RULE 100

ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE STANDARDS

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Section 1. Authority

This Rule is issued pursuant to Act 1233 of 2015 of the Arkansas 90th General Assembly, also known as the "Arkansas Healthcare Transparency Initiative Act of 2015" (hereafter "Healthcare Transparency Initiative Act" or "Act"). Pursuant to Act 1233 of 2015, which became effective upon signature by the Governor of the State of Arkansas on April 8, 2015, the Arkansas Insurance Department ("AID") is authorized to issue Rules to implement provisions of the Healthcare Transparency Initiative Act. In addition, this Rule is issued pursuant to Ark. Code Ann. § 23-61-108(b)(1) which states that the Arkansas Insurance Commissioner ("Commissioner") has authority to promulgate rules and regulations necessary for the effective regulation of the business of insurance.

Section 2. Purpose

The purpose of the this Rule is to establish the guidelines for submission of medical, dental, and pharmaceutical claims, unique identifiers and geographic and demographic information for covered individuals, and provider files to the Arkansas Healthcare Transparency Initiative for the purpose of creating and maintaining a multi-payer claims database as a source of healthcare information to support consumers, researchers, and policymakers in healthcare decisions within the state. The Rule is intended to create and maintain an informative source of healthcare information to support consumers, researchers and policymakers in healthcare decisions within the state and empower Arkansans to drive, deliver, and seek out value in the healthcare system.

Section 3. Applicability & Scope

This Rule applies to all submitting entities as defined in Section 4 of this Rule unless otherwise exempted pursuant to Section 5.C of this Rule.

Section 4. Definitions

The following definitions shall apply in this Rule:

(1) "Administrator" means the Arkansas Center for Health Improvement;
(2) "AID" means the Arkansas Insurance Department;
(3) "All-payer claims database" or "APCD" means the database created and maintained by the Arkansas Healthcare Transparency Initiative, including the ongoing all-payer claims database project funded through the Arkansas Insurance Department, that receives and stores data from submitting entities;
(4) "APCD Council" means a federation of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based APCDs;
(5) "Arkansas Healthcare Transparency Initiative" or "Initiative" means the initiative established pursuant to Act 1233 of 2015 to create and maintain a database, including the ongoing all-payer claims database project funded through the Arkansas Insurance Department, that receives and stores data from submitting entities;
(6) "Arkansas Healthcare Transparency Initiative Board" or "Initiative Board" means the advisory board established under Act 1233 of 2015;
(7) "Arkansas resident" means an individual for whom a submitting entity has identified an Arkansas address as the individual's primary place of residence. For individuals covered by a student health plan, Arkansas resident" means any student enrolled in a student plan for an Arkansas college or university regardless of his or her address of record;
(8) "Commissioner" means the person in charge of the Arkansas Insurance Department;
(9) "Covered individual" means a natural person who is an Arkansas resident and is eligible to receive medical, dental, or pharmaceutical benefits under any policy, contract, certificate, evidence of coverage, rider, binder, or endorsement that provides for or describes coverage;
(10) "Data" means information consisting of, or derived directly from enrollment files, medical claims files, dental claims files, pharmacy claims files, provider files and validation reports;
(11) "Data set" means a collection of individual data records and data elements that comprises the file types for an enrollment file, medical claims file, dental claims files, pharmacy claims file, and a provider file submitted quarterly, and in the format outlined in the DSG.
(12) "Data Submission Guide" or "DSG" means a document approved by the Commissioner in consultation with the Initiative Board, 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, validation reports, exception processes, adjustment files, and other information associated with the submitting entities' reporting duties;

(13) "Dental claims file" means, as further defined in the DSG, a data file that contains service level remittance information for all paid and denied claims for each billed dental service for covered individuals including without limitation unique identifiers, geographic and demographic information but not direct personal identifiers; provider information and services rendered to a covered individual; charge/payment information; and clinical diagnosis/procedure codes. Claims and benefits not subject to this Rule will not be included in a dental claims file. The term may exclude certain data that is prohibited to release according to state or federal law;

(14) "Direct personal identifiers" means information relating to a covered individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number. "Direct personal identifiers" does not include geographic or demographic information that would not allow the identification of a covered individual;

