

Form #2

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OFFICE OF THE VIRGINIA
SECRETARY OF STATE

ATTACH A BRIEF SUMMARY OF YOUR PROPOSAL

Insurance Commissioner
Secretary of DHHR
Chair of Health Care Authority
Joint Legislative Rule
Title 114A, Series 1

**ALL PAYER DATABASE --
DATA SUBMISSION REQUIREMENTS**

TITLE 114A, SERIES 1

BRIEF SUMMARY OF RULE

This is a joint rule proposed pursuant to HB 2745 (RS 2011, effective June 10), which provides that the Insurance Commissioner, Secretary of DHHR and the Chair of the Health Care Authority (collectively, the "MOU parties") "shall execute" an MOU to develop an all-payer claims. The statute assigns to each of the MOU parties an area of primary responsibility: The Insurance Commissioner is primarily responsible for the collection of the data from insurers. WV Code 33-4A-2. This proposed rule addresses only the data-collection aspects of the program (future rules will address the other areas -- DHHR will maintain the data, and HCA will release it to other agencies, researchers, etc.). The rule provides that the more technical aspects of data reporting will be addressed in detail in a "Submission Manual" to be developed by OIC through a process that mirrors rulemaking to a large degree, e.g. opportunity for public comment.

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STATEMENT OF CIRCUMSTANCES

HB 2745, enacted during the 2011 regular session of the Legislature, provides that the Insurance Commissioner, Secretary of DHHR and the Chair of the Health Care Authority (collectively, the "MOU parties") "shall execute" an MOU to develop an all-payer claims database and provides that these agencies may propose joint legislative rules "as are necessary to implement" the all-payer claims database program. See WV Code 33-4A-8. WV Code 33-4A-8 further provides that no claims data may be collected and no fees may be assessed to users of such data until rules are promulgated. The statute assigns to each of the MOU parties an area of primary responsibility; the Insurance Commissioner is primarily responsible for rules and enforcement related to the collection of the data from insurers (future rules will address the other areas -- DHHR will maintain the data, and HCA will release it to other agencies, researchers, etc.). WV Code 33-4A-2. This proposed rule addresses only the data collection aspects of the program.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: All-Payer Claims Database -- Data Submission Requirements (Title 114A, Series 1)

Type of Rule: X Legislative Interpretive Procedural

Agency: WV Offices of the Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-6279 x1210 Email: Timothy.Murphy@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

It is difficult to project the costs of the project prior to the design and feasibility analysis required as part of the rule development, however, budget estimates from other states operating or developing databases range from \$500,000 to \$1,500,000. The size of the population and the analytic services provided impact the overall operating costs.

The state has been awarded a federal State Health Access Program (SHAP) grant which will be utilized to capitalize the APCD. The state matching requirement of the grant is 20% or \$100,000 to \$300,000 of the estimates provided above. Ongoing operations are to be funded by user fees, penalties and other available funding sources of the MOU agencies.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	0	0
Personal Services		100,000	100,000
Current Expenses	0	0	0
Repairs & Alterations	0	0	0
Assets	0	0	0
Equipment	0	0	0
Other	0	0	400,000
2. Estimated Total Revenues	0	0	0

Rule Title: All-Payer Claims Database -- Data Submission Requirements (Title 114A, Series 1)

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

See #1 "Fiscal Note Summary," no fees until data has been collected (FY 2013 at earliest) and users pay for use of it, bulk of "other" is for IT support and operations as program develops and purchases are put out for bids, etc. It is envisioned that vendors will provide majority of services under an ED's oversight

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

See #1 "Fiscal Note Summary"

Date: _____

Signature of Agency Head or Authorized Representative

Timothy Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P. O. Box 50540
Charleston WV 25305-0540
Timothy.Murphy@wvinsurance.gov

TITLE 114A
JOINT LEGISLATIVE RULE
SECRETARY OF THE DEPARTMENT OF HEALTH AND
HUMAN RESOURCES, INSURANCE COMMISSIONER, AND
THE CHAIR OF THE HEALTH CARE AUTHORITY

SERIES 1
ALL-PAYER CLAIMS DATABASE --
DATA SUBMISSION REQUIREMENTS

Sections.

