

RULE CHAPTER 380
PROVIDER PROFILING DISCLOSURES

BASIS STATEMENT AND SUMMARY OF COMMENTS

Chapter 380 has been adopted pursuant to the Notice of Rulemaking published on August 28, 2015. A public hearing was convened on September 29, 2015 and the public comment period was held open until October 13, 2015. The initial development of this rule was also informed by an interested parties meeting at the Bureau of Insurance on April 4, 2014.

The Bureau received testimony at the public hearing from the following persons and organizations:

Jeff Austin testified at the hearing on behalf of the Maine Hospital Association
Kris Ossenfort testified at the hearing on behalf of Anthem.
Andrew MacLean testified on behalf of the Maine Medical Association

The Bureau received written comments from the following persons and organizations:

Dan Morin
Director of Government Affairs
MaineHealth

Jud Knox
Chief Executive Officer
York Hospital

Jeffrey Austin, on behalf of
The Maine Hospital Association

Kristine Ossenfort, Esq.
Director, Government Relations
Anthem BlueCross and BlueShield

The Bureau also received one comment about telecommunications from a member of the public who apparently misunderstood the subject matter of the proposed rule.

PUBLIC COMMENTS REGARDING THE RULE, IN GENERAL

Comment: York Hospital stated, in part:

The lack of access to the actual data attributed to York Hospital was problematic enough when we sought to challenge a payor's decision, the lack of transparency with respect to the actual data of other institutions that was used for the purpose of comparison interfered completely with York Hospital's ability to analyze or rebut the payor's conclusions in any meaningful way.

As I noted earlier, the reputational harm suffered by a hospital that is determined to be in a lower tier than another competing hospital can be substantial...Of primary concern to York Hospital is the fact that there seems to be no ability for a tiered provider to obtain the data of another provider to be able to analyze the comparison and rebut the comparison. Certainly, there are issues with sharing competitive pricing and cost, but the information could be shared in a manner that avoids those issues. It is important to understand the comparison and the provider to whom an institution [is] compared. For example, with respect to hospitals, depending on whether a hospital is part of the health system or is not, the price or cost of a particular service may not show up in the data in total as the price or cost of any particular service may be broken up and attributed to different entities.

Additionally, comparing groups of apparently the same services may be misleading. For example, at one hospital, oncology charges may include physician charges, infusion service charges and chemotherapy drug charges. At a second hospital, the apparently similar oncology charges might include only the infusion services share. Comparison of these service charges are grossly misleading. It is critical to examine the detail of such comparisons in order to reach valid conclusions.

Bureau Response: The Bureau understands and appreciates the issue York Hospital raised that requiring carriers to share comparative data from other providers would yield a more comprehensive picture. However, requiring carriers to share other providers' data for comparison would go well beyond the requirement specified in 24-A M.R.S.A. § 4303-A(3), which only requires a carrier to (emphasis added): "Provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program."

Comment: The Maine Hospital Association asserted that the Legislature's intended goal was to allow providers to reproduce the results of a provider profiling program from the information and data provided. Anthem disagreed with that assertion.

Bureau Response: The statute itself does not expressly address this issue. While some providers might want as much detail as possible, others might want to focus on the most significant information. The clarification process will allow providers to obtain additional information when the initial response is insufficient, and experience

implementing this process will allow an opportunity to develop best practices that are responsive to providers' expressed needs.

Comment: Andrew MacLean testified on behalf of the Maine Medical Association, stating in part:

Though we have a lot of large groups among individual practitioners today, we still, at the heart, are an association of individual members; so attribution is very much an issue for us. And as I recall -- when these programs were first initiated by Maine carriers, largely in specialty tiered networks, this was probably 10 years ago, the complaints we heard from members were largely about understanding the methodology, certainly, but then accuracy of data. And a lot of that really did have to do with attribution of patients to specific practitioners and, again, meaningful opportunity to provide feedback.

Bureau Response: We agree that attribution of patients to specific practitioners is an important issue, and the Rule will give practitioners the opportunity to correct misattributions.

