

DIVISION OF HEALTH CARE FINANCE AND POLICY

114.5 CMR 21.00: HEALTH CARE PAYERS CLAIMS DATA SUBMISSION

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21.01: General Provisions

(1) Scope and Purpose. 114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to the Division in accordance with M.G.L. c. 118G, § 6. Health care data and information submitted by Health Care Payers to the Division is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 114.5 CMR 21.00 or 114.5 CMR 22.00.

(2) Effective Date. These regulations shall be effective on July 23, 2010.

(3) Authority. 114.5 CMR 21.00 is adopted pursuant to M.G.L. c. 118G, § 6.

21.02: Definitions.

The following words shall have the following meanings:

CMS. The federal Centers for Medicare and Medicaid Services.

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

Encounter Data. Data relating to the treatment or services rendered by a provider to a patient.

Health Care Claims Data. Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to the Division.

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 services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third-Party Administrators, and self-insured plans.

Member Eligibility File. A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.

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

Private Health Care Payer. A carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.

Provider. A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.

Public Health Care Payer. The Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the Commonwealth Care Health Insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the Group Insurance Commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

Submission Guide. The document that sets forth the required data file format, record specifications, data elements, definitions, code tables and edit specifications.

Third-Party Administrator. Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.

21.03: Reporting Requirements

(1) General. Payers shall submit health plan information to the Division in accordance with 114.5 CMR 21.03(2) and Health Care Claims Data in accordance with 114.5 CMR 21.03(3).

(2) Health Plan Information

(a) Private Health Care Payers. All Private Health Care Payers shall provide data and information for all plan types, including self-insured plans, including but not limited to the following:

1. individual and family plan premiums for a representative range of group sizes, and annual individual and family plan premiums for the lowest cost plan in each group size for every plan with at least 1,000 Massachusetts residents that meets the minimum standards and guidelines established by the Division of Insurance under section 8H of chapter 26, organized by product codes that also appear in the Member Eligibility File;

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2. information supporting the actuarial assumptions that underlie the premiums for each plan;
3. summaries of the plan designs for each plan;
4. medical and administrative expenses by market sector, including medical loss ratios for each plan;
5. information regarding the payer's current level of reserves and surpluses; and
6. information on provider payment methods and levels, including but not limited to total amounts and specific capitated payments, risk sharing arrangements and settlements, and any other provider payments made outside the automated or manual claims payment system.

(b) Public Health Care Payers, and publicly-supported Managed Care Organizations and Senior Care Organizations, shall provide data and information for all plan types, subject to any applicable federal law, including but not limited to the following:

1. per-member per-month premiums for enrollees and the actuarial assumptions that support such premiums;
2. summaries of plan designs and covered services for each plan;
3. information concerning the medical and administrative expenses, including medical loss ratios for each Managed Care and Senior Care Organization and program;
4. information regarding a managed care organization's current level of reserves and surpluses; and
5. information on provider payment methods and levels, including payment methodologies.

(3) Health Care Claims Data.

(a) General.

1. Submission Guide. The Division will issue a Submission Guide to specify the filing requirements and data specifications for Payers to submit Medical Claims, Pharmacy Claims, Dental Claims, Member Eligibility Files, Provider Files, and Product Files.
2. Payer Filing Requirements. Private Health Care Payers must file data in accordance with 114.5 CMR 21.03(3) and the Submission Guide. Public Payers and the Commonwealth Health Insurance Connector may provide or authorize the provision of claims data to the Division pursuant to an interagency service agreement.
3. Required Data. Health Care Payers must provide claims-line detail for all health care services provided to Massachusetts residents, whether or not the health care was provided within Massachusetts. Such data shall include but is not limited to fully-insured and self-funded accounts and all commercial medical products for all individuals and all group sizes.
4. Administrative Bulletin. The Division may amend the filing requirements and data specifications, including filing deadlines, by Administrative Bulletin.

(b) Data to be Submitted.

