FINAL PROPOSED RULE # 21-P20

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 9.000: Data Release

/s/ Kevin Mullin , on 11/16/21
(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 9.000: Data Release

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   21P020

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?) Yes

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   18 V.S.A. § 9410; Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

   The rule covers the release of health care data from the database stewarded by the Board, which includes personally identifiable patient and provider health care claims and discharge data. 18 V.S.A. § 9410(3)(B)

instructs the Board to make the data from the databases available to the extent allowed by HIPAA. The confidentiality and other restrictions in the rule limit the release of data to comply with HIPAA restrictions. See 18 V.S.A. § 9410(2)("[t]he 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.") The rule also protects against the public disclosure of any data that contains direct personal identifiers, as required by 18 V.S.A. § 9410(3)(D). The rule sets out the processes for potential users to apply for access to the data and, if authorized, access data from the database. The rule also sets out processes to protect data from unauthorized use or disclosure, including by requiring data use agreements with any authorized user of the data.

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. §§ 9404 and 9410

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
Under 18 V.S.A. § 9410(3)(B), the data collected by the Board in the databases, "[t]o 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." The rule establishes the process, criteria, restrictions and protections for the release of data for legitimate purposes in a way that complies with HIPAA and other provisions for confidentiality. Under 18 V.S.A. § 9410(j)(2), the Board is authorized to adopt rules to carry out the provisions of the subsection.

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 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.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

Under 18 V.S.A. § 9410, the Board is required to make data in the database available to support analyses of health care utilization, expenditures, and performance in Vermont. The rule is necessary to establish the process and procedure for entities to obtain access to the data, and to establish protections around the disclosure and use of the data.

Currently, data release for the VHCURES (all-payer claims data) database is governed by Regulation H-2008-01, which was adopted by BISHCA in 2008. Data release for the VUHDDS (hospital discharge data) database is governed by contractual terms. Release of data from both data sets will be covered by the rule. Updating the rule is necessary to accommodate new technology for disclosing the data and to provide the Board greater flexibility to make data available for legitimate

research and analysis while also protecting the data from misuse or unauthorized disclosure.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rule facilitates valuable research and analysis by allowing disclosure and use of the data in a manner that is limited by the Board's statutory purpose, data protection and privacy requirements imposed by Vermont law, federal law and regulation, and contractual provisions applicable to the Board, and the data stewardship policies maintained by the Board. The Board's statutory obligations include the responsibilities listed in 18 V.S.A. § 9410(a). The data protection and privacy requirements are imposed by 18 V.S.A. § 9410, HIPAA, and data use agreements that the Board operates under with the Centers for Medicare and Medicaid Services and the Department of Vermont Health Access. The Board's data stewardship policies are maintained on the Board's website, and include the charter documents for the Board's Data Governance Council.

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

Any entity that requests access to the data contained in the database would be affected by the rule. The rule restricts access based on intended use of the data, not the identity of the person requesting access. The most frequent entities that seek access to the database are:

State agencies and instrumentalities

Research and academic institutions

Commercial entities

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

The rule facilitates the legitimate and responsible use of health care data for valuable research and analysis into health care utilization, expenditures, and performance in Vermont. The research and analysis can be used by Vermont regulators, policymakers, insurers, health care providers, and health care consumers to improve the quality, cost, and coverage of health care in the state. The Board contracts with a vendor to administer the databases and make restricted data sets

available to approved users. The cost of making restricted data sets available or providing access to approved users that are not state entities is paid directly by the approved users. There is no cost to other state entities. The Board's budget covers the management of the database. The economic impact will not be materially different than the existing rule and is positive to the state, as the benefits of the research and analysis completed with the data outweighs the costs to administer the database.

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: 03:00 PM

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

Zip Code: 05602

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

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).

