957 CMR 4.00: STANDARD QUALITY MEASURE SET

Section

4.01: General Provisions

(1) Scope and Purpose. The purpose of 957 CMR 4.00 is to define the Standard Quality Measure Set establishment, use, and uniform reporting requirements in accordance with M.G.L. c. 12C.

(2) Applicability. 957 CMR 4.00 applies to Payers, Providers and Provider Organizations.

(3) Authority. This regulation is issued pursuant to M.G.L. c. 12C, including but not limited to, §§ 3, 5, 8, 9, 10, 11, and 14.

4.02: Definitions

All defined terms in 957 CMR 4.00 are capitalized. Any other term used in this regulation but not defined herein shall have the meaning given to the term by M.G.L. c. 12C, other CHIA regulations, or Sub-Regulatory Guidance.

As used in 957 CMR 4.00, unless the context requires otherwise, the following words shall have the following meanings:

Accountable Care Organization. A provider organization certified under section 15 of chapter 6D.

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.

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

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Carrier. An insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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

Core Measures. The SQMS measures that meet the core criteria set by CHIA in consultation with the Statewide Quality Advisory Committee and that shall be used in contracts that incorporate quality measures into payment terms between Payers, including the Commonwealth and Carriers, and health care Providers, including Provider Organizations and Accountable Care Organizations.

Non-Core Measures. The SQMS measures established by CHIA in consultation with the Statewide Quality Advisory Committee that may be used in addition to Core Measures in contracts that incorporate quality measures into payment terms between Payers, including the Commonwealth and Carriers, and health care Providers, including Provider Organizations and Accountable Care Organizations.

Payer. Any entity, other than an individual, that pays providers for the provision of health care services; provided, however, that "payer" shall include both governmental and private entities; and provided further, that "payer" shall include self-insured plans to the extent allowed under the Employee Retirement Income Security Act of 1974.

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

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 1 or more health care 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.

Standard Quality Measure Set (SQMS). The standard sets of measures of health care provider quality and health system performance established by the Center in consultation with the Statewide Quality Advisory Committee.

Statewide Quality Advisory Committee (SQAC). The committee, established pursuant to M.G.L. c. 12C, which advises the Center in establishing the SQMS.

Sub-Regulatory Guidance. An Administrative Bulletin, notice, manual, guide, or other document that specifies deadlines, technical submission requirements, or contains methodological explanations and examples to facilitate understanding of and compliance with adopted regulations.

4.03: Standard Quality Measure Set Establishment, Use, and Reporting Requirements

(1) Establishment of the Standard Quality Measure Set. The Center will establish the Core Measures and Non-Core Measures that comprise the SQMS, in consultation with the SQAC. The SQAC shall submit its recommendations to the Center along with a report in support of its recommendations in accordance with M.G.L. c. 12C. If the SQMS established by the Center differs from the recommendations of the SQAC, the Center will issue a written report detailing each area of disagreement and the rationale for the Center's decision.

(2) Use of the Standard Quality Measure Set

a. The SQMS will designate:
   i. Core Measures that shall be used in contracts that incorporate quality measures into payment terms between Payers, including the Commonwealth and Carriers, and health care Providers, including Provider Organizations and Accountable Care Organizations; and
   ii. A menu of Non-Core Measures that may be used in such contracts.

b. The SQMS may be used for other purposes, including, but not limited to:
   i. Assigning tiers to health care Providers in the design of any health plan;
   ii. Consumer transparency websites and other methods of providing consumer information; and
   iii. Monitoring systemwide performance.

(3) SQMS Data Reporting Requirements

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a. General. Payers, Providers and Provider Organizations shall submit data and information to CHIA in accordance with the procedures provided in 957 CMR 4.00 or Sub-Regulatory Guidance from the Center.

b. Payer, Provider and Provider Organization Reporting Requirements. The Center will develop uniform reporting requirements, specified in Sub-Regulatory Guidance, for Payers, Providers, and Provider Organizations to submit the following to the Center:

i. Contract Information. Information regarding which SQMS measures are included in contracts that incorporate quality measures into payment terms between Payers and Providers, including but not limited to:
1. SQMS measures used in contracts for financial incentives;
2. Incentive model type;
3. Number of contracts in which each SQMS measure is used; and
4. Attestations that Core Measures are used as required by 957 CMR 4.00 and Sub-Regulatory Guidance.

ii. Provider-Level and Provider Organization-Level SQMS Performance Information. Information regarding Provider and Provider Organization performance on SQMS quality measures incentivized in their contracts with Payers, including but not limited to, the scores that were calculated and used for contract payments for the specified measurement year.

iii. Other Information. Additional information as necessary to enable the Center to monitor performance on SQMS measures for each health care provider facility, medical group, or provider group in the Commonwealth.