- 114A-1-1. General.
- 114A-1-2. Definitions.
- 114A-1-3. Determination of Health Care Payers Subject to Submission and Reporting Requirements; Exemptions.
- 114A-1-4. Development of Submission Manual; Amendments.
- 114A-1-5. Submission Requirements.
- 114A-1-6. Vendors.
- 114A-1-7. Advisory Boards.
- 114A-1-8. Enforcement; Examination; Penalties.

TITLE 114A
JOINT LEGISLATIVE RULE
SECRETARY OF THE DEPARTMENT OF HEALTH AND
HUMAN RESOURCES, INSURANCE COMMISSIONER, AND
THE CHAIR OF THE HEALTH CARE AUTHORITY

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SERIES 1
ALL-PAYER CLAIMS DATABASE --
DATA SUBMISSION REQUIREMENTS

§114A-1-1. General.

1.1. Scope. -- The purpose of this rule is to implement the provisions of W. Va. Code §33-4A-1 *et seq.* providing for the establishment of an all-payer claims database.

1.2. Authority. -- W. Va. Code §33-4A-8.

1.3. Filing Date. --

1.4. Effective Date. --

§114A-1-2. Definitions.

As used in this title:

2.1. "All-payer claims database" or "APCD" means the program established pursuant to W. Va. Code §33-4A-1 *et seq.* for the collection, management and release of medical claims data submitted by health care payers.

2.2. "Accredited Standards Committee (ASC) X12" means the standards development organization accredited by the American National Standards Institute (ANSI) that develops and maintains electronic data interchange (EDI) standards and related documents for national and global markets, including standards for insurance claims transactions, or any successor organization.

2.3. "American National Standards Institute" or "ANSI" means the nonprofit membership organization that acts as an administrator and coordinator of the United States private sector voluntary standardization system consisting of public agencies and private organizations.

2.4. "APCD Council" means the collaborative effort convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO) that is focused on improving the development and deployment of state-based all-payer claims database programs, including the development of a core data set for use by such programs.

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2.5. "Chair" means the chairperson of the West Virginia Health Care Authority.

2.6. "Commissioner" means the West Virginia Insurance Commissioner.

2.7. "Data" means information consisting of, or derived directly from, member eligibility files, medical claims files and pharmacy claims files.

2.8. "Data set" means a collection of individual data records and data elements, whether in electronic or manual files.

2.9. "Data submitter" means a health care payer that the Commissioner has determined is subject to the submission and reporting requirements of this rule for a given calendar year because it meets the threshold of having paid or administered the payment of health insurance claims in this state for policies for 500 or more covered lives in the prior calendar year and has not been exempted for cause from such requirements by the MOU parties.

2.10. "Data processor" means any entity that performs data collection and data management functions pursuant to a contract with the MOU parties.

2.11. "Health care payer" means any insurer or health maintenance organization licensed in this state that pays medical benefits pursuant to a policy, certificate or contract of health; any state and federal government payers of such benefits; or any third-party administrator that administers a self-funded health insurance plan. For the purposes of this rule, "health care payer" does not include workers' compensation payers.

2.12. "Health care provider" or "provider" means any physician, hospital or other person or organization that is licensed or otherwise authorized in this state to furnish health care services.

2.13. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics; provider information; charge/payment information; and clinical diagnosis/procedure codes. The term includes data related to behavioral, mental health, or substance abuse treatment.

2.14. "Member" means a subscriber and the spouse, dependent or other persons covered by the subscriber's policy.

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2.15. "Member Eligibility file" means a data file that contains demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting period.

2.16. "MOU parties" means, collectively, the Secretary, Insurance Commissioner and Chair.

2.17. "National Council for Prescription Drug Programs" or "NCPDP" means the standards development organization accredited by the American National Standards Institute (ANSI) that develops and maintains national standards for pharmacy payers and providers, including standards for the pharmacy claim transaction, or any successor organization.

2.18. "Personal identifiers" means information relating to an individual member or insured that identifies, or can be used to identify, locate or contact a particular individual member or insured.

2.19. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to member demographics; provider information; charge/payment information; and national drug codes.

