FINAL PROPOSED RULE # 21-P19

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Rule 8.000: Data Submission

/s/ Kevin Mullin , on 11/16/2021
(signature) (date)

Printed Name and Title:
Kevin Mullin
Chair, Green Mountain Care Board

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
   Rule 8.000: Data Submission

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   21P019

3. ADOPTING AGENCY:
   Green Mountain Care Board

4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Russ McCracken

   Agency: Green Mountain Care Board

   Mailing Address: 144 State Street, Montpelier, VT 05602

   Telephone: (802)505-3055 Fax:

   E-Mail: russ.mccracken@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   https://gmcboard.vermont.gov/publications/rules-statutes

5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Kathryn O'Neill

   Agency: Green Mountain Care Board

   Mailing Address: 144 State Street, Montpelier, VT 05602

   Telephone: (802)272-8602 Fax:

   E-Mail: kathryn.oneill@vermont.gov

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

7. LEGAL AUTHORITY / ENABLING LEGISLATION:
   (THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

18 V.S.A. §§ 9375, 9380, 9404, 9410, 9453, and 9454

EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

Under 18 V.S.A. § 9410, the Board is directed to establish and maintain a unified health care database, and "[health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section." The Board is authorized to establish by rule the types of information that are required to be filed and the manner of filing that information. 18 V.S.A. § 9410(d).

Under 18 V.S.A. § 9375, the Board shall collect data, including scope of service and volume data, from licensed ambulatory service centers and designated community mental health hospitals. Rulemaking is authorized by 18 V.S.A. § 9380.

8. Under 18 V.S.A. §§ 9453 and 9454, the Board may collect data, including scope of service and utilization data, from licensed hospitals. The Board is authorized to adopt rules to effectuate the collection of that data. 18 V.S.A. § 9453(b).

9. THE FILING HAS NOT CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE NOT RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

The Board stewards two sets of health care data: VHCURES (all-payer claims database) and VUHDDS (hospital discharge database). Health insurers, health

care providers, hospitals and other health care facilities, and governmental agencies must submit data for inclusion in the databases. The rule sets out the requirements for reporting health care claims and eligibility data, inpatient discharge data, outpatient procedure and service data, emergency department data, and other information relating to health care provided in Vermont and to Vermont residents outside the state.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

Under 18 V.S.A. § 9410, the Board is responsible for collecting and maintaining health care data, and health insurers, health care providers, health care facilities, and government agencies are required to submit certain health care data to the Board. The rule is necessary so that submitters know what specific data they are required to submit, the method and process for submitting the data, and the required timing for data submission.

Currently, data submission for the VHCURES database is governed by Regulation H-2008-01, which was adopted by BISHCA in 2008. Data submission for the VUHDDS database is governed by contractual terms. Both will be covered by the rule. Updates are needed to both in order to bring the submission rule up to date to reflect new technology and methods for data submission, to increase flexibility to modify data submission requirements to respond to changes in the health care industry.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The Board is authorized under 18 V.S.A. § 9410(c) to collect information regarding health insurance claims and enrollment, hospital data including scope of service and utilization, and other information relating to health care costs, prices, quality, utilization, or resources as determined by the Board to carry out the purposes of 18 V.S.A. § 9410. The data that the Board will collect under this rule is tailored to the data needed for research and analysis that further the purposes set out in 18 V.S.A. § 9410(a)(1). The data collected under the rule is based on the Board and its staff's experience with health care data, research and analysis.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

BlueCross BlueShield of Vermont

MVP Health Care

Cigna

UnitedHealthcare

Health Insurers as defined in 18 V.S.A. § 9410(j)(1)

General Hospitals as defined in 18 V.S.A. § 1902(1)(A)

Ambulatory Surgery Centers as defined in 18 V.S.A. § 2141(1)

Psychiatric Hospitals as defined in 18 V.S.A. § 1902(1)(B)

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

The economic impact of the proposed rule is not materially different than the economic impact of the current rule. Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies that are mandatory data submitters under the proposed rule are also mandatory submitters under the existing rule. The Board expects that these entities will not incur materially different costs of complying with the proposed rule than they incur for complying with the current data submission requirements.

The rule benefits health care consumers, providers, and regulators by providing the data necessary for valuable analysis of health care cost and utilization in Vermont.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 7/27/2021

Time: 02:00 PM

Street Address: 144 State Street, Montpelier, and virtual hearing (Please see Board website for link and instructions to join virtual meeting).

Zip Code: 05602

Date:
Time: AM
Street Address:
Zip Code:

Date:
Time: AM
Street Address:
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Date:
Time: AM
Street Address:
Zip Code:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/3/2021

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

healthcare data

VHCURES

VUHDDS

All-payer claims database

Data submission

VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05602
802-828-2177

November 16, 2021

Green Mountain Care Board Proposed Rule 8.000: Data Submission (21P019) – Public Comments and Responsiveness Summary

This letter is in regards to Green Mountain Care Board (GMCB) Proposed Rule 8.000: Data Submission (Rule). The Rule was posted by the Secretary of State (SOS) on June 30, 2021. A public hearing on the Rule was held on July 27, 2021, at 2pm, and was accessible virtually and at the GMCB offices. No comments on the rule were provided during the hearing. The public comment period for the Rule closed on August 3, 2021.

After filing with the SOS, publication, and the hearing, no public comments were received on the Rule. The text of the Rule has not changed from the filing of the proposed rule. There were no comments for the GMCB to consider, and consequently no comments are being submitted with the proposed final rule.

If you have any questions, please do not hesitate to contact me at russ.mccracken@vermont.gov.

Sincerely,

/s/ Russ McCracken

Russ McCracken
Staff Attorney
Green Mountain Care Board

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Rule 8.000: Data Submission
2. ADOPTING AGENCY:
   Green Mountain Care Board
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE .**

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:

   Secretary of State Rule Log #08-042

   REGULATION H-2008-01, Vermont Healthcare Claims Uniform Reporting and Evaluation System.

   Effective date: September 30, 2008

State of Vermont
Agency of Administration
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
[fax] 802-828-3320

Office of the Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: June 14, 2021, Microsoft Teams Virtual Meeting
Members Present: Chair Kristin Clouser, Diane Bothfeld, Jennifer Mojo, Matt Langham, Diane Sherman, Clare O'Shaughnessy and John Kessler
Members Absent: Ashley Berliner, Dirk Anderson
Minutes By: Melissa Mazza-Paquette

- 2:01 p.m. meeting called to order, welcome and introductions.
- Review and approval of minutes from the May 10, 2021 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules on pages 2-6 to follow:
  1. Allocation and Apportionment of Vermont Net Income By Corporations, Department of Taxes, page 2
  2. Electrical Safety Rules – 2020, Vermont Electricians' Licensing Board, page 3
  3. Rule 8.000: Data Submission, Green Mountain Care Board, page 4
  4. Rule 9.000: Data Release, Green Mountain Care Board, page 5
  5. Vermont Hazardous Waste Management Regulations, Agency of Natural Resources, page 6
- Next scheduled meeting is July 12, 2021 at 2:00 p.m. via Microsoft Teams.
- 3:45 p.m. meeting adjourned.

Proposed Rule: Rule 8.000: Data Submission, Green Mountain Care Board

Presented By: Russ McCracken and Kathryn O'Neill

Motion made to accept the rule by Diane Sherman, seconded by Matthew Langham, and passed unanimously with the following recommendations:

1. Proposed Rule Coversheet, #8: Define the two sets including their name and acronym. The acronyms may then be used throughout the filing.
2. Proposed Rule Coversheet, #12: State that the impact could be overall neutral if appropriate and reconcile the compliance costs as referenced in the Economic Impact.
3. Economic Impact Analysis, #7: Clarify neutral compliance costs.
4. Public Input, #4 and #5: Identify the general nature of the comments received, if the comments stated are in totality, and if they were incorporated. Rewrite the May 5, 2021 entry in #4 for clarity.

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Rule 8.000: Data Submission

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Categories of parties affected by the rule are:

   Health insurers

   General hospitals

   Psychiatric hospitals

   Ambulatory surgery centers

The Board anticipates that the rule will not impose materially different compliance costs on the affected parties than the compliance costs associated with the current data reporting requirements. The rule benefits the public, health care consumers, regulators, and health care providers by providing the data required to complete valuable analyses, including of health care utilization, resources, and costs in Vermont.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

The Board does not anticipate any impact on public education, public schools, or local school districts.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

Because the Board does not anticipate any impact on public education or local school districts, alternatives to the rule that could reduce or ameliorate costs to local school districts were not considered.

6. IMPACT ON SMALL BUSINESSES:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

The Board does not expect that any health insurers or general hospitals subject to the rule would be small businesses. Ambulatory surgery centers or psychiatric hospitals may be small businesses. The rule requires those entities, like general hospitals, to submit inpatient discharge data, outpatient procedure and service data, emergency department data, and other financial, scope- and volume-of-service, and utilization data. The Board anticipates that any compliance costs associated with data submission for any small businesses that are mandatory submitters under the rule will not be materially different than the compliance costs for such entities under the current data submission rule.

ERISA self-insured plans, many of which are small businesses, are not mandatory submitters under the rule, and therefore are not required to comply with the submission requirements under the rule.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

In order to collect the health care data needed to perform the research and analysis to carry out the Board's duties under 18 V.S.A. § 9410(a)(1), the Board currently collects and needs to continue to collect data from all hospitals and ambulatory surgery centers in a uniform format, regardless of the size of the hospital or ambulatory surgery center. This data collection is needed in order to have a complete understanding of health care provided in Vermont, provided in a consistent format for purposes of research and analysis. For that reason, the Board determined that reduced or different submission requirements for entities that are small businesses is not appropriate. The economic impact of the proposed rule, in the Board's view, is effectively neutral because the reporting requirements are consistent with the current data submission rule.

8. COMPARISON:

COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:

For the reasons noted above, the Board currently collects and needs to continue to collect uniform health care data from all hospitals and ambulatory surgery centers. Separate requirements or an alternative that does not include hospitals or ambulatory service centers that are small businesses was therefore not considered.

The Board does not anticipate any health insurers that will be required to submit data under the rule to be small businesses, and therefore alternative requirements for health insurers that are small businesses was not considered.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*

The proposed rule is not expected to have a materially different economic impact than the existing rule. The economic impact of the existing rule, which the Board expects to be effectively the same under the proposed rule, includes the cost of compliance for entities required to submit health care data under the rule and the benefit to Vermont consumers of healthcare, rate payers, regulators, and providers of having the health care data and the research that is enabled by the health care data submitted pursuant to the rule. The Board is directed by statute to collect health care data and maintain a health care database. The economic analysis is sufficient in light of the Board's statutory mandate and the benefit to Vermont of having health care data to support valuable analyses of the state's health care system.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Rule 8.000: Data Submission

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   None.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   None.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   None.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   None.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   None.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   None.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   None.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Rule 8.000: Data Submission

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   The Board has engaged in a multi-step public process over a period of more than a year to develop this proposed rule. The public process has involved both public meetings of the Board and its Data Governance Council, a formal committee of the Board, for the review and discussion of the rule, and direct outreach and engagement with stakeholders. The Board is committed to continuing its robust practice of engagement with the public and stakeholders throughout the rulemaking process.

   While the rule has been in development with the Board for more than a year, the recent steps that have been taken to maximize public engagement in the development of the rule are:

   Drafts of the rule were presented for review and discussion at various public meetings on the Data Governance Council during 2020 to gather stakeholder and Council input on the rule.

On December 1, 2020, the draft proposed rule was presented for approval, reviewed and discussed at a public meeting of the Data Governance Council of the Board.

On February 2, 2021, at a public meeting the Data Governance Council voted to approve the draft proposed rule and send to the Board for review.

On February 11, 2021, the draft proposed rule was circulated by email to specific stakeholders, including payers and other data submitters, soliciting their review and comment on the rule.

On April 21, 2021, the draft proposed rule was reviewed and discussed at a public meeting of the Board. Public comment was received, including from BlueCross BlueShield of Vermont regarding the timeline for implementing changes to the data submission manuals.

On May 5, 2021, modifications to the draft proposed rule in response to public comment from BlueCross BlueShield of Vermont were reviewed and discussed at a public meeting of the Board. The Board approved the modified rule to move into the formal rulemaking process.

Throughout this process, the draft of the proposed rule has been posted and available for public review and comment on the Board's website.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

The draft of the proposed rule was sent for review and comment to stakeholders, including representatives for health insurers BlueCross BlueShield of Vermont, MVP Healthcare, Cigna, and UnitedHealthcare, the Vermont Association of Hospitals and Health Systems, ambulatory surgery centers, and psychiatric hospitals, which are mandatory data submitters under the rule.

Comments on the rule have been received and incorporated from the following stakeholders, which are all comments received to date. Comments have generally addressed the processes for data submission, practical and technical aspects of the data submission

requirements, and notice and implementation periods for changes to the data submission manuals maintained by the Board.

Michael Durkin, Esq., Assistant General Counsel and HIPAA Privacy Officer, BCBSVT.

Onpoint Health Data, which is the Board's vendor and acts as administrator of one healthcare database.

Office of the Health Care Advocate.

The rule was also guided and reviewed by the Board's Data Governance Council, which is comprised of seven members representing the Board, Vermont Program for Quality in Health Care, Bi-State Primary Care, Vermont Blueprint for Health, and Vermont Department of Health.

Incorporation by Reference

THIS FORM IS ONLY REQUIRED WHEN INCORPORATING MATERIALS BY REFERENCE. PLEASE REMOVE PRIOR TO DELIVERY IF IT DOES NOT APPLY TO THIS RULE FILING:

Instructions:

In completing the incorporation by reference statement, an agency describes any materials that are incorporated into the rule by reference and how to obtain copies.

This form is only required when a rule incorporates materials by referencing another source without reproducing the text within the rule itself (e.g., federal or national standards, or regulations).

Incorporated materials will be maintained and available for inspection by the Agency.

1. TITLE OF RULE FILING:

   Rule 8.000: Data Submission

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. DESCRIPTION (*DESCRIBE THE MATERIALS INCORPORATED BY REFERENCE)*:

   The rule incorporates by reference two data reporting manuals, one for each database. The submission manuals contain the specific data reporting requirements for the database, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

   The rule also incorporates by references the definitions of certain terms from Vermont law and federal regulations.

4. FORMAL CITATION OF MATERIALS INCORPORATED BY REFERENCE:

   Reporting Manual for Vermont Uniform Hospital Discharge Data System (VUHDDS), Necessary Data and Reporting Schedule.
   Reporting Manual for Vermont Health Care Uniform

Reporting and Evaluation System (VHCURES).
18 V.S.A. § 2141(1); 18 V.S.A. § 1902(1)(A); 18 V.S.A. § 9432(8); 18 V.S.A. § 9432(9); 18 V.S.A. § 9410(j)(1); 18 V.S.A. § 9418(a)(10); 18 V.S.A. § 9471(5); 18 V.S.A. § 1902(1)(B).
45 C.F.R. § 160.103

5. OBTAINING COPIES: *(EXPLAIN WHERE THE PUBLIC MAY OBTAIN THE MATERIAL(S) IN WRITTEN OR ELECTRONIC FORM, AND AT WHAT COST)*:

   Copies of the reporting manuals are available on the Board's website and may be obtained, free of charge, in electronic form.

6. MODIFICATIONS (*PLEASE EXPLAIN ANY MODIFICATION TO THE INCORPORATED MATERIALS E.G., WHETHER ONLY PART OF THE MATERIAL IS ADOPTED AND IF SO, WHICH PART(S)ARE MODIFIED)*:

   The reporting manuals are incorporated in their entirety without change or modification. The reporting manuals are subject to change or revision in accordance with the process set out in the rule.

   Where the a term in the rule is defined by reference to Vermont law or federal regulation, only the definition of that term is incorporated by reference from the cited provision. The definitions are incorporated without change or modification.

Run Spell Check

Annotated Text

STATE OF VERMONT ~~DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH~~
GREEN MOUNTAIN CARE ~~ADMINISTRATION BOARD~~

~~REGULATION H-2008-01~~

~~Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES")~~

~~Table of Contents~~

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8.601 Waiver of Rules
8.602 Conflict
8.603 Severability

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~~APPENDICES~~

~~Appendix A~~	~~Source Codes~~
~~Appendix B1~~	~~Header Record Specifications~~
~~Appendix B2~~	~~Trailer Record Specifications~~
~~Appendix C1~~	~~Member Eligibility File Specifications~~
~~Appendix C2~~	~~Member Eligibility File Mapping to National Standards~~
~~Appendix D1~~	~~Medical Claims File Specifications~~
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~~Appendix E1~~	~~Pharmacy Claims File Specifications~~
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~~Appendix F~~	~~Reporter Registration Form~~
~~Appendix G~~	~~Third Party Administrator Registration Form~~
~~Appendix H~~	~~Pharmacy Benefit Manager Registration Form~~
~~Appendix I~~	~~Data Transmittal Sheet~~
~~Appendix J~~	~~Data Release Schedule~~

~~**Section 1: Purpose**~~

8.604 Effective Date

8.100 General Provisions

8.101 Authority

The ~~purpose of~~Board adopts this rule ~~is to~~pursuant to 18 V.S.A. §§ 9375, 9380, 9404, 9410, 9453, and 9454.