VHCURES

VUHDDS

Healthcare database

All payer claims database

Hospital discharge database

Data use agreement

VERMONT
GREEN MOUNTAIN CARE BOARD

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

November 16, 2021

Green Mountain Care Board Proposed Rule 9.000: Data Release (21P020) – Public Comments and Responsiveness Summary

This letter is in regards to Green Mountain Care Board (GMCB) Proposed Rule 9.000: Data Release (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 3pm, 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 9.000: Data Release
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 9.000: Data Release, Green Mountain Care Board

Presented By: Russ McCracken and Kathryn O'Neill

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

1. 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 9.000: Data Release

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:

   Any entity that requests access to the data contained in the database would be affected by the rule. The rule restricts access based on intended use of the data, not the identity of the person requesting access. The economic impact of the proposed rule is not expected to be materially different than the current

existing data release rule. The most frequent entities that seek access to the database are:

State agencies and instrumentalities

Research and academic institutions

Commercial entities

The costs to non-State entities that access the data is the time of preparing and submitting an application, the cost of preparing a restricted data set, which is paid to the Board's vendor administering the database, and the cost of maintaining the confidentiality of the restricted data. The cost to non-State entities is not expected to change as a result of the new rule. State entities do not pay to access the data. The Board's budget covers the cost of access for all authorized State agencies and instrumentalities.

The benefit to all authorized users is the ability to use the data for research and analysis. The rule offers potential benefit to Vermont by enabling research into health care utilization and cost in the state, which can be used to reduce healthcare costs.

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):

A small business that seeks access to data from the database would be subject to the costs of applying, obtaining, and keeping restricted data confidential. The impact of the proposed rule on small businesses is not expected to differ from the impact of the current rule. The rule does not obligate any small business to apply for access to restricted information from the database.

Small businesses provide health insurance coverage and would benefit from any reduction of cost or improvements in quality or coverage in health insurance enabled by the research and analysis permitted by 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.*

A small business could reduce the burden of compliance by not seeking access to restricted data from the databases.

The cost of preparing a restricted data set is established by the Board's database administrator, but under the rule the Board's Data Governance Council may grant full or partial waivers of the cost if the payment would constitute an undue financial hardship and the requested data would fulfill a public purpose. A small business seeking access to the data to fulfill a public purposes could request a cost waiver.

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:

The provisions of the rule regarding privacy and data protection are, in the Board's view, required by state and federal law and regulation, and by the Board's data use agreements with the Centers for Medicare and Medicaid Services and the Department of Vermont Health Access. The impact of the proposed rule is not expected to be materially different than the impact of the existing rule. For those reasons, an alternative

process for small businesses to access the material was not appropriate.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
The legitimate use of the data for research and analysis benefits all Vermonters by enabling a better understanding of health care utilization, expenditures, and performance in the State. The costs imposed by the rule affect only entities seeking access to restricted data, and the rule does not require any non-state entities to seek access. The restrictions on use and disclosure in the rule are required by state and federal privacy and data protection laws and regulations. The costs and restrictions in the proposed rule are not expected to be materially different than under the current rule. For these reasons, the economic impact analysis is sufficient.

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 9.000: Data Release

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.*
   This Rule is not expected to have any environmental impact. Therefore, the analysis is sufficient.

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 9.000: Data Release

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:

   On February 2, 2021, the draft proposed rule was reviewed and discussed at a public meeting of the Data Governance Council of the Board.

Public Input

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. The Board asked for additional information regarding costs paid by data users under the draft proposed rule.

On May 5, 2021, additional information regarding costs under the draft proposed rule was provided to the Board. The draft proposed rule was approved by the Board 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 Vermont Blueprint for Health, Vermont Department of Health, and the Health Care Advocate. No comments on the draft proposed rule were received.

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 9.000: Data Release

2. ADOPTING AGENCY:

   Green Mountain Care Board

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

   The rule incorporates by reference two data use and disclosure manuals, one for each database. The disclosure manuals specify procedures for the submission and review of applications for data from the respective data sets, limitations on the availability of such data, and requirements that persons seeking or receiving such data must comply with to ensure that the privacy and security of the data is maintained.

