathered health plans; coverage that is considered "excepted benefits" under 45 CFR § 146.145(c) or 45 CFR § 148.220; and any plan determined not to be a risk adjustment covered plan in the applicable State Payment Notice.

Risk Adjustment Data Extract. An extract of health plan data reported to CHIA under 957 CMR 8.00: *All Payer Claims Database (APCD) and Case Mix and Charge Data Submission*, containing only data elements that are necessary for risk adjustment, provided by CHIA to the Connector to conduct risk adjustment operations.

Risk Adjustment Methodology. The federally certified risk adjustment methodology that will be implemented in the Commonwealth for a particular Benefit Year.

Risk Adjustment Program. The risk mitigation program operated by the Connector, pursuant to the authority granted M.G.L. c. 176Q, § 3(v), as described in 42 U.S.C. § 18063, and as implemented in 956 CMR 13.00.

State Payment Notice. The Massachusetts Notice of Benefit and Payment Parameters, released by the Connector, describing the parameters, procedures, and methodology for Risk Adjustment for a given Benefit Year.

13.03: Requirements for Data Submission

(1) The Connector will utilize the Risk Adjustment Data Extract provided by CHIA for risk adjustment operations.

(2) Each Carrier must comply with requirements for submitting enrollment, claims, and other data to CHIA, in accordance with 957 CMR 8.00: *All Payer Claims Database (APCD) and Case Mix and Charge Data Submission* and related regulations and guidance and any additional instructions or guidance provided by the Connector. All applicable data for a Benefit Year must be submitted by April 30th of the year following the applicable Benefit Year.

(3) If a Carrier fails to submit data or submits incomplete or inaccurate date to the MA APCD within the timeframe required, the Connector may assess a default risk adjustment charge, as described in 956 CMR 13.05.

(4) The Carrier must comply with all applicable data privacy and security standards and requirements set forth by CHIA, by the Connector, or by federal regulators, including standards and requirements described in the applicable State Payment Notice.

13.04: Ongoing Discrepancy Resolution Process

(1) Reports provided to Carriers. During the course of each applicable Benefit Year, CHIA or the Connector will provide Carriers, at a frequency specified by the Connector, with Member Month Tracker Reports and Quarterly Simulation Reports.

(2) Carrier Review of Reports. Within 30 calendar days of receiving either of the reports described in 956 CMR 13.04(1), a Carrier must either:

(a) Confirm to the Connector that the information in the report accurately reflects the data that the Carrier has provided to CHIA for the timeframe specified in the report, or

(b) Identify and report to the Connector with appropriate reporting detail any discrepancy it identifies in the report. The Connector may through guidance provide the manner and format for reporting any discrepancies.

(3) If a Carrier neither confirms that the data are accurate nor reports a discrepancy, the Connector will deem the report to be accurate and that no discrepancies have been identified consistent with 956 CMR 13.04(5).

13.04: continued

(4) Efforts to Resolve the Discrepancy. Following the reporting of a discrepancy by the Carrier, the Connector and the Carrier, along with CHIA as appropriate or necessary, will work together to resolve the discrepancy. The Connector may at its discretion work with the Carrier for up to 60 calendar days to seek to resolve the discrepancy, or it may choose to close the case regarding the discrepancy at an earlier time.

(5) Discrepancies Subject to Reconsideration: Any discrepancies that are reported but that remain unresolved after April 30th of the year following the applicable Benefit Year (including discrepancy cases closed by the Connector prior to resolution), or discrepancies that could not have been identified by the Carrier by April 30th, may be addressed through the reconsideration process described in 956 CMR 13.06 and 13.07. Any discrepancy that could have been identified by the Carrier under 956 CMR 13.04(2) but was not so identified and reported to the Health Connector may not be raised in the reconsideration process.

13.05: Transfer Calculation and Payment

(1) The Connector will annually complete fund transfer calculations according to the Risk Adjustment Methodology established by the Connector for the applicable Benefit Year. The calculations will be based on the data that has been reported to CHIA as of April 30th of the year following the applicable Benefit Year.

(2) If a Carrier fails to submit data or submits inaccurate or incomplete data to the MA APCD within the timeframe required, such that the Connector cannot apply the applicable Risk Adjustment Methodology to calculate the risk adjustment payment transfer amount in a timely fashion, the Connector may assess a default risk adjustment charge, calculated according to the methodology established by the Connector for the applicable Benefit Year.

(3) The Connector will issue a Final Risk Adjustment Payments and Charges Report to each Carrier by July 1st of the year following the applicable Benefit Year, reporting on the calculation of risk scores and transfer payments. The report will state the amounts of the risk adjustment charges that must be paid or transfer payments that will be received by the Carrier.

(4) Carriers that are assessed risk adjustment charges must pay the amount specified in the Final Risk Adjustment Payments and Charges Report provided by the Connector within 30 calendar days after issuance of the Final Risk Adjustment Payments and Charges Report, in accordance with instructions provided by the Connector.

(5) Risk adjustment charges shall be subject to an interest rate of twelve per cent per annum that will begin to accrue 40 calendar days after issuance of the Final Risk Adjustment Payments and Charges Report stating those charges.

(6) Following receipt of charges from Carriers that are assessed charges, the Connector will, from the charges received, make payments to Carriers that are owed risk adjustment payments. Transfer payments will be made after and only to the extent of receipt of risk adjustment charges. To the extent that the Connector has not received full payment of all risk adjustment charges by the due date, the Connector will distribute payments to recipient Carriers on a pro-rated basis, proportional to the total risk adjustment payments due to each Carrier. If, after making the initial payments, the Connector receives additional risk adjustment charges from Carriers making late payments, additional payments will be made to recipient Carriers on a pro-rated basis, proportional to the total risk adjustment payments due to each Carrier.

