957 CMR 8.00: ALL PAYER CLAIMS DATABASE (APCD) AND CASE MIX AND CHARGE DATA SUBMISSION

Section

8.01: General Provisions

(1) Scope and Purpose. 957 CMR 8.00 governs the reporting requirements for Payers and Hospitals to submit health care data and information to the Center for Health Information and Analysis pursuant to M.G.L. c. 12C in connection with the All Payer Claims Database (APCD) and the Acute Hospital Case Mix and Charge Data (Case Mix and Charge) Databases. The purpose of 957 CMR 8.00 is to specify:

(a) the Health Care Claims Data and Health Plan Information that Payers must submit;
(b) the Case Mix and Charge Data that Hospitals must submit;
(c) the procedures for submitting such health care data and information; and
(d) the time frame for submitting such health care data and information.

(2) Applicability. 957 CMR 8.00 applies to all Payers and Hospitals, as defined in Section 8.02.

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

8.02: Definitions

All defined terms in 957 CMR 8.00 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 8.00, unless the context requires otherwise, the following words shall have the following meanings:

Acute Hospital Case Mix Databases. The CHIA databases housing Case Mix Data and Charge Data, including, but not limited to, the outpatient Emergency Department database, the inpatient discharge database and the outpatient observation database.

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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.

APCD. The All Payer Claims Database.

APCD Data. Information submitted to CHIA by Payers, including, but not limited to, data regarding Member eligibility, products, benefit plans, providers, encounters, and medical, pharmacy, or dental claims.

Calendar Year. The 12-month period commencing January 1st and ending December 31st.

Case Mix. The description and categorization of a Hospital's patient population according to criteria approved by CHIA including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

Case Mix Data. Case specific, encounter type data, including provider details, patient details, such as admission, diagnostic discharge data that describes the demographic characteristics of the patient, the medical reason for the admission, procedural coding, treatment and services provided to the patient, and the duration and status of the patient's stay in the Hospital. Case Mix data includes, but is not limited to, Hospital inpatient discharge data, outpatient observation data, Emergency Department visit data, and behavioral health inpatient discharge data.

Charge Data. The full, undiscounted total and service-specific charges billed by a Hospital to the general public.

CHIA or Center. The Center for Health Information and Analysis.

CMS. The federal Centers for Medicare & Medicaid Services.

Data. APCD Data, Case Mix Data or Charge Data as defined in 957 CMR 8.02.

Data Submission Guide. A manual that specifies data submission requirements including, but not limited to, required fields, file layouts, file components, edit specifications, instructions and other technical specifications.

Emergency Department. The department of a Hospital, or health care facility off the premises of a Hospital that is listed on the license of the Hospital and qualifies as a Satellite Emergency Facility under 105 CMR 130.820 through 130.836, that provides emergency services as defined in 105 CMR 130.020: Satellite Unit. For purposes of 957 CMR 8.00, outpatient Emergency Departments include both the on-campus department of the Hospitals that provides emergency services and any satellite emergency facilities on the Hospital's license as defined in 105 CMR 130.820: Satellite Emergency Facility (SEF).

Emergency Department Visit. Any visit by a patient to an Emergency Department that results in registration at the Emergency Department but does not result in an outpatient observation stay nor the inpatient admission of the patient at the reporting facility. An Emergency Department visit occurs even if the only service provided to a registered patient is triage or screening.

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 other data submitted by health care Payers to CHIA.

Health Care Services. Supplies, care and services of a 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 Plan Information. Information submitted to CHIA by Payers, including, but not limited to, aggregate data on membership and financials by insurance products and plan design, administrative expenses, benefit levels, premiums, Member utilization and medical expenses, provider price variation and provider payment arrangements.

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.

Hospital Fiscal Year. The 12-month period during which a Hospital keeps its accounts and which ends in the calendar year by which it is identified. For Case Mix submissions this is October 1st through September 30th.

Integrated Care Organization (ICO). A comprehensive network of medical, behavioral-health care, and long-term services and support providers that integrates all components of care, either directly or through subcontracts, and has been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare and MassHealth covered services.