   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:
   GMCB VHCURES Data Use and Disclosure Manual

5. GMCB VUHDDS Data Use and Disclosure Manual

6. 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).

7. 45 C.F.R. § 164.514(e)(2)

8. 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.

9. 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 disclosure manuals are incorporated in their entirety without change or modification. The disclosure manuals are subject to change or revision by the Board.

   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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~~Section 11.~~ 9.601 Sanctions for Violations

9.7600 Other Matters

9.701 Waiver of Rules

9.702 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~~
~~Appendix D2~~	~~Medical Claims File Mapping to National Standards~~
~~Appendix E1~~	~~Pharmacy Claims File Specifications~~
~~Appendix E2~~	~~Pharmacy Claims File Mapping to National Standards~~
~~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**~~

~~The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility 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 of such claims data, all as required by and consistent with the purposes of 18 V.S.A. §9410.~~

~~Section 2.~~ 9.703 Conflict

9.704 Effective Date

9.100 General Provisions

9.101 Authority.

~~This rule is issued~~ The Board adopts this Rule **pursuant to** ~~the authority~~ vested in ~~the Commissioner of the~~ 18 V.S.A. §§ 9404 and 9410.

~~Department of Banking, Insurance, Securities and~~ **9.102 Purpose**

The Green Mountain Care Board ("Board" or "GMCB") stewards two data sets (collectively "the health care database"). The Vermont **Hea**lth 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.~~

~~G. "Co-payment" means the fixed dollar amount a member pays to a health care provider at 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.~~

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I. "Data set" means a collection of individual data records, whether in electronic or manual files.

J. "Deductible" 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.

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect 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 infomnation 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 the 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. "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 health care services.~~

~~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~~") data set contains information related to health care utilization, costs, and resources provided in Vermont and to Vermont residents in other states. The Vermont Uniform Hospital Discharge Data Set ("VUHDDS") contains information 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 [15 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 patients at health care facilities in Vermont and 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. in other states.

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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.~~ 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. This rule establishes processes by which the Board will make data in the health care database available to support legitimate and beneficial research and analysis.

9.103 Definitions

For purposes of this rule:

(1) "Analytic table" means a file developed to answer specialized questions with detailed information related to claims, patients, health insurers, or health care providers.

(2) "Authorized User" means a person authorized by the Board to access restricted data under the terms of a data use agreement.

(3) "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.

(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 use agreement" or "DUA" means a written agreement detailing an Authorized User's commitment to data privacy and security and setting forth restrictions, limitations, and conditions on the use and disclosure of data from the health care database.

(8) "Data Use and Disclosure Manuals" means the publicly available manuals created and maintained by the Board that specify procedures for the submission and review of applications for data from the VHCURES and VUHDDS data sets, limitations on the availability of such data, and requirements that persons seeking or receiving such data must comply with to ensure that the privacy and security of the data is maintained.

(9) "Data Release Schedules" means the documents created and maintained by the Board that classify data elements based on the risk that release would pose for identification of individuals and disclosure of proprietary or other sensitive information.

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

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

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

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

(14) "Individual user affidavit" means the form created and maintained by the Board for Principal Investigators and any individual who will be allowed to access data under a DUA acknowledge and affirm that they have read, understand, and agree to abide by the DUA's terms and conditions.

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

(16) "Limited data set" has the same meaning as in 45 C.F.R. § 164.514(e)(2).

