

Total Medical Expenses and Relative Prices
Technical Call Summary
April 4 - 7, 2011

Verifying Submission of TME Data

- To verify that your TME file has been accepted without errors log in to INET.

Turnaround time in INET for TME Reports

- It takes less than one day from the time a file passes after submission in INET to the generation of a return report with the calculations.

DHCFP Number in Regulations

- The DHCFP Number field in the regulation is a redundancy in combination with the ORGID field. Payers will not need to report DHCFP Number.

Relative Price Regulation Changes

- Acute hospital behavioral health Relative Price data should be reported for acute hospitals with psych or substance abuse units, rather than 20% of licensed beds.
- Non-acute hospital inpatient base rates may be calculated on per unit rate, so long as uniform unit is selected within each hospital type.
- Payers may seek a waiver from the requirement to use DRG for acute hospital inpatient if 1) payer does not pay acute hospitals on DRG and 2) payer does not have DRG software and would incur costs obtaining such software.
- The distinction between outlier and non-outlier has been removed from the hospital inpatient file; payers will report total payments, all-inclusive case mix, and total number of discharges.
- The Hospital Relative Price time period is now a calendar year rather than hospital fiscal year.
- Initial filing is June 1 for CY09 hospital, CY10 hospital, and CY09 physician group Relative Price data.
- Initial filing for CY10 other provider Relative Price data is June 30.

Categorization of Hospitals

- The Uniform Provider List posted on the Division's website has hospitals categorized into the appropriate fields.

Behavioral Health / Psychiatric Hospitals

- Acute hospital behavioral health data is reported twice: once in combination with all other claim data for acute hospitals and on its own with the psychiatric hospital records.

HMO and POS

- HMO and POS rates should be reported separately as of today; however, the Division is taking the possibility of combining the two rates into consideration.

Network Averages

- Network averages should be reported for every insurance category and product type combination.

Payment Changes in Reporting Year

- If the method of paying a provider changes during the reporting year, then use the Header Record to note the change and report blended data.

Massachusetts Provider Reporting for Relative Price

- Carriers should report on all Massachusetts providers for Relative Prices since Relative Prices are a provider-focused measure.
- Payers should report claim data for all members who receive service from Massachusetts providers, even if they are not a resident of Massachusetts.

No Standard Fee Schedule

- If a payer does not have a standard fee schedule, then the payer must derive the average payment for each service line and use the averages as the equivalent to a standard fee schedule.

ORGID/PIP

- The same procedures apply for ORGID and Payer Internal Provider Number usage as in TME reporting.

No Aggregate Hospital reporting

- There is no threshold for hospital reporting. If a payer does any business with a hospital listed on the Division's Uniform Provider List, the payer must report Relative Price data for that hospital. *Note this is a correction from what was previously stated.*

Non-Claims Payments for Specific Products

- The Division will explore amending its non-claims payment allocation to allow for specific allocation to certain insurance products.

Claim Settlement Allocation

- The settlement component of a claim should be reported as a non-claims payment, not as part of the claim.

Technical Calls for Relative Prices

- The semi-weekly technical calls will continue on the same schedule; Mondays and Thursdays 1:00pm – 1:30pm.