(15) "Enrollment file" means unique identifiers, demographic and geographic information relating to covered individuals;

(16) "HIPAA" means the Health Insurance Portability and Accountability Act, 42 U.S.C. Section 1320d – 1320d-8 and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164, as may be amended;

(17) "Historical data" means a one-time data submission following submission of a test file and for a period commencing on January 1, 2013 and ending according to the data submission schedule in this Rule;

(18) "Medical claims file" means, as further defined in the DSG, a data file that contains service level remittance information for all paid and denied claims for each billed medical service for covered individuals including without limitation unique identifiers, geographic and demographic information but not personal identifiers; provider information and services rendered to a covered individual; charge/payment information; and clinical diagnosis/procedure codes. Claims and benefits not subject to this Rule will not be included in a medical claims file. The term may exclude certain data that is prohibited to release according to state or federal law;

(19) "Pharmacy claims file" means a data file containing service level remittance information from all paid and denied claims for each prescription for covered individuals including without limitation unique identifiers, geographic and demographic information but not personal identifiers; provider information; charge/payment information; and national drug codes. The term may exclude certain data that is prohibited to release according to state or federal law;

(20) "Provider file" means a data file that includes additional information as set forth in the DSG about the providers that are included in a medical claims file, dental claims file, or pharmacy claims file;

(21) "Submitting entity" means an entity that is subject to this Rule and its data reporting requirements;

a. "Submitting entity" includes the following entities:

i. an entity that provides health or dental insurance or a health or dental benefit plan in the state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefits society, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals as of December 31 in the previous calendar year;
ii. a health benefit plan offered or administered by or on behalf of the state or an agency or instrumentality of the state;
iii. a health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government;
iv. the Arkansas Workers' Compensation Commission;
v. any other entity providing a plan of health insurance or medical, dental, or pharmaceutical benefits subject to state insurance regulation, a third-party administrator, or a pharmacy benefits manager, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals as of December 31 in the previous calendar year; and
vi. an entity that contracts with institutions of the Department of Correction or Department of Community Correction to provide medical, dental, or pharmaceutical care to inmates;
vii. A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406 ("ERISA");

b. "Submitting entity" does not include an entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity and other fixed indemnity, long-term care, disability income, Medicare supplement, or other supplemental benefit coverage from which benefit payments are directly to the covered individual;
c. In instances where more than one submitting entity is involved in the administration of a policy, the payer shall be responsible for submitting the claims data on policies that it has written or sold as a bundle, provided however that in instances where more than one submitting entity is involved in the administration of a policy, those entities will work together to use the same unique identifier for a covered individual across separate feeds for medical, prescription, and other claims; and
d. If a "submitting entity" contracts with another entity to provide subcontracted claims processing services, the entity which contracts directly with the customer shall be the submitting entity for purposes of this Rule;

(22) "Test file" means a data file, as further defined by the DSG, that includes a sample of service level remittance information for billed medical or dental services or prescriptions for covered individuals;

(23) "Unique identifier" means, as further defined in the DSG, an identifier that is guaranteed to be unique among all identifiers for covered individuals but does not include direct personal identifiers;

(24) "Validation report" means, as further defined in the DSG, a report from the submitting entity that provides aggregated information about a quarterly data submission to provide control totals and record counts.

Section 5. General Reporting Requirements; Exemptions.

A. Submitting Entity Requirements. Unless exempted by the Commissioner in accordance with Section 5.C of this Rule or by the explicit language of this Rule, a submitting entity shall submit to the Arkansas Insurance Department through the Administrator a completed data set for an enrollment file, a medical claims file, a dental claims file, a pharmacy claims file, a provider file, and a validation report in accordance with Section 5 of this Rule and with the requirements outlined in the Data Submission Guide.