(17) **"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 ~~and/~~or dependent ~~covered by the subscriber's policy.~~

~~Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.~~

(18) ~~Af.~~ "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"~~"Person" means ~~a third-party payer or third-party administrator.~~

~~Ah. "Payment" means~~any natural person, business entity, municipality, **the** ~~actual dollar amount paid for a claim by a health insurer.~~

~~Ai. "Personal identifiers" means information relating to an individual that contains direct~~State of Vermont or any department, agency, **or** ~~indirect identifiers to which a reasonable basis exists to believe that~~subdivision of the ~~information can be used to identify an individual.~~

(19) ~~Aj. "Pharmacy Benefit Manager"~~State, and any partnership, unincorporated association, **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~~other legal **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.~~

(20) ~~Am.~~ **"P**rincipal 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~~ individual designated by an Authorized User to be responsible for

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ensuring compliance with ~~all restrictions, limitations and conditions of use associated with the data release.~~ the requirements in a DUA. An Authorized User may also be a Principal Investigator.

~~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.~~

(21) ~~Ap.~~ "Secure Analytic Environment" or "SAE" means a secure, virtual remote desktop, server, or other portal that provides access to restricted data in a data set through individual accounts provided to Authorized Users as specified in their Individual User Affidavit.

(22) "Standard report" means a recurring report derived from the VHCURES or VUHDDS data sets that is intended to provide information pertaining to claims, members, patients, health insurers, health insurance, health care providers, and/or health care services.

(23) "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.

~~Aq. "Third-party Administrator" 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 ~~health care providers and facilities.~~

(24) ~~Ar.~~ "~~Vermont Healthcare Claims~~ Health Care Uniform Reporting and Evaluation System" or "VHCURES" means the ~~Department's system for the collection, management and reporting of~~data 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.

~~As. "Voluntary Reporter" includes any entity other than a mandated reporter, 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, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.~~

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

~~Registration and Reporting Requirements~~

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A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether 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 submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides 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. §9121. 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 regularly submit medical 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

Mandated Reporters shall submit to BISHCA or its designee health care claims data 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. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless such 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.

A. General Requirements for Data Submission

(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.

(2) Behavioral or Mental Health Claims. All claims related to behavioral or mental health 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.

(e) 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

(c) (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).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. 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.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter 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.

F. Rejection of Files. Failure to conform to subsections A, B, or C 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 BISHCA or its designee within 10 days.

G. Replacement of Data Files. No Reporter may replace a complete data file submission more than one 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 must be approved by BISHCA. Individual adjustment records may be submitted with any monthly data file submission.

H. Run-Out Period. Reporters shall submit medical and pharmacy claims files for at least a six 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.

I. Data Submission Schedule. The reporting period for submission of each specified file listed in Section 5 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 for any one month of the calendar year. *Data files* are to be submitted in accordance with the following schedule:

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	

If the data files submitted by an individual Reporter support or are related to the files submitted by another Reporter, BISHCA shall establish a filing period for the parties involved.

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~~

(25) ~~Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be~~ "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.

9.200 Release of Data

9.201 Availability of Data in the Health Care Database

(a) The Data Release Schedules shall classify data elements in the health care database as "unrestricted," "restricted," or "unavailable" based on the level of risk that release of the data would pose for identification of individuals and disclosure of proprietary or other sensitive information.

~~(1)~~ (b)(1) Data elements classified as "unrestricted" may be available for general use and public release ~~as part~~under section 9.203 ~~of a Public Use File.~~ this rule.

~~(2) Restricted Data Elements:~~ Data elements ~~designated in Appendix J~~classified as

(2) ~~"Restricted"~~"restricted" shall not be available for use ~~and~~or release outside the Board unless permitted under the terms of an executed DUA.

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~~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~~classified as "unavailable," including any data element **not** ~~designated in Appendix I~~classified as ~~either Unrestricted~~unrestricted **or** ~~Restricted, or are designated as~~

(3) ~~"Unavailable",~~ restricted, **shall not be available for** use or **release** ~~or use~~ **outside the** ~~Department in any data set or disclosed in publicly released reports~~Board **in any** circumstance.

(c) The Data Use and Disclosure Manuals may specify additional restrictions or limitations on the availability of data in the health care database, such as restrictions or limitations required by the agreements under which the Board obtains the data and the laws that apply to the data.