2.20. "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

2.21. "Standards Development Organization" or "SDO" means an entity accredited by the American National Standards Institute (ANSI), such as ASC X-12, National Council for Prescription Drug Programs (NCPDP) and Health Level Seven (HL-7), that is responsible for maintaining the structure and control elements of transactions, or any of its successors.

2.22. "Submission Manual" or "Manual" means that document approved by the Commissioner, including amendments adopted by the Commissioner subsequent to its initial adoption, and published on the West Virginia Offices of the Insurance Commissioner's ("OIC") website that sets forth the required data file format, data elements, code tables, edit specifications, thresholds required for a submission to be deemed complete, methods for submitting data, submission schedules, and other information associated with the data submitters' submission and reporting duties.

2.23. "TPA" means a third-party administrator licensed by the Commissioner under W. Va. Code §33-46-12 or §33-46-14 or registered with the Commissioner under W. Va. Code §33-46-13.

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§114A-1-3. Determination of Health Care Payers Subject to Submission and Reporting Requirements; Exemptions.

3.1. Presumptive data submitters:

3.1.a. Any health care payer is presumed to be a data submitter for any calendar year if it issued a policy, certificate or contract under which it paid medical and/or pharmacy claims to a provider in this state in the immediately preceding calendar year; and

3.1.b. Any TPA is presumed to be a data submitter for any calendar year if it administered the payment of medical and/or pharmacy claims on behalf of a self-funded health plan in the immediately preceding calendar year.

3.2. The Commissioner shall maintain and publish on the OIC website a list of data submitters and the periods with respect to which each must report and submit data in accordance with this rule.

3.2.a. The Commissioner shall exclude from the list presumptive data submitters that, as reflected in OIC records or as otherwise determined by the Commissioner, did not pay or administer the payment of medical claims for 500 or more persons in the preceding calendar year.

3.2.b. Any entity that believes it should not be included on the list for any given year, on the ground that it did not meet the relevant 500-life threshold or that it is not a health care payer covered by this rule, may dispute the Commissioner's determination in accordance with the procedure set forth in W. Va. Code §33-2-13.

3.2.c. The MOU parties may grant an exemption for cause to any presumed data submitter or class of presumed data submitters from all or some of the requirements of this rule. Cause for an exemption includes but is not limited to the increased cost or difficulty in complying with the submission requirements or the marginal value of the data that would be reported by the exempt payers.

3.2.d. Payers of benefits under Medicare supplemental policies are categorically exempt from submitting data associated with claims made under such policies until such time as data is being obtained by the APCD from Medicare and the Commissioner includes such payers on the list provided for in subsection 3.2 of this section.

3.3. Data related to the following claims and benefits are not subject to this rule:

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3.3.a. Claims under policies providing coverage for only accident, disability or a combination of both; liability insurance or coverage issued as a supplement to liability insurance; credit only insurance; coverage for on-site clinics; similar insurance where medical benefits are secondary or incidental to other insurance benefits;

3.3.b. The following benefits if provided under a separate policy or certificate: Limited scope dental or vision; long-term care, nursing home care, home health care, community-based care, or any combination thereof; coverage for only a specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

3.4. Any data submitter that has contracted to have its reporting and submission duties under this rule fulfilled by another person (including a TPA that administers that payer's claims) remains responsible for compliance with this rule regardless of the terms of any such contractual arrangement, and such data submitter remains subject to the investigation and enforcement provisions of section 7 of this rule notwithstanding that suspected or demonstrated noncompliance is attributable to the fault of such other person with which the data submitter has an arrangement for submission and reporting.

§114A-1-4. Development of Submission Manual; Amendments.

4.1. The proposed Manual shall include, at a minimum, the following:

4.1.a. Specifications based on existing standards for claims transactions developed and maintained by standards development organizations such as ANSI, ASC, X12N and NCPDP, and referenced by the APCD Council core data set. Where a standard does not currently exist or is not feasible for use, a standard shall be established by the Commissioner after consultation with the APCD Council and the standing advisory board.

4.1.b. Reporting requirements related to submission of adjustment records, capitated service claims, co-insurance/co-payments, coordination of benefit claims, denied claims and exclusions.

