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SENATE BILL NO. 634

Offered January 10, 2018

Prefiled January 10, 2018

A BILL to amend and reenact § 32.1-276.7:1 of the Code of Virginia, relating to the All-Payer Claims Database.

Patron—Dunnavant

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:**1. That § 32.1-276.7:1 of the Code of Virginia is amended and reenacted as follows:****§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.**

A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system.

B. The Commissioner, in cooperation with the Bureau of Insurance, ~~may~~ *shall* collect paid claims data for covered benefits, pursuant to data submission and use agreements as specified in subsection C, *to the extent permitted by federal law*, from ~~entities electing to participate as data suppliers, which may include:~~

1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing a health care plan for health care services;

2. Third-party administrators and any other entities that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, Virginia residents;

3. The Department of Medical Assistance Services with respect to services provided under programs administered pursuant to Titles XIX and XXI of the Social Security Act; and

4. Federal health insurance plans, if available, including but not limited to Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

C. The Commissioner shall ensure that the nonprofit organization executes a standard data submission and use agreement with each entity listed in subsection B that submits paid claims data to the All-Payer Claims Database and each entity that subscribes to data products and reports. Such agreements shall include procedures for submission, collection, aggregation, and distribution of specified data and shall provide for, at a minimum:

1. Protection of patient privacy and data security pursuant to provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115);

2. Identification of the type of paid claims to be collected by the All-Payer Claims Database, and the entities that are subject to the submission of such claims as well as identification of specific data elements from existing claims systems to be submitted and collected, including but not limited to patient demographics, diagnosis and procedure codes, provider information, plan payments, member payment responsibility, and service dates;

3. Geographic, demographic, economic, and peer group comparisons;

4. Identification and comparison of health plans by public and private health care purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers, and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

5. Use of existing national data collection standards and methods, including the electronic Uniform Medical Claims Payer Reporting Standard, as adopted by The Accredited Standards Committee X12 (ASC X12) and APCD Council, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created pursuant to subsection D;

6. Prohibition on disclosure or reporting of provider-specific, facility-specific, or carrier-specific

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59 reimbursement information, and of information capable of being reverse-engineered, combined, or
60 otherwise used to calculate or derive such reimbursement information, from the All-Payer Claims
61 Database;

62 7. Responsible use of claims data to improve health care value and preserve the integrity and utility
63 of the All-Payer Claims Database; and

64 8. Stipulation that analyses comparing providers or health plans using data from the All-Payer Claims
65 Database use national standards, or, when such national standards are unavailable, provide full
66 transparency to providers or health plans of the alternative methodology used.

67 D. The Commissioner shall appoint an advisory committee to assist in the formation and operation of
68 the All-Payer Claims Database. Such committee shall include a balanced representation of all the
69 stakeholders serving on the governing board of the nonprofit organization as well as individuals with
70 expertise in public health and specific expertise in health care performance measurement and reporting.
71 Each stakeholder on the board of the nonprofit organization shall nominate a member and an alternate
72 member to serve on the committee. The meetings of the advisory committee shall be open to all
73 nominating member organizations and to the public.

74 E. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the
75 provisions of this chapter, to include:

76 1. The reporting of data that can be used to improve public health surveillance and population health,
77 including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes,
78 cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women,
79 infants, and children; and (iv) geographic and demographic information for use in community health
80 assessment, prevention education, and public health improvement. This data shall be developed in a
81 format that allows comparison of information in the All-Payer Claims Database with other nationwide
82 data programs and that allows employers to compare their employee health plans statewide and between
83 and among regions of the Commonwealth and nationally.

84 2. The reporting of data that health care purchasers, including employers and consumers, may use to
85 compare quality and efficiency of health care, including development of information on utilization
86 patterns and information that permits comparison of providers statewide between and among regions of
87 the Commonwealth. The advisory committee created pursuant to subsection D shall make
88 recommendations to the nonprofit organization on the appropriate level of specificity of reported data in
89 order to protect patient privacy and to accurately attribute services and resource utilization rates to
90 providers.

91 3. The reporting of data that permits design and evaluation of alternative delivery and payment
92 models.

93 F. Reporting of data shall not commence until such data has been processed and verified at levels of
94 accuracy consistent with existing nonprofit organization data standards. Prior to release of any report
95 specifically naming any provider or payer, the nonprofit organization shall provide affected entities with
96 notice of the pending report and allow for a 60-day period of review to ensure accuracy. During this
97 period, affected entities may seek explanations of results and correction of data that they prove to be
98 inaccurate. The nonprofit organization shall make these corrections prior to any release of the report. At
99 the end of the review period, upon completion of all necessary corrections, the report may be released.

100 G. The Commissioner and the nonprofit organization shall develop recommendations for elimination
101 of existing state health care data submission and reporting requirements, including those imposed by this
102 chapter, that may be replaced by All-Payer Claims Database submissions and reports. In addition, the
103 Commissioner and the nonprofit organization shall consider and recommend, as appropriate, integration
104 of new data sources into the All-Payer Claims Database, based on the findings and recommendations of
105 the workgroup established pursuant to § 32.1-276.9:1.

106 H. Information acquired pursuant to this section shall be confidential and shall be exempt from
107 disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

108 I. No person shall assess costs or charge a fee to any health care practitioner related to formation or
109 operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care
110 practitioners who voluntarily subscribe to access the database for purposes other than data verification.

111 J. As used in this section, "provider" means a hospital or physician as defined in this chapter or any
112 other health care practitioner licensed, certified, or authorized under state law to provide covered
113 services represented in claims reported pursuant to this section.

114 K. The board of directors of the nonprofit organization shall develop short-term and long-term
115 funding strategies for the creation and operation of the All-Payer Claims Database that may include
116 public and private grant funding, subscriptions for access to data reports, and revenue for specific data
117 projects.

118 L. The Department of Health shall have access to data reported by the All-Payer Claims Database
119 pursuant to this section at no cost for the purposes of public health improvement research and activities.