9.202 Modes of Access; Secure Analytic Environment

(a) Persons with access to VHCURES or VUHDDS data sets may receive extracts generated from the data or permission to access the data set through the Secure Analytic Environment.

(b) No person outside the Board may access the Secure Analytic Environment unless permitted under the terms of an executed DUA.

~~B.~~ 9.203 Release of **Public Use Data** ~~Sets; Release,~~ **Analytic Tables, and** ~~Availability~~ **Standard Reports**

(a) ~~Unrestricted Data Elements collected or generated by the Department or its designee~~**If** beneficial to the public, usable, and technically feasible, the Board may from time to time publish unrestricted data elements and information derived from unrestricted data **elements** in public use data files, analytic tables, or standard reports.

(b) Public use data files, analytic tables, and standard reports published under subsection (a) of this section **shall**~~:~~

(1) be made available ~~in public use files and provided to any person~~ upon ~~written~~ request~~. except where otherwise prohibited~~ for no or minimal cost **by** ~~law.~~ Web-based electronic data download; and

~~(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~~

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~~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.~~

~~(2) Identity of person requesting access, including any entities for whom that person is acting in requesting the data.~~

~~(a) Name, address, 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;~~

~~(c) The research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested;~~

(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:

(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.

(e) 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~~ contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, underlying methodology, and other disclaimers that provide appropriate context.

9.300 Data Use Agreements; Application and Review

9.301 Application

(a) A person may request authorization to access the Secure Analytic Environment or data sets or analytic tables that include restricted data elements by applying for a limited data set on forms maintained by the Board.

(b) The Board may require a prospective applicant for access to the Secure Analytic Environment or data sets or analytic tables that include restricted data elements to complete and submit a pre-application review form.

(c) The Board will create and maintain one or more Data Use and Disclosure Manuals that specify procedures for the submission and review of applications. The Board's procedures may require review and approval of applications by agencies other than the Board and may specify different procedures for different types of requests and requestors.

9.302 Review of Applications

(a) The Data Governance Council shall approve or deny applications submitted under section 9.301(a) of this rule on behalf of the Board. The Council shall solicit and consider public comment relating to applications.

~~(2)~~ (b) The Data Governance Council may approve applications submitted under section 9.301(a) of this rule only when satisfied as to the following:

~~(a)~~ The application submitted to the Council is complete and ~~the requesting individuals or entities and principal investigator have~~ has been signed by the Principal Investigator(s) and a ~~data use agreement as specified:~~

(1) person with authority to bind the applicant, or, if the applicant is an individual, by the individual;

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~~(b)~~(2) Procedures to ensure the confidentiality of any patient ~~and any~~ data or other confidential data are documented;

~~(c)~~(3) The qualifications of the ~~investigator~~investigators and ~~research~~ staff, as evidenced by:

~~(1)~~(A) ~~Training~~credentials, training and previous research~~, including prior publications~~; and

~~(2)~~(B) ~~An~~an affiliation with a university, private research organization, ~~medical center~~health care facility, state agency, or other qualified institutional entity~~.~~;

~~(d)~~(4) No ~~other~~ state or federal law or regulation prohibits release of the requested information~~.~~; and

(5) ~~If the Commissioner declines to release the requested limited use data sets within 60 days of receipt of a complete application, the Department~~The data will be used in a way that aligns with GMCB's statutory responsibilities; federal and state data protection and privacy requirements; and the data stewardship policies adopted and amended from time to time by the Data Governance Council, which the Board shall make available on its website.

~~(3)~~ (c) If the Council denies an application submitted under section 9.301(a) of this rule, it shall give written notice of the basis for denial ~~of the application and the requestor shall have leave~~and give the applicant an opportunity to resubmit or supplement the application to address the ~~Commissioner's~~Council's concerns. ~~A~~any adverse decision regarding an application made by or on behalf of the Council may be appealed to the Board within 30 days by filing a ~~request for hearing with the Commissioner pursuant to Department Rule 82-1.~~ notice of appeal to the Chair of the Board.