B. Data Submission Timing. Submitting entities shall provide data in accordance with the following schedule:

1. Test files for submitting entities must be submitted no later than January 1, 2016.

2. Historical data and regular quarterly submission will commence following submission of test files according to the submission schedule in Appendix A. For purposes of the submission schedule the following groupings apply:
   a. Group 1 means submitting entities listed in the Definition Section 4(21)a.i. with at least 100,000 covered individuals as of December 31, 2015 and entities listed in the Definition Section 4(21)a.ii., iii., iv., and vi.;
   b. Group 2 means submitting entities listed in Definition Section 4(21)a.i. with at least 25,000 covered individuals but fewer than 100,000 covered individuals as of December 31, 2015;
   c. Group 3 means submitting entities listed in Definition Section 4(21)a.i. with at least 10,000 covered individuals but fewer than 25,000 covered individuals as of December 31, 2015;
   d. Group 4 means submitting entities listed in Definition Section 4(21)a.v. and submitting entities listed in Definition Section 4(21)a.i. with at least 2,000 covered individuals but fewer than 10,000 covered individuals as of December 31, 2015.

3. Unless otherwise exempted under Section 5.C of this Rule, submitting entities must submit data according to the established patterns identified in the submission schedule in Appendix A for future years not explicitly listed in the schedule.

4. Entities qualifying in more than one Group listed in Section 5.B.2 must submit claims for all covered individuals according to the schedule listed for the first Group in which the entity qualifies.

C. Submitting Entity Exemptions. An entity with fewer than two thousand (2,000) covered individuals as of December 31 of the previous calendar year will not be required to submit data in accordance with this Rule. For purposes of determining whether an entity is subject to the requirements of this rule and for data submission timing in Section 5.B of this Rule, entities must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners. Entities that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the two thousand (2,000) covered individual threshold.

The Arkansas Workers' Compensation Commission is exempt from submitting a provider file as required by this Section. Until further notice, employer self-funded health plans are exempt from all requirements in this Rule.

The Commissioner may, for good cause, grant an exemption to a submitting entity (or to a class of which the entity is a member) for all or some of the requirements of this Rule. "Good cause" includes without limitation pending litigation which may preempt application of the Act to a submitting entity. The Commissioner will respond in writing within 30 days to any exemption request.

If an entity does not believe it meets the definition of a submitting entity herein or does not believe it meets the 2,000 covered individuals threshold, that entity may dispute the Commissioner's decision in accordance with the administrative procedures of the State of Arkansas.

Section 6. Submission Exclusions; Data Submission Guide.

A. Extension, Variance or Waiver of Data Submission Requirements. If a submitting entity is temporarily unable to meet the requirements of this Rule including the standards in the Data Submission Guide other than those outlined in the exceptions process in the DSG for specific data variables, a submitting entity may submit an exemption request to the Commissioner including the specific requirement to be extended, varied or waived; an explanation of the reason or cause; the methodology proposed to eliminate the necessity of the extension, variance or waiver, if applicable; and the time frame required to come into compliance. The Commissioner will respond in writing within 30 days to any exemption request.

B. Submission Exclusions. For purposes of clarity and without limiting the foregoing, the following data are excluded from this Rule: data related to a health benefit plan that is accident-only, specified disease, hospital indemnity and other fixed indemnity, long-term care, disability income, Medicare supplement, or other supplemental benefit coverage where benefits are paid directly to the covered individual.

Section 7. Data Submission Guide.

A. Data Submission Guide Standards. The Administrator in consultation with the Initiative Board will develop and make publicly available a Data Submission Guide that will be used to evaluate data submissions, including minimum completion rates ("thresholds") as well as detailed information about criteria tested in automated reviews. The Administrator will provide a periodic update of data submission standards to facilitate submitting entities' creation of files that conform to the DSG. In developing the DSG the Administrator will consult with organizations such as the APCD Council in order to examine appropriate APCD Core Standard provisions.

B. Revisions to Data Submission Guide. The Administrator may make material DSG revisions no more than once per year. Material DSG revisions include adding new data elements, adding new codes to existing data elements or otherwise significantly amending the DSG. Submitting entities will have 30 days to review and comment on the proposed revisions. The Administrator will review the comments with the Initiative Board and Commissioner prior to issuing a revised DSG. The Initiative Board shall approve material DSG revisions. The Commissioner will post a final revised version on the AID website. The revised DSG will be effective for the files to be submitted not less than 120 days after the posting date on the AID website.