8.102 Purpose

The Green Mountain Care Board ("Board" or "GMCB") stewards two data sets (collectively "the health care database"). The Vermont Health Care Uniform Reporting and Evaluation System ("VHCURES") data set contains information related to health care utilization, costs, and resources provided to Vermont residents. The Vermont Uniform Hospital Discharge Data Set ("VUHDDS") contains information related to health care provided to patients at health care facilities in Vermont and health care provided to Vermont residents at health care facilities in other states.

Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies must submit reports, data, schedules, statistics, and other information specified by the Board for inclusion in the health care database. This rule sets forth the Board's requirements for ~~the submission of~~reporting health care claims ~~data, member~~and eligibility data, inpatient discharge data, outpatient procedure and service data, emergency department data, and other information relating to health care provided ~~to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care Administration and conditions for the use and dissemination~~in Vermont and to Vermont residents outside the state. Green Mountain Care Board Rule 9,000 sets forth the processes by which the Board makes data available to support legitimate and beneficial research and analysis.

8.103 Definitions

For purposes of this rule:

(1) "Ambulatory surgery center" has the same meaning as in 18 V.S.A. § 2141(1).

(2) "Board" or "GMCB" means the Green Mountain Care Board established in Title 18, Chapter 220 of the Vermont Statutes Annotated, the Board's staff, or other designee of the Board.

(3) "Claims data" means service-level remittance and other related administrative information generated from the interaction of ~~such~~ patients and the health care delivery system. Examples of claims data~~, all as required by and consistent with the purposes of 18 V.S.A. §9410~~ include provider information; charge and payment information; clinical diagnosis, procedure, and service codes; and national drug codes. Claims data also include information intended to represent payments made under an accountable care organization-based payment reform model.

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~~**Section 2: Authority**~~

~~This rule is issued pursuant to the authority vested in the Commissioner of the~~

Department of Banking, Insurance, Securities and Health Care Administration by 18 V.S.A. §9410, as well as 8 V.S.A. §15 and other applicable portions of Chapter 221 of Title 18.

Section 3: Definitions

As used in this Rule

A. "BISHCA" or "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

B. "Capitated services" means services rendered by a provider through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

C. "Cell size" means the count of persons that share a set of characteristics contained in a statistical table.

D. "Charge" means the actual dollar amount charged on the claim.

E. "Co-insurance" means the percentage a member pays toward the cost of a covered service.

F. "Commissioner" means the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration or his or her designee.

(4) "Co-payment" means the fixed dollar amount a member pays to a health care provider at "Council chair" means the chair of the Data Governance Council.

G. "Data Governance Council" or "Council" means the committee established by the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

H. "Current Procedural Terminology (CPT)" means a medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the U.S. Secretary of Health and Human Services as the standard for reporting physician and other services on standard transactions.

(5) Board and given responsibilities for the Board's data governance program.

I.(6)"Data set" means a collection of logical individual data records, whether in electronic or manual filesregardless of format.

J. "Deductible"Data collection vendor" means the total dollar amount a member pays towards the cost of covered services over an established period of time before the contracted thirdparty payer makes any payments.

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K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and vendor with respectwhom the Board contracts to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health information is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

M. "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

N. "Encrypted identifier" is a code or other means of record identification to allow patients, members or enrollees to be tracked across themanage data set without revealing their identity. Encrypted identifiers are not direct identifiers.

O. "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

P.(7) "Health benefit plan" means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of collection, cleansing, validation, integration, and consolidation related to the health care services. database.

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Q. "Healthcare claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

R. "Healthcare premium" means the dollar amount charged for any policies offered by health insurers which partially or fully cover the cost of health care services.

S. "Healthcare Common Procedure Coding System (HCPCS)" means a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. These are often known as "local codes".

T. "Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR § 160.103].

U. "Health care facility" shall be defined as per 18 V.S.A. §9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. §9432.

W. "Health information" means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR § 160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§ 9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

Y. "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

Aa. "International Classification of Diseases" or "ICD" shall mean that medical code set maintained by the World Health Organization..

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any nonresidents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

~~(8) Ae.~~ ~~"Member eligibility file" means a data file containing~~ "Days" means calendar days unless otherwise indicated.

(9) "Eligibility data" means demographic information for each individual member ~~eligible~~enrolled for medical or pharmacy benefits for one or more days of coverage at any time during ~~the~~a reporting ~~month~~period.

(10) ~~Af.~~ "General hospital" has the same meaning as in 18 V.S.A. § 1902(1)(A).

(11) "Health care" has the same meaning as in 45 C.F.R. § 160.103.

(12) "Health care database" means the VHCURES and VUHDDS data sets, collectively.

(13) "Health care facility" has the same meaning as in 18 V.S.A. § 9432(8).

(14) "Health care provider" has the same meaning as in 18 V.S.A. § 9432(9).

(15) "Health insurer" has the same meaning as in 18 V.S.A. § 9410(j)(1).

(16) "Insured" has the same meaning as in 18 V.S.A. § 9418(a)(10).

(17) "Mandatory submitter" means any person required to submit data for inclusion in the health care database.

(18) "Member" means the insured subscriber and any other person(s) eligible for health care benefits under the subscriber's policy, such as the subscriber's spouse or dependent.

(19) "Patient" means any person in ~~the~~a data set that is the subject of the activities of the claim performed by the health care provider.

~~Ag. "Payer" means a third-party payer or third-party administrator.~~

~~Ah. "Payment" means the actual dollar amount paid for a claim by a health insurer.~~

~~Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.~~

~~Aj. "Pharmacy Benefit Manager" or "PBM" means a person or entity that performs pharmacy benefit management as that term is defined at 18 V.S.A. §9471(4). The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.~~

~~Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.~~

~~Al. "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.~~

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Am. "Principal Investigator" means the person in charge of a project that makes use of limited use research health care claims data sets. The principal investigator is the custodian of the data and is responsible for compliance with all restrictions, limitations and conditions of use associated with the data release.

An. "Public Use Data Set" means a publicly available data set containing only the public use data elements specified in this Rule as unrestricted data elements in Appendix J.

Ao. "Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1), and shall include Voluntary Reporters as defined herein.

(20) Ap. "Person" means any natural person, business entity, municipality, the State of Vermont or any department, agency, or subdivision of the State, and any partnership, unincorporated association, or other legal entity.

(21) "Pharmacy benefit manager" or "PBM" has the same meaning as in 18 V.S.A. § 9471(5).

(22) "Psychiatric hospital" has the same meaning as in 18 V.S.A. § 1902(1)(B).

(23) "Reporting manual(s)" means either the VHCURES Reporting Manual or the VUHDDS Reporting Manual or the two documents collectively.

(24) "Submitters" means mandatory submitters and voluntary submitters collectively.

(25) "Subscriber" means the individual responsible for payment of premiums or whose employment-, income, or other circumstances is the basis for eligibility for membership in a health benefit plan.

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(26) Aq. "Third-party Administratoradministrator" or "TPA" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions, or premiums for, or adjusts or settles claims on or for residents of this State or Vermont or health care providers and facilities. insurers.

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(27) Ar. "Vermont Healthcare Claims Health Care Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting ofdata set containing information related to eligibility, health care claims, and related data submitted pursuant to 18 V.S.A. § 9410. by health care insurers to the GMCB.

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(28) As. "Vermont Uniform Hospital Discharge Data Set" or "VUHDDS" means the data set consisting of inpatient discharge data, outpatient procedures and services data, and emergency department data submitted by general hospitals, ambulatory surgery centers, and psychiatric hospitals that is maintained by the Vermont Department of Health.

(29) "VHCURES members" means members who are Vermont residents.

(30) "VHCURES Reporting Manual" means the document created and maintained by the Board or the Data Governance Council that specifies data submission requirements for the

VHCURES data set, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

(31) "Voluntary ~~Reporter~~submitter" includes ~~any entity~~persons other than ~~a mandated reporter~~mandatory submitters, including any health benefit plan offered or administered by or on behalf of the federal government ~~where such plan, with the agreement of the federal government,~~ or a self-insured employer, that voluntarily submits data to the ~~BISHCA commissioner~~Board for inclusion in the health care database ~~on such terms as may be appropriate.~~

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~~**Section 4: Reporting Requirements**~~

(32) "VUHDDS Reporting Manual" means the document created and maintained by the Board or the Data Governance Council that specifies data submission requirements for the VUHDDS data set, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

8.200 VHCURES Registration and ~~Reporting Requirements~~ Submission

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~~VHCURES Reporter~~ **8.201 Registration.** ~~On an annual basis prior~~

(a) Prior to doing business in Vermont and by each December 31, ~~Health Insurers~~ thereafter, health insurers shall register with the ~~Department on a form established by the Commissioner and~~ Board on the form(s) described in subsection (b) of this section. Health insurers that are VHCURES submitters shall also identify whether ~~health care claims are being paid for members who are Vermont residents and whether~~ they are paying health care claims ~~are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be~~ for VHCURES members.

(b) The Board, in conjunction with the data collection vendor, shall issue and maintain registration forms for health insurers. The forms shall require health insurers to provide the Board with information on their organization and lines of business, including whether the health insurer is a VHCURES mandatory submitter and what data the health insurer will report to the Board.

~~A.~~ (c) Health insurers shall notify the Board when changes are made to any of the health insurer's contact information or the data being submitted ~~per Section 5. This~~to the Board. The amended registration form shall be submitted ~~to BISHCA or its designee. See Appendix F.~~ no later than fifteen (15) days after the applicable change goes into effect.

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~~Third Party Administrator Registration. Any person or entity that provides~~**8.202 VHCURES Submitters**

(a)(1) VHCURES Mandatory Submitters. VHCURES mandatory submitters are health insurers with an average of two hundred (200) or more members in each month of the last calendar year who are VHCURES members.

~~B.~~ A VHCURES mandatory submitter, as defined in subpart (a)(1) of this subsection, must, for each health line of business (e.g., comprehensive major medical, third ~~party administration services, a third~~ -party administrator ~~or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. §9410. See Appendix G.~~

~~C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. §9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont enrollees or beneficiaries. 18 V.S.A. §9471. See Appendix H.~~

~~D. Health Insurers shall~~(TPA)/administrative services only (ASO), Medicare Part C, and Medicare Part D), regularly submit ~~medical~~to the VHCURES data collection vendor medical claims data, dental claims data, ~~-~~pharmacy claims data, member eligibility data, provider data, and other ~~information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the data submission requirements contained in the appendices to this Rule.~~

~~E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.~~

~~**Section 5: Required Healthcare Data Files**~~

(2) ~~Mandated Reporters shall submit to BISHCA or its designee health care claims data~~non-claims information for all members who are ~~Vermont residents and all non-residents who~~

~~received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section.~~ VHCURES members. The data must be submitted in the manner and format(s) and at the times specified in this rule and the VHCURES Reporting Manual.

(3) Each ~~Mandated Reporter~~VHCURES mandatory submitter is ~~also~~ responsible for the submission of data relating to all health care claims processed by ~~any sub-~~a contractor or subcontractor on its behalf unless such contractor or subcontractor is already submitting ~~the~~ identical data as a ~~Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes~~VHCURES mandatory submitter in its own right.

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~~A. General Requirements for~~(b)(1) VHCURES Voluntary Submitters. A VHCURES voluntary submitter may submit the data specified in subpart (a)(2) of this subsection to the VHCURES data collection vendor.

(2) The Board encourages VHCURES voluntary submitters to follow the data submission specifications and schedule outlined in section 8.203 of this rule and the VHCURES Reporting Manual.

8.203 VHCURES Data Submission

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~~(1) Adjustment Records. Adjustment records shall be reported with the appropriate positive or negative fields with the medical and pharmacy claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.~~

(a) ~~Behavioral or Mental Health Claims. All claims related to behavioral or mental health~~ File Organization. Data shall be submitted in the format(s) specified in the VHCURES Reporting Manual.

~~(2)~~ Submission Protocol. Files shall be ~~included in the medical claims file.~~

~~(3) Capitated Service Claims. Claims for capitated services shall be reported with all medical and pharmacy claims file submissions.~~

~~(4) Claims Records. Records for the medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims is based upon the paid dates and not upon the dates of service associated with the claims.~~

~~(5) Codes and Encryption Requirements~~

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete twodigit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/ subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryption methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

(c) Specific/Unique Coding. With the exception of provider, provider specialty, and procedure/diagnosis codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(6) Co-Insurance/Co-Payment. Co-insurance and co-payment are to be reported in two separate fields in the medical and pharmacy claims file submissions.

(7) Coordination of Benefits Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

(9) Eligibility Records. Records for the member eligibility file submission shall be reported at the individual member level with one record submitted for each claim type. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(10) Exceptions.

(a) Medical Claims File Exclusions. All claims related to services provided under stand-alone health care policies shall be excluded if the services are not covered by comprehensive medical insurance policies and are provided on a stand-alone basis for: 1. Specific disease; 2. Accident;
3. Injury;
4. Hospital indemnity;
5. Disability;
6. Long-term care;
7. Student liability;
8. Vision coverage; or 9. Durable medical equipment.

(b) Claims for pharmacy services containing national drug codes are to be included in the pharmacy claims file, but excluded from the medical claims file.

(c) Member Eligibility File Exclusions. Members without medical or pharmacy coverage for the month reported shall be excluded.

(11) File Format. Each file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, the entire value shall be enclosed in double quotes.

(12) Insured Group or Policy Number Key Look-up Table. Reporters are required to submit a key look-up table when submitting member eligibility files. The key look-up table shall link Insured Group or Policy Number (ME006) to the name of the group associated with each Insured Group or Policy Number, but shall not identify any individual policyholders in connection with non-group policies.

(13) Header and Trailer Records. Each member eligibility file and each medical and pharmacy claims file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. The header and trailer record formats shall be as detailed in Appendices B-1 and B-2.

(14) Pharmacy Claims. Claims for pharmacy services shall be included in the following files:

(a) If the pharmacy claims are covered under the medical benefit then the claim shall be included in the medical claims file and not the pharmacy claims file: and

(b) If the claim is covered under the prescription benefit then the claim shall be included in the pharmacy claims file.

(15) Prepaid Amount. Any prepaid amounts are to be reported in a separate field in the medical and pharmacy claims file submissions.

(16) Supplemental Health Insurance. Claims related to supplemental health insurance are to be included if the policies are for health care services entirely excluded by the Medicare, Tricare, or other publicly funded health benefit programs.

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Nonrequired text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA-1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a) (1) Member Eligibility File Specifications – Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats – Appendix C-2

(b) (1) Medical Claims File Specifications – Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats - Appendix D-2

(e) (1) Pharmacy Claims File Specifications - Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats - Appendix E-2

Section 6: Submission Requirements

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the registration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files. Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

(b) Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD.electronically by either secure sockets layer (SSL) web upload interface, or electronic transmission through a File Transfer Protocol. E-mail or secure file transfer protocol (FTP), or as specified in the VHCURES Reporting Manual. Email attachments shall not be accepted.

C. Testing of Files. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and Email address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

(a)

E.(c) Testing of Files. At least sixty (60) days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5the VHCURES Reporting Manual is subsequently altered, each ReporterVHCURES submitter shall submit to BISHCA or its designee a data set for comparison to the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section. data to the data collection vendor in accordance with the VHCURES Reporting Manual for testing and validation.

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~~F.~~(d) Rejection of Files. ~~-~~Failure to conform to subsections ~~A. B.~~(a) or ~~C~~(b) of this ~~Section~~section shall result in the rejection and return of the applicable data file(s). ~~-~~All rejected and returned files shall be resubmitted in the appropriate~~.~~ corrected form to ~~BISHCA or its designee~~the VHCURES data collection vendor within ten (10) days.

~~G.~~(e) Replacement of Data Files. ~~No Reporter may replace~~In the event a complete data file submission is replaced more than one (1) year after the end of the month in which the file was submitted ~~unless it can establish exceptional circumstances for the replacement. Any replacements after this period~~, the VHCURES submitter must ~~be approved by BISHCA.~~ notify the Board. Individual adjustment records may be submitted with any ~~monthly~~ data file submission~~.~~ in accordance with the applicable data submission schedule.