4.04: Data Submission Procedures

(1) General. Payers, Providers, and Provider Organizations shall submit data and information to CHIA in accordance with the procedures, deadlines, and schedules provided in 957 CMR 4.00 or Sub-Regulatory Guidance from the Center. In the event a data submission deadline falls on a Saturday, Sunday, or Commonwealth holiday, the data shall be due on the business day immediately thereafter.

(2) Sub-Regulatory Guidance. CHIA will issue Sub-Regulatory Guidance to clarify its requirements, policies, and procedures under 957 CMR 4.00, including requirements for mandatory use of Core Measures, and to set forth the required technical information, such as: data file format, record specifications, data elements, definitions, code tables and edit specifications for data and information submitted pursuant to 957 CMR 4.00.

CHIA may also issue Sub-Regulatory Guidance to specify or amend data and information

required to be submitted; to specify or amend the procedures for submitting data and information; to specify or amend the timeframes for submitting data and information; and to specify or amend mandatory use of Core Measures.

(3) Amended Data Submissions. Payers, Providers, and Provider Organizations may amend data submissions, subject to the approval of CHIA, upon notice of the proposed amended data submissions, and the reasons for such changes. Amended data submissions shall be made in accordance with the procedures provided in Sub-Regulatory Guidance.

(4) Data Review, Verification, and Resubmission. If necessary, Payers, Providers, and Provider Organizations may be required to review, verify, or resubmit certain data and information previously submitted. CHIA will notify Payers, Providers, and Provider Organizations of when such data and information must be reviewed, verified, or resubmitted and will provide to applicable Payers, Providers, and Provider Organizations such health care data and information, or summary reports of such data and information, for review, verification, or resubmission.

(5) Additional Documentation. The Center may request that Payers, Providers, and Provider Organizations submit additional documentation related to reported data and information through Sub-Regulatory Guidance or by written request.

(6) Accuracy. The Payer, Provider, or Provider Organization (i) certifies that an authorized representative of the Payer, Provider, or Provider Organization submitted information and data to the Center, and (ii) attests that information and data submitted to the Center is true, correct, and complete.

(7) Mergers. Payers, Providers, and Provider Organizations must submit data for newly merged facilities in accordance with Sub-Regulatory Guidance. CHIA must approve organizational reporting structure changes prior to implementation. The Payer, Provider, or Provider Organization must notify CHIA in writing as to any organization ID change, for approval, prior to a data submission.

(8) Extension Requests. CHIA may grant, for good cause, an extension in time to Payers, Providers, and Provider Organizations to submit health care data and information.

(9) Notification to Health Policy Commission and Department of Public Health. The Center is required by M.G.L. c. 12C § 11 to notify the Health Policy Commission and the Department of Public Health if a Provider or Provider Organization has failed to timely report required data or information.

4.05: Penalties

The Center will provide written notice to Payers, Providers, and Provider Organizations that fail to comply with the reporting deadlines established in 957 CMR 4.00.

(1) The Center will notify Payers, Providers, and Provider Organizations 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, Providers, and Provider Organizations may be subject to a penalty of up to $25,000 per week for each week that they fail to provide the required data and information.

(2) Any remedy available under 957 CMR 4.00 is in addition to other sanctions and penalties that may apply under the provisions of other statutes and regulations.

(3) Payers, Providers, and Provider Organizations that fail to comply with the requirements of 957 CMR 4.00 will be subject to all penalties and remedies allowed by law and the Center will take all necessary steps to enforce 957 CMR 4.00, including a petition to the Superior Court for an order enforcing the same.

(4) Before assessing a penalty, the Center shall notify the Payer, Provider, or Provider Organization that has failed to comply with the requirements of 957 CMR 4.00 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 4.05(1).

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

4.06: Severability

The provisions of 957 CMR 4.00 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 4.00 or the application of such provisions.

REGULATORY AUTHORITY
957 CMR 4.00: M.G.L. c. 12C