

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia, relating to the All-Payer Claims Database; penalty.

[H 2798]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-276.3. Definitions.

As used in this chapter:

"Actual reimbursement amount" means reimbursement information included in the claims data submitted by data suppliers to the Virginia All-Payer Claims Database, whether such information is referred to in the claims data as "paid amounts," "allowed amounts," or another term having the same or similar meaning and whether in reference to the payer who paid the actual reimbursement amount or the provider who received the actual reimbursement amount.

"Board" means the Board of Health.

"Common data layout" means the national data collection standard adopted and maintained by the APCD Council.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Covered lives" means subscribers, policyholders, members, enrollees, or dependents, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"ERISA plan" means any self-funded employee welfare benefit plan governed by the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Behavioral Health and Developmental Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; or (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial

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surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

"Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial surgeon's office, as defined above. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians; and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

§ 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 shall ensure that the Department meets the requirements to be a health oversight agency as defined in 45 C.F.R. § 164.501.*

C. 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, from entities electing to participate as from data suppliers, which ~~may~~ shall 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, for at least 1,000 covered lives in the most recent calendar year;

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, at least 1,000 Virginia residents covered lives on behalf of group health plans other than ERISA plans;

3. *Third-party administrators, and any other entities, that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;*

4. 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. 5. State government health insurance plans;~~

6. *Local government health insurance plans, subject to their ability to provide such data and to the extent permitted by state and federal law; and*

7. *Federal health insurance plans, if available to the extent permitted by federal law, including but not limited to Medicare, TRICARE, and the Federal Employees Health Benefits Plan.*

Such collection of paid claims data for covered benefits shall not include data related to Medigap, disability income, workers' compensation claims, standard benefits provided by long-term care insurance, disease specific health insurance, dental or vision claims, or other supplemental health insurance products;

~~C. D.~~ 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: *Additionally, the Commissioner shall ensure that the nonprofit organization:*

1. ~~Protection of~~ *Protects* 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) *as if the nonprofit organization were covered by such laws;*

2. ~~Identification of~~ *Identifies* 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~~ *Administers the All-Payer Claims Database in a manner to allow for geographic,* demographic, economic, and peer group comparisons;

4. ~~Identification and comparison of~~ *Develops public analyses identifying and comparing* 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~~ *Uses common data layout or other* national data collection standards and methods, including the electronic Uniform Medical Claims Payer Reporting Standard, *that utilize a standard set of core data elements for data submissions, as adopted or endorsed by The Accredited Standards Committee X12 (ASC X12) and the 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 E;*

6. ~~Prohibition on disclosure or reporting of~~ *Does not disclose or report* provider-specific, facility-specific, or carrier-specific reimbursement information, ~~and of or~~ information capable of being reverse-engineered, combined, or otherwise used to calculate or derive such reimbursement information, from the All-Payer Claims Database;

7. ~~Responsible~~ *Promotes the responsible* use of claims data to improve health care value and preserve the integrity and utility of the All-Payer Claims Database; and

8. ~~Stipulation~~ *Requires that all public reports and analyses* comparing providers or health plans using data from the All-Payer Claims Database use national standards; or, when such national standards are unavailable, provide full transparency to providers or health plans of the alternative methodology used.

~~D. E.~~ The Commissioner shall ~~appoint~~ *establish* an advisory committee to assist in the formation and operation of the All-Payer Claims Database. Such committee shall include a balanced representation of all the stakeholders serving on the governing board of the nonprofit organization as well as individuals with expertise in public health and specific expertise in health care performance measurement and reporting. Each stakeholder on the board of the nonprofit organization shall nominate a member and an alternate member to serve on the committee consist of (i) a representative from each of the following: a statewide hospital association, a statewide association of health plans, a professional organization representing physicians, a professional organization representing pharmacists, an organization that processes insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental health center who has experience in behavioral health data collection, a nursing home health care provider who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii) up to two representatives with a demonstrated record of advocating health care issues on behalf of consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or broker of health insurance from small employers that purchase group health insurance for employees; (vi) a representative who is not a supplier or broker of health insurance from large employers that purchase health insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director of the Department of Medical Assistance Services, the Director of the Department of Human Resource Management, or their

180 designees, shall serve *ex officio*.

181 In appointing members to the advisory committee, the Commissioner shall adopt reasonable
182 measures to select representatives in a manner that provides balanced representation within and among
183 the appointments and that any representative appointed is without any actual or apparent conflict of
184 interest, including conflicts of interest created by virtue of the individual's employer's corporate
185 affiliations or ownership interests.

186 The nonprofit organization shall provide the advisory committee with details at least annually on the
187 use and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit
188 organization; details on methods used to extract, transform, and load data; and efforts to protect patient
189 privacy and data security.

190 The meetings of the advisory committee shall be open to all nominating member organizations and to
191 the public.

192 ~~E. F.~~ The Commissioner shall establish a data release committee to review and approve requests for
193 access to data. The data release committee shall consist of the Commissioner or his designee, and upon
194 recommendation of the advisory committee, the Commissioner shall appoint an individual with academic
195 experience in health care data and cost-efficiency research; a representative of a health insurer; a
196 health care practitioner; a representative from a hospital with a background in administration,
197 analytics, or research; and a representative with a demonstrated record of advocating health care issues
198 on behalf of consumers. In making its recommendations, the advisory committee shall adopt reasonable
199 measures to select representatives in a manner that provides balanced representation within and among
200 the appointments and that any representative appointed is without any actual or apparent conflict of
201 interest, including conflicts of interest created by virtue of the individual's employer's corporate
202 affiliations or ownership interests. The data release committee shall ensure that (i) all data approvals
203 are consistent with the purposes of the All-Payer Claims Database as provided in subsection A; (ii) all
204 data approvals comply with applicable state and federal privacy laws and state and federal laws
205 regarding the exchange of price and cost information to protect the confidentiality of the data and
206 encourage a competitive marketplace for health care services; and (iii) the level of detail, as provided in
207 subsection H, is appropriate for each request and is accompanied by a standardized data use
208 agreement.