~~H.~~(f) Run-Out Period. ~~Reporters~~VHCURES submitters shall submit ~~medical and pharmacy claims files~~ data for at least a six (6) month period following the termination of coverage date for ~~all members who are Vermont residents or non-residents receiving covered services provided by Vermont health care providers or facilities.~~ the particular VHCURES member.

~~I.~~ ~~Data Submission Schedule.~~(h)(1) Reporting Period. The reporting period for submission ~~of each specified file listed in Section 5~~for all VHCURES mandatory submitters shall be determined ~~on a separate basis for Vermont members and non-resident members~~ by the highest total number of ~~Vermont resident members or non-resident members receiving covered services provided by Vermont providers or facilities for which claims are being paid~~ VHCURES members for any one month of the calendar year. Data files are to be submitted in accordance with the ~~following~~ schedule: contained in the VHCURES Reporting Manual.

~~Total # of Members~~	~~Reporting Period~~	~~Reporting Schedule~~
~~≥ 2,000~~	~~Monthly~~	~~Prior to the end of the month following the month in which claims were paid~~
~~500 – 1,999~~	~~Quarterly~~	~~Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid~~
~~200 – 499~~	~~Annually~~	~~Prior to April 30 of the following year for the preceding twelve months in which claims were paid~~
~~< 200~~	~~N/A~~	

(2) If ~~the~~ data files submitted by an individual ~~Reporter~~VHCURES submitter support or are related to ~~the~~ files submitted by another ~~Reporter. BISHCA shall~~ VHCURES submitter.

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the Data Governance Council may establish a ~~filing~~different reporting period for the parties involved.

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~~**Section 7: Compliance with Data Standards**~~

~~A. Standards. BISHCA or its designee shall evaluate each member eligibility file, medical claims file and pharmacy claims file in accordance with the following standards:~~

~~(1) The applicable code for each data element shall be as identified in Appendices C-1, D-1, and E-1 and shall be included within eligible values for the element;~~

~~(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;~~

~~(3) Member sex, diagnosis and procedure codes, and date of birth and all other date fields shall be consistent within an individual record;~~

~~(4) Member identifiers shall be consistent across files; and~~

~~(5) Files submitted shall not contain direct personal identifiers.~~

~~B. Notification. Upon completion of this evaluation, BISHCA or its designee will promptly notify each Reporter whose data submissions do not satisfy the standards for any reporting period. This notification will identify the specific file and the data elements that are determined to be unsatisfactory.~~

~~C. Response. Each Reporter notified under subsection 7.B shall resubmit within 60 days of the date of notification with the required changes.~~

~~D. Compliance. Failure to file, report, or correct health care claims data sets in accordance with the provisions of this regulation may be considered a violation of 18 V.S.A. § 9410 (g).~~

~~**Section 8: Procedures for the Approval and Release of Claims Data**~~

~~The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall~~

depend upon the requestor and the characteristics of the particular information requested. all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance.

B. Public Use Data Sets: Release and Availability

(1) Unrestricted Data Elements collected or generated by the Department or its designee shall be made available in public use files and provided to any person upon written request, except where otherwise prohibited by law.

(2) The Department shall maintain a public record of all requests for and releases of public use data sets.

C. Limited Use Health Care Claims Research Data Sets- Release and Availability

(1) Limited Use Health Care Claims Research Data Sets shall be those sets which contain restricted data elements, shall not be available to the general public and shall be released to a requestor only for the purpose of research upon a determination by the Commissioner that the following conditions have been met:

(a) Application: Any person requesting access to or use of Limited Use Health Care Claims Research Data Sets shall submit an application, in written and electronic form, to the Commissioner disclosing the information listed below. Studies utilizing data sets for longer than 2 years may be required to reapply.

~~(1) Identity of principal investigator:~~

~~(a) Name, address, and phone number:~~

~~(b) Organizational affiliation:~~

~~(c) Professional qualification; and~~

~~(d) Phone number of principal investigator's contact person, if any.~~

~~Identity of person requesting access~~(i) Data Collection Vendor's Submission Requirements. The VHCURES data collection vendor may provide additional guidelines, information, and instructions regarding the submission of data to VHCURES. Subject to section 8.400 of this rule, VHCURES mandatory submitters shall comply with the guidelines, information, and instructions the VHCURES data collection vendor sets.

8.204 GMCB VHCURES Reporting Manual

The Board, through its Data Governance Council, shall issue and maintain a publicly accessible document entitled "VHCURES Reporting Manual" addressing the following topics:

(a) The data VHCURES mandatory submitters shall submit:

~~(2)~~ Technical specifications for the data, including ~~any entities for whom that person is acting in requesting~~ the member eligibility data.

~~(a) Name, address,~~ medical claims data, and ~~phone number:~~

~~(b) Organizational affiliation:~~

~~(c) Professional qualification; and~~

~~(d) Name and phone number of contact person.~~

~~(3) Identity of and qualifications of any other persons who may have access to the data.~~

~~(4) A detailed research protocol, to include:~~

~~(a) A summary of background, purposes, and origin of the research:~~

~~(b) A statement of the health-related problem or issue to be addressed by the research:~~

(b) pharmacy claims data;

(c) The ~~research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested;~~ reporting schedule for VHCURES mandatory submitters; and

~~(d) The procedures that will be followed to maintain the confidentiality of any data or copies of records provided to the principal investigator or other persons; and~~

~~(e) The intended research completion date;~~

~~(5) Particular data set requested, including:~~

~~(a) The time period of the data requested;~~

~~(b) The specific data elements or fields of information required;~~

~~(c) A justification of the need for each restricted element or field, as identified in the data release schedule;~~

~~(d) The minimum needed specificity of the requested data elements, including the manner in which the data may be recoded by the department to be less specific;~~

~~(e) The selection criteria for the minimum needed data records required; and~~

~~(f) Any particular format or layout of data requested by the principal investigator.~~

~~(6) Any changes to information submitted as part of an application pursuant to (a)(1)-(4) shall require notice to the Department by the applicant and shall be subject to the approval of the Commissioner.~~

~~(b) The person or entity requesting access and the principal investigator or investigators shall be subject to the following requirements and limitations and shall, in addition, sign and submit a data use agreement acknowledging and accepting these same provisions as a necessary condition to any data access:~~

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(1) Use of data for any purpose other than as specified in the application and approved by the Commissioner shall be prohibited:

(2) Appropriate safeguards to protect the confidentiality of the data and prevent unauthorized use of the data shall be established:

(3) The use or disclosure, sale, or dissemination of the data set or statistical tabulations derived from the data set to any person or organization for any purpose other than as described in the application and as permitted by the data use agreement shall be prohibited without the express written consent of the Commissioner.

(4) The use or disclosure, sale, or dissemination of any information contrary to law shall be prohibited:

(5) No person shall disclose the identity of patients, employer groups or purchaser groups from information contained in the limited use data set:

(6) No person shall disclose any of the information that has been encrypted or removed from the data:

(7) The content of cells that contain counts of persons in statistical tables in which the cell size is more than 0 and less than 5 shall not be disclosed, published or made public in any manner except as "<5":

(8) The publication, dissemination or disclosure of any information that could be used to identify providers of abortion services shall be prohibited:

(9) Any use or disclosure of the information that is contrary to the Data Use Agreement or this Regulation shall be reported to the Department within five (5) days of when the principal investigator becomes aware of such disclosure.

(10) The Department and the "Vermont Healthcare Claims Uniform Reporting and Evaluation System" shall be acknowledged as the source and owner of the data in any and all public reports, publications, or presentations generated from the data:

(11) Written materials shall prominently state that the analyses, conclusions and recommendations drawn from such data are solely those of the requestor or principal investigator and are not necessarily those of the Department;

(12) The Department shall be provided with a copy of any proposed report or publication containing information derived from the data at least 15 days prior to any publication or release to allow the department to review the proposed report or publication and confirm that the conditions of the agreement have been applied. When multiple reports of a similar nature will be created from the data, the Department may, on request, waive the requirement that any subsequent reports or publications be provided to the Department prior to release by the requesting party

(13) Data elements shall not be retained for any period of time beyond that necessary to fulfill the requirements of the data request.

(14) Within 30 days after the scheduled completion date of the project, the requestor shall delete, destroy or otherwise render the data unreadable, so certifying by submitting a written notice to the Department or by reapplying for approval if the end date of the project needs to be extended;

(15) Any draft reports or publications supplied to the department shall be considered confidential and exempt from public review under 1 V.S.A. §315 et seq. and shall not be released by the Department; and

(16) Failure to adhere to the data use agreement or the limitations and restrictions detailed above will be cause for immediate recall by the Department of the data, revocation of permission to use the data, and grounds for civil or administrative enforcement action by the Department under applicable Vermont state law.

(c) The Department shall establish a claims data release advisory committee with a chair person and members appointed annually by the Commissioner, to provide non-binding advice and opinion to the Commissioner, as and when requested, on the merits of applications for access to limited use data sets. If the Commissioner has requested a review of the application, the claims data release advisory committee shall provide the Commissioner

with any comment on the merits of the application and the research protocol described therein within thirty (30) days. The committee shall be comprised of seven (7) members and include:

(1) At least one member representing health insurers;

(2) At least one member representing health care facilities;

(3) At least one member representing health care providers;

(4) At least one member representing purchasers of health insurance or health benefits; and

(5) At least one member representing healthcare researchers.

(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

(3) If the Commissioner declines to release the requested limited use data sets within 60 days of receipt of a complete application, the Department shall give written notice of the basis for denial of the application and the requestor shall have leave to resubmit or supplement the application to address the Commissioner's concerns. Any adverse decision regarding an

~~application may be appealed within 30 days by filing a request for hearing with the Commissioner pursuant to Department Rule 82-1.~~

~~**Section 9: Prices for Data Sets, Fees for Programming and Report Generation, Duplication Rates**~~

~~This Section lists the prices for data sets from the Vermont Healthcare Claims Uniform Reporting and Evaluation System, including the fees for programming and report generation, duplicating charges and other costs associated with the production and transmission of data sets approved for release by the Department.~~

~~A. An annual public use file consisting of unrestricted fields and data elements shall be made available to any person upon request at the cost required for the Department to process, package and ship the data set, including any electronic medium used to store the data.~~

~~B. Limited Use Research Health Care Claims Data Sets approved by the Department shall be made available to the requesting party at the cost charged by the Department's designated vendor to program and process the requested data extract, including any consulting services and costs to package and ship the data set on particular electronic medium.~~

~~C. Payments are due in full from the requesting party within thirty days of receipt of BISHCA data sets, files, reports, or other released material.~~

(d) ~~Section 10:~~ Any other matters the Board deems appropriate.

8.205 Data Quality Assurance

The Board shall work in collaboration with the VHCURES data collection vendor to ensure that submitted data are accurate and consistent with the VHCURES Reporting Manual and the data collection vendor's submission requirements.

8.300 VUHDDS Submission

8.301 VUHDDS Submitters

(a)(1) VUHDDS Mandatory Submitters. VUHDDS mandatory submitters are ambulatory surgery centers, general hospitals, and psychiatric hospitals in Vermont.

(2) A VUHDDS mandatory submitter, as defined in subpart (a)(1) of this subsection, must submit including inpatient discharge data, outpatient procedure and service data, emergency department data, and other financial, scope- and volume-of-service, and

utilization data to the VUHDDS data collection vendor. The data must be submitted in the manner and format(s) and at the times specified in the VUHDDS Reporting Manual.

(3) The submissions required under this section shall be in addition to any submissions required by the uniform reporting manual described in GMCB Rule 3.000.

(b)(1) VUHDDS Voluntary Submitters. A VUHDDS voluntary submitter may submit the data specified in subsection 8.301(a)(2) to the VUHDDS data collection vendor.

(2) The Board encourages VUHDDS voluntary submitters to follow the data submission specifications and schedule outlined in the VUHDDS Reporting Manual.

(c) Data Collection Vendor's Submission Requirements. The VUHDDS data collection vendor may provide additional guidelines, information, and instructions regarding the submission of data to VUHDDS. Subject to section 8.400 of this rule, VUHDDS mandatory submitters shall comply with the guidelines, information, and instructions the VUHDDS data collection vendor sets.

8.302 GMCB VUHDDS Reporting Manual

VUHDDS Reporting Manual. The Board, through its Data Governance Council, shall issue and maintain a publicly accessible guidance document, entitled "VUHDDS Reporting Manual," addressing topics including:

(a) The data VUHDDS mandatory submitters shall submit;

(b) Technical specifications for the data submitted to VUHDDS;

(c) The reporting schedule for VUHDDS mandatory submitters; and

(d) Any other matters the Board deems appropriate.

8.303 Data Quality Assurance

The Board shall work in collaboration with its data collection vendor to ensure that submitted data are accurate and consistent with the VUHDDS Reporting Manual and any additional guidelines, information, and instructions the data collection vendor may issue.

8.400 Changes to a Reporting Manual

8.401 Modifications and Revisions to a Reporting Manual

The Data Governance Council may revise or modify reporting manuals as appropriate. Prior to approving any revisions or modifications, the Council will send each affected submitter notice and a copy of the proposed revisions or modifications. The Board will also post the notice and proposed revisions or modifications on its website. The Council will accept public comments on the proposed revisions or modifications for thirty (30) days from the date of posting and will review and consider all comments received before approving revisions or modifications.

8.402 Public Meeting

The Data Governance Council may hold a public meeting to discuss and receive comments on proposed revisions or modifications to reporting manuals. Such meetings, if held, must be held in accordance with the Vermont Open Meeting Law, 1 V.S.A. §§ 310, *et seq.*

8.403 Implementation

Revisions or modifications to reporting manuals shall become effective one hundred twenty (120) days, or such longer time specified by the Data Governance Council, after the Data Governance Council votes to approve them. The Data Governance Council shall review all comments related to the time required by submitters to comply with any revisions or modifications to the reporting manuals, and the Council shall consider such comments when determining whether to specify a time period longer than one hundred twenty days before revisions or modifications become effective. During that 120-day period (or longer, if specified by the Data Governance Council), affected mandatory submitters shall work with the Board and the data collection vendor to ensure the revisions or modifications can be implemented effectively. For good cause, an affected submitter may request a reasonable extension to the 120-day (or longer, if specified by the Data Governance Council) implementation period, which the Council may grant as it deems appropriate. Any such request shall be submitted to the Council chair in writing and contain the length of the extension requested and a detailed explanation as to why there is good cause to grant the extension.

8.404 Appeal Procedure

A decision by the Data Governance Council to deny a request for an extension to the 120-day (or longer, if specified by the Data Governance Council) implementation period may be appealed to the Board by filing a written request to the Board chair within thirty (30) days of the Council's decision. If the request does not include a request for a hearing, the Board may decide the appeal based on the record developed by the Data Governance Council.

8.500 Enforcement

8.501 Sanctions for Violations

Violations of data submission requirements, confidentiality requirements, ~~data use limitations or~~ any other provisions of 18 V.S.A. § 9410 or this rule ~~shall~~, may be subject to sanction by the ~~Commissioner as set out in 18 V.S.A. §9410~~Board in accordance with 18 V.S.A. § 9410(g) after written notice and an opportunity for a hearing. The Board's authority to impose sanctions is in addition to any other powers granted to the ~~Commissioner~~Board to investigate, subpoena, ~~fine~~ or seek other legal or equitable remedies~~.~~, including the power of the Board to enforce the terms of a governing contract.

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~~Section 11:~~ **8.600 Other Matters**

8.601 Waiver of Rules

In order to prevent unnecessary hardship, delay, or injustice, or for other good cause, the Board may waive the application of any provision of this rule upon such conditions as it may require, unless precluded by the rule itself or by statute.

8.602 Conflict

In the event this rule or any section thereof conflicts with a federal statute, rule, or regulation or a Vermont statute, the federal or state statute, or the federal rule or regulation shall govern.

