957 CMR 2.00: PAYER DATA REPORTING

Section

2.01: General Provisions

Scope and Purpose. 957 CMR 2.00 governs the methodology and filing requirements for Health Care Payers to calculate and report Health Status Adjusted Total Medical Expenses, Relative Prices, Alternative Payment Methods, Prescription Drug Rebate information, Primary Care and Behavioral Health Expenses, and other aggregate data as the Center for Health Information and Analysis may require to ensure the uniform reporting of information from Private and Public Health Care Payers, including Third Party Administrators.

2.02: Definitions

All defined terms in 957 CMR 2.00 are capitalized. As used in 957 CMR 2.00, unless the context requires otherwise, the following terms shall have the following meanings:

Adjudicatory Proceeding. A proceeding before an agency in which the legal rights, duties or privileges of specifically named persons or entities are required by constitutional right or by any provision of the General Laws to be determined after an opportunity for an agency hearing.

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

Alternative Payment Methods (APM). Payment methods not based solely on Fee-for-service reimbursements. Alternative payment methods may include, but are not be limited to, shared savings arrangements, bundled payments and global payments. Alternative payment methodologies may also include Fee-for-service payments, which are settled or reconciled with a bundled or global payment.

Ambulatory Surgical Center. Any distinct entity that operates exclusively to provide surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

Behavioral Health Expenses. Payments to Providers, including payer paid and Member cost share amounts, for the provision of behavioral health services.

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

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

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

Fee-for-service. A payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each Provider is separately reimbursed for each discrete service rendered to a patient. Fee-for-service payments include Diagnosis-related Groups (DRGs), *per diem* payments, fixed procedure code-based fee schedule (including Ambulatory Payment Classification (APC)), and discounted charges-based payments.

Freestanding. Existing independently or physically separated from another health care facility and administered by separate staff with separate records.

2.02: continued

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, behavioral health, substance use disorder, mental health, 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 957 CMR 2.04.

Hospital. Any hospital licensed by the Department of Public Health in accordance with the provisions of M.G.L. c. 111, § 51, the teaching hospital of the University of Massachusetts Medical School, and any psychiatric facility licensed in accordance with M.G.L. c. 19, § 19, or any public health care facility.

Incurred but Not Reported (IBNR). Health Care Payer liabilities for claims or non-claims that, as of the date of data extraction, are anticipated but have not been reported to the Payer, have been reported but not yet adjudicated, have been adjudicated but not fully paid, or are in dispute.

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 Due to Financial Performance. Includes adjustments to a contracted payment amount, or additions to a base payment amount, or any other payments that are based solely on the achievement of financial or cost-based measures.

Payments Due to Quality Performance. Includes adjustments to a contracted payment amount, or additions to a base payment amount, or any other payments that are based on the achievement of quality measures (*e.g.*, quality, access, and/or patient experience).

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

Pharmacy Benefit Manager (PBM). A Third Party Administrator of prescription drug coverage programs. A PBM includes an entity that provides any of the following services on behalf of Payers or self-insured employer plans: pharmacy claims processing, pharmacy network contracting, drug formulary management, or manufacturer drug rebate contracting.

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

2.02: continued

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

Prescription Drug Rebates. Any rebates, discounts, and other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided fair market value *bona fide* service fees.

Presiding Officer. The individual(s) authorized by law or designated by the Center to conduct an Adjudicatory Proceeding.

Primary Care Expenses. Payments to Providers, including payer paid and Member cost share amounts, for the provision of primary care services.

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 also include any carrier or Third Party Administrator that contracts with the office of Medicaid, the Massachusetts Health 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 ConnectorCare Health Insurance program, Medicaid managed care organizations, Medicare Advantage Plans, 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.

Provider Organization. Any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents one or more Providers in contracting with carriers for the payments of Heath Care Services including, but not limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for 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.

Registered Provider Organization. A Provider Organization that has been registered in accordance with M.G.L. c. 6D, § 11.

Relative Prices. The contractually negotiated amounts paid to Massachusetts Providers by each 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 957 CMR 2.05.

Surcharge Payer. An individual or entity, including a managed care organization, that pays for or arranges for the purchase of Health Care Services provided by Hospitals and Ambulatory Surgical Center services provided by Ambulatory Surgical Centers; provided however, that the term "Surcharge Payer" shall not include:

(a) Title XVIII and Title XIX programs and their beneficiaries or recipients;

(b) other governmental programs of public assistance and their beneficiaries or recipients; and

(c) the workers' compensation program established pursuant to M.G.L. c. 152.