(7) If a Carrier that is owed a risk adjustment transfer payment for a particular calendar year has at that time an unpaid risk adjustment charge from a prior year, the amount of the transfer payment will be reduced by the amount of the unpaid charge.

(8) A Carrier's compliance with the requirements of the Risk Adjustment Program, including submitting accurate and timely data and making required risk adjustment transfer payments in a timely manner, shall be considered a condition of participation as a qualified health plan offered through the Connector, and a Carrier's failure to comply with these requirements constitutes grounds for the Connector to de-certify that Carrier as a qualified health plan.

13.06: Request for Reconsideration

(1) Grounds for Reconsideration Request. A Carrier may request reconsideration of the Final Risk Adjustment Payments and Charges Report only with respect to the following:

(a) An incorrect application by the Connector of the risk adjustment methodology, including issues related to unresolved data discrepancies; or

(b) Mathematical error.

(2) Risk Adjustment Methodology. The risk adjustment methodology cannot be the subject of a request for reconsideration.

(3) Materiality Threshold. Notwithstanding 956 CMR 13.06(1), a Carrier may file a request for reconsideration under 956 CMR 13.06 only if the amount in dispute is equal to or exceeds one percent of the applicable payment or charge listed in the Final Risk Adjustment Payments and Charges Report, or $10,000, whichever is less.

(4) Time for Filing Request for Reconsideration. The request for reconsideration must be filed within 30 calendar days after issuance of the Final Risk Adjustment Payments and Charges Report.

(5) Manner and Content of Reconsideration Request. The request for reconsideration must be in writing. It must specify the calculations or issues that the Carrier is challenging, the reasons for the challenge, and the amount of money that is in dispute. The Carrier must include in the request for reconsideration any additional documentary evidence that supports its request. The Carrier may not submit in evidence any data that could have been submitted during the discrepancy resolution process, but that was not timely submitted.

(6) Reconsideration Does Not Stay Obligation to Pay. The filing of a request for reconsideration shall not stay either the obligation to pay a risk adjustment charge, or the accrual of interest for late payment.

13.07: Reconsideration Procedures

(1) Scope of Reconsideration. The Connector will not consider any claim or issue raised in the request for reconsideration that could have been raised in the ongoing discrepancy resolution process, but that was not.

(2) Burden of Proof. The burden of proving a ground for reconsideration will be on the Carrier seeking reconsideration.

(3) First-level Review. The Connector will review the request for reconsideration. In conducting this review, the Connector will consider the Final Risk Adjustment Payments and Charges Report, along with all the data, calculations, and other evidence supporting that report. Additionally, the Connector will consider any documentary evidence included by the Carrier in its request for reconsideration. The Connector may consider other evidence that it considers to be relevant, provided that it will provide such evidence to the Carrier with a reasonable opportunity to review and comment on such evidence. The Connector may conduct this first-level review based solely on documentary evidence. The Connector will inform the Carrier of its reconsideration decision in writing.

(4) Request for Hearing. A Carrier that is aggrieved by the Connector's decision after the first-level review may file a request for hearing. The request must be in writing and must be submitted within ten calendar days after issuance of the first-level reconsideration decision.

(5) Hearing. The hearing will be conducted using the policies and procedures set forth for informal hearings pursuant to 801 CMR 1.02: *Informal Fair Hearing Rules* or in any administrative bulletins issued by the Connector.

13.07: continued

(6) Conduct of Hearing. The hearing officer will not consider any issue or claim that was not raised in the request for reconsideration. The hearing officer will not accept any evidence that was not presented by the Carrier with the reconsideration request or considered by the Connector in the first-level review.

(7) Decision. The hearing officer will issue a final decision in writing. The decision of the hearing officer will be the final decision of the Connector.

(8) Adjustment. In the event the final decision would cause a change in the relative risk adjustment payment and transfers among Carriers that would have been made in a Benefit Year, the Connector will determine the level of adjustment required to be applied to each Carrier's transfer amounts, with the adjustment made to the next risk adjustment transfer after the issuance of the final decision and the conclusion of any proceedings for judicial review arising from that decision.

13.08: Risk Adjustment Data Validation

(1) The Connector will employ a Risk Adjustment Data Validation (RADV) program, under which a statistically valid sample of risk adjustment data from each Carrier will be validated. Each Carrier must comply with the Connector's RADV procedures as laid out in applicable regulation, administrative bulletin, or other guidance.

(2) A Carrier must supply the Connector or the Connector's designee with all relevant source enrollment documentation, all claims and encounter data, and medical record documentation from providers of services to each enrollee in the applicable sample without unreasonable delay and in a manner that reasonably assures confidentiality and security in transmission.

13.09: Administrative Bulletins

The Connector may issue administrative bulletins that contain interpretations of or policies and procedures consistent with 956 CMR 13.00, or that contain such other information as may assist individuals subject to 956 CMR 13.00 to meet their obligations under 956 CMR 13.00.

13.10: Severability

The provisions of 956 CMR 13.00 are severable. If any provisions 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 956 CMR 13.00 or the application of such provisions.

REGULATORY AUTHORITY

956 CMR 13.00: M.G.L. c. 176Q.

NON-TEXT PAGE