8.603 Severability

If any provision of this ~~regulation~~rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the ~~regulation~~rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

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~~H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)~~

~~Appendix A: Source Codes~~

~~**Admission Source Code**~~
~~**(Data Element: MC021)**~~

~~SOURCE: National Uniform Billing Data Element Specifications~~

~~AVAILABLE FROM:~~
~~National Uniform Billing Committee~~
~~American Hospital Association~~
~~840 Lake Shore Drive~~
~~Chicago, IL 60697~~

~~ABSTRACT: A variety of codes explaining who recommended admission~~ **8.604 Effective Date**

This rule shall become effective fifteen (15) days after adoption and supersedes all previously issued rules and policies related to ~~a medical facility.~~

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~~**Admission Type Code**~~
~~**(Data Element: MC020)**~~

~~SOURCE: National Uniform Billing Data Element Specifications~~

~~AVAILABLE FROM:~~
~~National Uniform Billing Committee~~
~~American Hospital Association~~
~~840 Lake Shore Drive~~
~~Chicago, IL 60697~~

~~ABSTRACT: A variety of codes explaining~~ the ~~priority of~~ health care database, including Regulation H-2008-01 issued by the ~~admission to a medical facility.~~

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~~**Current Procedural Terminology (CPT) Codes**~~
~~**(Data Element: MC055)**~~

~~SOURCE: Physicians' Current Procedural Terminology (CPT) Manual~~

~~AVAILABLE FROM:~~
~~Order~~Vermont Department
~~American Medical Association~~
~~515 North State Street~~
~~Chicago, IL 60610~~

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~~ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.~~

of Banking, Insurance, Securities and Health Care ~~**Common Procedural Coding System**~~
~~**(Data Element: MC055)**~~

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~~SOURCE: Health Care Common Procedural Coding System~~

Appendix A: Source Codes

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm Centers
for Medicare and Medicaid Services
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Centers for Medicare and Medicaid Services National Plan ID
(Data Elements: HD003, MC002, ME002, PC002, TR003)

SOURCE: Plan ID Database

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Center for Beneficiary Services
Administration Group
Division of Membership Operations
SI-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

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ABSTRACT: The Centers for Medicare and Medicaid Services is developing the Plan ID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

Centers for Medicare and Medicaid Services National Provider Identifier
(Data Elements: MC026)

SOURCE: National Provider System

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

Discharge Status Code
(Data Element: MC023)

Appendix A: Source Codes

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes indicating Member status as of the date of service thru field.

International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
(Data Elements: MC040, MC041, MC042, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058)

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

AVAILABLE FROM:
U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

National Association of Boards of Pharmacy Number
(Data Element: PC021)

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:
National Council for Prescription Drug Programs
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of

Appendix A: Source Codes

Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number. NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Association of Insurance Commissioners (NAIC) Code
(Data Elements: HD002, MC001, ME001, PC001, TR002)

SOURCE: National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM:
National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT: Codes that uniquely identify each insurance company.

National Drug Code
(Data Element: PC026)

SOURCE: Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM:
First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

National Uniform Billing Committee (NUBC) Codes
(Data Element: MC054)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

States and Outlying Areas of the U.S.
(Data Elements: MC015, MC034, ME016, PC015, PC023)

SOURCE: National Zip Code and Post Office Directory

AVAILABLE FROM:

Appendix A: Source Codes

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche AVAILABLE FROM: NTIS (same as address above). The Canadian Post Office lists the following as "official" codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT – Yukon

Uniform Billing Claim Form Bill Type
(Data Element: MC036)

SOURCE: National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes describing the type of medical facility.

X12 Directories

SOURCE: X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT: The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

Appendix A: Source Codes

ZIP Code
(Data Elements: MC016, MC035, ME017, PC016, PC024)

SOURCE: National ZIP Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual

AVAILABLE FROM:
U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT: The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

Appendix B-1: Header Record Specifications

Data Element	Required	Maximum #	Element	Start Date	Type	Length	Description/Codes/Sources
HD001	Record Type	1/31/2007	Text		2		HD
HD002	Payer	1/31/2007	Text		8		Payer submitting payments BISHCA Submitter Code
HD003	National Plan ID	1/31/2007	Text		30		CMS National Plan ID
HD004	Type of File	1/31/2007	Text		2		DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
HD005	Period Beginning Date	1/31/2007	Integer		6		CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
HD006	Period Ending Date	1/31/2007	Integer		6		CCYYMM End of paid period for Claims End of month covered for Eligibility
HD007	Record Count	1/31/2007	Integer		10		Total number of records submitted in this file Exclude header and trailer record in count
HD008	Comments	1/31/2007	Text		80		Submitter may use to document this submission by assigning a filename, system source, etc.

Appendix B-2: Trailer Record Specifications

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
TR001	Record Type	1/31/2007	Text	2	TR
TR002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
TR003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
TR004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
TR005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
TR006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
TR007	Date Processed	1/31/2007	Date	8	CCYYMMDD Date file was created

ME001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
ME002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product **13** Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan **14** Medicare Secondary, No-fault insurance including Auto is primary **15** Medicare Secondary Worker's Compensation **16** Medicare Secondary Public Health Service or Other Federal Agency **41** Medicare Secondary Black Lung **42** Medicare Secondary Veteran's Administration **43** Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary *AP Auto Insurance Policy CP Medicare Conditionally Primary *D Disability *DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) Medicare Advantage HS Special Low Income Medicare Beneficiary IN Indemnity *LC Long Term Care *LD Long Term Policy *LI Life Insurance *LT Litigation MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid MH Medigap Part A	1/31/2007	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan

Appendix C-1: Member Eligibility File Specifications

Data Element		Required		Maximum	
#	Element	Start Date	Type	Length	Description/Codes/Sources
					MI Medigap Part B
					MP Medicare Primary

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME003 (Cont'd)	Insurance Type Code/Product				PC - Personal Care PE - Property Insurance – Personal PR - Preferred Provider Organization (PPO) PS - Point of Service (POS) QM - Qualified Medicare Beneficiary SP - Supplemental Policy * WC - Workers' Compensation * - Indicates that code is not to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
ME004	Year	1/31/2007	Integer	4	The year for which eligibility is reported in this submission.
ME005	Month	1/31/2007	Integer	2	The month for which eligibility is reported in this submission.
ME006	Insured Group or Policy Number	1/31/2007	Text	30	The group or policy number - not the number that uniquely identifies the subscriber.
ME007	Coverage Level Code	1/31/2007	Text	3	Benefit coverage level CHD - Children Only DEP - Dependents Only ECH - Employee and Children EMP - Employee Only ESP - Employee and Spouse

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
ME008	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
ME009	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
ME010	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
ME011	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
ME012	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 18 Self/Employee 19 Child 21 Unknown 34 Other Adult
ME013	Member Gender	1/31/2007	Text	1	M Male F Female

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					U Unknown
ME014	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
ME015	Member City Name	1/31/2007	Text	30	The city location of the member.
ME016	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member - may include non-US codes. Do not include dash.
ME018	Medical Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC019. N No
ME019	Prescription Drug Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC018. N No
ME020	Placeholder		Text	1	Used and or proposed by other states for – Dental coverage.
ME021	Placeholder		Text	6	Used and or proposed by other states for - Race 1.
ME022	Placeholder		Text	6	Used and or proposed by other states for - Race 2.
ME023	Placeholder		Text	15	Used and or proposed by other states for – Other Race.
ME024	Placeholder		Text	1	Used and or proposed by other states for – Hispanic indicator.

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME025	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 1.
ME026	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 2.
ME027	Placeholder		Text	20	Used and or proposed by other states for – Other Ethnicity.
ME028	Primary Insurance Indicator	1/31/2007	Text	1	1- Yes, primary insurance 2- No, secondary or tertiary insurance
ME029	Coverage Type	1/31/2007	Text	3	ASW – for self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO – for self funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage STN – for short-term non-renewable health insurance. UND – for plans underwritten by the insurer OTH – for any other plan. Insurers using this code shall obtain prior approval from BISHCA
ME030	Market Category Code	1/31/2007	Text	4	IND – for policies sold and issued directly to individuals. (Non-group) FCH – or policies sold and issued directly to individuals on a franchise basis. GCV – for policies sold and issued directly to individuals as group conversion policies. GS1 – for policies sold and issued directly to employers having exactly one employee

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					GS2 - for policies sold and issued directly to employers having between two and nine employees GS3 - for policies sold and issued directly to employers having between 10 and 25 employees GS4 - for policies sold and issued directly to employers having between 26 and 50 employees
ME030 (Cont'd)	Market Category Code (Cont'd)	1/31/2007	Text	4	GLG1 -for policies sold and issued directly to employers having between 51 and 99 employees GLG2 -for policies sold and issued directly to employers having 100 or more employees GSA - for policies sold and issued directly to small employers through a qualified association trust OTH - For policies sold to other types of entities. Insurers using this market code shall obtain prior approval from BISHCA
ME031	Placeholder		Text	3	Used and or proposed by other states for Special Coverage: 0 -N/A 1 -NH HealthFirst 2 -VT Catamount
ME101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
ME102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
ME103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
ME104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
ME106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
ME899	Record Type	1/31/2007	Text	2	Value = ME

Appendix C-2: Member Eligibility File Mapping to National Standards

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2110D/EB/ /03
ME008	Encrypted Subscriber Unique Identification Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	271/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Placeholder	N/A
ME021	Placeholder	N/A
ME022	Placeholder	N/A
ME023	Placeholder	N/A
ME024	Placeholder	N/A
ME025	Placeholder	N/A

ME026	Placeholder	N/A
ME027	Placeholder	N/A

Appendix C-2: Member Eligibility File Mapping to National Standards

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category Code	N/A
ME031	Placeholder	N/A
ME101	Encrypted Subscriber Last Name	N/A
ME102	Encrypted Subscriber First Name	N/A
ME103	Encrypted Subscriber Middle Initial	N/A
ME104	Encrypted Member Last Name	N/A
ME105	Encrypted Member First Name	N/A
ME106	Encrypted Member Middle Initial	N/A
ME899	Record Type	N/A

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
MC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	1/31/2007	Text	2	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Advantage HM Health Maintenance Organization MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Worker's Compensation * Indicates that code is not to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
MC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
MC005	Line Counter	1/31/2007	Integer	4	The line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.
MC005A	Version Number	1/31/2007	Integer	4	The version number of this claim service line.

					The version number begins with 0 and is incremented by 1 for each subsequent version of that service line.
MC006	Insured Group or Policy Number	1/31/2007	Text	30	Group or policy number - not the number that uniquely identifies the subscriber.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
MC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
MC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
MC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
MC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent
MC012	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
MC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
MC014	Member City Name	1/31/2007	Text	30	The city name of the member.
MC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
MC016	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member - may include non-US codes. Do not include dash.
MC017	Date Service Approved/Accounts Payable Date/Actual Paid Date	1/31/2007	Date	8	CCYYMMDD
MC018	Admission Date	1/31/2007	Date	8	Required for all inpatient claims. CCYYMMDD
MC019	Admission Hour	1/31/2007	Integer	4	Required for all inpatient claims. Time is expressed in military time – HHMM

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC020	Admission Type	1/31/2007	Integer	1	Required for all inpatient claims. Refer to Appendix A.
MC021	Admission Source	1/31/2007	Text	1	Required for all inpatient claims. Refer to Appendix A.
MC022	Discharge Hour	1/31/2007	Integer	4	Hour in military time - HHMM
MC023	Discharge Status	1/31/2007	Integer	2	Required for all inpatient claims. 01 Discharged to home or self care 02 Discharged/transferred to another short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to nursing facility (NF)
MC023 (Cont'd)	Discharge Status (Cont'd)				05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital 20 Expired 30 Still patient or expected to return for outpatient services 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 43 Discharged/transferred to a Federal Hospital 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital 63 Discharged/transferred to a long term care hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
MC024	Service Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. In many cases, it will be the provider Medicare number.
MC025	Service Provider Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number.
MC026	National Service Provider ID	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA. The preferred code for this element is for the rendering provider. For the billing provider, see MC077.
MC027	Service Provider Entity Type Qualifier	1/31/2007	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Insurers and health care processors shall code according to: 1 Person 2 Non-Person Entity
MC028	Service Provider First Name	1/31/2007	Text	25	Individual first name.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					Set to null if provider is a facility or organization.
MC029	Service Provider Middle Name	1/31/2007	Text	25	Individual middle name or initial. Set to null if provider is a facility or organization.
MC030	Service Provider Last Name or Organization Name	1/31/2007	Text	60	Full name of provider organization or last name of individual provider.
MC031	Service Provider Suffix	1/31/2007	Text	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LCSW).
MC032	Service Provider Specialty	1/31/2007	Text	50	As defined by payer Dictionary for specialty code values must be supplied during testing.
MC033	Service Provider City Name	1/31/2007	Text	30	City name of provider and preferably the practice location.
MC034	Service Provider State or Province	1/31/2007	Text	2	As defined by the US Postal Service.
MC035	Service Provider ZIP Code	1/31/2007	Text	11	ZIP Code of provider - may include non-US codes. Do not include dash.
MC036	Type of Bill - Institutional/ Facility Claims, such as those submitted using on UB04 forms	1/31/2007	Integer	2	Required for institutional claims. Not to be used for professional claims. **Type of Facility - First Digit**
					1 Hospital
					2 Skilled Nursing
MC036 (Cont'd)	Type of Bill - Institutional/ Facility Claims (Cont'd)				3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type Maximum Length	Description/Codes/Sources
				6 Intermediate Care 7 Clinic 8 Special Facility
				Bill Classification - Second Digit if First Digit = 1-6
				1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care - Level III Nursing Facility 8 Swing Beds
				Bill Classification - Second Digit if First Digit = 7
				1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORF) 6 Community Mental Health Center 9 Other
				Bill Classification - Second Digit if First Digit = 8
				1 Hospice (Non Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other
MC037	Site of Service – on NSF/CMS 1500 Claims	1/31/2007 Text	2	Required for professional claims. Not to be used for institutional claims. 11 Office 12 Home 21 Inpatient Hospital

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					22 Outpatient Hospital
MC037 (Cont'd)	Site of Service – on NSF/CMS 1500 Claims (Cont'd)				23 Emergency Room - Hospital 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 35 Boarding Home 41 Ambulance - Land 42 Ambulance - Air or Water 50 Federally Qualified Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility
MC038	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					03 Processed as tertiary 04 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment
MC039	Admitting Diagnosis	1/31/2007	Text	5	Required on all inpatient admission claims and encounters using the ICD-9-CM. Do not code decimal point.
MC040	E-Code	1/31/2007	Text	5	Describes an injury, poisoning or adverse effect using the ICD-9-CM. Do not include decimal point.
MC041	Principal Diagnosis	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC042	Other Diagnosis – 1	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC043	Other Diagnosis – 2	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC044	Other Diagnosis – 3	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC045	Other Diagnosis – 4	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC046	Other Diagnosis – 5	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC047	Other Diagnosis – 6	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC048	Other Diagnosis – 7	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC049	Other Diagnosis – 8	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC050	Other Diagnosis – 9	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC051	Other Diagnosis – 10	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC052	Other Diagnosis – 11	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC053	Other Diagnosis – 12	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC054	Revenue Code	1/31/2007	Integer	4	National Uniform Billing Committee Codes. Code using leading zeroes, left justified and four digits.
MC055	Procedure 1 Code	1/31/2007	Text	5	Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association.
MC056	Procedure 1 Modifier – 1	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. When the insurer utilizes a local code system for modifiers, a reference table shall be submitted.
MC057	Procedure 1 Modifier – 2	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. When the insurer utilizes a local code system for modifiers, a reference table shall be submitted.
MC058	ICD-9-CM Procedure Code	1/31/2007	Text	4	Primary ICD-9-CM code for this line of service. Do not code decimal point.
MC059	Date of Service – From	1/31/2007	Date	8	First date of service for this service line.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					CCYYMMDD
MC060	Date of Service – Thru	1/31/2007	Date	8	Last date of service for this service line. CCYYMMDD
MC061	Quantity	1/31/2007	Integer	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.
MC062	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
MC063	Paid Amount	1/31/2007	Decimal	10	Includes any withhold amounts. Do not code decimal point. This element includes all payments made by the insurer except capitation.
MC064	Prepaid Amount	1/31/2007	Decimal	10	For capitated services - the fee for service equivalent amount. Do not code decimal point.
MC065	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
MC066	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.
MC067	Deductible Amount	1/31/2007	Decimal	10	The dollar amount of the deductible. Do not code decimal point.
MC068	Patient Account/Control Number	1/31/2007	Text	20	Number assigned by hospital.
MC069	Discharge Date	1/31/2007	Date	8	Date patient discharged. Required for all inpatient claims.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					CCYYMMDD
MC070	Service Provider Country Name	1/31/2007	Text	30	Code US for United States.
MC071	DRG	1/31/2007	Text	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	1/31/2007	Text	2	Version number of the grouper used.
MC073	APC	1/31/2007	Text	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.
MC074	APC Version	1/31/2007	Text	2	Version number of the grouper used.
MC075	Drug Code	1/31/2007	Text	11	Insurers and health care claims processors shall code according to NDC code.
MC076	Billing Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.
MC077	National Billing Provider ID	1/31/2007	Text	20	National Provider ID mandated for use under HIPAA.
MC078	Billing Provider Last Name	1/31/2007	Text	60	Full name of billing organization or last name of individual billing or Organization Name.
MC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
MC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
MC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
MC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
MC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
MC899	Record Type	1/31/2007	Text	2	Value = MC