PUBLIC COMMENTS ADDRESSING SPECIFIC SECTIONS OF THE PROPOSED RULE

Section 4, Subsection 4

Comment: The Maine Hospital Association asserted in its comments on Section 5(2) that the phrase "its data" is ambiguous, and stated:

Note: A similar issue exists with section 3(B)(1) and the definitions part, section 4(4). In a sense, this is the provider's "own data"; but we are concerned that there not be any confusion. By comparison, for quality metrics, the data used is sometimes the "provider's data" and not the carrier's in that the provider generated the data set.

Bureau Response: The phrase "its data" comes from the statute, 24-A M.R.S.A. § 4303(3), which provides that a provider may request a copy of "its data" within 30 days. The statute goes on to require that "a carrier shall provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program." The context and purpose make clear that "its data" does not mean only data that is generated or owned directly by the provider, but all the data attributed to the provider, regardless of whether the data came from the provider, from the carrier's records, or from an outside organization like the Maine Health Data Organization.

Section 5, Subsection 1

The proposed rule requires: At least 60 days before using or publicly disclosing the results of a provider profiling program, a carrier shall disclose to providers:

Comment: Jeff Austin testified at the public hearing on behalf of the Maine Hospital Association, stating in part:

The first level of disclosure is in Section 5... It says that carriers must disclose to all provider their methodology and criteria. The second sentence says that a carrier meets the goal of this rule if it, quote, describes the methodology.... But as you can imagine, there are different kinds of descriptions that may or may not satisfy this rule. There's a description that says we use data from commercial carriers related to surgery where we made some adjustments using 2015 data to come up with your profile. That's a description of the methodology. Or we used only our own carrier data from 2015 for neck and back surgery with exclusions for cases over \$100,000 in cases that were rare and performed in less than 10 percent of hospitals.... We want it to be a meaningful level of data so that our members understand how they were profiled, can explain it to their board members, can explain it to their staff, can explain it to their patients....

I have for you copies of a document...the so-called OnPoint Report from 2010 that describes in some detail the methodology that was used by OnPoint as a vendor to help come up with a profiling program. Certainly I don't think...that that does not meet the goal of the rule, neither do I think every carrier has to produce a 10-page report to describe their methodology. But this is the kind of level of detail which is, I would note, not sufficient to reproduce the numbers in the report, but it is a description of the methodology that would allow someone to describe that's going on to third parties.

The second level of disclosure in the rule...is the data section.... To varying degrees, we've been given descriptions before. We've been given one-page descriptions and we've been given 10-page descriptions of the methodology and criteria that are out there. What we haven't received is the data that would allow us to apply that methodology to the data set to come up with a score...

...Our concern here is the same concern with Subsection 1, and that is will the spirit of the rule be met. If you turn to page... 10 of the... On-Point Report, I'll try to illustrate our concerns. If you look at the second table on Page 10, it lists some of the hospitals and an explanation or a representation of the math that's behind the profiling. If you look at York Hospital...it says that they were judged on 29,726 visits. I think that means claims. We were told by York that they had approximately 40,000 claims that year. So the issue for the hospital is can we figure out...how the carrier arrived at those 29,000 claims....

...So...if a carrier were to say in response to a request from York Hospital, here is all 40,000 of your claims and here is the On-Point Report, would that be satisfactory to the Bureau in meeting the obligations under this rule? Our concern is it might satisfy the rule, but it doesn't satisfy what we're trying to get at, which is the ability to reproduce the number that's in that table, \$1,107 in York's case. It's a manufactured number. Can they reproduce it and check it for errors or mistakes? Can they understand it?

The Maine Hospital Association written comments also expressed concern about requiring carriers to provide a meaningful level of clarity or detail, and they also provided an example of a report that would meet the MHA's expected level of clarity and detail.

Bureau Response: We believe the rule, in its current form, will allow providers to access the data they need to assess the accuracy and fairness of the carrier's provider profiling program. If the carrier's initial response is unclear, the MHA described specific questions the provider could ask in order to obtain a more meaningful response. The rule cannot anticipate in advance every specific question that might arise, and all parties will be expected to implement the process in good faith and to learn from experience.

Comment: The Maine Hospital Association suggested making the lead-times 90 days before usage, not 60.