4.1.c. File format, data elements and mapping locators, and code value sources to be submitted for each required file; and file transmission procedures, file testing, and run-out period;

4.1.d. A data submission schedule; and

4.1.e. Data quality standards, including but not limited to thresholds for determining the completeness and accuracy of a submitted file; and procedures for notifying data submitters of file rejections; procedures and timelines for correcting or resubmitting files that do not meet quality standards.

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4.2. After a proposed Manual has been developed:

4.2.a. The Commissioner shall file it with the Secretary of State for publication in the state register for 30 days, with a request for public comment.

4.2.b. After the comment period set forth in subdivision a of this subsection, the Commissioner may, after consideration of any comments or suggestions received, revise the proposed Manual and publish it on the OIC website for at least 30 days before such Manual is made effective.

4.3. *Amendments.* Subsequent amendments to the Manual are subject to the procedure set forth in subsection 4.2 of this rule for adoption of the initial version of the Manual.

4.4. Except as provided in this rule, order or other directive issued by the Commissioner, each data submitter shall submit data in the form and manner set forth in the applicable version of the submission manual and at such times set forth in the applicable submission schedules.

§114A-1-5. Submission Requirements.

5.1. Each data submitter shall submit to the Commissioner or his or her designee a completed health care claims data set, including a member eligibility file, a medical claims file, and a pharmacy claims file for all members who are West Virginia residents, in accordance with the requirements set forth in the submission manual.

5.2. If a data submitter is unable to meet the terms and conditions of this rule and the submission manual due to circumstances beyond its control, a written request must be made to the MOU parties as soon as it is practicable after the data submitter has determined that an extension or waiver is required. The written request shall include the specific requirement to be extended or waived; an explanation of the cause; the methodology proposed to eliminate the necessity of the extension or waiver; and the time frame required to come into compliance. The decision of the MOU parties is not subject to further review.

114A-1-6. Vendors.

6.1. The MOU parties may enter into an agreement(s) with one or more data processors. The agreement shall provide that the third party designee shall be strictly prohibited from collecting, releasing or using data or information obtained in its capacity as a collector and processor of the data for any purposes other than those specifically authorized by the agreement.

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§114A-1-7. Advisory Boards.

7.1. The MOU parties shall establish a standing advisory board to provide input on the various functions of the APCD. Such board shall be composed of the following persons:

7.1.a. Two persons designated by the Commissioner to represent data submitters;

7.1.b. Two persons designated by the Chair to represent health care providers; and

7.1.c. Two persons designated by the Secretary to represent the interests of health care consumers;

7.1.d. Two persons designated by the Secretary from public and/or private health care research organizations; and

7.1.e. A representative from each of the following: PEIA, the state Medicaid office and the state Children's Health Insurance Program.

7.2. The MOU parties may appoint *ad hoc* advisory groups to study and report on various issues.

7.3. Members of the standing advisory board or an *ad hoc* advisory group shall not be compensated. Terms of membership will be determined according to the designating party, but any member may be removed at any time by the MOU party that designated such member. Any member may serve on more than one board simultaneously.

§114A-1-8. Enforcement; Examination; Penalties.

8.1. The Commissioner may, acting individually or jointly with one or both of the other MOU parties, seek to enjoin any further violation of W. Va. Code §33-4A-1 *et seq.* of this rule by filing a petition in the Circuit Court of Kanawha County.

8.2. The Commissioner may deny, suspend or revoke the license of a TPA for any violation of this rule or, in lieu of such action, impose a penalty pursuant of W. Va. Code §33-46-17(d) in a sum not to exceed \$10,000.

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8.3. Pursuant to the authority granted by W. Va. Code §33-2-3a, the Commissioner may conduct an investigation of any person he or she has cause to believe is violating or has violated any provision of W. Va. Code §33-4A-1 *et seq.* or this rule.

8.4. The Commissioner may conduct an examination of any insurer or TPA pursuant to W. Va. Code §33-2-9 to determine compliance with the provisions of W. Va. Code §33-4A-1 *et seq.* and this rule.

8.5. The Commissioner may, in addition to or in lieu of any other sanctions, impose a penalty on any data submitter for failure to comply with the submission requirements of this rule in an amount not to exceed \$100 per day for the first two weeks of non-compliance and \$500 per day thereafter, not to exceed a maximum of \$25,000 per any single occurrence.