Title of Rule:	Revision to the Executive Director for Health Care Policy and Financing Rule Concerning the All-Payers Claims Database, Section 1.200
Rule Number:	ED 11-06-01-A
Division / Contact / Phone:	Rates and Analysis Division / Jed Ziegenhagen / 303-866-3200

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   These rules establish the basis for the submission of medical and pharmacy claims and eligibility and provider data to the Colorado All-Payer Claims Database for the purpose of facilitating the reporting of health care and health quality data that allows public and private health care purchasers, consumers, and data analysts to identify and compare health plans, health insurers, health care facilities and health care providers regarding the provision of safe, cost effective, high quality health care services.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-105, C.R.S. (2010);
   25.5-1-204, C.R.S. (2010)

Initial Review	**07/12/2011**	Final Adoption	**08/24/2011**
Proposed Effective Date	**08/24/2011**	Emergency Adoption	

DOCUMENT #01

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The purpose of this rule is to establish the requirements for the Colorado All-Payer Claims Database ("APCD"), This initiative supports statewide efforts to identify and implement strategies that help our health care system to promote quality of care and effective use of our health care resources.

To achieve the goal of improved value in health, the proposed rule at 25.5-1-204, C.R.S. directs private health care insurance companies, public health care payer and a third party administrator of employer group health plans selling policies in the State of Colorado to submit claims data to the APCD.

The All-Payer Claims Database will be a resource for insurers, consumers, employers, providers, purchasers of health care, and state agencies to allow for continuous, transparent monitoring, analysis and reporting about health care utilization, expenditures, quality of care and patient safety for all Coloradans.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The quantitative impact on private health care insurers will be due to the cost of implementation and will vary according to each company. Health insurers that already have a system in place for providing claims data (i.e. insurers that work in states that already have APCDs in operation) will be able to implement this system in Colorado at a lower cost than others.

The qualitative and quantitative impact on all classes should result in usable and comparable information that allows public and private health care purchasers, consumers and data analysts to identify and compare health plans, health insurers, health care facilities and health care providers regarding the provision of safe, cost-effective, high-quality health care services (25.5-1-204, C.R.S.).

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The cost to the Department to implement this rule will be minimal. The Center for Improving Value in Health Care (CIVHC), an independent 501(c)3 nonprofit organization, has been designated as the administrator for the APCD by the Executive Director of the Department of

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Health Care Policy and Financing. As the APCD Administrator, CIVHC is entirely responsible for implementation and ongoing operations of the APCD, including developing revenue streams from public contracts and private sources. The Department's formal involvement is to provide a representative to attend periodic advisory committee meetings. As the administrator, CIVHC will be responsible for tracking compliance. If a payer fails to submit required data to the APCD in a timely basis, or fails to correct submissions rejected because of errors, CIVHC will provide written notice to the payer. If the payer fails to provide the required information within thirty days following receipt of the written notice, the administrator will provide the payer with notice of the failure. At this point, the Department may assess a penalty of up to $1,000 per week for each week that payer fails to provide the required data to the APCD. The maximum penalty is $50,000.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

COSTS OF PROPOSED RULE
The primary costs of implementing this proposed rule will be building the database to collect the data and for the payers to implement the necessary IT changes to be able to submit data in the required way. CIVHC, the administrator, will be required to raise the necessary funds to build the database. The costs are currently estimated at $1.2 million. The costs for payers to submit data will vary significantly from payer to payer depending on their existing infrastructure.

BENEFITS OF PROPOSED RULE
The data collected by the APCD will have a number of benefits including:
- Provide cost and quality data required for appropriate and informed decisions by all stakeholders.
- Identify opportunities for improvements within the health care system.
- Assess quality improvement initiatives at community, regional and state levels.
- Determine utilization patterns and rates.
- Identify gaps in needed disease prevention and health promotion services.
- Evaluate access to care.
- Assist with benefit design and planning.
- Establish clinical guideline measurements related to quality, safety and continuity of care.