2.02: continued

Third Party Administrator. An entity who, on behalf of a Payer 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 include any entity with claims data, eligibility data, provider files, and other information relating to health care provided to residents of the Commonwealth and Health Care Services 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.

2.03: 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; its Relative Prices for Hospitals, Physicians, and Other Providers; its APMs by Registered Provider Organization, Hospital, Physician Group, Physician Local Practice Group, Other Provider, and Member zip code, its Prescription Drug Rebate data, and its Primary Care and Behavioral Health Expenses by Physician Group in accordance with the requirements of 957 CMR 2.04, 2.05, 2.06, 2.07 and 2.08.

(b) A Private Health Care Payer is subject to the reporting requirements in 957 CMR 2.00 if:

1. The Payer is a Surcharge Payer and the Payer's surcharge payments made pursuant to M.G.L. c. 118E, § 68 placed the Payer at the company level within the top ten Surcharge Payers for the period October 1, 2009 through September 30, 2010 as determined by the Health Safety Net Office and posted on the Center's website; or

2. The Payer contracts with the office of Medicaid, the Massachusetts Health 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 ConnectorCare 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 957 CMR 2.00 makes separate surcharge payments pursuant to M.G.L. c. 118E, § 68 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 Center pursuant to an interagency service agreement.

(2) Data Submission Requirements.

(a) Payers shall submit data and information to the Center in accordance with the procedures provided in 957 CMR 2.00, a *Data Specification Manual*, or an Administrative Bulletin. The Center 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 the penalties of perjury that all reports and records filed with the Center are true, correct and accurate.

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

2.04: Reporting 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, separated into the following categories:

a. Members required to select a primary care physician;

b. Members attributed to a primary care provider pursuant to a contract between the Payer and Provider for financial or quality performance;

c. All other Members who have been, "to the maximum extent possible", attributed to a primary care provider pursuant to M.G.L. c. 176J, § 16; and

d. Members not attributable to a primary care provider.

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

3. Payers shall report TME separately for Medicaid, Medicare, commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined in the *Data Specification Manual*. Commercial (self- and fully-insured) data for Physicians' Groups 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 Related 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 Related Payments by Member Months.

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

7. When reporting preliminary TME by Physician Group and Physician Local Practice Group, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

(b) Required Data Elements.

1. Center for Health Information and Analysis (CHIA) Organization ID or Payer's Internal Provider Number;

2. Insurance Category;

3. Physician Group Name;

4. Physician Local Practice Group Name;

5. Product Type;

6. PCP Member Attribution Designation;

7. Pediatric Indicator;

8. Member Months (annual);

9. Health Status Adjustment Score;

10. Normalized Health Status Adjustment Score: the Health Status Adjustment Score divided by the Payer's average health status adjustment score;

11. Total Medical Claims (annual): the medical claims expenses by the following subcategories: hospital inpatient, hospital outpatient, professional physician, other professional, pharmacy, and any other categories as defined in the *Data Specification Manual*;

12. Total Non-claims Payments (annual): the Non-claims Related Payments by the following subcategories: incentive programs, risk settlements, care management expenses, and any other categories as defined in the *Data Specification Manual*; and

13. The Center will delineate any other required data elements in the *Data Specification Manual*.

2.04: continued

(c) Calculation of TME by Physician Group and Physician Local Practice Group. Based upon the data specified in 957 CMR 2.04(1)(b) the Center 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 results.

(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 Center shall not publicly report zip code TME data, unless aggregated to an amount appropriate to protect patient confidentiality.
2. Payers shall report TME separately for Medicaid, Medicare, commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined in the *Data Specification Manual*. Commercial (self- and fully-insured) data for 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 data for 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.
3. Payers must report TME data separately by product type as defined by the *Data Specification Manual*.
4. Payers shall allocate Non-claims Related Payments by Member Months.
5. Payers must report the risk adjustment tool and version used to report the Health Status Adjustment Score. The Center may specify additional requirements for reporting the Health Status Adjustment Score by Administrative Bulletin or in the *Data Specification Manual*;
6. When reporting preliminary TME by zip code, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

(b) Required Data Elements.

