Title of Rule:	Revision to the Executive Director of Health Care Policy and Financing Rule Concerning the All-Payer Claims Database, 10 CCR 2505-5, Sections 1.200.1, 1.200.2 1.200.3
Rule Number:	ED 15-02-11-A
Division / Contact / Phone:	Health Care Policy and Financing/Health Information Office/Joel Dalzell/303-720-2095, CIVHC-Tracey Campbell/ 720-242-7683

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).

Currently, only fully insured and Public payers are submitting data to the CO APCD.
The purpose of this rule is to include additional insured Coloradans in the CO APCD in order to establish a comprehensive resource for all Colorado stakeholders for health care improvement initiates that support the Triple Aim.
This rule changes makes two sets of amendments

1: Update the DSG with a new version for housekeeping changes to align with carrier claims data and to improve provider claims identification and to allow for the inclusion of Self-funded Employer-sponsored health plan submissions.

2: Self-insured employer-sponsored health plans will be added to the definition of "private payer" and required to submit monthly files in the same format as fully insured companies. The ERISA organizations may opt-out of the claims data submission process for 2015 and 2016 claims submissions. Beginning in 2017 these claims data submissions will become mandatory.

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:

   §25.5-1-108, C.R.S. (2014);

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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 revised rule affects "private health care payers" as defined in Section 1.200.1.

This amendment would change the definition of "private health care payer" under 1.200.1 to include "a self-insured employer-sponsored health plan." Additionally, this amendment would change the Data Submission Guide in effect under 1.200.1 to Data Submission Guide version 7, 2015. The amendment will also add Mandatory Data Reporting guidelines for 1.200.3.A, 1.200.3.B. and 1.200.3.C.

The proposed amendment will also add an opt out clause in 1.200.2.B to read as: A private health care payer subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. Chap. 18 (an "ERISA Entity") may opt-out of the data submission otherwise required under this rule for data files related to claims data for calendar years 2015 and 2016 only. To avoid the penalties, as defined at Section 1.200.6, such ERISA Entity, must declare that it has elected to "opt out" from data submission for calendar year 2015, calendar year 2016 or both calendar years' claims data by submitting the opt out form identified by the administrator, or its equivalent, via certified mail sent to the administrator within 160 calendar days after the effective date of this rule. Such ERISA Entity, may revoke its opt out decision at any time, by providing written notice to the administrator.

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

CIVHC will work collaboratively with all private health payers to meet the requirements of the revised submission guide, including using the established waiver process to provide a short term relaxed data standard or an extended timeline to submit conforming data. United Health Care provided one question, 4/13/15, regarding the DSG which CIVHC answered 4/14/15.

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 APCD is not state funded; this amendment will have no impact on state appropriations.

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

   The state will not incur any costs due to action or inaction. The state would benefit from this rule change because the additional information would add to the collaborative understanding of health system performance now underway such as the State Innovation Model (SIM) project and other state based projects.

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

   There are no other less costly or intrusive strategies to achieve the purpose of the proposed rule.

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.

   None

1.200 ALL-PAYERS CLAIMS DATABASE

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, .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. For the purposes of this regulation, a "private health care payer" also means a self-insured employer-sponsored health plan. It does not include a self-insured employer-sponsored health plan, if such health plan is administered by a third-party administrator or administrative services only organization ("TPA/ASO") that services less than an aggregate of 1,000 enrolled lives in Colorado; ~~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 entitled "Colorado All-Payer Claims Database Data Submission Guide" 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 March ~~2014~~ 2015 version ~~6~~7, which document is hereby incorporated by reference.

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 120 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. A private health care payer subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. Chap. 18 (an "ERISA Entity") may opt-out of the data submission otherwise required under this rule for data files related to claims data for calendar years 2015 and 2016 only. To avoid the penalties, as defined at Section 1.200.6, such ERISA Entity, or a TPA/ASO acting on such ERISA Entity's behalf, must declare that it has elected to "opt out" from (*i.e.*, decline) data submission for calendar year 2015, calendar year 2016 or both calendar years' claims data by submitting the opt out form identified by the administrator, or its equivalent, via certified mail sent to the administrator within 160 calendar days after the effective date of this rule. Such ERISA Entity, or a TPA/ASO acting on such ERISA Entity's behalf, may revoke its opt out decision at any time, by providing written notice to the administrator.

1.200.3 Schedule for Mandatory Data Reporting

This section 1.200.3 does not apply to a private health care payer that has chosen to opt-out in accordance with 1.200.2.B.

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 ~~.~~ or no later than 160 calendar days after the effective date of this rule, whichever is later.

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 or no later than 250 calendar days after the effective date of this rule, whichever is later.~~.~~

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 or for the period as specified by the administrator no later than 305 days after the effective date of this rule, whichever is later.~~.~~

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. For each month thereafter, files shall be submitted no later than ten (10) business days of the second month following the end of the reporting month. Any time extension shall be provided to payers in writing by administrator at least 30 days prior to established deadlines~~.~~ or for the period as specified by the administrator no later than 305 days after the effective date of this rule, whichever is later.

1.200.4 APCD Reports