Bureau Response: Title 24-A M.R.S.A. § 4303-A(1) provides for disclosure to providers "at least 60 days" prior to using or publicly disclosing the results of a provider profiling program." The Bureau does not interpret the words "at least 60 days" to provide rulemaking authority to increase the mandatory lead-time to 90 days. However, carriers that choose to do so are not prohibited from increasing the lead times.

Comment on Section 5(1)(A)(1): Anthem stated:

Subparagraph 5(1)(A)(1) provides that a carrier satisfies the requirements of the subparagraph "by describing the data used in the evaluation, the source of the data, the time period subject to evaluation, and, if applicable, the types of claims used in the evaluation, including any adjustments to the data and exclusions from the data." We believe this is consistent with the provisions of the statute.

Comment on Section 5(1)(A)(2): Anthem stated:

Section 5(1)(A)(2) of the proposed rule provides that a carrier shall disclose to providers "[a]ll ratings and other profiling information specific to the provider **that will be posted on the Internet or otherwise disclosed to plan enrollees or prospective enrollees.** The language in **bold italics** differs from that of the statute, which applies to the use or "public" disclosure of a provider profiling program. However, the statute is silent on what constitutes "public disclosure," so some clarification might be useful. For example, if a member has to log in to a website

in order to access provider profiling information that is not available to the general public, that may constitute “uses” of a profiling program, it does not constitute public disclosure.”

Anthem also testified at the public hearing, stating in part:

It says all ratings and other profiling information specific to the provider that will be posted on the internet or otherwise disclosed to plan enrollees or prospective enrollees. We did note that that is slightly different than what is envisioned in the statute. And just for consistency sake, you may want to make sure that they are parallel to that. The statute requires public disclosure, and that’s really not clear as to what is intended by public disclosure. To me that would be where the general public can go and obtain information; but I would note that in a lot of our cost comparison tools, the member has to log in so that information isn’t publically available to the general public but is only available to our members. So some clarification about what constitutes public disclosure might be helpful.

Bureau Response: The provision that Internet posting is considered public disclosure, even if access is limited to plan enrollees, is adopted as proposed. The Bureau believes this is a clarification of the legislative intent. Disclosure to tens of thousands of enrollees or prospective enrollees is, for all practical purposes, disclosure to the carrier’s “public.”

Comment on Section 5(1)(B): Anthem stated:

Section 5(1)(B) of the proposed rule currently reads:

B. To whom disclosure is made. The carrier shall provide the disclosures required by this Rule to each facility, practice group, or individual practitioner identified by the carrier in the provider profiling program.

We would suggest adding the word “specifically” (so that the sentence would read each facility, practice group, or individual practitioner specifically identified by the carrier” to avoid confusion or unintentional application. For example, if the profile applies to the practice as a whole, and not individual practitioners, disclosure to those individual practitioners should not be required.

Anthem also testified at the public hearing, stating in part:

We would suggest adding the word “specifically” to avoid confusion because sometimes these ratings apply to practice groups but not individual practitioners within the group. So if you have ABC Medical Group and the profiling appears to the group as a whole and not Dr. Smith or Dr. Jones within the practice, it would seem burdensome to provide individual disclosures for each doctor when the rating is based on sort of the aggregated or the practice basis. So we would suggest something like saying this practitioner is specifically identified. And the

same concern applies with respect to newly added providers. If the ranking or tiering is—profiling is based on the practice as a whole, then the addition of a new provider shouldn't trigger, unless somehow it changes the result or the status of the profiling.

Bureau Response: As suggested, Section 5(1)(B) has been amended to read:

B. To whom disclosure is made. The carrier shall provide the disclosures required by this rule to each facility, practice group, or individual practitioner specifically identified by the carrier in the provider profiling program.

Comment on Section 5(1)(C): Anthem stated:

Similar to the previous comment, the disclosure requirement for newly added providers contained in section 5(1)(C) should only apply when the individual provider is profiled, not when the provider joins a practice that has an existing profile.