1. Member Zip Code;
2. Product Type;
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 Medical Claims (annual): the sum of medical claims expenses designated into the following subcategories: hospital inpatient, hospital outpatient, professional physician, other professional, pharmacy, and any other categories as defined in the *Data Specification Manual*;
7. Total Non-claims Payments (annual): the sum of all Non-claims Related Payments; and
8. The Center will delineate any other required data elements in the *Data Specification Manual*.

(c) Calculation of TME by Zip Code. Based upon the data specified in 957 CMR 2.04(2)(b), the Center 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 results.

2.04: continued

(3) Due Dates: Annual Reports. Each year, Payers must submit:
(a) preliminary data for the prior Calendar Year; and
(b) final data for the Calendar Year for which the Payer submitted preliminary data during the previous reporting cycle. Payers shall allow for a claims run-out period of at least 90 days after December 31st of the previous Calendar Year; final data should reflect at least 15 months of claims run-out. Specific deadlines will be established in the *Data Specification Manual*.

2.05: Reporting Relative Prices

(1) Relative Prices for Hospitals.
(a) Payers must report Relative Price data separately by Medicare, Medicaid, commercial (fully-insured and self-insured), and any other insurance categories as specified by the *Data Specification Manual*.
(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 957 CMR 2.05(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 957 CMR 2.05(1)(d).
(e) Required Data Elements – Hospital Inpatient.
1. CHIA Organization ID;
2. Hospital Type;
3. Insurance Category;
4. Product Type;
5. 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 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 Center for a waiver to use a standard per unit rate.
b. For chronic, rehabilitation, or psychiatric hospitals, Payers may use a per unit rate as long as a uniform unit is applied within each hospital category.
6. Network Average Base Rate: the simple average of the Hospital-specific Base Rate for all Hospitals within a Payer's network.
7. Total Non-claims Payments: the sum of all Non-claims Related Payments. The allocation method for Non-claims Related Payments is outlined in the *Data Specifications Manual*.
8. Total Claims-based Payments: the sum of all medical claims payments.
9. Total Payments: the sum of total claims-based and Non-claims Related 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 and POS, PPO, Indemnity, and any other Massachusetts Provider network products.
13. Network-wide Product Mix: the proportion of the Payer's payments for HMO and POS, PPO, Indemnity, and any other Massachusetts Provider network products.
14. DRG version and group number used in calculation.
15. The Center will delineate any other required data elements in the *Data Specification Manual*.
(f) Calculation of Relative Prices - Hospital Inpatient. Based upon the data specified in 957 CMR 2.05(1)(e), the Center shall calculate Hospital Inpatient Relative Prices by dividing Total Claims-based and Non-claims Related 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.

2.05: continued

(g) Required Data Elements – Hospital Outpatient.

1. CHIA Organization ID;
2. Hospital Type;
3. Insurance Category;
4. Product Type;
5. 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;
6. Total Claims-based Payments: the sum of all medical claims payments;
7. Total Non-claims Payments: the sum of all Non-claims Related Payments. The allocation method for Non-claims Related Payments is outlined in the *Data Specification Manual*;
8. Hospital-specific Service Mix: the proportion of the Hospital's revenue for outpatient categories established by the Payer in 957 CMR 2.05(1)(g)5.;
9. Network-wide Service Mix: the proportion of the Payer's payments for outpatient categories established by the Payer in 957 CMR 2.05(1)(g)5.;
10. Hospital-specific Product Mix: the proportion of the Hospital's outpatient payments for HMO and POS, PPO, Indemnity, and other Massachusetts Provider network products;
11. Network-wide Product Mix: the proportion of the Payer's payments for HMO and POS, PPO, Indemnity, and other Massachusetts Provider network products; and
12. The Center will delineate any other required data elements in the *Data Specification Manual*.

(h) Calculation of Relative Prices – Hospital Outpatient. Hospital Outpatient Relative Prices shall be calculated by the Center 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 Center shall derive a Non-claims Multiplier of each product for each Hospital by dividing Total Non-claims Payments by Total Claims-based 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 results.

(2) Physician Groups.

(a) Payers must separately identify and report Relative Price data for the top 30 Physician Groups within a Payer's network, determined by revenue from the Payer.

(b) Payers shall report aggregate Relative Price data for all remaining Physician Groups outside of the top 30 in the relevant reporting period. The Center may request additional information on such Providers.

