



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

March 7, 2016

**RE: Filing Requirements pursuant to §38a-478c, C.G.S.**

Dear Managed Care Contact Person:

Section 38a-478c of the Connecticut General Statutes requires all managed care organizations to file certain information annually with the Insurance Department. Reporting specifications are outlined in this letter to ensure uniformity.

The information requested in this letter is with respect to activities conducted under all managed care plans issued in Connecticut by a managed care organization and shall include the activities conducted with respect to any out of network benefits that are provided. **All information requested in this letter, with the exception of the 2016 Consumer Report Card Survey, Part 2, Mental & Nervous Addendum, Claim Denial Data, and HEDIS data must be received by the Insurance Department on or before May 2, 2016. The response to the 2016 Consumer Report Card Survey – Part 2, M & N Addendum, Claim Denial Data, and HEDIS data must be received by the Insurance Department on or before July 1, 2016.**

**§38a-478b, C.G.S. requires a late fee of one hundred dollars per day for each day from the due date of all filing requirements.**

**Responses of “Not Available” are not acceptable, and will be considered an incomplete response. A late filing fees will be imposed in accordance with the statute until such time as a complete response is received in the Insurance Department.**

A “managed care organization” as defined in §38a-478 means “an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing or amending any individual or group health managed care plan in this state.”

A “managed care plan” means “a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through (A) arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risk with providers, provided the organization offering a plan described in (A), (B), (C) or (D) above is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 of the general statutes and that the plan includes utilization review as defined in §38a-591a.”

[www.ct.gov/cid](http://www.ct.gov/cid)

P.O. Box 816 Hartford, CT 06142-0816

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## **A. 2016 CONSUMER REPORT CARD SURVEY – PART 1 and PART 2**

All managed care organizations must complete both parts of the enclosed consumer report card survey. All submitted data should be for the period January 1, 2015 through December 31, 2015, unless otherwise noted. All information must be certified as accurate by an **officer of the managed care company**. The information requested in the “2016 Consumer Report Card Survey – Part 1” must be received by the Insurance Department on or before May 2, 2016. The information requested in the “2016 Consumer Report Card Survey – Part 2” must be received by the Insurance Department on or before July 1, 2016. **Please read the surveys and questions carefully, as there have been significant changes from the previous editions.**

## **B. FINANCIAL ARRANGEMENT**

A written statement of the types of financial arrangements between the managed care organization and hospitals, utilization review companies, physicians, pharmacies and any other health care provider(s) must be filed.

## **C. MEDICAL PROTOCOLS**

Managed care organizations must obtain input from physicians actively practicing in the state in the relevant specialty prior to substantially or materially altering existing medical protocols. **An officer of the managed care organization must file a certify compliance. (questions added to Part 1)**

## **D. PROVIDER CONTRACTS**

Model provider contracts between the managed care organization and hospitals, physicians, pharmacies and any other health care provider(s) must be filed. The model contract must contain the provision(s) currently in force in contracts between the managed care organization and participating providers in the State of Connecticut. Upon request, a copy of any individual contract must be filed, but proprietary fee schedule information may be withheld or redacted. Please note any substantive changes from the contract(s) filed with the Department in 2015.

## **E. QUALITY ASSURANCE PLANS**

1. A report on the managed care organization’s quality assurance plan is required to be filed. All data in the report must be as of December 31, 2015, and must pertain to fully insured Connecticut managed care business only. The report must include, but not be limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage, and on utilization review statistics.

A “complaint” is defined as a written or verbal expression of dissatisfaction with a provider or the manner in which services have been provided or not provided, for fully insured managed care plans only.

2. All data required by the National Committee for Quality Assurance (NCQA) for the Healthcare Effectiveness Data and Information Set (HEDIS). For managed care organizations that do not submit information to the NCQA, the completed 2016 Consumer Report Card Survey – Part 2 will be deemed equivalent data.

3. In lieu of submitting the report on the quality assurance plan as outlined above, a managed care organization may submit proof of NCQA accreditation and the required HEDIS data.

#### **F. COMPLAINT SUMMARY**

A summary of complaints received related to providers and delivery of care or services and actions taken on the complaint must be filed. **Also, provide the ratio of the number of complaints received to the number of total enrollees reported in Part 1 of the survey.**

***Individual insured information should be masked as all submitted information is accessible to the public.***

A complaint is defined as a written or verbal expression of dissatisfaction with a provider or the manner in which services have been provided or not provided. The summary submitted shall contain only complaint information that is **specific to the submitting managed care organization.**

#### **G. CREDENTIALING PROCEDURES**

A summary of the procedures used by the managed care organization to credential providers.

#### **H. NETWORK ADEQUACY CERTIFICATION**

Please return the required data to the Connecticut Insurance Department, Life & Health Division, at the following address:

Mailing Address: P.O. Box 816  
Hartford, CT 06142-0816

Office Address: 153 Market Street, 7th Floor  
Hartford, CT 06103

**The office address must be used for all express or special delivery mail or for hand delivery of any documents. (Not for regular mailing)**

**All questions regarding the reporting requirements must be in writing and may be faxed or e-mailed.**

Sincerely,

*Marjorie Breen*

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Life & Health Division  
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