209 G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the
210 provisions of this chapter, to include:

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

219 2. The reporting of data that payers, providers, and health care purchasers, including employers and
220 consumers, may use to compare quality and efficiency of health care, including development of
221 information on utilization patterns and information that permits comparison of health plans and
222 providers statewide between and among regions of the Commonwealth. The advisory committee created
223 pursuant to subsection ~~D~~ E shall make recommendations to the nonprofit organization on the appropriate
224 level of specificity of reported data in order to protect patient privacy and to accurately attribute services
225 and resource utilization rates to providers.

226 3. The reporting of data that permits design and evaluation of alternative delivery and payment
227 models.

228 4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database
229 as set forth in subsection A as determined to be appropriate by the data release committee created
230 pursuant to subsection F.

231 H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to
232 data without the approval of the data release committee. Upon approval, the nonprofit organization may
233 provide data or access to data at levels of detail that may include (i) aggregate reports, which are
234 defined as data releases with all observation counts greater than 10; (ii) de-identified data sets that
235 meet the standard set forth in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the
236 National Institutes of Health guidelines for release of personal health information.

237 ~~F. I.~~ Reporting of data shall not commence until such data has been processed and verified at levels
238 of accuracy consistent with existing nonprofit organization data standards. Prior to public release of any
239 report specifically naming any provider or payer, or public reports in which an individual provider or
240 payers represents 60 percent or more of the data, the nonprofit organization shall provide affected

entities with notice of the pending report and allow for a ~~60-day~~ 30-day period of review to ensure accuracy. During this period, affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The nonprofit organization shall make these corrections prior to any public release of the report. At the end of the review period, upon completion of all necessary corrections, the report may be released. *For the purposes of this subsection, "public release" means the release of any report to the general public and does not include the preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved for access by the data release committee and have entered into written agreements with the nonprofit organization.*

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

H. K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). *The reporting and release of data pursuant to this section shall comply with all state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services.*

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

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

K. N. ~~The Commissioner, in consultation with the board of directors of the nonprofit organization, shall develop short-term and long-term funding strategies for the creation and operation of the All-Payer Claims Database that may include public and private grant funding, subscriptions for access to data reports, and revenue for specific data projects operation of the All-Payer Claims Database to provide necessary funding in excess of any budget appropriation by the Commonwealth.~~

L. ~~The O. The nonprofit organization, the Department of Health, the Department of Medical Assistance Services, and the Bureau of Insurance shall have access to data reported by the All-Payer Claims Database pursuant to this section at no cost for the purposes of public health improvement research and activities.~~

P. Each employer that maintains an ERISA plan may opt-in to allow a third-party administer or other entity to submit data to the All-Payer Claims Database. For any such employer that opts-in, the third-party administrator or other entity shall (i) submit data for the next reporting period after the opt-in and all future reporting periods until the employer opts-out and (ii) include data from any such employer as part of its data submission, if any, otherwise required by this section. Such an employer may opt-out at any time but shall provide written notice to the third-party administrator or other entity of its decision at least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA plan shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party administrator or other entity shall be required to submit claims processed before it was contracted to provide services. Each third-party administrator or other entity providing claim administration services for an employer shall submit annually to the nonprofit organization by January 31 of each year a list of the ERISA plans whose employer has opted-in to data submission to the All-Payer Claims Database and a list identifying all employers that maintain an ERISA plan with Virginia employees for which it provides claim administration services. Such information submitted shall be considered proprietary and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

Q. Any data release shall make use of a masked proxy reimbursement amount, for which the methodology is publicly available and approved by the data release committee except that the Department may request that the nonprofit organization generate the following reports based on actual reimbursement amounts: (i) the total cost burden of a disease, chronic disease, injury, or health condition across the state, health planning region, health planning district, county, or city, provided that the total cost shall be an aggregate amount encompassing costs attributable to all data suppliers and not identifying or attributable to any individual provider, and (ii) any analyses to determine the average reimbursement that is paid for health care services that may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require the approval of the data release

302 committee.

303 R. The nonprofit organization shall ensure the timely reporting of information by private data
304 suppliers to meet the requirements of this section. The nonprofit organization shall notify private data
305 suppliers of any applicable reporting deadlines. The nonprofit shall notify, in writing, a private data
306 supplier of a failure to meet a reporting deadline, and that failure to respond within two weeks
307 following receipt of the written notice may result in a penalty. The Board may assess a civil penalty of
308 up to \$1,000 per week per violation, not to exceed a total of \$50,000 per violation, against a private
309 data supplier that fails, within its determination, to make a good faith effort to provide the requested
310 information within two weeks following receipt of the written notice required by this subsection. Civil
311 penalties assessed under this subsection shall be maintained by the Department and used for the
312 ongoing improvement of the All-Payer Claims Database.