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1. Medical Claims and Encounter Data. Payers shall report health care service paid claims and encounters for all Massachusetts resident members, and all members of a Massachusetts employer group including those who reside outside of Massachusetts. Payers must identify encounters corresponding to a capitation payment.

a. Payers will be not be required to submit denied claims effective January 31, 2011. The Division will issue an Administrative Bulletin at least 120 days in advance notifying Payers when the requirement to submit denied claims will become effective, and will notify Payers about the procedures and due dates for submitting such claims.

b. Payers must provide data and information for payments and financial transactions that do not utilize the claims system, including but not limited to:

- i. encounters;
- ii. amounts withheld for any reason;
- iii. claims associated with risk-sharing arrangements
- iv. paper-based claims;
- v. pay-for-performance payments and
- vi. claims not otherwise described.

c. Payers must provide information according to the Submission Guide to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data.

2. Pharmacy Claims. Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid.

3. Dental Claims. Health Care Payers must provide data containing all dental claims and encounter data for members.

4. Member Eligibility Data. Health Care Payers must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from product, pharmacy, dental and medical claims data sets.

5. Provider Files. Health Care Payers must provide a file that includes standard identifiers such as provider name and locations, and standard identifier codes such as NPI, for hospital based services, ambulatory care, specialty providers and pharmacy providers.

6. Product Files. Health Care Payers must provide detailed information on covered services, group size, coverage levels, and copayments.

(4) Submission Deadlines. Unless otherwise directed by the Division by Administrative Bulletin, Payers shall submit information to the Division in the specified format in accordance with the following schedule:

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(a) Initial Data Submissions. Payers shall submit the data required under 114.5 CMR 21.03(3) for calendar years 2008, 2009 and 2010 no later than January 31, 2011.

(b) Monthly Data Submissions. Effective February, 2011, Payers shall submit claims data sets under 114.5 CMR 21.03(3) on a monthly basis. Monthly data files are due to the Division by the last day of the following month. For example, files containing data relating to services paid during September must be submitted by October 31. Plans with fewer than 2,000 enrolled lives may opt to submit on a quarterly basis upon advance notice to the Division.

(c) Quarterly Data Submissions. Reports required to be filed quarterly must be filed by the last day of the month after the calendar quarter closes. For example, the report for files containing medical claims, pharmacy claims and member eligibility data for services paid during the first quarter of the calendar year should be submitted by April 30.

(d) Claims Data for 2011 Cost Trends Report. Payers that submitted claims data for the 2010 Cost Trends Report, pursuant to the Division's March, 2009 data request, must submit self-insured claims data for calendar years 2007 through 2009 by October 1, 2010 in accordance with the Health Care Quality and Cost Council's data specifications. Such Payers must also submit 2009 premium information as specified in Section 1 of the Division's March, 2009 data request by October 1, 2010.

21.04: Penalties

If any payer fails to submit required data to the Division on a timely basis, or fails to correct submissions rejected because of errors, the Division or its designee shall provide written notice to the Payer. If the Payer fails to provide the required information within two weeks following receipt of said written notice, the Division will take all necessary steps to enforce this provision to the fullest extent of the law. Private Health Care Payers that do not comply with the reporting requirements of 114.5 CMR 21.00 are subject to a penalty of up to \$1,000 per week for each week that the Payer fails to provide the required data, up to a maximum of \$50,000 in accordance with M.G.L. c. 118G, § 6. The Division will notify the Attorney General's Office to enforce this provision. The Division may grant an extension of time for just cause. Any remedy available in this section is in addition to any sanctions and penalties that may apply under the provisions of any other state entity, to the extent that the Division collects information on behalf of such other entity or entities.

21.05: Confidentiality

(a) Pursuant to M.G.L. c. 118G, § 6, health care data and information collected pursuant to M.G.L. c. 118G, § 6 and 114.5 CMR 21.00 are not a public record. Disclosure of claims data collected under M.G.L. c. 118G, § 6 is governed by 114.5 CMR 22.00. The Division will not disclose or release specific health plan actuarial assumptions submitted in accordance with 114.5 CMR 21.02.

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(b) The Division shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, to the extent that the claims data collected is “personal data” within the meaning of that statute, and the security provisions of the Health Insurance Portability and Accountability Act. In addition, the Division shall ensure that any contractor or third party that processed or analyzes the data shall comply with these statutory requirements.

21.06: Severability

The provisions of 114.5 CMR 21.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 22.00 or the application of such provisions.

REGULATORY AUTHORITY

114.5 CMR 21.00: M.G.L. c. 118G