



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Instructions for Consumer Report Card Survey Reporting

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

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 to ensure uniformity.

The information requested 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, with the exception of the Consumer Report Card Survey, Part 2 Data, and HEDIS data must be received by the Insurance Department on or before May 1, each year. The response to the Consumer Report Card Survey – Part 2 data and HEDIS data must be received by the Insurance Department on or before July 1, each year.**

All information including the surveys and all backup must be submitted electronically to LHCompliance@ct.gov email

Please note that Part 1 of the Consumer Report Card Survey contains 3 tabs to be completed within the workbook. Part 2 of the Consumer Report Card Survey contains 5 tabs to be completed within the workbook.

§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.”

CONSUMER REPORT CARD SURVEY – PART 1 and PART 2

www.ct.gov/cid

**P.O. Box 816 Hartford, CT 06142-0816
An Equal Opportunity Employer**

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, through December 31, of the prior year, unless otherwise noted. All information must be certified as accurate by an **officer of the managed care company**. The information requested in the “Consumer Report Card Survey – Part 1” must be received by the Insurance Department on or before May 1, each year. The information requested in the “Consumer Report Card Survey – Part 2” must be received by the Insurance Department on or before July 1, each year.

All information including the surveys and all backup must be submitted electronically to LHCompliance@ct.gov email. Please note that Part 1 of the Consumer Report Card Survey contains 3 tabs to be completed within the workbook. Part 2 of the Consumer Report Card Survey contains 5 tabs to be completed within the workbook.

A. 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.

B. MEDICAL PROTOCOLS

No longer a separate item as Survey includes questions.

C. 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 the prior year. (changes to comply with the network adequacy surveys)

D. 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, of the prior year, 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 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.

E. 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 MUST 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.**

F. CREDENTIALING PROCEDURES

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

G. NETWORK ADEQUACY CERTIFICATION – no longer required as a separate survey must be submitted for each network

H. Provider Network Addendum – to be completed for each separate provider network contracted with the managed care organization.

Please return the required data to the Connecticut Insurance Department, Life & Health Division, at LHCompliance@ct.gov Please Do Not submit via secure email as we have had problems retrieving and saving items. All information is required by statute and therefore are subject to freedom of information.

All questions regarding the reporting requirements must be in writing, and must be e-mailed.

Sincerely,

Marjorie Breen

Marjorie Breen

Program Manager

Life & Health Division

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