Appendix D2: Medical Claims File Mapping to National Standards

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	835/2100/CLP/ /07
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC005A	Version Number	N/A	N/A	N/A	N/A	N/A
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Encrypted Subscriber Unique Identification Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/09
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/09
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Identification Code	N/A	N/A	N/A	N/A	835/2100/NM1/MI/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG//03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Date Service Approved	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03

Appendix D2: Medical Claims File Mapping to National Standards

MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11	N/A	N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22	N/A	N/A	837/2300/DTP/096/03
MC023	Discharge Status	22	20/21	N/A	N/A	837/2300/CL1/ /03

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC024	Service Provider Number	N/A	N/A	N/A	N/A	835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01

Appendix D2: Medical Claims File Mapping to National Standards

MC034	Service Provider State or Province	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill - Institutional/ Facility Claims	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Site of Service – on NSF/CMS-1500 Claims	N/A	N/A	24B	FA0-07.0, GU0-0.50	837/2300/CLM/ /05-1
MC038	Claim Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/01-2

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/03-2
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/04-2
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/05-2
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/06-2
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/07-2
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/08-2
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/09-2
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/10-2
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/11-2
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/12-2

Appendix D2: Medical Claims File Mapping to National Standards

MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2
MC055	Procedure Code	44	60/6,15-16, 61/6,15-16	24.1-6 D	FA0-09.0, FB0-15.0, GU0-07.0	835/2110/SVC/HC/01-2
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-4
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,1516, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8,11-13, 60/10, 15-16, 61/11,15-16	24.1-6 F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Prepaid Amount	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Patient Account/Control Number	3	20/3	26	CAO-03.0	837/2300/CLM//01
MC069	Discharge Date	6	20/20	24A	EAO-29.0	N/A
MC070	Service Provider Country Name	9	N/A	N/A	N/A	837/2310E/N4/04
MC071	DRG	N/A	N/A	N/A	N/A	N/A
MC072	DRG Version	N/A	N/A	N/A	N/A	N/A

MC073	APC	N/A	N/A	N/A	N/A	N/A
MC074	APC Version	N/A	N/A	N/A	N/A	N/A
MC075	Drug Code	N/A	N/A	N/A	N/A	N/A
MC076	Billing Provider Number	N/A	N/A	N/A	N/A	N/A
MC077	National Billing Provider ID	N/A	N/A	N/A	N/A	N/A
MC078	Billing Provider Last Name	N/A	N/A	N/A	N/A	N/A
MC101	Encrypted Subscriber Last Name	N/A	N/A	N/A	N/A	N/A
MC102	Encrypted Subscriber First Name	N/A	N/A	N/A	N/A	N/A
MC103	Encrypted Subscriber Middle Initial	N/A	N/A	N/A	N/A	N/A
MC104	Encrypted Member Last Name	N/A	N/A	N/A	N/A	N/A
MC105	Encrypted Member First Name	N/A	N/A	N/A	N/A	N/A
MC106	Encrypted Member Middle Initial	N/A	N/A	N/A	N/A	N/A
MC899	Record Type	N/A	N/A	N/A	N/A	N/A

Appendix E-1: Pharmacy Claims File Specifications

PC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
PC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
PC003	Insurance Type/Product Code	1/31/2007	Text	2	Preferred Provider Organization (PPO) Point of Service (POS) Exclusive Provider Organization (EPO) Indemnity Insurance Health Maintenance Organization (HMO) Medicare Advantage * AM Automobile Medical * DS Disability HM Health Maintenance Organization * LI Liability * LM Liability Medical MA Medicare Part A MB Medicare Part B Medicare Part D Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Workers' Compensation * Indicates that code is not to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules
PC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
PC005	Line Counter	1/31/2007	Integer	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC006	Insured Group Number	1/31/2007	Text	50	The group or policy number – not the number that uniquely identifies the subscriber.

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
PC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
PC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number that identifies the member within the contract.
PC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
PC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent
PC012	Member Gender	1/31/2007	Integer	1	1 Male 2 Female 3 Unknown
PC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
PC014	Member City Name of Residence	1/31/2007	Text	30	The city name of member.
PC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
PC016	Member ZIP Code	1/31/2007	Text	9	ZIP Code of member – may include non-US codes. Do not include dash.
PC017	Date Service Approved (AP Date)	1/31/2007	Date	8	CCYYMMDD This date is generally the same date as the paid date or the pharmacy benefits manager's billing date.
PC018	Pharmacy Number	1/31/2007	Text	30	The payer assigned pharmacy number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. An AHFS number is acceptable.
PC019	Pharmacy Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					Insurers and health care claims processors shall provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.
PC020	Pharmacy Name	1/31/2007	Text	30	The name of pharmacy
PC021	National Pharmacy ID Number	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA
PC022	Pharmacy Location City	1/31/2007	Text	30	The city name of pharmacy, preferably pharmacy location.
PC023	Pharmacy Location State	1/31/2007	Text	2	As defined by the US Postal Service
PC024	Pharmacy ZIP Code	1/31/2007	Text	10	ZIP Code of pharmacy – may include non-US codes. Do not include dash.
PC024A	Pharmacy Country Name	1/31/2007	Text	30	Code US for United States
PC025	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary 03 Processed as tertiary 04 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment
PC026	Drug Code	1/31/2007	Text	11	NDC Code
PC027	Drug Name	1/31/2007	Text	80	Text name of drug
PC028	New Prescription or Refill	1/31/2007	Integer	2	00 New prescription 01-99 Number of refill

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC029	Generic Drug Indicator	1/31/2007	Text	1	N No, branded drug Y Yes, generic drug
PC030	Dispense as Written Code	1/31/2007	Integer	1	0 Not dispensed as written 1 Physician dispense as written 2 Member dispense as written 3 Pharmacy dispense as written 4 No generic available 5 Brand dispensed as generic 6 Override 7 Substitution not allowed – brand drug mandated by law 8 Substitution allowed – generic drug not available in marketplace 9 Other
PC031	Compound Drug Indicator	1/31/2007	Text	1	N Non-compound drug Y Compound drug U Non-specified drug compound
PC032	Date Prescription Filled	1/31/2007	Date	8	CCYYMMDD
PC033	Quantity Dispensed	1/31/2007	Integer	5	The number of metric units of medication dispensed.
PC034	Days Supply	1/31/2007	Integer	3	The estimated number of days the prescription will last.
PC035	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
PC036	Paid Amount	1/31/2007	Decimal	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC037	Ingredient Cost/List Price	1/31/2007	Decimal	10	The cost of the drug dispensed. Do not code decimal point.
PC038	Postage Amount Claimed	1/31/2007	Decimal	10	Do not code decimal point.
PC039	Dispensing Fee	1/31/2007	Decimal	10	Do not code decimal point.
PC040	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
PC041	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.
PC042	Deductible Amount	1/31/2007	Decimal	10	Do not code decimal point.
PC044	Prescribing Physician First Name	1/31/2007	Text	25	Physician first name. Required if PC046 is not filled.
PC045	Prescribing Physician Middle Name	1/31/2007	Text	25	Physician middle name or initial. Required if PC046 is not filled.
PC046	Prescribing Physician Last Name	1/31/2007	Text	60	Physician last name. Required if PC046 is not filled.
PC047	Prescribing Physician Number	1/31/2007	Text	20	The DEA or NPI number for the prescribing physician.
PC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
PC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
PC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
PC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
PC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
PC899	Record Type	1/31/2007	Text	2	Value = PC

Appendix E-2: Pharmacy Claims Mapping to National Standards

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #
PC001	Payer	N/A
PC002	Plan ID	N/A
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	N/A
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	Encrypted Subscriber Unique Identification Number	302-C2
PC008	Plan Specific Contract Number	N/A
PC009	Member Suffix or Sequence Number	N/A
PC010	Member Identification Code	302-CY
PC011	Individual Relationship Code	306-C6
PC012	Member Gender	305-C5
PC013	Member Date of Birth	304-C4
PC014	Member City Name of Residence	323-CN
PC015	Member State or Province	324-CO
PC016	Member ZIP Code	325-CP
PC017	Date Service Approved (AP Date)	N/A
PC018	Pharmacy Number	202-B2
PC019	Pharmacy Tax ID Number	N/A
PC020	Pharmacy Name	833-5P
PC021	National Pharmacy ID Number	N/A
PC022	Pharmacy Location City	831-5N
PC023	Pharmacy Location State	832-6F
PC024	Pharmacy ZIP Code	835-5R
PC024A	Pharmacy Country Name	N/A
PC025	Claim Status	N/A
PC026	Drug Code	407-D7

PC027	Drug Name	516-FG

Appendix E-2: Pharmacy Claims Mapping to National Standards

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #
PC028	New Prescription or Refill	403-D3
PC029	Generic Drug Indicator	N/A
PC030	Dispense as Written Code	408-D8
PC031	Compound Drug Indicator	406-D6
PC032	Date Prescription Filled	401-D1
PC033	Quantity Dispensed	442-E7
PC034	Days Supply	405-D5
PC035	Charge Amount	804-5B
PC036	Paid Amount	509-F9
PC037	Ingredient Cost/List Price	506-F6
PC038	Postage Amount Claimed	428-DS
PC039	Dispensing Fee	507-F7
PC040	Co-pay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC044	Prescribing Physician First Name	N/A
PC045	Prescribing Physician Middle Name	N/A

PC046	Prescribing Physician Last Name	N/A
PC047	Prescribing Physician Number	N/A
PC101	Encrypted Subscriber Last Name	N/A
PC102	Encrypted Subscriber First Name	N/A
PC103	Encrypted Subscriber Middle Initial	N/A
PC104	Encrypted Member Last Name	N/A
PC105	Encrypted Member First Name	N/A
PC106	Encrypted Member Middle Initial	N/A
PC899	Record Type	N/A

Appendix F: Reporter Registration Form

Vermont Healthcare Claims Uniform Reporting and Evaluation System Registration Form

Company Name: _____

Mailing Address: _____

_____

_____

1. Does your company currently conduct health insurance related business for 500 or more residents of the state of Vermont? _____ Yes _____ No

2. Does your company currently conduct health insurance related business for health care provided by Vermont health care providers and facilities? _____ Yes _____ No

If 1 and 2 are both No: Skip to #6

3. Please complete information below in relationship to the eligibility data your company will be submitting.

Medical Pharmacy

Estimated # Members/Covered Lives/Eligibles for 1 Month: _____ _____

Estimated # Medicare Supplemental Covered Lives in one month: _____

_____

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____

_____

_____

Data files will be submitted utilizing which media?

_____ CD-ROM _____ DVD-ROM _____ Secure SFTP Web Upload _____ FTP

4. Will your company be submitting medical claims data? _____ Yes _____ No: Skip to #6

Estimated # of medical claims paid per month: _____

Estimated total $ amount of medical claims paid per month: _____

Estimated $ amount of total premiums earned per month for Vermont residents: _____

Is the Contact for Medical the same as Eligibility? _____ Yes _____ No

Appendix F: Reporter Registration Form

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____

Data files will be submitted utilizing which media?

_____CE-ROM _____DVE-ROM _____Secure SSL Web Upload _____FTP

5. Will your company be submitting pharmacy claims data? _____Yes _____No (Skip to #6)
Estimated # of pharmacy claims paid per month: _____

Estimated total $ amount of pharmacy claims paid per month: _____

Estimated $ amount of total premiums earned per month for Vermont residents: _____

Is the contact for Pharmacy the same contact as: Eligibility _____ Yes _____ No
_____ Medical _____ Yes _____ No

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____

Data files will be submitted utilizing which media?

_____CE-ROM _____DVE-ROM _____Secure SSL Web Upload _____FTP

6. Person completing this form:

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Appendix F: Reporter Registration Form

Mailing Address: _____

Date Completed: _____

1. Is the person completing this form the compliance contact? _____ Yes _____ No If no, provide legal/compliance contact information.

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____

*Total Premiums = Total amount of premium from policyholders to provide insurance coverage. This is commonly referred to as "earned" premium. Earned premium = premiums collected + change in due and uncollected - change in unearned and advance premium. If premium is collected prior to January 1 to provide insurance coverage in the following year, it must be included. **Third party administrators** shall calculate the earned premium equivalent based on the contribution rates established for the coverages being reported. These premium equivalents shall include all funds collected by the TPA from the account in relation to the TPA's administration of the group's or employer's health plan. These funds include provisions for claims, administration, stop-loss insurance, wellness programs, network fees, and disease management programs. **Pharmacy Benefit Managers** shall calculate the earned premium equivalent based on the contribution rates established for the coverages being reported. These premium equivalents shall include all funds collected by the PBM from the account in relation to the PBM's administration of the group's or employer's pharmacy benefit plan. These funds include provisions for mail service pharmacy, claims processing, retail network management, payment of claims to pharmacies for prescription drugs dispensed to beneficiaries, clinical formulary development and management services, rebate contracting and administration, patient compliance, therapeutic interventions, generic substitution programs, and disease or chronic care management programs.

Appendix G: Third Party Administrator Registration Form

Vermont Third Party Administrator Registration Form

Company Name: _____

Mailing Address: _____

_____

_____

_____

Domicile: _____ Domicile outside of US _____

FEIN #: _____ NAIC #: _____

E.B.I.: _____

Parent Company Name: _____

Parent FEIN #: _____ Parent NAIC #: _____

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____

_____

_____

1) Did the company provide administrative services for a health line of business for 50 or more Vermont residents within any of the listed health lines for any given month within calendar year 2007 or within the most current business year?

Check all that apply

Comprehensive Major Medical _____ Other Medical (Non-Comprehensive) _____

Pharmacy _____ Specified Named Disease _____

_____

Medicare Supplemental (Medigap) _____ Limited Benefit _____

Behavioral Health _____ Student Policy _____

Substance Abuse _____ Workers Compensation _____

Long Term Care _____ Indemnity Only or HIPC _____

Disability _____ Group Long _____

Dental _____ Vision _____

2) Does the company provide the following business services for plan sponsors, insurers or other entities providing benefits for the following health lines of business?

Business Services	Comprehensive	Pharmacy	Behavioral	Medicare Supplement	Major Medical
Collect and hold premiums					
Adjust claims					
Pay claims					
Utilization review					

3) List all plan sponsors that are entities that have self-funded ERISA plans that include any Vermont residents. Check all health lines of business that apply for each plan sponsor.

Plan Sponsor Name	Comprehensive	Pharmacy	Behavioral	Major Medical	Health

4) List all carriers and government insurers and payers covering any Vermont resident that are contracting with your company for third party administration business services in any of the health lines of business.

Appendix H: Pharmacy Benefit Manager Registration Form

Vermont Pharmacy Benefit Manager Registration Form

Filing Information for Person Completing This Form

Filing Date (mm/dd/yyyy): _____

First Name of person completing this form: _____

Last Name of person completing this form: _____

Title of person completing this form: _____

Phone # of person completing this form: _____

Email address of person completing this form: _____

Mailing Address for Person Completing Form

P.O. Box and/or Street Address: _____

City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Company Information

Company Name: _____

Domicile (U.S.)/State of Incorporation or Organization: _____
Domicile (Outside of U.S.)/Country of Incorporation or Organization: _____
FEIN: _____ NAIC # (if applicable): _____
DBA/Trade Name 1 (if applicable): _____
DBA/Trade Name 2 (if applicable): _____

Appendix H: Pharmacy Benefit Manager Registration Form

Principal Office or Headquarters Mailing Address

P.O. Box and/or Street: _____

City: _____

State: _____

ZIP/Postal Code: _____

Country: _____

Parent Company: _____
(Another company owns Company named above in Company Information)
Parent Company NAIC # (if applicable): _____
Parent Company FEIN: _____

Company Contact Information

Contact for notices related to regulatory bulletins, rule making and compliance issues:

First Name: _____
Last Name: _____

Title/Position: _____
Phone: _____

Email: _____

Fax: _____

P.O. Box and/or Street: _____
City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Appendix H: Pharmacy Benefit Manager Registration Form

ADDITIONAL REQUIRED INFORMATON

1. Do you perform pharmacy benefit management for individuals enrolled in a health plan in which coverage of prescription drugs is administered by a PBM and includes their dependents or other persons provided health coverage through that health plan, per 18 V.S.A. § 9471?

( ) Yes ( ) No

2. Do you perform pharmacy benefit management for a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont? For these purposes, "health insurer" includes a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations as well as an employer, labor union, or other group of persons organized in Vermont that provides a health plan to beneficiaries employed or residing in Vermont, per 18 V.S.A. §9471.

( ) Yes ( ) No

3. Check any pharmacy benefit management services that you provide for Vermont residents or employees. Check all that apply.