Bureau Response: As suggested, Section 5(1)(C) has been amended to provide:

C. Newly added providers. The initial disclosure required by this Subsection shall also be made to any provider that is added to an existing profiling program, at least 60 days before the carrier uses or publicly discloses the new provider's profiling results. The requirement to provide disclosure to newly added providers only applies when the individual provider is profiled, not when the provider joins a practice that has an existing profile.

Comment on Section 5(1)(D): Anthem stated:

Section 5(1)(D) refers to "all affected providers"; however, it is not clear what is meant by an "affected" provider. But as noted above, it should not apply to an individual provider who is part of a practice or facility that has been profiled as a whole.

Bureau Response: Section 5(1)(B) provides for disclosure to be made to "each facility, practice group, or individual practitioner identified by the carrier in the provider profiling program." With the addition of clarifying language in Section 5(1)(C) regarding initial disclosure to newly added providers, we believe the rule is clear that the requirement to provide supplemental disclosures applies to the facility as a whole or the practice group as a whole, and only applies to an individual practitioner when that practitioner is individually profiled.

Section 5, Subsection 2

Comment: The Maine Hospital Association commented, in part:

“The proposed rule says that a provider may request a copy of “its data” that was used in the profiling program...we would suggest that you not use the phrase “provider data.” The data typically used in cost profiling is “commercial claims data” or “carrier data.” That is, data sets created by the carriers that was submitted to a third-party like MHDO by the carriers or carrier agents.

Carriers don’t generally possess what is understood to mean “provider data” or “clinical data.” That is data that the providers generate and submit to various third-parties. While the current draft is clear enough, if you know that background and context of the rule. Nevertheless, you may consider whether a clarification is worthwhile.

We would suggest that the regulation read: “A provider may request a copy of ~~its~~ the data that was used to profile the provider within 30 days after receiving the carriers...”

The source of the data then becomes irrelevant.

Our primary issue here is similar to the one we raised in the first section: to what extent will the data actually be provided?

Each time a hospital provides a distinct service to an individual covered by commercial insurance there is a corresponding “claim.” Each year every one of those claims is provided to the Maine Health Data Organization (MHDO). MHDO sells to interested parties data sets including all of these claims. The MHDO data set is what was used by Onpoint, in its report.

Now, other data sets exist; whatever data is used should be available to those who are profiled by it. At least, each hospital should see its own claims data (but not that of competitors).

For example, York Hospital indicated to us that they had approximately 40,000 commercial claims for 2010. If you turn to page 10 of the Onpoint Report, you will see York Hospital listed second in the lower table. For York Hospital, Onpoint used 29,726 claims to calculate its ranking number.

So, in response to a hypothetical data request pursuant to Section 5(2) of the proposed rule, does the Bureau believe the request is satisfied if York is provided all 40,000 claims and a copy of the Onpoint Report?

We do not. No provider would have enough information such that they could screen the universe of 40,000 claims down to the actual 29,726 used. We need the key.

Now, please look at page 5 of the report. You will see a few times where Onpoint indicates they took the raw claims data and made an analysis, computation, exclusion or other such adjustment. It is these adjustments and the underlying claims data that we would like access to before these rankings are uses.

Bureau Response: As explained in the response to the comment on Section 4(4), the statutory phrase “its data,” in this context, includes all the profiling data associated with requesting provider, regardless of whether the data came from the provider, from the carrier’s records, or from an outside organization like the Maine Health Data Organization.

Section 5, Subsection 2(B)

Comment: York Hospital commented that:

With respect to the proposed Section 5, Paragraph 2(B), which permits a payor to object to a request for data, York Hospital opposes any ability for an objection to a request for data. There can be no legitimate reason for not providing a provider with the actual data that was used to tier or rank that provider. Further, the right to object in the proposed rules provides for no method of resolving such an objection.

Bureau Response: When all parties are acting in good faith, objections will be rare, but it is important for all parties to have due process rights. The Rule contains deadlines and other provisions to prevent carriers from raising objections lightly or for purposes of delay.

