

(957 CMR 1.00: RESERVED)

NON-TEXT PAGE

957 CMR 2.00: PAYER DATA REPORTING

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2.01: General Provisions

(1) 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, and Alternative Payment Method information to the Center for Health Information and Analysis.

(2) Authority. 957 CMR 2.00 is adopted pursuant to M.G.L. c. 12C.

2.02: Definitions

The following terms as used in 957 CMR 2.00 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.

Alternative Payment Methods (APM). Payment methods not based solely on Fee-for-service payments. 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.

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.

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 payment.

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, 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. 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 Due to Financial Performance. Total payments for financial performance are payment additions to the base payment or adjustments to a contracted payment amount that are made based solely on the achievement of financial or cost-based measures.

Payments Due to Quality Performance. Total payments for quality performance are those where a performance-based payment is made either as an addition to the base payment or as an adjustment to a contracted payment amount, in both cases to reward a provider for the achievement of quality measures. Payments based on quality performance do not include payments that incorporate payment adjustments based solely on provider cost or efficiency performance.

Payments Subject to Surcharge. Payments subject to the surcharge established by M.G.L. c. 118E, § 68.

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.

2.02: continued

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.

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 Health 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 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 957 CMR 2.05.

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

Surcharge Payer. An individual or entity, including a Managed Care Organization, that pays for or arranges for the purchase of Health Services provided by Hospitals and Ambulatory Surgical Center Service 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.

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.

2.02: continued

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; and its APMs by Registered Provider Organization, Hospital, Physician Group, Physician Local Practice Group, Other Provider, and Member Zip Code in accordance with the requirements of 957 CMR 2.04 through 2.06.

(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 Center and posted on the Center'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 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) Each Payer shall submit data directly to the Center in electronic format. Data submissions must conform with edit specifications as set forth in the Data Specification Manual. 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 pains and 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, and APMs. 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.

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

(3) Penalties.

(a) If a Payer fails to submit required data to the Center on a timely basis, or fails to correct submissions rejected because of errors, the Center 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 Center will take all necessary steps to enforce this provision to the fullest extent of the law.

2.03: continued

(b) Private Health Care Payers that do not comply with the reporting requirements of 957 CMR 2.00 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. 12C, § 11.

(c) The Center will notify the Attorney General's Office to enforce the provisions of 957 CMR 2.03(3)(a) and (b).

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

2.04: continued

(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 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 Center 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 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 calculation.

(3) Due Dates Annual Reports. Each year, Payers must submit preliminary TME data for the prior Calendar Year and final TME data for the Calendar Year ending 16 months prior by May 1st.

2.05: 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.

2.05: continued

(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 (Medicare, Medicaid, Commonwealth Care, or commercial);
4. Product Type (HMO and POS, PPO, Indemnity, other);
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.
 - i. 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 Center for a waiver to use a standard per unit rate.
 - ii. 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.
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 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 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 other Massachusetts provider network products.
13. Network-wide Product Mix: the proportion of the Payer's payments for HMO and POS, PPO, Indemnity, 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 957 CMR 2.05(1)(e) the Center shall calculate Hospital Inpatient Relative Prices by dividing Total Claims-based and Non-claims 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. CHIA Organization ID.
2. Hospital Type.
3. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
4. Product Type (HMO and POS, PPO, Indemnity, other)
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 payments is outlined in the Data Specifications 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.

2.05: continued

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.
- (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 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 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 (Medicare, Medicaid, Commonwealth Care, or commercial);
 6. Product Type (HMO and POS, PPO, Indemnity, Other);
 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;
 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 non-claims payments is outlined in the *Data Specifications Manual*.

2.05: continued

(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 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 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(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 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 (Medicare, Medicaid, Commonwealth Care, or commercial)
4. Product Type (HMO and POS, PPO, Indemnity, other);
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 non-claims payments is outlined in the *Data Specifications Manual*.

2.05: continued

(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 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) 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 with specifications as set forth in the Data Specification Manual.

(5) Due Dates.

(a) Annual Reports.

1. Hospitals. Payers must submit required Relative Price data reports for Hospitals by May 1st each year for the prior Calendar Year.
2. Physician Groups. Payers must submit Relative Price data reports for Physician Groups by May 1st each year for the Calendar Year ending 16 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 May 1st each year for the prior Calendar Year.
4. Network Average Relative Price Amount. Payers must submit required dollar value information by May 15th each year for the prior Calendar Year.

2.06: Reporting Alternative Payment Methods

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

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

(d) Notwithstanding 957 CMR 2.06(1)(c), 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(1).

(e) Required Data Elements.