( ) Mail service pharmacy
( ) Claims processing
( ) Retail network management
( ) Payment of claims to pharmacies for prescription drugs dispensed to beneficiaries
( ) Clinical formulary development and management services
( ) Rebate contracting and administration
( ) Patient compliance, therapeutic intervention, and generic substitution programs
( ) Disease or chronic care management programs.
( ) Other: _____

Contact Information for claims data management information services and/or information technology:

Contact First Name: _____

Contact Last Name: _____

Contact Title/Position: _____

Phone: _____

Email: _____

Fax: _____

P.O. Box and/or Street: _____

City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Appendix I: Data Transmittal Sheet

Vermont Healthcare Claims Uniform Reporting and Evaluation System
Claims Data Submission Form

Payer Name:

VHCURES Submitter Code:

Contact Person Name:

Address:

City, State, Postal Code:

Phone:

E-mail:

	Eligibility	Medical	Prescription Drugs
File Name			
Period Beginning Date			
Period Ending Date			
Record Count†			
Date Processed			
Original Submission			

Resubmission			

† *Excluding header and trailer record*

Media: ____ CD ROM 650 MB ____ FTP ____ DVD

Do not use below

Date Received: _____

Date Loaded: _____

Comments: _____

Appendix J-1: Data Release Schedule

DATA RELEASE SCHEDULE: PUBLIC USE DENOMINATOR FILE

Unrestricted Included in the public use file for public release and general use. Restricted May be included in limited use research health care data sets as approved by BISHCA. Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

ME004 Year ME005 Month
ME007 Coverage Level Code
ME013 Member Gender
ME016 Member State or Province ME018 Medical Coverage
ME019 Prescription Drug Coverage ME028 Primary Insurance Indicator
ME029 Coverage Type
ME030 Market Category Code

Derived or calculated from submitted data

PAYER901 Payer Name
ME902 Record ID#
ME905 Medicare coverage
ME911 Standardized Insurance Individual Relationship Code ME912 Standardized Insurance Type/Product Code
ME914 Eligibility Year and Month
ME915 Member County Code
* Member Age by Age Group (0-17, 18-29, 30-44, 45-54, 55-64, 65+)
* Unique Member Number (Derived from ME910 and for use only in the Public Use Denominator File)
* No assigned data element number

Appendix J-2: Data Release Schedule

DATA RELEASE SCHEDULE: MEDICAL MEMBER ELIGIBILITY FILE

Unrestricted Included in the public use file for public release and general use. Restricted May be included in limited use research health care data sets as approved by BISHCA. Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

ME007 Coverage Level Code ME013 Member Gender
ME016 Member State or Province
ME018 Medical Coverage
ME028 Primary Insurance Indicator
ME029 Coverage Type
ME030 Market Category Code

Derived or calculated from submitted data

ME901 Member Age: VT aggregate 90+
ME902 Record ID#
ME905 Medicare coverage
ME910 Double Encrypted Member ID
ME911 Standardized Insurance Individual Relationship Code ME912 Standardized Insurance Type/Product Code
ME914 Eligibility Year and Month
ME915 Member County Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

ME001 Payer
ME002 National Plan ID
ME006 Insured Group or Policy Number
ME015 Member City Name
ME017 Member ZIP Code

Derived or calculated from submitted data ME907 Double Encrypted Subscriber SSN
ME908 Double Encrypted Plan Specific Contract Number
ME909 Double Encrypted Member Identification Code
* Insured Group Name (Derived from ME006 and Key Look up Table)

* No assigned data element number Appendix J-2: Data Release Schedule

UNAVAILABLE FOR RELEASE

ME004 Year ME005 Month
ME003 Insurance Type/Product Code
ME008 Encrypted Subscriber Social Security Number
ME009 Plan Specific Contract Number ME010 Member Suffix or Sequence Number
ME011 Member Identification Code ME012 Individual Relationship Code ME014 Member Date of Birth ME019 Prescription Drug Coverage ME101 Encrypted Subscriber Last Name
ME102 Encrypted Subscriber First Name
ME103 Encrypted Subscriber Middle Initial
ME104 Encrypted Member Last Name
ME105 Encrypted Member First Name
ME106 Encrypted Member Middle Initial
ME899 Record Type

Derived or calculated from submitted data

ME903 BISHCA Extract Date ME904 Unique Member ID
ME906 Submission ID#
ME913 Duplicate Member Flag

Appendix J-3: Data Release Schedule

DATA RELEASE SCHEDULE: PHARMACY MEMBER ELIGIBILITY FILE

[redacted]

Unrestricted Included in the public use file for public release and general use. Restricted May be included in limited use research health care data sets as approved by BISHCA. Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PE004 Year PE005 Month
PE007 Coverage Level Code PE013 Member Gender

PE016 Member State or Province PE019 Prescription Drug Coverage
PE028 Primary Insurance Indicator
PE029 Coverage Type
PE030 Market Category Code

Derived or calculated from submitted data PE901 Member Age: VT aggregate 90+
PE902 Record ID#
PE905 Medicare coverage
PE910 Double Encrypted Member ID
PE911 Standardized Insurance Individual Relationship Code PE912
Standardized Insurance Type/Product Code
PE914 Eligibility Year and Month
PE915 Member County Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PE001 Payer
PE002 National Plan ID
PE006 Insured Group or Policy Number
PE015 Member City Name
PE017 Member ZIP Code

Derived or calculated from submitted data PE907 Double Encrypted Subscriber SSN
PE908 Double Encrypted Plan Specific Contract Number
PE909 Double Encrypted Member Identification Code
* Insured Group Name (Derived from PE006 and Key Look up Table)
Appendix J-3: Data Release Schedule

* No assigned data element number

UNAVAILABLE FOR RELEASE

PE003 Insurance Type/Product Code
PE008 Encrypted Subscriber Social Security Number
PE009 Plan Specific Contract Number PE010 Member Suffix or Sequence Number PE011 Member Identification Code
PE012 Individual Relationship Code PE014 Member Date of Birth
PE018 Medical Coverage
PE101 Encrypted Subscriber Last Name
PE102 Encrypted Subscriber First Name
PE103 Encrypted Subscriber Middle Initial
PE104 Encrypted Member Last Name
PE105 Encrypted Member First Name
PE106 Encrypted Member Middle Initial
PE899 Record Type

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Derived or calculated from submitted data

PE903 BISHCA Extract Date

PE904 Unique Member ID

PE906 Submission ID#

PE913 Duplicate Member Flag

DATA RELEASE SCHEDULE: MEDICAL CLAIMS FILE

Unrestricted Included in the public use file for public release and general use.

Restricted May be included in limited use research health care data sets as approved by BISHCA. Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MC005A Version Number
MC011 Individual Relationship Code
MC012 Member Gender
MC015 Member State or Province
MC020 Admission Type MC021 Admission Source
MC023 Discharge Status
MC032 Service Provider Specialty** MC033 Service Provider City Name**
MC034 Service Provider State or Province**
MC035 Service Provider ZIP Code**
MC036 Type of Bill - Institutional/Facility Claims MC037 Site of Service- NSF/CMS 1500 Claims
MC038 Claim Status
MC039 Admitting Diagnosis
MC040 E Code
MC041 Principal Diagnosis MC042 Other Diagnosis 1
MC043 Other Diagnosis 2
MC044 Other Diagnosis 3
MC045 Other Diagnosis 4
MC046 Other Diagnosis 5
MC047 Other Diagnosis 6
MC048 Other Diagnosis 7
MC049 Other Diagnosis 8
MC050 Other Diagnosis 9 MC051 Other Diagnosis 10
MC052 Other Diagnosis 11
MC053 Other Diagnosis 12
MC054 Revenue Code
MC055 Procedure 1 Code

MC056 Procedure 1 Modifier 1 MC057 Procedure 1 Modifier 2
MC058 ICD-9-CM Procedure Code
MC061 Quantity MC063 Paid Amount MC064
Prepaid Amount MC065 Copay Amount
MC066 Coinsurance Amount MC067 Deductible Amount

MC070 Service Provider Country Name**
MC071 DRG
MC072 DRG Version
MC073 APC
MC074 APC Version
MC075 Drug Code

Derived or calculated from submitted data MC901 Member Age: VT aggregate 90+
MC902 Record ID#
MC905 Medicare Coverage
MC911 Double-Encrypted Member ID#
MC913 Standardized Insurance Type/Product Code
MC914 Medical Abortion Flag**
MC915 Year Paid MC916 Month Paid
MC917 Year of Service MC918 Month of Service
MC919 Payment Quarter
MC920 Quarter Service Performed * Medication Abortion Flag**
* Service Provider County Code**
* Member County Code * Admission Year *
Discharge Year * Length of Stay
* Service Event Primary Key
* Length of Service in Days

* No assigned data element number

**Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MC001 Payer
MC002 National Plan ID
MC006 Insured Group or Policy Number
MC014 Member City Name MC016 Member ZIP Code
MC017 Date Service Approved (AP Date)
MC018 Admission Date MC019 Admission Hour MC022
Discharge Hour
MC024 Service Provider Number**

Appendix J-4: Data Release Schedule

MC026 National Service Provider ID** MC027 Service Provider Entity Type Qualifier MC028 Service Provider First Name** MC029 Service Provider Middle Name**

MC030 Service Provider Last Name or Organization Name**

MC031 Service Provider Suffix** MC059 Date of Service From MC060 Date of Service Thru MC062 Charge Amount

MC076 Billing Provider Number** MC077 National Billing Provider ID**

MC078 Billing Provider Last Name or Organization**

MC069 Discharge Date

Derived or calculated from submitted data MC907 Double Encrypted Payer Claim Control Number MC908 Double Encrypted Subscriber Social Security Number MC909 Double Encrypted Plan Specific Contract Number MC910 Double Encrypted Member Identification Code

MC912 Provider ID#

* Insured Group Name (Derived from MC006 and Key Look-up Table)

* No assigned data element number

**Provider data elements not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

UNAVAILABLE FOR RELEASE

MC003 Insurance Type/Product Code MC004 Payer Claim Control Number

MC005 Line Counter

MC007 Encrypted Subscriber Social Security Number

MC008 Plan Specific Contract Number MC009 Member Suffix or Sequence Number MC010 Member Identification Code MC013 Member Date of Birth

MC025 Service Provider Tax ID Number MC027 Service Provider Entity Type Qualifier MC068 Patient Account/Control Number

MC101 Encrypted Subscriber Last Name

MC102 Encrypted Subscriber First Name

MC103 Encrypted Subscriber Middle Initial

MC104 Encrypted Member Last Name

MC105 Encrypted Member First Name

MC106 Encrypted Member Middle Initial

MC899 Record Type

Derived or calculated from submitted data

MC903 BISHCA Extract Date MC904 Encrypted Member ID#

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix J-4: Data Release Schedule

MC906 Submission ID#

DATA RELEASE SCHEDULE: PHARMACY CLAIMS FILE

Unrestricted — Included in the public use file for public release and general use.

Restricted — May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release — Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PC011 Individual Relationship Code
PC012 Member Gender
PC015 Member State or Province
PC023 Pharmacy Location State
PC024A Pharmacy Country Name
PC025 Claim Status PC026 Drug Code PC027 Drug Name
PC028 New Prescription or Refill PC029 Generic Drug Indicator PC030 Dispense as Written Code PC031 Compound Drug Indicator PC033 Quantity Dispensed
PC034 Days Supply PC036 Paid Amount
PC037 Ingredient Cost/List Price
PC038 Postage Amount Claimed
PC039 Dispensing Fee PC040 Copay Amount
PC041 Coinsurance Amount
PC042 Deductible Amount

Derived or calculated from submitted data

PC901 Member Age: VT aggregate 90+
PC902 Record ID#
PC910 Double Encrypted Member ID#
PC911 Standardized Member Gender
PC912 Standardized Insurance Type/Product Code
PC914 Year Paid
PC916 Year of Service PC918 Payment Quarter
PC919 Quarter Service Performed
* Member County Code
* Year Prescription Filled * Medication Abortion Flag** *
No assigned data element number

LIMITED USE FILE-RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PC001 Payer
PC002 National Plan ID PC006 Insured Group Number

PC014 Member City Name of Residence
PC016 Member ZIP Code
PC017 Date Service Approved (AP Date)
PC018 Pharmacy Number
PC020 Pharmacy Name
PC021 National Pharmacy ID Number
PC022 Pharmacy Location City
PC024 Pharmacy ZIP Code
PC032 Date Prescription Filled
PC035 Charge Amount
PC044 Prescribing Physician First Name**
PC045 Prescribing Physician Middle Name**
PC046 Prescribing Physician Last Name**

Derived or calculated from submitted data

PC906 Double Encrypted Payer Claim Control Number
PC907 Double Encrypted Subscriber Social Security Number
PC908 Double Encrypted Plan Specific Contract Number
PC909 Double Encrypted Member Identification Code
PC913 Pharmacy ID #
PC915 Month Paid
PC917 Month of Service
PC920 Prescribing Physician ID# **
* Insured Group Name (Derived from PC006 and Key Look up Table)
* No assigned data element number

**Provider data elements will not be released in records where the Medication Abortion Flag = 1.

UNAVAILABLE FOR RELEASE

PC003 Insurance Type/Product Code
PC004 Payer Claim Control Number
PC005 Line Counter
PC007 Encrypted Subscriber Social Security Number
PC008 Plan Specific Contract Number
PC009 Member Suffix or Sequence Number
PC010 Member Identification Code
PC013 Member Date of Birth
PC019 Pharmacy Tax ID Number
PC047 Prescribing Physician DEA Number
PC101 Encrypted Subscriber Last Name
PC102 Encrypted Subscriber First Name
PC103 Encrypted Subscriber Middle Initial
PC104 Encrypted Member Last Name
PC105 Encrypted Member First Name
PC106 Encrypted Member Middle Initial
PC899 Record Type

Derived or calculated from submitted data

PC903 BISHCA Transfer Date
PC904 Unique Member ID
PC905 Submission ID#

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Appendix J-6: Data Release Schedule

DATA RELEASE SCHEDULE: MEDICAL SERVICE PROVIDER FILE

Special Note: Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

[redacted]

Unrestricted Included in the public use file for public release and general use.

Restricted May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MCSP010 Service Provider Specialty MCSP011
Service Provider City Name MCSP012
Service Provider State or Province MCSP013
Service Provider ZIP Code
MCSP015 Taxonomy Code

Derived or calculated from submitted data

* Service Provider County Code

* No assigned data element number

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LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MCSP001	Provider ID#
MCSP002	Payer
MCSP006	Service/Prescribing Provider First Name
MCSP007	Service/Prescribing Provider Middle Name
MCSP008	Service/Prescribing Provider Last Name or Organization Name
MCSP009	Service Provider Suffix
MCSP018	National Provider Identifier

UNAVAILABLE FOR RELEASE

MCSP003	Service Provider Number
MCSP004	Service Provider Tax ID Number
MCSP005	Service Provider Entity Type Qualifier
MCSP017	Prescribing Physician's DEA (Drug Enforcement Authority) Registration Number
MCSP019	Indicates Source of Information as Medical or Pharmacy File

Appendix J-7 Data Release Schedule

DATA RELEASE SCHEDULE: MEDICAL PROVIDER MASTER FILE

Special Note: Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

[redacted]

Unrestricted Included in the public use file for public release and general use.

Restricted May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release Unavailable for release by the department due to a variety of factors including: - used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

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PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MPM904 Service Provider Facility Code MPM910
Service Provider State or Province
MPM911 Taxonomy Code

Derived or calculated from submitted data

* Service Provider County Code

* No assigned data element number

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MPM901	Data Processing Center Code
MPM903	Service Provider Facility Name
MPM905	Service Provider First Name
MPM906	Service Provider Middle Name
MPM907	Service Provider Last Name
MPM908	Service Provider Suffix
MPM909	Service Provider Title
MPM912	Unique Physician Identification Number
MPM913	National Provider Identifier

UNAVAILABLE FOR RELEASE

MPM902	Service Provider Tax ID Number
MPM914	Prescribing Physician's DEA Registration Number

Appendix J-8: Data Release Schedule

DATA RELEASE SCHEDULE: PHARMACY DETAIL FILE

[redacted]

Unrestricted Included in the public use file for public release and general use.
Restricted May be included in limited use research health care data sets as approved by BISHCA.

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Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PCSP908 Pharmacy Location State

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PCSP901	Payer
PCSP902	Data Processing Center Code
PCSP903	Pharmacy Number
PCSP905	Pharmacy Name
PCSP906	National Pharmacy ID Number
PCSP907	Pharmacy Location City
PCSP909	Pharmacy ZIP Code
PCSP910	Key to Pharmacy Claims

UNAVAILABLE FOR RELEASE

PCSP904 Pharmacy Tax ID Number

Appendix J-9 Data Release Schedule

DATA RELEASE SCHEDULE: PHARMACY MASTER FILE

[redacted]

Unrestricted Included in the public use file for public release and general use.