Section 5, Subsection 3

Comment: Anthem stated:

The request for clarification referred to in subsection 3 seems to be duplicative of the appeal process envisioned by 4303-A(4), which provides:

A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile pursuant to subsection 2. The appeal process must:

A. Afford the provider the opportunity to correct material errors, submit additional information for consideration and seek review of data and performance ratings;

B. Afford the provider the opportunity to review any information or evaluation prepared by a 3rd party and used by the carrier as part of its provider profiling program; however, if the 3rd party provides the right to review and correct that data, any appeal pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by a 3rd party; and

C. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data error.

The proposed section 5(3) establishes a “request for clarification” process that is essentially duplicative of the appeal process required by 4303-A(4) and Section 6 of the proposed rule.

Comment: Anthem also stated:

As discussed above, we believe Section 5(3) is duplicative of Section 6. Since Section 6 is consistent with the requirements of the statute, we believe Section 5(3) should be excluded from the final rule.

Comment: The Maine Hospital Association responded to Anthem’s testimony at the public hearing, stating in part: *“Anthem argued that Section 5(3), the clarification provision, was redundant to the appeal provision in Section 6. That is not our reading of the rule. In essence, you can’t appeal what you don’t know. The clarification provision in Section 5(3) is intended to further flesh-out the issues in an effort to avoid appeals. We strongly support identifying the kinds of information that can be accessed upon clarification.*

Bureau Response: We do not view the request for clarification as duplicative of the appeals process, but rather as an important part of a roadmap for carriers and providers to be reasonable and work together in good faith to resolve any issues that may arise. It is not unique in a rule for a right to request an appeal to be preceded by a right to request a clarification or reconsideration prior to appeal. Consistent with the intent of the proposed rule and the comment of the Maine Hospital Association we believe that in practice the requirements of Section 5(3) will help resolve those issues that can be resolved and substantially narrow the issues that need to be reviewed on appeal. At the same time we recognize the need to make sure the request for clarification and appeal requirements do not result in wasteful duplication of effort and unnecessary delays. Therefore, we have provided the following clarification at Section 6, Subsection 4.

[4. In order to avoid unnecessary duplication of effort, the process established by the carrier to afford the provider an opportunity to review and dispute its provider](#)

profiling result may incorporate the requirements of Section 5, Subsections 3 and 4, except that the carrier must allow for a separate appeal of its response to the provider's request for clarification and correction under Section 5, Subsections 3 and 4.

Comment: The Maine Hospital Association stated, in part:

A minor point is whether you need deadlines here as you've established in other sections of the rule. We believe a 30 day deadline to provide the data absent an objection is appropriate but we're open to alternatives.

Proposed section 5(3)(A) is good in that it states that providers must be given an opportunity to correct erroneous data....

Bureau Response: Requests for correction under Section 5(3) are subject to the 30-day deadline established in Section 5(4). If there are any matters that fall outside the deadlines already established within the Rule, there is no need to impose additional deadlines as long as the carrier is required to comply with the disclosure requirements of this rule before making the provider's profile public.

Section 5, Subsection 3(B)(1)

Comment: The Maine Hospital Association stated, in part:

...An example of an item that gives us pause is Section 5(3)(B)(1) which says that carriers should give to providers a copy of the provider's own data. We believe Section 5(2)(A) does that already. Is Section 5(3)(B)(1) envisioning a case where a provider has received the methodology description under 5(1) but not made a request for data under 5(2)?

Bureau Response: As the MHA observes, the provider will often already have this information in response to an initial disclosure under Section 5(1) or a supplemental request under Section 5(2).

Section 5, Subsection 3(B)(3)

Comment: The Maine Hospital Association stated in its written comments:

Finally, Section 5(3)(B)(3) is great but we're wondering if that isn't what is required under 5(2)(A) already as part of the data disclosure. We believe this is the kind of information that must accompany any data request under 5(2)(B) to make those data requests useful.

Previously, at the hearing, MHA had testified:

If you look at 3(B)1, the first clarification that a provider could seek is its own data. I thought that was already available under Subsection 2. So I guess the question is, can you get to Subsection 3 a request for clarification without going through Subsection 2, which is the request for data. If so, this structure makes sense to me. You don't have to ask for Subsection 2, additional data, to get into Subsection 3, which is your clarification section. That would make sense to me as to why you would have a 3(B)1, a data set.