(c) Required Data Elements.

1. CHIA Organization ID or Payer's Internal Provider Number;
2. Name of Physician Group Practice;
3. Name of Physician Local Practice Group;
4. Pediatric Indicator;
5. Insurance Category;
6. Product Type;
7. 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;

2.05: continued

8. Physician Group-specific Service Mix: the proportion of the Physician Group's revenue for service categories established by the Payer in 957 CMR 2.05(2)(c)7.;
9. Network-wide Service Mix: the proportion of the Payer's payments to Physician Groups for service categories established by the Payer in 957 CMR 2.05(2)(c)7.;
10. Physician Group-specific Product Mix: the proportion of the Physician Group's payments for HMO and POS, PPO, Indemnity, and other Massachusetts Provider network products;
11. Network-wide Product Mix: the proportion of the Payer's payments for HMO and POS, PPO, Indemnity, 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 Total Non-claims Payments is outlined in the *Data Specification Manual*; and
14. The Center will delineate any other required data elements in the *Data Specification Manual*.

(d) Calculation of Relative Prices – Physician Groups. Physician Group Relative Prices shall be calculated by the Center 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 Center shall derive a Non-claims Multiplier for each Physician Group by dividing Total Non-claims Payments by Total Claims-based 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 results.

(3) Other Providers.

(a) Payers must report the Relative Price 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 centers;
6. Home health agencies;
7. Skilled nursing facilities; and
8. The Center 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 957 CMR 2.05(3)(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 Center 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 Center may request additional information on such Providers.

(e) Required Data Elements.

1. CHIA Organization ID or Payer's Internal Provider Number;
2. Pediatric Indicator;
3. Insurance Category;
4. Product Type;

2.05: continued

5. 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;

6. Provider-specific Service Mix: the proportion of the Provider's revenue for service categories established by the Payer in 957 CMR 2.05(3)(e)5.;

7. Network-wide Service Mix: the proportion of the Payer's payments for service categories established by the Payer in 957 CMR 2.05(3)(e)5.;

8. Provider-specific Product Mix: the proportion of the Provider's payments for HMO and POS, PPO, Indemnity, and other Massachusetts Provider network products;

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

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

11. Total Non-claims Payments: the sum of all Non-claims Related Payments. The allocation method for Total Non-claims Payments is outlined in the *Data Specification Manual*; and

12. The Center will delineate any other required data elements in the *Data Specification Manual*.

(f) Calculation of Relative Prices – Other Providers. Other Provider Relative Prices shall be calculated by the Center 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 Center shall derive a Non-claims Multiplier for each Provider by dividing Total Non-claims Payments by Total Claims-based 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 results.

(4) Network Average Relative Price Amount. Payers must report the dollar value associated with the network average Relative Prices that are used in the Relative Price calculations for each product type of each insurance category if applicable for Hospitals, Physician Groups, and Other Providers. Data submissions must conform to specifications as set forth in the *Data Specification Manual*.

(5) Due Dates: Annual Reports.

(a) Hospitals. Payers must submit required Relative Price data reports for Hospitals each year for the Calendar Year prior to the deadline as specified in the *Data Specification Manual*.

(b) Physician Groups. Payers must submit Relative Price data reports for Physician Groups each year for the Calendar Year ending 18 months prior by the deadline as specified in the *Data Specification Manual*.

(c) 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 the deadline as specified in the *Data Specification Manual* each year for the prior Calendar Year.

(d) Network Average Relative Price Amount. Payers must submit required dollar value information by the deadline as specified in the *Data Specification Manual* each year for the prior Calendar Year.

2.06: Reporting Alternative Payment Methods

(1) APM for Registered Provider Organizations, Physician Groups, and Physician Local Practice Groups.

(a) Reporting Requirements.

1. Payers must report APM data separately by Medicare, Medicaid, commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined by the *Data Specification Manual*. Commercial (self- and fully-insured) data for Registered Provider Organizations, Physician Groups, and Physician Local Practice Groups 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 Registered Provider Organizations, or Physician Groups, Physician Local Practice Groups 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.

2. Payers must report APM data separately by product type as defined by the *Data Specification Manual*.

3. When reporting preliminary APM data, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

4. Payers shall report APM for Physician Groups and Physician Local Practice Groups with at least 36,000 Member Months for the Calendar Year. Payers shall report APM 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 Related 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 Related Payments by Member Months.