1. Hospital Inpatient and Hospital Outpatient.

- a. CHIA Organization ID or Payer's Internal Provider Number;
- b. Hospital Type;
- c. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial);
- d. Product Type (HMO and POS, PPO, Indemnity, other);
- e. Payment Method (Global Budget/Payment; Limited Budget; Bundled Payments; Other, non-fee-for-service Based Payments; or Fee-for-service Payments);
- f. 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;
- g. Total Claims-based Payments: the sum of all medical claims payments;
- h. Total Payments: the sum of total claim-based and non-claims payments;

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- i. Amount of Total Payments Due to Financial Performance;
 - j. Amount of Total Payments Due to Quality Performance;
 - k. Amount of Total Payments Due to Financial and Quality Performance Combined.
2. Physician Groups.
- a. CHIA Organization ID or Payer's Internal Provider Number;
 - b. Name of Physician Group;
 - c. Name of Physician Local Practice Group;
 - d. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
 - e. Product Type (HMO and POS, PPO, Indemnity, other);
 - f. Payment Method (Global Budget/Payment; Limited Budget; Bundled Payments; Other, non-fee-for-service Based Payments; or Fee-for-service Payments);
 - g. 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;
 - h. Total Claims-based Payments: the sum of all medical claims payments;
 - i. Total Payments: the sum of total claim-based and non-claims payments;
 - j. Amount of Total Payments Due to Financial Performance;
 - k. Amount of Total Payments Due to Quality Performance;
 - l. Amount of Total Payments Due to Financial and Quality Performance Combined.
3. Other Providers.
- a. CHIA Organization ID or Payer's Internal Provider Number;
 - b. Name of Other Provider;
 - c. Organization Type;
 - d. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
 - e. Product Type (HMO and POS, PPO, Indemnity, other);
 - f. Payment Method (Global Budget/Payment; Limited Budget; Bundled Payments; Other, non-fee-for-service Based Payments; or Fee-for-service Payments);
 - g. 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*;
 - h. Total Claims-based Payments: the sum of all medical claims payments;
 - i. Total Payments: the sum of total claim-based and non-claims payments;
 - j. Amount of Total Payments Due to Financial Performance;
 - k. Amount of Total Payments Due to Quality Performance;
 - l. Amount of Total Payments Due to Financial and Quality Performance Combined.
- (f) Reporting APM. Based upon the data specified in 957 CMR2.06(1)(e).

(2) APM for Registered Provider Organizations, Physician Group, and Physician Local Practice Group.

- (a) Payers must report APM data separately by Medicare, Medicaid, Commonwealth Care, and commercial (fully-insured and self-insured).
- (b) Payers must report APM data separately by product type (HMO and POS, PPO, Indemnity, Other).
- (c) Required Data Elements.
 - 1. Registered Provider Organization ID: For Calendar Year 2012, Payer's Internal Contracting Entity ID may be used;
 - 2. Registered Provider Organization Name;
 - 3. Physician Group Name;
 - 4. Physician Local Practice Group Name;
 - 5. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
 - 6. Product Type (HMO and POS, PPO, Indemnity, other);
 - 7. Payment Method (Global Budget/Payment; Limited Budget; Bundled Payments; Other, non-fee-for-service Based Payments; or Fee-for-service Payments);
 - 8. Member Months;
 - 9. Health Status Adjustment Score;
 - 10. Average Monthly Budget per Member;
 - 11. 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;

2.06: continued

12. Total Claims-Based Payments: the sum of all medical claims payments;
 13. Total Payments: the sum of total claim-based and non-claims payments;
 14. Amount of Total Payments Due to Financial Performance;
 15. Amount of Total Payments Due to Quality Performance;
 16. Amount of Total Payments Due to Financial and Quality Performance Combined.
- (d) Reporting APM. Based upon the data specified in 957 CMR 2.06(1)(e).

(3) 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 and Commonwealth Care (combined), Medicare, and commercial. 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 shall allocate Non-claims Payments by Member Months.
4. 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*.

(b) Required Data Elements.

1. Member Zip Code;
2. Insurance Category (Medicare, Medicaid, Commonwealth Care, or commercial)
3. Product Type (HMO and POS, PPO, Indemnity, other);
4. Payment Method (Global Budget/Payment; Limited Budget; Bundled Payments; Other, non-fee-for-service Based Payments; or Fee-for-service Payments);
5. Member Months;
6. Health Status Adjustment Score;
7. Total Claims-based Payments (Annual): the sum of medical claims payments;
8. Total Non-claims Payments (Annual): the sum of non-claims payments;
9. Total Payments: the sum of total claims-based and non-claims payments.

- (4) Due Dates Annual Reports. Each year, Payers must submit APM data for the prior Calendar Year by May 15th.

2.07: Other Provisions

(1) 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) 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.