Managed Care Organization. A managed care organization, as defined in 42 CFR 438.2, and any eligible health insurance plan, as defined in M.G.L. c. 118H, § 1, that contracts with MassHealth or the Commonwealth Health Insurance Connector Authority; provided, however, that a managed care organization shall not include a senior care organization, as defined in M.G.L. c.118E, § 9D.

Medical Record Number. The unique number assigned to each patient within a Hospital that distinguishes the patient and the patient's Hospital record(s) from all others in that institution.

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

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 (including, but not limited to, 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.

Observation Services. Those services furnished on a Hospital's premises that are reasonable and necessary to further evaluate the patient's condition and provide treatment to determine the need for possible admission to the Hospital. These services include the use of a bed and periodic monitoring by a Hospital's physician, nursing and other staff. If the patient is admitted, Observation Services are reported as inpatient Observation Services and included in the inpatient discharge record. If the patient is not admitted, Observation Services are reported as outpatient Observation Services and included in the outpatient observation stay record.

Payer. A Private Health Care Payer and a Public Health Care Payer.

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

Private Health Care Payer. A private entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. A Private Health Care Payer includes 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, a health maintenance organization licensed under chapter 176G, an ICO, a SCO, and third-party administrators.

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; 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 Connector Care Health Insurance program, including prepaid health plans subject to the provisions of St. 1997, c. 47, § 28; the Group Insurance Commission established under M.G.L. c. 32A; and any city or town with a population of more than 60,000 that has adopted M.G.L. c. 32B.

Quarter. The three-month period including January 1st through March 31st; April 1st through June 30th; July 1st through September 30th; and October 1st through December 31st.

Self-funded Employee Plan. An employer-sponsored health benefit plan, where the employer is liable for the incurred costs of the Health Care Services for its employees and plan Members and the administrative service fees. A Self-funded Employee Plan shall not include a governmental plan as defined in Section 414(d), Internal Revenue Code or a non-electing church plan as described in Section 410(d), Internal Revenue Code.

Senior Care Organization (SCO). A comprehensive network of medical, health care and social service providers that integrates all components of care, either directly or through subcontracts. Senior Care Organizations are responsible for providing enrollees with the full continuum of Medicare and MassHealth covered services.

Sub-Regulatory Guidance. An Administrative Bulletin, notice, manual, guide, or other document, including the *Data Submission Guide*, that specifies deadlines, technical submission requirements, or contains methodological explanations and examples to facilitate understanding of and compliance with adopted regulations. Such guidance shall be made publicly available and shall carry the force of this regulation, provided that it does not impose additional substantive obligations beyond those set forth in this regulation.

Website. The website of the Center for Health Information and Analysis located at www.chiamass.gov.

8.03: Data Reporting Requirements

(1) Payer Reporting Requirements. Payers shall submit APCD Health Care Claims Data and Health Plan Information.

(a) APCD Health Care Claims and Associated Data. Payers shall provide data relating to Medical Claims, Pharmacy Claims, Dental Claims, Member Eligibility Files, Provider Files, Benefit Plan and Product Files. 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, including out-of-state residents of a Massachusetts-based employer or Massachusetts employment site, and out-of-state residents of a Massachusetts licensed health care Payer. Such data shall include but is not limited to fully-insured and self-funded accounts, to the extent allowable under federal law governing health care provided by employers to employees, and all commercial medical products for all individuals and all group sizes.

(b) CHIA will issue Sub-Regulatory Guidance to delineate the reporting structure and requirements for this data.

(c) A Self-funded Employee Plan or third-party administrator or carrier providing claims administration services to a Self-funded Employee Plan, shall not be required to submit data pursuant to Section 8.03; provided, however, that such data may be submitted on a voluntary basis in accordance with the Sub-Regulatory Guidance referenced in Section 8.03(1)(b).

