

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 380: PROVIDER PROFILING DISCLOSURES

Table of Contents

Section 1.	Authority
Section 2.	Purpose
Section 3.	Scope
Section 4.	Definitions
Section 5.	Disclosure of Provider Profiling Data
Section 6.	Appeals
Section 7.	Severability
Section 8.	Effective Date

SECTION 1: AUTHORITY

This Rule is adopted by the Superintendent pursuant to 24-A M.R.S.A. §§ 212 and 4303-A.

SECTION 2: PURPOSE

The purpose of this Rule is to establish requirements for the disclosure of data by a carrier to a provider as required by 24-A M.R.S.A. § 4303-A.

SECTION 3: SCOPE

This Rule applies to all carriers offering health plans in this State.

SECTION 4: DEFINITIONS

Terms defined in 24-A M.R.S.A. § 4301-A have the same meanings when used in this Rule. At the time of adoption of this Rule, the following terms have the following statutory definitions:

1. “Carrier” means:
 - A. An insurance company licensed in accordance with the Maine Insurance Code (Title 24-A M.R.S.A.) to provide health insurance;
 - B. A health maintenance organization licensed pursuant to chapter 56 of the Insurance Code;
 - C. A preferred provider arrangement administrator registered pursuant to chapter 32 of the Insurance Code;
 - D. A fraternal benefit society, as defined by 24-A M.R.S.A. § 4101;
 - E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24 M.R.S.A.;
 - F. A multiple-employer welfare arrangement licensed pursuant to chapter 81 of the Insurance Code;
 - G. A self-insured employer subject to state regulation as described in 24-A M.R.S.A. § 2848-A; or
 - H. Notwithstanding any other provision of the Insurance Code, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.
2. “Health plan” means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care, or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this Rule.
3. “Provider” means a practitioner or facility licensed, accredited, or certified to perform specified health care services consistent with state law.

4. “Provider profiling program” means a program that uses provider data in order to rate or rank provider quality, cost, or efficiency of care by the use of a grade, star, tier, rating, or any other form of designation that provides an enrollee with an incentive to use a designated provider based on quality, cost, or efficiency of care.

SECTION 5: DISCLOSURE OF PROVIDER PROFILING DATA

1. Initial Disclosure.
 - A. Required disclosure. At least 60 days before using or publicly disclosing the results of a provider profiling program, a carrier shall disclose to providers:
 - (1) The methodologies, criteria, data, and analysis the carrier uses to evaluate provider quality, performance, and cost, including but not limited to unit cost, price, and cost-efficiency ratings. A carrier satisfies the requirements of this 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;
 - (2) All ratings and other profiling information specific to a provider that will be posted on the Internet or otherwise disclosed to plan enrollees or prospective enrollees.
 - 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.
 - 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.
 - D. Supplemental disclosures of changes. A supplemental disclosure of all material changes to the initial disclosure shall be made:

- (1) To all affected providers, at least 60 days before the implementation of any changes to the methodologies and criteria disclosed pursuant to Paragraph A; and
 - (2) To any provider whose publicly disclosed profiling results are changed, at least 60 days before the changes are disclosed to the public.
2. Additional Disclosure Upon Request.
 - A. Request for data. A provider may request a copy of its data within 30 days after receiving the carrier's initial or supplemental disclosure under Subsection 1. The provider's request must be sent to the carrier in writing, either electronically or by mail. The carrier shall provide 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.
 - B. Acknowledgment. Within 10 days after receipt of a provider's request for additional information, the carrier shall acknowledge the request and explain any objection to the request. Objections to the request must be in writing.
3. Requests for clarification. The provider may make reasonable requests for clarification and correction. If so requested, the carrier must:
 - A. Give the provider an opportunity to clarify or correct erroneous data or analysis.
 - B. Respond with a disclosure of additional information including:
 - (1) The provider's own data relied upon to establish the provider's profile;
 - (2) A description of the standards or baselines against which the provider's data is being compared in connection with the provider profiling program; and
 - (3) To the extent applicable, a detailed description of the documented process and methodology used in comparing the provider's data, including but not limited to:
 - (a) The providers measured, including specialties and geographic areas;

- (b) The criteria for inclusion and exclusion in any element of a formula used in calculating each performance measure;
- (c) The attribution of patients to providers;
- (d) For quality: the minimum number of observations for each measure for assessment of physicians, practices, or medical groups;
- (e) The consideration of measurement error in recording actual performance differences among providers;
- (f) The peer groups used for comparison;
- (g) The consideration of risk adjustments to make comparisons, including differences in the health of patient populations;
- (h) For cost, resource use, or utilization: The measurement and treatment of data outliers with respect to quality, cost, or cost efficiency.

Drafting Note: Subparagraph 3 was derived from NCQA 2103 Physician Hospital Quality (PHQ) Standards and Guidelines, Element C “Define methodology,” at page 46-47.

- 4. Responses to requests. Carriers must respond to requests for correction within 30 days. Responses to requests denied in whole or in part must include at a minimum:
 - A. Documentation of the basis for the carrier’s conclusions;
 - B. The specific reasons for the carrier’s decision;
 - C. Notice of any appeal right available to the provider; and
 - D. A description of the carrier’s ongoing process by which additional information or data can be provided in response to requests for corrections or changes.
- 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

Pursuant to 24-A M.R.S.A. §§ 4303-A(1) and 4303-A(4), a carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days after being provided with its provider profile. The appeal process must:

1. Afford the provider the opportunity to correct material errors, submit additional information for consideration, and seek review of data and performance ratings;
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
3. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data errors.
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 7: SEVERABILITY

If any section, term, or provision of this Rule shall be deemed invalid for any reason, any remaining section, provision, or definition shall remain in full force and effect.

SECTION 8: EFFECTIVE DATE

This Rule is effective March 12, 2016.