The Administrator may make technical corrections to the DSG at any time. Technical corrections are simple revisions to formatting of existing data elements, the addition of codes to existing data elements, changes to thresholds that can be accommodated by updated exceptions, and those intended to clarify or otherwise expedite the process of submitting files that conform to the DSG. Submitting entities will have 120 days to implement a technical correction.

The Administrator will notify submitting entities about all material and technical revisions, including the start and end of comment periods for material revisions.

C. Manner of Data Submission. Submitting entities will submit data in accordance with the manner outlined in the DSG and in compliance with the HIPAA Security Rule or any applicable state law that is more restrictive than the HIPAA Security Rule.

Except as provided in this Rule, bulletin, order or directive issued by the Commissioner, each submitting entity shall provide data in the form and manner set forth in this Rule and according to the applicable version of the Data Submission Guide and at such times set forth in any applicable submission schedules.

Section 8. Arkansas Healthcare Transparency Initiative Board; Subcommittees.

A. Initiative Board Duties and Composition.

1. The Initiative Board will serve in an advisory capacity, providing input into the various functions of the Arkansas Healthcare Transparency

Initiative and its APCD, assisting in the development of and revisions to the Data Submission Guide, and reviewing recommendations from the Data Oversight and Scientific Advisory subcommittee regarding data use and release.

2. The Initiative Board will be composed of the following members:
   a. A representative of the Arkansas Department of Human Services;
   b. A representative of the Department of Health;
   c. A representative of the Office of Health Information Technology or its successor entity;
   d. The Arkansas Surgeon General; and
   e. The following Governor-appointed members:
      i. Two representatives from the health insurance industry, one of whom will be a multi-state representative and one of whom will be a domestic representative;
      ii. A representative from a self-insured employer;
      iii. A representative from an employer of fewer than one hundred (100) full-time employees that provides healthcare coverage to employees through a fully-insured product;
      iv. A representative from a healthcare consumer organization;
      v. A representative from the academic research community with expertise in healthcare claims data analysis; and
      vi. An representative with expertise in health data privacy and security.

3. Governor-appointed members of the Initiative Board will serve a term of three (3) years. The Initiative Board will appoint one (1) member as a chair and determine the qualifications, duties and term of office for the chair. Seven (7) members constitute a quorum for a meeting of the Initiative Board; provided however, that the lack of a quorum does not preclude action by the Commissioner with respect to the duties required by the Act or this Rule.

B. Subcommittees.

1. The Data Oversight Committee, which will be composed of three (3) Governor-appointed members and an individual healthcare consumer appointed by the Commissioner, will review and make recommendations to AID regarding:
   a. Whether specific data requests are consistent with the purpose and intent of the Act 1233, including without limitation whether the data request contains the minimum required information; and
   b. Reports and publications generated from data requests to ensure compliance with the Act.

3. The Scientific Advisory Committee, which will be composed of the Governor-appointed member of the Initiative Board from the academic

research community and two (2) nonmembers of the Initiative Board who are academic researchers and appointed by the Commissioner, will serve as peer review for academic researchers and provide advice regarding data requests for academic proposals and the scientific rigor of analytic work.

4. The Commissioner may establish and convene as necessary additional subcommittees to carry out the responsibilities of the Act and this Rule.

Section 9. Administrator. The Arkansas Center for Health Improvement will host and administer the APCD and have custody of the data collected by the APCD as part of the Arkansas Healthcare Transparency Initiative. Except as authorized in state law, the Administrator is prohibited from collecting, disclosing or using data obtained in its capacity as Administrator for any purposes other than those specifically authorized in the Act, this Rule, or any agreement with AID to administer the APCD.

Section 10. Initiative Public Use and Reports. Contingent upon available funding and in consultation with the Initiative Board, the Arkansas Insurance Department will issue reports from data collected by the Initiative which may include descriptions of patterns of incidence and variation of medical treatment options, comparisons of health care quality and performance, state and regional cost patterns, utilization of services, how health care dollars are being spent and health care research activities. Reports generated by AID will be available to the public on a website.

Any and all reports will comply with federal and state privacy laws. Any and all reports will preserve competition consistent with Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy and not deprive payers of existing trade secret protections.