(2) Hospital Reporting Requirements. Hospitals shall submit data on patient demographics, diagnoses and procedures, physicians, and charges for each inpatient discharge, outpatient observation stay, and Emergency Department visit. CHIA will issue Sub-Regulatory Guidance to delineate the reporting structure and requirements for this data.

(a) Inpatient Merged Case Mix and Charge Data. Hospitals shall submit inpatient Hospital merged case mix and charge data for all discharges. This data includes, but is not limited to, information about patient demographics, physicians, diagnoses, E-codes, procedures, admission type and source, patient status disposition, payment type and source, accommodation revenue center charges and days, and ancillary revenue center charges. If the patient is admitted after an Emergency Department Visit or outpatient observation stay, the record should be reported as an inpatient discharge with the appropriate ED and observation identifiers. Upon admission, Observation Services should be reported as inpatient Observation Services and included with the inpatient discharge record.

(b) Outpatient Observation Data. Hospitals shall submit Outpatient Observation Data for all observation stays. An outpatient observation stay is reported for each patient that receives Observation Services and is not admitted**.** An example of an outpatient observation stay might be a post-surgical day care patient that, after a normal recovery period, continues to require Hospital observation and is then released from the Hospital**.** The Outpatient Observation Data includes, but is not limited to, information about patient demographics, physicians, diagnoses, procedures, observation type and source, patient's

departure status, payment source and charges. If the patient received Observation Services but is not admitted following an Emergency Department visit, the visit should be reported as an outpatient observation stay with an appropriate ED identifier.

(c) Outpatient Emergency Department Visit Data. Hospitals shall submit Outpatient Emergency Department Visit data for all Emergency Department Visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility. This data includes, but is not limited to, information about patient demographics, physicians, diagnoses, services, visit source and disposition, payment source, charges, mode of transport, and E-codes.

8.04: Data Submission Procedures

(1) General. Payers and Hospitals shall submit data and information to CHIA in accordance with the procedures, deadlines, and schedules provided in 957 CMR 8.00 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 8.00 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 8.00.

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; and to specify or amend the timeframes for submitting data and information.

(3) Amended Data Submissions. Payers and Hospitals 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 and Verification. If necessary, Payers and Hospitals may be required to review, verify, or resubmit certain data and information previously submitted. CHIA will notify a Payer or Hospital of when such data and information must be reviewed, verified, or resubmitted and will provide to applicable Payers or Hospitals 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 and Hospitals submit additional documentation related to reported data and information through Sub-Regulatory Guidance or by written request

(6) Accuracy. Each Payer and Hospital (i) certifies that an authorized representative of the Payer or Hospital 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 and Hospitals must submit data for newly merged entities in accordance with Sub-Regulatory Guidance. CHIA must approve organizational reporting structure changes prior to implementation. Payers and Hospitals 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 and Hospitals, 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.

8.05: Penalties

CHIA will provide written notice to Payers and Hospitals that fail to comply with the reporting deadlines established in 957 CMR 8.00.

(1) CHIA will notify Payers and Hospitals 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 and Hospitals may be subject to a penalty of up to $25,000 per week for each week that they fail to provide the required health care data and information.

(2) Any remedy available under 957 CMR 8.05 is in addition to other sanctions and penalties that may apply under the provisions of other statutes and regulations.

(3) Payers and Hospitals that fail to comply with the requirements of 957 CMR 8.00 will be subject to all penalties and remedies allowed by law and CHIA will take all necessary steps to enforce 957 CMR 8.05 including a petition to the Superior Court for an order enforcing the same.

(4) Voluntary submitters pursuant to Section 8.03(1)(c) shall not be subject to penalties.

(5) Before assessing a penalty, the Center shall notify the Payer or Hospital that has failed to comply with the requirements of 957 CMR 8.00 that it has the right to request a hearing in accordance with M.G.L. c. 30A, § 10.

(6) 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 8.05.

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

8.06: Severability

The provisions of 957 CMR 8.00 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 8.00 or the application of such provisions.

REGULATORY AUTHORITY

957 CMR 8:00: M.G.L. c. 12C