Restricted May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

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PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PM906 Pharmacy Location State

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PM901 Data Processing Center Code

PM903 Pharmacy Name

PM904 National Pharmacy ID Number

PM905 Pharmacy Location City

PM907 Pharmacy ZIP Code

UNAVAILABLE FOR RELEASE

PM902 Pharmacy Tax ID Number

Appendix J-10: Data Release Schedule

DATA RELEASE SCHEDULE: LOCAL CPT CODES

[redacted]

Unrestricted – Included in the public use file for public release and general use.

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Restricted May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

HGCPT901	Procedure Code
HGCPT902	Payer Code
HGCPT903	Procedure Code Description
HGCPT904	Date HGCPT code was inserted into table

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

Appendix J-11: Data Release Schedule

DATA RELEASE SCHEDULE: LOCAL DIAGNOSIS CODES

[redacted]

Unrestricted Included in the public use file for public release and general use.

Restricted May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

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Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

HGDX901	Principal Diagnosis
HGDX902	Payer Code
HGDX903	Principal Diagnosis Description

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

DATA RELEASE SCHEDULE: PAYER SPECIALTY CODES

Special Note: Provider data elements will not be released in records were the Abortion Flag MC914=1.

Unrestricted – Included in the public use file for public release and general use.

Restricted – May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release Unavailable for release by the department due to a variety of factors including: - used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PS901	Service Provider Specialty
PS902	Payer Code

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PS903 Service Provider Specialty Description

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

Appendix J-13: Data Release Schedule

DATA RELEASE SCHEDULE: PAYER CODES

[redacted]

Unrestricted Included in the public use file for public release and general use. Restricted May be included in limited use research health care data sets as approved by BISHCA. Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PAYER901 Payer Name

PAYER902 Payer Code

UNAVAILABLE FOR RELEASE

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Currently there are no fields or data elements in this release category from this file.

Appendix J-14: Data Release Schedule

DATA RELEASE SCHEDULE: TAXONOMY FOR PROVIDER SPECIALTY CODES

Special Note: Provider data elements will not be released in records were the Abortion Flag MC914=1.

Unrestricted Included in the public use file for public release and general use.
Restricted May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

TX901 Category
TX902 Provider Type
TX903 Classification
TX904 Area of Specialization
TX905 Taxonomy Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

Currently there are no fields or data elements in this release category from this file.

UNAVAILABLE FOR RELEASE

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
Rule 8.000: Data Submission

8.100 General Provisions

8.101 Authority

The Board adopts this rule pursuant to 18 V.S.A. §§ 9375, 9380, 9404, 9410, 9453, and 9454.

8.102 Purpose

The Green Mountain Care Board ("Board" or "GMCB") stewards two data sets (collectively "the health care database"). The Vermont Health Care Uniform Reporting and Evaluation System ("VHCURES") data set contains information related to health care utilization, costs, and resources provided to Vermont residents. The Vermont Uniform Hospital Discharge Data Set ("VUHDDS") contains information related to health care provided to patients at health care facilities in Vermont and health care provided to Vermont residents at health care facilities in other states.

Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies must submit reports, data, schedules, statistics, and other information specified by the Board for inclusion in the health care database. This rule sets forth the Board's requirements for reporting health care claims and eligibility data, inpatient discharge data, outpatient procedure and service data, emergency department data, and other information relating to health care provided in Vermont and to Vermont residents outside the state. Green Mountain Care Board Rule 9.000 sets forth the processes by which the Board makes data available to support legitimate and beneficial research and analysis.

8.103 Definitions

For purposes of this rule:

(1) "Ambulatory surgery center" has the same meaning as in 18 V.S.A. § 2141(1).

(2) "Board" or "GMCB" means the Green Mountain Care Board established in Title 18, Chapter 220 of the Vermont Statutes Annotated, the Board's staff, or other designee of the Board.

(3) "Claims data" means service-level remittance and other related administrative information generated from the interaction of patients and the health care delivery system. Examples of claims data include provider information; charge and payment information; clinical diagnosis, procedure, and service codes; and national drug codes. Claims data also include information intended to represent payments made under an accountable care organization-based payment reform model.

(4) "Council chair" means the chair of the Data Governance Council.

(5) "Data Governance Council" or "Council" means the committee established by the Board and given responsibilities for the Board's data governance program.

(6) "Data set" means a collection of logical individual data records, regardless of format.

(7) "Data collection vendor" means a vendor with whom the Board contracts to manage data collection, cleansing, validation, integration, and consolidation related to the health care database.

(8) "Days" means calendar days unless otherwise indicated.

(9) "Eligibility data" means demographic information for each individual member enrolled for medical or pharmacy benefits for one or more days of coverage at any time during a reporting period.

(10) "General hospital" has the same meaning as in 18 V.S.A. § 1902(1)(A).

(11) "Health care" has the same meaning as in 45 C.F.R. § 160.103.

(12) "Health care database" means the VHCURES and VUHDDS data sets, collectively.

(13) "Health care facility" has the same meaning as in 18 V.S.A. § 9432(8).

(14) "Health care provider" has the same meaning as in 18 V.S.A. § 9432(9).

(15) "Health insurer" has the same meaning as in 18 V.S.A. § 9410(j)(1).

(16) "Insured" has the same meaning as in 18 V.S.A. § 9418(a)(10).

(17) "Mandatory submitter" means any person required to submit data for inclusion in the health care database.

(18) "Member" means the insured subscriber and any other person(s) eligible for health care benefits under the subscriber's policy, such as the subscriber's spouse or dependent.

(19) "Patient" means any person in a data set that is the subject of the activities of the claim performed by the health care provider.

(20) "Person" means any natural person, business entity, municipality, the State of Vermont or any department, agency, or subdivision of the State, and any partnership, unincorporated association, or other legal entity.

(21) "Pharmacy benefit manager" or "PBM" has the same meaning as in 18 V.S.A. § 9471(5).

(22) "Psychiatric hospital" has the same meaning as in 18 V.S.A. § 1902(1)(B).

(23) "Reporting manual(s)" means either the VHCURES Reporting Manual or the VUHDDS Reporting Manual or the two documents collectively.

(24) "Submitters" means mandatory submitters and voluntary submitters collectively.

(25) "Subscriber" means the individual responsible for payment of premiums or whose employment, income, or other circumstances is the basis for eligibility for membership in a health benefit plan.

(26) "Third-party administrator" or "TPA" means any person who receives or collects charges, contributions, or premiums for, or adjusts or settles claims on or for residents of Vermont or health insurers.

(27) "Vermont Health Care Uniform Reporting and Evaluation System" or "VHCURES" means the data set containing information related to eligibility, health care claims, and related data submitted by health care insurers to the GMCB.

(28) "Vermont Uniform Hospital Discharge Data Set" or "VUHDDS" means the data set consisting of inpatient discharge data, outpatient procedures and services data, and emergency department data submitted by general hospitals, ambulatory surgery centers, and psychiatric hospitals that is maintained by the Vermont Department of Health.

(29) "VHCURES members" means members who are Vermont residents.

(30) "VHCURES Reporting Manual" means the document created and maintained by the Board or the Data Governance Council that specifies data submission requirements for the VHCURES data set, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

(31) "Voluntary submitter" includes persons other than mandatory submitters, including any health benefit plan offered or administered by or on behalf of the federal government or a self-insured employer, that voluntarily submits data to the Board for inclusion in the health care database.

(32) "VUHDDS Reporting Manual" means the document created and maintained by the Board or the Data Governance Council that specifies data submission requirements for the VUHDDS data set, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

8.200 VHCURES Registration and Submission

8.201 Registration

(a) Prior to doing business in Vermont and by each December 31 thereafter, health insurers shall register with the Board on the form(s) described in subsection (b) of this section. Health insurers that are VHCURES submitters shall also identify whether they are paying health care claims for VHCURES members.

(b) The Board, in conjunction with the data collection vendor, shall issue and maintain registration forms for health insurers. The forms shall require health insurers to provide the Board with information on their organization and lines of business, including whether the health insurer is a VHCURES mandatory submitter and what data the health insurer will report to the Board.

(c) Health insurers shall notify the Board when changes are made to any of the health insurer's contact information or the data being submitted to the Board. The amended registration form shall be submitted no later than fifteen (15) days after the applicable change goes into effect.

8.202 VHCURES Submitters

(a)(1) VHCURES Mandatory Submitters. VHCURES mandatory submitters are health insurers with an average of two hundred (200) or more members in each month of the last calendar year who are VHCURES members.

(2) A VHCURES mandatory submitter, as defined in subpart (a)(1) of this subsection, must, for each health line of business (e.g., comprehensive major medical, third-party

administrator (TPA)/administrative services only (ASO), Medicare Part C, and Medicare Part D), regularly submit to the VHCURES data collection vendor medical claims data, dental claims data, pharmacy claims data, member eligibility data, provider data, and other non-claims information for all members who are VHCURES members. The data must be submitted in the manner and format(s) and at the times specified in this rule and the VHCURES Reporting Manual.

(3) Each VHCURES mandatory submitter is responsible for the submission of data relating to all health care claims processed by a contractor or subcontractor on its behalf unless such contractor or subcontractor is already submitting identical data as a VHCURES mandatory submitter in its own right.

(b)(1) VHCURES Voluntary Submitters. A VHCURES voluntary submitter may submit the data specified in subpart (a)(2) of this subsection to the VHCURES data collection vendor.

(2) The Board encourages VHCURES voluntary submitters to follow the data submission specifications and schedule outlined in section 8.203 of this rule and the VHCURES Reporting Manual.

8.203 VHCURES Data Submission

(a) File Organization. Data shall be submitted in the format(s) specified in the VHCURES Reporting Manual.

(b) Submission Protocol. Files shall be submitted electronically by either secure sockets layer (SSL) web upload interface or secure file transfer protocol (FTP), or as specified in the VHCURES Reporting Manual. Email attachments shall not be accepted.

(c) Testing of Files. At least sixty (60) days prior to the initial submission of files or whenever the data element content of the files as described in the VHCURES Reporting Manual is subsequently altered, each VHCURES submitter shall submit data to the data collection vendor in accordance with the VHCURES Reporting Manual for testing and validation.

(d) Rejection of Files. Failure to conform to subsections (a) or (b) of this section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate corrected form to the VHCURES data collection vendor within ten (10) days.

(e) Replacement of Data Files. In the event a complete data file submission is replaced more than one (1) year after the end of the month in which the file was submitted, the VHCURES submitter must notify the Board. Individual adjustment records may be submitted with any data file submission in accordance with the applicable data submission schedule.

(f) Run-Out Period. VHCURES submitters shall submit data for at least a six (6) month period following the termination of coverage date for the particular VHCURES member.

(h)(1) Reporting Period. The reporting period for submission for all VHCURES mandatory submitters shall be determined by the highest total number of VHCURES members for any one month of the calendar year. Data files are to be submitted in accordance with the schedule contained in the VHCURES Reporting Manual.

(2) If data files submitted by an individual VHCURES submitter support or are related to files submitted by another VHCURES submitter, the Data Governance Council may establish a different reporting period for the parties involved.

(i) Data Collection Vendor's Submission Requirements. The VHCURES data collection vendor may provide additional guidelines, information, and instructions regarding the submission of data to VHCURES. Subject to section 8.400 of this rule, VHCURES mandatory submitters shall comply with the guidelines, information, and instructions the VHCURES data collection vendor sets.

8.204 GMCB VHCURES Reporting Manual

The Board, through its Data Governance Council, shall issue and maintain a publicly accessible document entitled "VHCURES Reporting Manual" addressing the following topics:

(a) The data VHCURES mandatory submitters shall submit;

(b) Technical specifications for the data, including the member eligibility data, medical claims data, and pharmacy claims data;

(c) The reporting schedule for VHCURES mandatory submitters; and

(d) Any other matters the Board deems appropriate.

8.205 Data Quality Assurance

The Board shall work in collaboration with the VHCURES data collection vendor to ensure that submitted data are accurate and consistent with the VHCURES Reporting Manual and the data collection vendor's submission requirements.

8.300 VUHDDS Submission

8.301 VUHDDS Submitters

(a)(1) VUHDDS Mandatory Submitters. VUHDDS mandatory submitters are ambulatory surgery centers, general hospitals, and psychiatric hospitals in Vermont.

(2) A VUHDDS mandatory submitter, as defined in subpart (a)(1) of this subsection, must submit including inpatient discharge data, outpatient procedure and service data, emergency department data, and other financial, scope- and volume-of-service, and

utilization data to the VUHDDS data collection vendor. The data must be submitted in the manner and format(s) and at the times specified in the VUHDDS Reporting Manual.

(3) The submissions required under this section shall be in addition to any submissions required by the uniform reporting manual described in GMCB Rule 3.000.

(b)(1) VUHDDS Voluntary Submitters. A VUHDDS voluntary submitter may submit the data specified in subsection 8.301(a)(2) to the VUHDDS data collection vendor.

(2) The Board encourages VUHDDS voluntary submitters to follow the data submission specifications and schedule outlined in the VUHDDS Reporting Manual.

(c) Data Collection Vendor's Submission Requirements. The VUHDDS data collection vendor may provide additional guidelines, information, and instructions regarding the submission of data to VUHDDS. Subject to section 8.400 of this rule, VUHDDS mandatory submitters shall comply with the guidelines, information, and instructions the VUHDDS data collection vendor sets.

8.302 GMCB VUHDDS Reporting Manual

VUHDDS Reporting Manual. The Board, through its Data Governance Council, shall issue and maintain a publicly accessible guidance document, entitled "VUHDDS Reporting Manual," addressing topics including:

(a) The data VUHDDS mandatory submitters shall submit;

(b) Technical specifications for the data submitted to VUHDDS;

(c) The reporting schedule for VUHDDS mandatory submitters; and

(d) Any other matters the Board deems appropriate.

8.303 Data Quality Assurance

The Board shall work in collaboration with its data collection vendor to ensure that submitted data are accurate and consistent with the VUHDDS Reporting Manual and any additional guidelines, information, and instructions the data collection vendor may issue.

8.400 Changes to a Reporting Manual

8.401 Modifications and Revisions to a Reporting Manual

The Data Governance Council may revise or modify reporting manuals as appropriate. Prior to approving any revisions or modifications, the Council will send each affected submitter notice and a copy of the proposed revisions or modifications. The Board will also post the notice and proposed revisions or modifications on its website. The Council will accept public comments on the proposed revisions or modifications for thirty (30) days from the date of posting and will review and consider all comments received before approving revisions or modifications.

8.402 Public Meeting

The Data Governance Council may hold a public meeting to discuss and receive comments on proposed revisions or modifications to reporting manuals. Such meetings, if held, must be held in

accordance with the Vermont Open Meeting Law, 1 V.S.A. §§ 310, *et seq.*

8.403 Implementation

Revisions or modifications to reporting manuals shall become effective one hundred twenty (120) days, or such longer time specified by the Data Governance Council, after the Data Governance Council votes to approve them. The Data Governance Council shall review all comments related to the time required by submitters to comply with any revisions or modifications to the reporting manuals, and the Council shall consider such comments when determining whether to specify a time period longer than one hundred twenty days before revisions or modifications become effective. During that 120-day period (or longer, if specified by the Data Governance Council), affected mandatory submitters shall work with the Board and the data collection vendor to ensure the revisions or modifications can be implemented effectively. For good cause, an affected submitter may request a reasonable extension to the 120-day (or longer, if specified by the Data Governance Council) implementation period, which the Council may grant as it deems appropriate. Any such request shall be submitted to the Council chair in writing and contain the length of the extension requested and a detailed explanation as to why there is good cause to grant the extension.

8.404 Appeal Procedure

A decision by the Data Governance Council to deny a request for an extension to the 120-day (or longer, if specified by the Data Governance Council) implementation period may be appealed to the Board by filing a written request to the Board chair within thirty (30) days of the Council's decision. If the request does not include a request for a hearing, the Board may decide the appeal based on the record developed by the Data Governance Council.

8.500 Enforcement

8.501 Sanctions for Violations

Violations of data submission requirements, confidentiality requirements, or any other provisions of 18 V.S.A. § 9410 or this rule, may be subject to sanction by the Board in accordance with 18 V.S.A. § 9410(g) after written notice and an opportunity for a hearing. The Board's authority to impose sanctions is in addition to any other powers granted to the Board to investigate, subpoena, or seek other legal or equitable remedies, including the power of the Board to enforce the terms of a governing contract.