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

7. When reporting preliminary APM by Physician Group and Physician Local Practice Group, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

(b) Required Data Elements. The Center will delineate required data elements in the *Data Specification Manual*.

(c) Reporting APM. Based upon the data specified in the *Data Specification Manual*.

(2) APM by Zip Code.

(a) Reporting Requirements.

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

2. Payers shall report APM separately for Medicaid, Medicare, commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined in the *Data Specification Manual*. Commercial (self- and fully-insured) data for 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 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.

3. Payers must report APM data separately by product type as defined by the *Data Specification Manual*.

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

2.06: continued

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

6. When reporting preliminary APM by zip code, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

(b) Required Data Elements. The Center will delineate required data elements in the *Data Specification Manual*.

(c) Reporting APM. Based upon the data specified in the *Data Specification Manual*.

(3) APM for Hospitals, Physician Groups, and Other Providers.

(a) Reporting Requirements.

1. Payers must report APM data separately by Medicare, Medicaid, and commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined in the *Data Specification Manual*. Commercial (self- and fully-insured) data for Physician Groups, Physician Local Practice 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 Registered Provider Organizations, Physician Groups, Physician Local Practice 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.

2. Payers shall report hospital categories separately for inpatient and outpatient.

3. Payers must report APM data separately by hospital category for acute hospitals, chronic hospitals, rehabilitation hospitals, and psychiatric hospitals.

4. When reporting preliminary APM data, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

5. Notwithstanding 957 CMR 2.06(3)(a)3., Payers shall report additional behavioral health-only APM 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 957 CMR 2.06(3).

(b) Required Data Elements. The Center will delineate required data elements in the *Data Specification Manual*.

(c) Reporting APM. Based upon the data specified in the *Data Specification Manual*.

(4) Due Dates: Annual Reports. Each year, Payers must submit:

(a) preliminary data for the prior Calendar Year; and

(b) final data for the Calendar Year for which the payer submitted preliminary data during the last reporting cycle. Payers shall allow for a claims run-out period of at least 90 days after December 31st of the previous Calendar Year. Final data should reflect at least 15 months of claims run-out. Specific deadlines will be established in the *Data Specification Manual*.

2.07: Reporting Prescription Drug Rebates

(1) Prescription Drug Rebate Reporting.

(a) Reporting Requirements.

1. Payers must report rebate data for all Massachusetts residents for whom the payer has complete pharmacy claim and rebate data.

a. If Payers are not able to report data solely for Massachusetts residents, they must notify the Center in writing and propose a different Member population definition for Center approval.

b. Any Members for which a Payer has no pharmacy expenditure or prescription drug rebate data, or partial pharmacy expenditure or prescription drug rebate data, should be excluded from this data reporting.

2.07: continued

2. Payers must report rebate data separately by Medicare, Medicaid, and commercial plans (fully-insured and self-insured), and any other insurance categories as defined by the *Data Specification Manual*.

If rebate data is only available to a Payer at an aggregated level and cannot be separated to provide unique information for each insurance category, the Payer shall report data at the most granular level available. In such instances, the Payer shall report a separate observation with all required data elements for each insurance category using a Combined Rebate Identifier, as specified in the *Data Specification Manual*.

3. Payers shall report all data in the prescription drug rebate data submission at the aggregate level for all Massachusetts residents, or in the aggregate for any alternative Member population approved by the Center.

4. Payers shall report prescription drug rebate and pharmacy expenditure data using IBNR estimates resulting in approximated completed claim and rebate amounts for periods that are not yet considered complete.

(b) Required Data Elements. The Center will delineate required data elements in the *Data Specification Manual*.

(2) Pharmacy Benefit Manager (PBM) Reporting.

(a) Reporting Requirements.

1. Payers must report PBM data separately by Medicare, Medicaid, and commercial plans (fully-insured and self-insured), and any other insurance categories as defined by the *Data Specification Manual*.

2. Payers must identify the level of services performed by each PBM vendor for each insurance category. Payers shall identify the level of services in the following categories:

a. Claims Processing;

b. Drug Formulary Management;

c. Manufacturer Drug Rebate Contracting; or

d. any other category defined in the *Data Specification Manual*. Payers shall identify whether a PBM performed a given service for "all", "some", or "none" of its Members in a given insurance category. Payers may report multiple PBMs in an insurance category.