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~~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.~~

~~Limited Use Research Health Care Claims Data Sets approved by the Department~~ (d) A decision by the Board to deny an appeal filed under subsection (c) of this section shall be a final decision that is appealable pursuant to 18 V.S.A. § 9381.

9.302 Data Use Agreements

(a) To access the Secure Analytic Environment or data sets or analytic tables that include restricted data elements, an Authorized User and Principal Investigator must execute a data use agreement with the Board.

(b) The Board will create and maintain standard data use agreements that set forth the restrictions, limitations, and conditions on the use and disclosure of data from the health care database.

(c) The Principal Investigator and any individual who will be allowed to access data under a DUA must sign an individual user affidavit.

(d) An Authorized User and the Principal Investigator must comply with the terms of the DUA. Failure to do so will be cause for immediate recall of the data or revocation of permission to use the data and may be grounds for sanctions under section 9.601 of this rule.

9.400 Costs of Data and Services

9.401 Analytic and Information Services

Upon request, the Board or its designated vendor may provide analytic and information services for members of the public.

9.402 Costs and Fees

(a) Data sets containing restricted data elements approved for release under this rule shall be made available to an Authorized User at the cost charged by the Board's designated vendor to program and process the requested data set. An Authorized User must pay these costs directly to the designated vendor within thirty days of receipt of the data set.

(b) Access to the Secure Analytic Environment access will be provided to an Authorized User at the cost charged by the Board's designated vendor. An Authorized User must pay these costs directly to the designated vendor prior to receiving access to the SAE.

~~B.~~ ~~(c)~~ Analytic tables approved for release under this rule and analytic and information services 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.~~ at the maximum allowable rate under law for time spent extracting data and performing similar tasks necessary to create the table or provide the services. Payments are due ~~in full from the requesting party~~ within thirty days of receipt of ~~BISHCA data sets, files, reports, or other~~

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~~released material~~the analytic tables or receipt of an invoice for the analytic or information services.

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~~Section 10.~~ **9.403 Cost and Fee Waivers**

Subject to budgetary limitations of the Board, the Data Governance Council may grant full or partial cost or fee waivers or may enter into alternative payment arrangements with applicants who can demonstrate that: (1) the requested data will be used to fulfill a public purpose, and (2) the payment of the costs or fees would constitute an undue financial hardship. Costs and fees shall be waived for any department, agency, or subdivision of the State of Vermont.

9.500 Special Considerations

9.501 Data Linkage

(a) No person outside the Board may link VHCURES or VUHDDS data, including public use data, with any data sources containing personally identifiable information or other data sources that could result in the identification of individuals in the data set without the express written consent of the Board. For purposes of this section, data linkage means the merging of two or more unique data sets or files to connect common identifiers across the data sets.

(b) If necessary to conduct research that would otherwise not be practicable, a person may request authorization to link VHCURES or VUHDDS data with identifiable record data sources using forms created and maintained by the Board. Requestors must provide a list of data sources to which the data would be linked and identify which data sources include personally identifiable information, including the specific identifiers within those data sources, as well as any other information specified by the Board.

(c) Any data set linked to VHCURES or VUHDDS data must, at a minimum, adhere to the protections, constraints and requirements set forth in the underlying GMCB data use agreement.

(d) If the Board denies a data linkage request, it shall provide a written explanation to the requestor identifying reasons for the denial.

9.502 Data Redisclosure

(a) An Authorized User may not redisclose VHCURES or VUHDDS data or extracts generated from the data to third parties or external agents such as contractors, subcontractors, grantees, and subgrantees without the express written approval of the Board or the Council.

(b) An Authorized User may request authorization to redisclose VHCURES or VUHDDS data. Requestors must provide a full list of individuals who will have access to the data upon the effective date of an approved redisclosure and assurances that the recipient of the redisclosed data will be bound by a written agreement to the same restrictions and conditions that apply to the Authorized User under its DUA with the Board. Requests for redisclosure can be made as part of an application under section 9.301(b) of this rule.