After soliciting input from the Initiative Board, AID will develop a process by which individuals can request data sets to be reviewed by the Data Oversight Subcommittee and the Initiative Board and approved by the Commissioner. Where appropriate, individuals requesting data sets will sign a data use agreement to be approved or denied by the Commissioner, upon recommendation of the Data Oversight Subcommittee and the Initiative Board. AID will not release data sets for solely commercial purposes. The Commissioner may adopt a fee schedule to fulfill data requests under this Section.

Section 11. Limited Data Set Requests. AID, in consultation with the Initiative Board, will determine a limited data set of elements to be made available for research projects. The requester will submit to the Scientific Advisory Committee through the Administrator a detailed research scope and purpose to determine if a limited data set can be made available. The Commissioner will approve or deny each request for a Limited Data Set, upon recommendation by the Scientific Advisory Committee and the Initiative Board. The requester will sign a data use agreement with the Commissioner if data is supplied to the requestor.

The requester shall protect patient privacy and confidentiality information contained in the limited data set according to HIPAA, applicable laws of the Arkansas, and the data use agreement. The Commissioner may adopt a fee schedule to fulfill the data requests under this Section.

Section 12. Public Record. Data submitted by submitting entities to the Arkansas Insurance Department through the Administrator are confidential and are exempt from disclosure under the Freedom of Information Act of 1967, Ark Code. Ann. § 25-19-101 et seq., and are not subject to subpoena, except to the extent provided in Ark. Code Ann § 23-61-205.

Section 13. Compliance. Each time a submitting entity submits a file, AID will evaluate each submitting entity's submissions in accordance with the DSG. Upon completion of the evaluation, AID will promptly notify each submitting entity in writing whether its submissions satisfy the DSG standards. This notification shall identify the specific files and the data sets that do not conform to DSG standards. Each submitting entity notified of a non-compliant data submission shall respond within 30 days of the notification by making the changes necessary to satisfy the DSG standards unless an extension, variance or waiver has been submitted in accordance with Section 6.B.

Section 14. Penalties for Non-Compliance. Following notice to the submitting entity and the failure to comply during the 30-day cure period, the Commissioner may impose a maximum penalty on a submitting entity of one thousand dollars ($1000.00) per day, not to exceed thirty thousand dollars ($30,000.00). The Commissioner may delay, reduce, or waive any penalty. The Commissioner agrees to consider a lower maximum penalty per day than authorized, including a waiver of the penalty, for test data and data receipts due in the 2016 year, based upon the good cause of the submitting entity.

Section 15. Privacy and Security. AID will 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 applicable federal and state law. AID will also ensure that the Administrator and any vendors comply with applicable federal and state law related to protecting patient privacy and confidentiality.

Section 16. Effective Date. This Rule will be effective on November 2, 2015.

ALLEN W. KERR
INSURANCE COMMISSIONER

7-15-2015
DATE

APPENDIX A
SUBMISSION SCHEDULE

Group Number	Date of Data Receipt	Claims Dates From:	To:
Group 1	3/31/2016	1/1/2013	12/31/2015
Group 2	6/30/2016	1/1/2013	12/31/2015
Group 3	9/30/2016	1/1/2013	12/31/2015
Group 4	12/31/2016	1/1/2013	12/31/2015
All Groups	3/31/2017	1/1/2016	12/31/2016
All Groups	6/30/2017	1/1/2017	3/31/2017
All Groups	9/30/2017	4/1/2017	6/30/2017
All Groups	12/31/2017	7/1/2017	9/30/2017
All Groups	3/31/2018	10/1/2017	12/31/2017
All Groups	6/30/2018	1/1/2018	3/31/2018
All Groups	9/30/2018	4/1/2018	6/30/2018
All Groups	12/31/2018	7/1/2018	9/30/2018
All Groups	3/31/2019	10/1/2018	12/31/2018
All Groups	6/30/2019	1/1/2019	3/31/2019
All Groups	9/30/2019	4/1/2019	6/30/2019
All Groups	12/31/2019	7/1/2019	9/30/2019

Data submitters who are newly required to submit files under this rule after January 1, 2016 shall submit data according to a schedule developed by the Administrator in consultation with AID.