Reports from the APCD will help measure the progress on bending the cost curve, target more efficient care delivery, and give consumers, providers and businesses an invaluable lens for identifying the highest value for health care services see the "Report to the Governor and General Assembly" at http://www.civhc.org/CIVHC-Initiatives/Data-and-Transparency/All-Payer-Claims-Database-Activities.aspx). This will create usable and comparable information that allows public and private health care purchasers, consumers and data analysts to identify and compare health plans, health insurers, health care facilities and health care providers regarding the provision of safe, cost-effective, high-quality health care services.

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COSTS OF INACTION

We cannot manage what we cannot measure. Our health care delivery system does not consistently deliver high-quality or cost effective care. It is currently not possible to identify where unexplained variations exist in Colorado's health care system. Employers, patients, and providers do not have information to compare quality and cost, making it difficult to determine the value of health care.

A significant cost of inaction would be continuing to allow this to happen. Currently, there is not another solution for collecting this data on a consistent level.

BENEFITS OF INACTION

The benefits of inaction are limited. If the proposed rule is not adopted, payers would not have to adjust their claims systems to submit data. There would also not be a need to raise funds to build the APCD. In turn, this will result in a continuation of our current progress and the rising health care costs.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Currently, there is not a way to compare claims data across payers in Colorado. Developing a consistent system to collect this data and store it in one place will allow for continuous review of health care utilization, expenditures, and quality and safety performance in Colorado. Eleven other states have APCDs in existence with other states interested in following suit. No other states have developed a system to allow for collection and analysis of claims across payers other than creating an APCD.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

A section in the Patient Protection and Affordable Care Act (ACA) gives the Office of Personnel Management the authority to create a Health Claims Data Warehouse. This data would include claims information from the Federal Employee Health Benefit Program (FEHBP), National Pre-Existing Condition Insurance Program (program commencing August 2010), and Multi-State Option Plan (program commencing January 2014). OPM will collect, manage and analyze health services data on an ongoing basis by establishing regular data feeds for each of three programs.

This option was rejected in favor of the proposed rule because the data collected specifically for Colorado will not be as comprehensive as the APCD data will be.

1.200 All-Payers Claims Database 10 CCR 2505-5

1.200.1 Definitions

“administrator” means the administrator of the APCD appointed by the director of the department.

“APCD” means the Colorado All-Payer Claims Database.

“department” means the Colorado Department of Health Care Policy and Financing.

“director” means the Executive Director of the department.

“eligibility data file” means a file that includes data about a person who receives health care coverage from a payer, according to the requirements contained in the submission guide.

“HIPAA” means the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d – 1320d-8, and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164, as may be amended.

“historic data” means eligibility data file(s), medical claims data file(s), pharmacy file(s) and provider file(s) for the period commencing January 1, 2009 through December 31, 2011. “medical claims data file” means a file that includes data about medical claims and other encounter information , according to the requirements contained in the submission guide.

“medical claims data file” means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

“payer” means a private health care payer and a public health care payer.

“pharmacy file” means a file that includes data about prescription medications and claims filed by pharmacies, according to the requirements contained in the submission guide.

“private health care payer” means an insurance carrier as defined in C.R.S. § 10-16-102(8) covering an aggregate of 1,000 enrolled lives in health coverage plans as defined in CRS 10-16-102(22.5). For purposes, of this regulation, “private health care payer” includes carriers offering health benefits plans under C.R.S. 10-16-102(21)(a) and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. It does not include carriers offering only accident liability; credit; benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage issued as a supplement to liability insurance; worker’s compensation or similar insurance; or automobile medical payment insurance, specified disease, or hospital confinement indemnity insurance.

“provider file” means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file; and is submitted according to the requirements contained in the submission guide.

“public health care payer” means the Colorado Medicaid program established under articles 4, 5 and 6 of title 25.5, C.R.S., the children’s basic health plan established under article 8 of title 25.5, C.R.S. and CoverColorado established under part 5 article 8 of title 10, C.R.S.

“submission guide” means the document developed by the administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical and pharmacy claims data files and provider data files to the APCD dated August 2011 version 2. This document is available from the

department at 1570 Grant St, Denver CO 80203 and the administrator on the following website: [provide html link].

1.200.2 Reporting Requirements

1.200.2.A Payers shall submit complete and accurate eligibility data files, medical and pharmacy claims data files and provider files to the APCD pursuant to the submission guide. The administrator may amend the submission guide and shall provide notice of the revisions to payers. Any revision to the submission guide will be effective only when incorporated into this rule and issued in compliance with the requirements of C.R.S. § 24-4-103(12.5). Reports submitted 90 days following the effective date of the revision of this rule and the submission guide shall follow the revised submission guide.