(b) Required Data Elements. The Center will delineate required data elements in the *Data Specification Manual*.

(3) Due Dates: Annual Reports. Each year, Payers must submit:

(a) preliminary data for the prior Calendar Year; and

(b) final data for the Calendar Year for which the payer submitted preliminary data during the last reporting cycle. Payers shall allow for a claims run-out period of at least 90 days after December 31st of the previous Calendar Year. Final data should reflect at least 15 months of claims run-out. Specific deadlines will be established in the *Data Specification Manual*.

2.08: Reporting Primary Care and Behavioral Health Expenses

(1) Primary Care and Behavioral Health Expenses Reporting by Physician Group.

(a) Reporting Requirements.

1. Payers shall report Primary Care and Behavioral Health Expenses and Member Months information by Physician Group for Massachusetts Members, separated into the following categories:

a. Members required to select a primary care physician;

b. Members attributed to a primary care provider pursuant to a contract between the Payer and Provider for financial or quality performance;

c. All other Members who have been, "to the maximum extent possible", attributed to a primary care provider pursuant to M.G.L. c. 176J, § 16; and

d. Members not attributable to a primary care provider.

2. Payers shall report Primary Care and Behavioral Health Expenses for Physician Groups with at least 36,000 Member Months for the Calendar Year.

2.08: continued

3. Payers must report data separately by Medicare, Medicaid, commercial full-claim, and commercial partial-claim plans, and any other insurance categories as defined by the *Data Specification Manual*. Commercial (self- and fully-insured) data for Physician Groups 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 Physician Groups 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 Primary Care and Behavioral Health Expenses data in the aggregate for all Physician Groups with fewer than 36,000 Member Months for the Calendar Year.

5. When reporting preliminary data, Payers shall include IBNR estimates resulting in approximated completed claims for periods that are not yet considered complete.

(b) Required Data Elements. The Center will delineate required data elements and qualitative response questions in the *Data Specification Manual*. For purposes of 957 CMR 2.08, primary care and behavioral health services are defined by standardized coding logic set forth in the *Data Specification Manual*.

(2) Due Dates: Annual Reports. Each year, Payers must submit:

(a) preliminary data for the prior Calendar Year; and

(b) final data for the Calendar Year for which the payer submitted preliminary data during the previous reporting cycle. Payers shall allow for a claims run-out period of at least 90 days after December 31st of the previous Calendar Year. Final data should reflect at least 15 months of claims run-out. Specific deadlines will be established in the *Data Specification Manual*.

2.09: Compliance and Penalties

The Center will provide written notice to Payers that fail to comply with the reporting deadlines established in 957 CMR 2.00.

(1) The Center will notify Payers that failure to respond within two weeks of the written notice, without just cause, may result in penalties. In accordance with M.G.L. c. 12C, § 11, Payers may be subject to a penalty of up to $1,000 per week for each week that they fail to provide the required health care data and information, up to an annual maximum of $50,000.

(2) Any remedy available under 957 CMR 2.09 is in addition to other sanctions and penalties that may apply under the provisions of other statutes and regulations.

(3) Payers that fail to comply with the requirements of 957 CMR 2.00 will be subject to all penalties and remedies allowed by law and the Center will take all necessary steps to enforce 957 CMR 2.09, including a petition to the Superior Court for an order enforcing the same.

(4) Before assessing a penalty, the Center shall notify the Payer that has failed to comply with the requirements of 957 CMR 2.00 that it has the right to request a hearing in accordance with M.G.L. c. 30A, § 10.

(5) If a hearing is timely requested in writing, the Center, including through a Presiding Officer, will conduct the hearing in accordance with 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure*. After the hearing, the Center shall render a written decision and may assess a civil penalty pursuant to 957 CMR 2.09(1).

(6) After the issuance of a final decision, except where any provision of law precludes judicial review, a Payer aggrieved by such final decision may seek judicial review thereof in accordance with M.G.L. c. 30A, § 14.

2.10: Administrative and Technical Information Bulletins

The Center may revise the specifications or other administrative requirements from time to time by notice or Administrative Bulletin.

2.11: Severability

The provisions of 957 CMR 2.00 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 957 CMR 2.00 or the application of such provisions.

REGULATORY AUTHORITY

957 CMR 2.00: M.G.L. c. 12C.