8.600 Other Matters

8.601 Waiver of Rules

In order to prevent unnecessary hardship, delay, or injustice, or for other good cause, the Board may waive the application of any provision of this rule upon such conditions as it may require, unless precluded by the rule itself or by statute.

8.602 Conflict

In the event this rule or any section thereof conflicts with a federal statute, rule, or regulation or a Vermont statute, the federal or state statute, or the federal rule or regulation shall govern.

8.603 Severability

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

8.604 Effective Date

This rule shall become effective fifteen (15) days after adoption and supersedes all previously issued rules and policies related to the health care database, including Regulation H-2008-01 issued by the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 220 : Green Mountain Care Board

Subchapter 001 : Green Mountain Care Board

(Cite as: 18 V.S.A. § 9375)

§ 9375. Duties

(a) The Board shall execute its duties consistent with the principles expressed in section 9371 of this title.

(b) The Board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs that may include the participation of Medicare and Medicaid, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(i) The Board shall work in collaboration with providers to develop payment models that preserve access to care and quality in each community.

(ii) The rule shall take into consideration current Medicare designations and payment methodologies, including critical access hospitals, prospective payment system hospitals, graduate medical education payments, Medicare dependent hospitals, and federally qualified health centers.

(iii) The payment reform methodologies developed by the Board shall encourage coordination and planning on a regional basis, taking into account existing local relationships between providers and human services organizations.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the Board's proposed methodologies to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision

(1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of State government to engage in additional cost-containment activities to the extent permitted by State and federal law.

(2)(A) Review and approve Vermont's statewide Health Information Technology Plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the State to achieve the principles expressed in section 9371 of this title.

(B) Review and approve the criteria required for health care providers and health care facilities to create or maintain connectivity to the State's health information exchange as set forth in section 9352 of this title. Within 90 days following this approval, the Board shall issue an order explaining its decision.

(C) Annually review and approve the budget, consistent with available funds, of the Vermont Information Technology Leaders, Inc. (VITL). This review shall take into account VITL's responsibilities pursuant to section 9352 of this title and the availability of funds needed to support those responsibilities.

(3) Review and approve the Health Care Workforce Development Strategic Plan created in chapter 222 of this title.

(4) Publish on its website the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources in accordance with section 9405 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the Board.

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title.

(9) Review and approve, with recommendations from the Commissioner of Vermont Health Access, the benefit package or packages for qualified health benefit plans and reflective health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1. The Board shall report to the House Committee on Health Care and the Senate Committee on

Health and Welfare within 15 days following its approval of any substantive changes to the benefit packages.

(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the Department of Health and the Director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this State;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the Board.

(11) Develop the health care spending estimate pursuant to section 9383 of this title.

(12) Review data regarding mental health and substance abuse treatment reported to the Department of Financial Regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the Mental Health Technical Advisory Group established pursuant to subdivision 9374(e)(2) of this title.

(13) Adopt by rule pursuant to 3 V.S.A. chapter 25 such standards as the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter, including reporting requirements, patient protections, and solvency and ability to assume financial risk.

[Subsection (b)(14) repealed effective January 16, 2026.]

(14)(A) Collect and review annualized data from ambulatory surgical centers licensed pursuant to chapter 49 of this title, which shall include net patient revenues and which may include data on an ambulatory surgical center's scope of services, volume, payer mix, and coordination with other aspects of the health care system. The Board's processes shall be appropriate to ambulatory surgical centers' scale, their role in Vermont's health care system, and their administrative capacity, and the Board shall seek to minimize the administrative burden of data collection on ambulatory surgical centers. The Board shall also consider ways in which ambulatory surgical centers can be integrated into systemwide payment and delivery system reform.

(B) In its annual report pursuant to subsection (d) of this section, the Board shall describe its oversight of ambulatory surgical centers pursuant to subdivision (A) of this subdivision (14) for the most recently concluded 12-month period of the Board's review, including the amount of each ambulatory surgical center's net patient revenues and, using claims data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), information regarding high-volume outpatient surgeries and procedures performed in ambulatory surgical center and hospital settings in Vermont, any changes in utilization over time, and a comparison of the commercial insurance rates paid for the same surgeries and procedures performed in ambulatory surgical centers and in hospitals in Vermont.

(15) Collect and review data from each community mental health and developmental disability agency designated by the Commissioner of Mental Health or of Disabilities, Aging, and Independent Living pursuant to chapter 207 of this title, which may include data regarding a designated or specialized service agency's scope of services, volume, utilization, payer mix, quality, coordination with other aspects of the health care system, and financial condition, including solvency. The Board's processes shall be appropriate to the designated and specialized service agencies' scale and their role in Vermont's health care system, and the Board shall consider ways in which the designated and specialized service agencies can be integrated fully into systemwide payment and delivery system reform.

(c) The Board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the Agency of Human Services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the Agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the Agency of Human Services shall present a report on the benefit package proposal to the House Committee on Health Care and the Senate Committee on Health and Welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost-sharing requirements. If the General Assembly is not in session at the time that the Agency makes its recommendations, the Agency shall send its report electronically or by first class mail to each member of the House Committee on Health Care and the Senate Committee on Health and Welfare.

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the Governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax

rates and other assessments.

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

(A) any changes to the payment rates for health care professionals pursuant to section 9376 of this title;

(B) any new developments with respect to health information technology;

(C) the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications;

(D) the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations;

(E) the process and outcome measures used in the evaluation;

(F) the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates and any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

(G) any recommendations for modifications to Vermont statutes; and

(H) any actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs.

(2) The report shall identify how the work of the Board comports with the principles expressed in section 9371 of this title.

(e) All reports prepared by the Board shall be available to the public and shall be posted on the Board's website. (Added 2011, No. 48, § 3, eff. May 26, 2011; amended 2011, No. 171 (Adj. Sess.), § 12, eff. May 16, 2012; 2013, No. 79, § 5 I, eff. Jan. 1, 2014; 2013, No. 79, § 41; 2015, No. 54, § 7, eff. June 5, 2015; 2015, No. 113 (Adj. Sess.), § 4, eff. Jan. 1, 2018; 2017, No. 88 (Adj. Sess.), § 1, eff. Feb. 20, 2018; 2017, No. 113 (Adj. Sess.), § 105; 2017, No. 154 (Adj. Sess.), § 3, eff. May 21, 2018; 2017, No. 167 (Adj. Sess.), §§ 1, 8, eff. May 22, 2018; 2017, No. 187 (Adj. Sess.), § 4, eff. May 28, 2018; 2019, No. 19, § 3, eff. Jan. 1, 2020; 2019, No. 53, § 2; 2019, No. 55, § 4, eff. June 10, 2019; 2019, No. 63, § 10 eff. June 17, 2019; 2019, No. 140 (Adj. Sess.), § 1, eff. July 6, 2020.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 220 : Green Mountain Care Board

Subchapter 001 : Green Mountain Care Board

(Cite as: 18 V.S.A. § 9380)

§ 9380. Rules

The Board may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the provisions of this chapter. (Added 2011, No. 48, § 3, eff. May 26, 2011.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 221 : Health Care Administration

Subchapter 001 : Quality, Resource Allocation, And Cost Containment

(Cite as: 18 V.S.A. § 9404)

§ 9404. Administration

(a) The Commissioner and the Green Mountain Care Board shall supervise and direct the execution of all laws vested in the Department and the Board, respectively, by this chapter, and shall formulate and carry out all policies relating to this chapter.

(b) The Commissioner and the Board may:

(1) apply for and accept gifts, grants, or contributions from any person for purposes consistent with this chapter;

(2) adopt rules necessary to implement the provisions of this chapter; and

(3) enter into contracts and perform such acts as are necessary to accomplish the purposes of this chapter.

(c) [Repealed.]

(d) There is hereby created a special fund to be known as the Green Mountain Care Board Regulatory and Administrative Fund pursuant to 32 V.S.A. chapter 7, subchapter 5, for the purpose of providing the financial means for the Green Mountain Care Board to administer its obligations, responsibilities, and duties as required by law, including pursuant to 8 V.S.A. § 4062, chapters 220 and 221 of this title, and 33 V.S.A. chapter 18. All fees, fines, penalties, and similar assessments received by the Board in the administration of its obligations, responsibilities, and duties shall be credited to the Fund. The Fund may also be used by the Department of Health to administer its obligations, responsibilities, and duties as required by chapter 221 of this title. (Added 1991, No. 160 (Adj. Sess.), § 1, eff. May 11, 1992; amended 1995, No. 180 (Adj. Sess.), §§ 10, 38(a); 1999, No. 49, § 222; 2013, No. 79, § 36; 2015, No. 54, § 34; 2015, No. 68 (Adj. Sess.), § 67.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 221 : Health Care Administration

Subchapter 001 : Quality, Resource Allocation, And Cost Containment

(Cite as: 18 V.S.A. § 9410)

§ 9410. Health care database

(a)(1) The Board shall establish and maintain a unified health care database to enable the Board to carry out its duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2) [Repealed.]

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this State, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed.

(d) The Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The Board may impose an administrative penalty of not more than $10,000.00 each for those violations the Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that are subject to the federal requirements of the Health Insurance Portability and Accountability Act (HIPAA) shall be governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the Board in a form and in a manner prescribed by the Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contain direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2018 and every three years thereafter, the Commissioner of Health shall submit a recommendation to the General Assembly for conducting a survey of the health insurance status of Vermont residents. The provisions of 2 V.S.A. § 20(d)(expiration of required reports) shall not apply to the report to be made under this subsection.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and

facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the State of Vermont or an agency or instrumentality of the State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The Board may adopt rules to carry out the provisions of this subsection, including criteria for the required filing of such claims data, eligibility data, provider files, and other information as the Board determines to be necessary to carry out the purposes of this section and this chapter. (Added 1991, No. 160 (Adj. Sess.), § 1, eff. May 11, 1992; amended 1995, No. 180 (Adj. Sess.), §§ 16, 38(a); 2005, No. 71, § 312; 2005, No. 122 (Adj. Sess.), § 14; 2005, No. 191 (Adj. Sess.), § 57; 2007, No. 15, § 22; 2007, No. 70, § 25; 2007, No. 80, § 19; 2009, No. 42, § 33; 2009, No. 61, § 3; 2009, No. 156 (Adj. Sess.), § I.27; 2011, No. 48, § 27, eff. Oct. 1, 2011; 2013, No. 79, § 40, eff. June 7, 2013; 2013, No. 142 (Adj. Sess.), § 35; 2015, No. 54, § 35.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 221 : Health Care Administration

Subchapter 007 : Hospital Budget Review

(Cite as: 18 V.S.A. § 9453)

§ 9453. Powers and duties

(a) The Board shall:

(1) adopt uniform formats that hospitals shall use to report financial, scope-of-services, and utilization data and information;

(2) designate a data organization with which hospitals shall file financial, scope-of-services, and utilization data and information; and

(3) designate a data organization or organizations to process, analyze, store, or retrieve data or information.

(b) To effectuate the purposes of this subchapter, the Board may adopt rules under 3 V.S.A. chapter 25. (Added 1983, No. 93 § 1, eff. May 4, 1983; amended 1991, No. 160 (Adj. Sess.), § 11, eff. May 11, 1992; 1995, No. 180 (Adj. Sess.), §§ 34, 38(a); 2003, No. 53, §§ 22, 26; 2011, No. 171 (Adj. Sess.), § 23, eff. May 16, 2012.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 221 : Health Care Administration

Subchapter 007 : Hospital Budget Review

(Cite as: 18 V.S.A. § 9454)

§ 9454. Hospitals; duties

(a) Hospitals shall file the following information at the time and place and in the manner established by the Board:

(1) a budget for the forthcoming fiscal year;

(2) financial information, including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of services, and wage and salary data;

(3) scope-of-service and volume-of-service information, including inpatient services, outpatient services, and ancillary services by type of service provided;

(4) utilization information;

(5) new hospital services and programs proposed for the forthcoming fiscal year;

(6) known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan; and

(7) such other information as the Board may require.

(b) Hospitals shall adopt a fiscal year which shall begin on October 1. (Added 1983, No. 93, § 1, eff. May 4, 1983; amended 1991, No. 160 (Adj. Sess.), § 17, eff. May 11, 1992; 1995, No. 180 (Adj. Sess.), § 38; 2003, No. 53, § 23; 2011, No. 171 (Adj. Sess.), § 23, eff. May 16, 2012; 2015, No. 97 (Adj. Sess.), § 51a.)

VERMONT

Proposed Rules Postings
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Search Rules

Deadline For Public Comment

Deadline: Aug 10, 2021

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	21P019
Title:	Rule 8.000: Data Submission.
Type:	Standard
Status:	Proposed
Agency:	Green Mountain Care Board
Legal Authority:	18 V.S.A. §§ 9375, 9380, 9404, 9410, 9453, and 9454
Summary:	The Board stewards two sets of health care data: VHCURES (all-payer claims database) and VUHDDS (hospital discharge database). Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies

	must submit data for inclusion in the databases. The rule sets out the requirements for reporting health care claims and eligibility data, inpatient discharge data, outpatient procedure and service data, emergency department data, and other information relating to health care provided in Vermont and to Vermont residents outside the state.
Persons Affected:	BlueCross BlueShield of Vermont; MVP Health Care; Cigna; UnitedHealthcare; Health Insurers as defined in 18 V.S.A. § 9410(j)(1); General Hospitals as defined in 18 V.S.A. § 1902(1)(A); Ambulatory Surgery Centers as defined in 18 V.S.A. § 2141(1); Psychiatric Hospitals as defined in 18 V.S.A. §1902(1)(B)
Economic Impact:	The economic impact of the proposed rule is not materially different than the economic impact of the current rule. Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies that are mandatory data submitters under the proposed rule are also mandatory submitters under the existing rule. The Board expects that these entities will not incur materially different costs of complying with the proposed rule than they incur for complying with the current data submission requirements. The rule benefits health care consumers, providers, and regulators by providing the data necessary for valuable analysis of health care cost and utilization in Vermont.
Posting date:	Jun 30,2021

Hearing Information

Information for Hearing # 1

Hearing date:	08-02-2021 2:00 PM
Location:	Green Mountain Care Board
Address:	144 State Street
City:	Montpelier
State:	VT
Zip:	05602
Hearing Notes:	Please see Board Website for link and instructions to join a virtual hearing.

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level: Primary
Name: Russ McCracken
Agency: Green Mountain Care Board
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Telephone: 802-505-3055
Fax:
Email: russ.mccracken@vermont.gov

Website Address: https://gmcboard.vermont.gov/publications/rules-statutes

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

Level: Secondary
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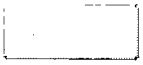
Keyword Information

Keywords:

VHCURES
VUHDDS
Healthcare database

All payer claims database
data submission



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	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** June 28, 2021

RE: The "Proposed State Rules " ad copy to run on **July 8, 2021**

PAGES INCLUDING THIS COVER MEMO: **2**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Rule 8.000: Data Submission.

Vermont Proposed Rule: 21P019

AGENCY: Green Mountain Care Board

CONCISE SUMMARY: The Board stewards two sets of health care data: VHCURES (all-payer claims database) and VUHDDS (hospital discharge database). Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies must submit data for inclusion in the databases. The rule sets out the requirements for reporting health care claims and eligibility data, inpatient discharge data, outpatient procedure and service data, emergency department data, and other information relating to health care provided in Vermont and to Vermont residents outside the state.

FOR FURTHER INFORMATION, CONTACT: Russ McCracken, Green Mountain Care Board, 144 State Street, Montpelier, VT 05602 Tel: 802-505-3055 Email: russ.mccracken@vermont.gov URL: https://gmcboard.vermont.gov/publications/rules-statutes.

FOR COPIES: Kathryn O'Neill, Green Mountain Care Board, 144 State Street, Montpelier, VT 05602 Tel: 802-272-8602 Email: kathryn.oneill@vermont.gov.

Rule 9.000: Data Release.

Vermont Proposed Rule: 21P020

AGENCY: Green Mountain Care Board

CONCISE SUMMARY: The Board stewards two sets of health care data: VHCURES (all-payer claims data) and VUHDDS (hospital discharge data). Subject to certain restrictions and limitations, the Board makes some of the information in the health care database available as a resource for individuals and entities to review health care utilization, expenditures, and performance in Vermont. The rule establishes processes by which the Board will make data in the health care database available to support legitimate and beneficial research and analysis.

FOR FURTHER INFORMATION, CONTACT: Russ McCracken, Green Mountain Care Board, 144 State Street, Montpelier, VT 05602 Tel: 802-505-3055 Email: russ.mccracken@vermont.gov URL: https://gmcboard.vermont.gov/publications/rules-statutes.

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