1.200.2.B Medical claims data and pharmacy files shall exclude small group plans as defined in C.R.S. 10-16-102(42).

1.200.3 Schedule for Mandatory Data Reporting

1.200.3.A. Payers shall submit a test file of its eligibility data, medical and pharmacy claims data and provider files for a consecutive twelve month period to the administrator by no later than March 31, 2012.

1.200.3.B. Payers shall submit complete and accurate historic data to the administrator that conforms to submission guide requirements by no later than June 30, 2012.

1.200.3.C. Payers will transmit complete and accurate eligibility data, medical and pharmacy claims data and provider files covering the period from January 1, 2012 and ending June 30, 2012 to the administrator by no later than August 15, 2012.

1.200.3.D. On a monthly basis thereafter, payers will transmit complete and accurate monthly eligibility data, medical and pharmacy claims data, and provider files to the administrator. These data files for the period ending July 31, 2012, shall be submitted no later than September 15, 2012, and by the 15th of each month thereafter for the month ending approximately 45 days prior to the monthly submission date. Any time extension shall be provided to payers in writing by administrator, at it's discretion, at least 30 days prior to established deadlines.

1.200.4 APCD Reports

1.200.4.A. The administrator shall, at a minimum, issue reports from the APCD data at an aggregate level to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns and utilization of services.

1.200.4.B. The APCD reports shall be available to the public on consumer facing websites and shall provide aggregate and summary reports to achieve the purposes of the APCD. Any such reports shall protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information.

1.200.5 Requests for Data and Reports

1.200.5.A. A state agency or private entity engaged in efforts to improve health care for Colorado residents may request a specialized report from the APCD by submitting to the administrator a written request detailing the purpose of the project, the methodology, the qualifications of the research entity, and by executing a data use agreement, to comply with the requirements of HIPAA.

1.200.5.B. A data release review committee shall review the request and advise the administrator on whether release of the data is consistent with the statutory purpose of the APCD, will contribute to efforts to improve health care for Colorado residents and complies with the requirements of HIPAA. The administrator shall include a representative of a physician organization and a payer organization on the data release review committee.

1.200.5.C. The administrator may charge a reasonable fee to provide the requested data.

1.200.6 Penalties

1.200.6.A. If any payer fails to submit required data to the APCD in a timely basis, or fails to correct submissions rejected because of errors, the administrator shall provide written notice to the payer. The administrator may grant an extension of time for just cause. If the payer fails to provide the required information within thirty days following receipt of said written notice, the administrator shall provide the payer with notice of the failure to report and will notify the director of the payer's failure to report. The director shall assess a penalty of up to $1,000 per week for each week that a payer fails to provide the required data to the APCD up to a maximum penalty of $50,000. In determining the imposition of a penalty, the director may consider mitigating factors such as the size and sophistication of a payer, the reasons for the failure to report and the detrimental impact upon the public purpose served by the APCD.

1.200.7 Interagency Agreement

1.200.7.A. The director shall enter into an Interagency Agreement on behalf of the APCD and the administrator with the Division of Insurance in the Colorado Department of Regulatory Agencies to assist in the enforcement of these regulations and under the Divisions' authority in Title 10 of the Colorado Revised Statues.

1.200.8 Privacy and Confidentiality

1.200.8.A. Pursuant to C.R.S. § 24-72-204(3)(a)(I) medical and other health care data on individual persons is not an open record and the department shall deny any open records request for such information.

1.200.8.B. Certain aggregate and de-identified data reports from the APCD shall be available to the public pursuant to C.R.S. § 25.5-1-204(7) when disclosed in a form and manner that ensures the privacy and security of personal health information in compliance with HIPAA.

1.200.8.C. The administrator shall institute appropriate administrative, physical and technical safeguards to ensure that the APCD, its operations, data collection and storage, and reporting disclosures are in compliance with the requirements of HIPAA. All eligibility claims data and medical claims data shall be transmitted to the APCD and stored by the APCD in a secure manner compliant with HIPAA.