Bureau Response: MHA's analysis at the hearing accurately describes the structure of the Rule. These processes are not mutually exclusive, and neither is a precondition before a provider can exercise its rights to the other remedy.

Comment: Anthem stated:

We have several concerns with respect to the proposed Section 5(3)(B)(3), including that:

- It goes well beyond the requirements of the statute, which requires disclosure of the methodologies, criteria, data and analysis used in a provider profiling program.*
- The elements required in the proposed paragraph 3(B)(3) proposes to take aspects of a voluntary certification program offered by NCQA and make it mandatory. We would also note that plans receiving NCQA certification are not required to meet all of the elements – only 5 out of 9 are required in order to receive points for that element.*
- It will be extremely burdensome, and has the potential to enable providers to delay or derail the implementation of a provider profiling program, particularly when layered on top of a separate appeals process. Providers can request this information for any reason, or no reason at all.*

Bureau Response: The voluntary nature of the NCQA guidelines is not a sufficient basis to object to the incorporation of some of the NCQA standards into the Rule. This is the first time that profiling disclosure has been mandatory in Maine, so any standards currently in use within the industry will, by their nature, be voluntary until the Rule is adopted. This rule does not require carriers to use all of the enumerated items (a-h) listed in Section 5(3)(B)(3). It only provides examples of the types of information that must be disclosed “to the extent applicable.” If any of these items of information are requested, and are not applicable, the carrier can simply explain why they are not applicable.

Comment: York Hospital stated:

Section 5, Paragraph 3(B)(3), which...provides for a “detailed description of the documented process and methodology used in comparing the provider’s data” only “to the extent applicable.” York Hospital asserts that the words “to the extent applicable” should be removed. If a provider seeks a “detailed description”, the provider should receive it and there should be no basis for a payor to object or claim that the detailed description is not “applicable.”

Bureau Response: Subsection 3(B)(3) is not designed or intended to require carriers to use all of the enumerated items (a-f) in their provider profiling program analysis. They are only illustrative of the types of information that must be disclosed “if applicable.” The requirement to disclose information about any of these items is only “applicable” if it is actually used.

Section 5, Subsection 4

Comment: Anthem stated:

Section 5(4) proposes to require carriers to respond to requests for correction within 30 days. However, we would note that the statute does not establish a time frame for response.

Bureau Response: In response to Anthem’s comment we considered whether the 30-day time limit to respond is necessary to the implementation of the statute. On the one hand the requirement to respond to requests for corrections within 30 days is arguably unnecessary because the rule prohibits the carrier from making the provider profile public until the carrier has responded to the request for correction. However, we think it is important that the carrier provide a timely response and not just ignore the request, even if the provider’s profile is withdrawn or is not made public until a later date. Therefore, we have left this requirement as proposed.

Section 6

Comment: Anthem stated:

As discussed above, we believe Section 5(3) is duplicative of Section 6. Since Section 6 is consistent with the requirements of the statute, we believe Section 5(3) should be excluded from the final rule.

Comment: The Maine Hospital Association responded to Anthem’s testimony at the public hearing, stating in part:

Anthem argued that Section 5(3), the clarification provision, was redundant to the appeal provision in Section 6. That is not our reading of the rule. In essence, you

can't appeal what you don't know. The clarification provision in Section 5(3) is intended to further flesh-out the issues in an effort to avoid appeals. We strongly support identifying the kinds of information that can be accessed upon clarification.

Bureau Response: We do not view the request for clarification as duplicative of the appeals process, but rather as an important part of a roadmap for carriers and providers to be reasonable and work together in good faith to resolve any issues that may arise. It is not unique in a rule for a right to request an appeal to be preceded by a right to request a clarification or even a reconsideration prior to appeal. Consistent with the intent of the proposed rule and the comment of the Maine Hospital Association we believe that in practice the requirements of Section 5(3) will help resolve those issues that can be resolved and substantially narrow the issues that need to be reviewed on appeal. The Bureau also strongly believes that it is important to providers to have an actual decision from the carrier in order to have a clear understanding of what the provider needs to appeal. At the same time we also recognize the need to make sure the request for clarification and appeal requirements does not result in wasteful duplication of effort and unnecessary delays. Therefore, we have provided the following clarification at Section 6, Paragraph 4.

4. In order to avoid unnecessary duplication of effort, the appeal process established by the carrier to afford the provider an opportunity to review and dispute its provider profiling result may incorporate the requirements of Section 5, Subsections 3 and 4, except that the carrier must allow for a separate appeal of its response to the provider's request for clarification and correction under Section 5, Subsections 3 and 4.

Section 6, Appeals

Comment: Maine Hospital Association stated:

The Section 6 appeal period is “within 30 days after being provided with its provider profile.” We believe the rule needs clarification the provider profile has been provided only after additional information or clarifications pursuant to Section 5(2) or 5(3) has been provided or the deadlines associated with 5(2) and (3) have passed.

Again, the appeal can only occur if you have a basis to appeal. The descriptive information required under Section 5(1) will never be subject to appeal because it does not afford providers any opportunity to truly understand the profile. It is only after the data is provided understood that errors of math can be identified.

Bureau Response: Title 24-A M.R.S.A. § 4303(4), Appeals, provides: “A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile

pursuant to subsection 2.” We agree that that there is a need to clarify when the 30-day timeframe for appeal begins. In response to comments, the Bureau has considered three possible avenues for addressing the timing issues inherent in the 30-day time frame.

One alternative is the Maine Hospital Association’s suggestion that the 30 days runs from the time the carrier has provided the additional information or clarifications required by Section 5(2) and 5(3). However, this approach is not the common interpretation of the phrase of “provider profile.” Furthermore, it might not provide the carrier with notice of which providers will be appealing the provider profiling program until well beyond 30 days after the provider profiling program has been shared with affected providers, and could unnecessarily delay the implementation of the provider profiling programs.

A second approach would be to deem a request for information to be an initiation of the appeal process, unless the provider has notified the carrier that it only wants to obtain additional information and does not want to appeal its rating.

We think the best alternative is to simply clarify that the statutory language controls, and therefore confirm that the provider has 30 days to review the initial disclosure and notify the carrier if the provider intends to dispute or appeal its provider profile. For providers who do intend to dispute or appeal their profile, the requirements of Section 5, Subsections 2 through 4, will permit providers who do intend to dispute or appeal an opportunity to properly prepare and frame the appeal.

Therefore we have added the following language as Section 5, Subsection 5.

5. Notice of Right to Dispute or Appeal. The disclosure required in Subsection 1 must include prominent notice to the provider of any time limits for notifying the carrier that the provider intends to review, dispute, or appeal the provider profile. The time limit shall not be less than 30 days. The requirements of Subsections 2 through 4 may be incorporated into any appeal process established by the carrier in compliance with the appeal requirements of 24-A M.R.S.A. § 4303-A(4), except that the carrier must allow for a separate appeal of its response to the provider’s request for clarification and correction under Subsections 3 and 4.

Section 6, Appeals, Subsection 2, copied below as proposed:

2. Afford the provider the opportunity to review any information or evaluation prepared by a third party and used by the carrier as part of its provider profiling program; however, if the third party provides a right to review and correct that data, any appeal from the carrier’s determination pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by the third party; and

Comment: MaineHealth commented that:

“Our contention is that the carrier should have in place, measures and guidelines to ensure the accuracy of third party sponsored profiling data. While the provider is afforded the opportunity to review any third party information or evaluation under the draft rule, there should be explicit direction that a carrier shall not be completely divorced from investigating the accuracy, validity or reliability of third party profiling data. Without appropriate safeguards in place, a carrier could simply claim during an appeals process that the information used and provided is consistent with third party submissions, thereby removing them from responsibility of accuracy.

Bureau Response: This subsection is copied verbatim from 24-A M.R.S.A. § 4303-A(4)(B). The purpose of this section is to avoid duplicative and conflicting remedies. If a carrier uses a third-party contractor that is error-prone and requires frequent correction, that does raise regulatory issues that are appropriate to bring to the Superintendent’s attention, but those issues are separate from the scope of this Rule as long as a correction process is available.

Minor grammatical and syntax changes to the rule have also been made upon advice of counsel.