(c) The Principal Investigator(s) identified in the Board's DUA with the Authorized User shall ensure that individual user affidavits are submitted to the Board for all data users prior to granting access to VHCURES or VUHDDS data under a redisclosure.

9.600 Enforcement

9.601 Sanctions for Violations ~~of data submission~~

(a) A person who knowingly fails to comply with the **requirements**~~, confidentiality requirements, data use limitations~~ of 18 V.S.A. § 9410 or ~~any other provisions of~~ this **rule** ~~sh~~allmay be subject to sanction by the ~~Commissioner~~Board as set out in 18 V.S.A. §~~9410~~ 9410(g) after written notice and an opportunity to be heard. The Board's authority to sanction individuals shall be 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 DUA.

(b) ~~Section 11:~~ Hearings under this section shall be conducted by the Board in accordance with 3 V.S.A. §§ 809, 809a, 809b, and 810. Decisions of the Board under this section shall comply with the requirements of 3 V.S.A. § 812 and may be appealed pursuant to 18 V.S.A. § 9381.

9.700 Other Matters

9.701 Waiver of Rules

In order to prevent unnecessary hardship or delay, in order to prevent 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.

9.702 Conflict

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

9.703 Severability

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

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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 to a medical facility.

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 the admission to a medical facility.

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

SOURCE: Physicians' Current Procedural Terminology (CPT) Manual

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

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

Health Care Common Procedural Coding System
(Data **Element: MC055)**

SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm Centers
for Medicare and Medicaid Services
Center for Health Plans and Providers
CCPR/DCPC

Appendix A: Source Codes

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

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)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee

Appendix A: Source Codes

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 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.

Appendix A: Source Codes

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

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

Appendix A: Source Codes

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.

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

Appendix A: Source Codes

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.

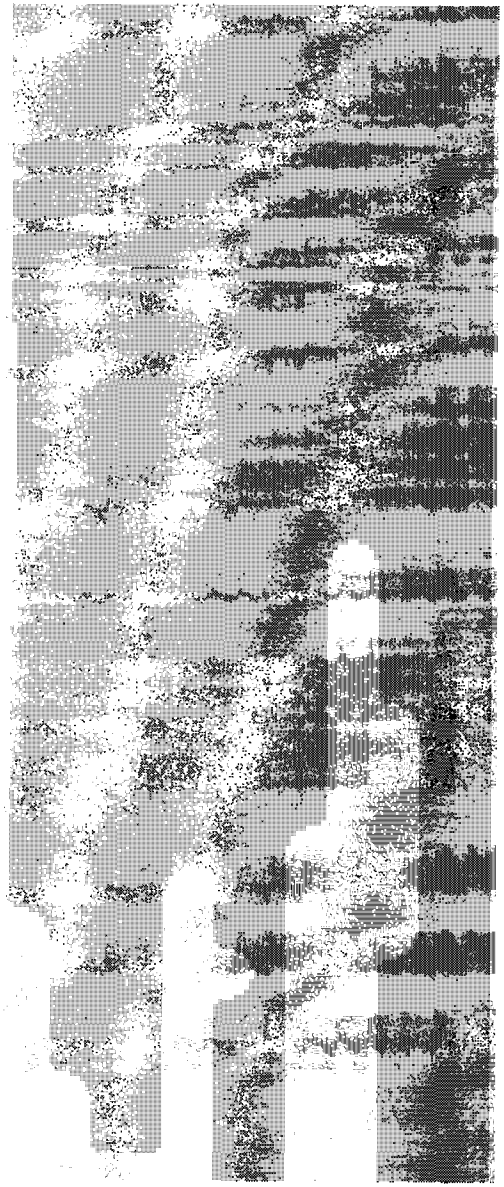
Appendix B-1: Header Record Specifications

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

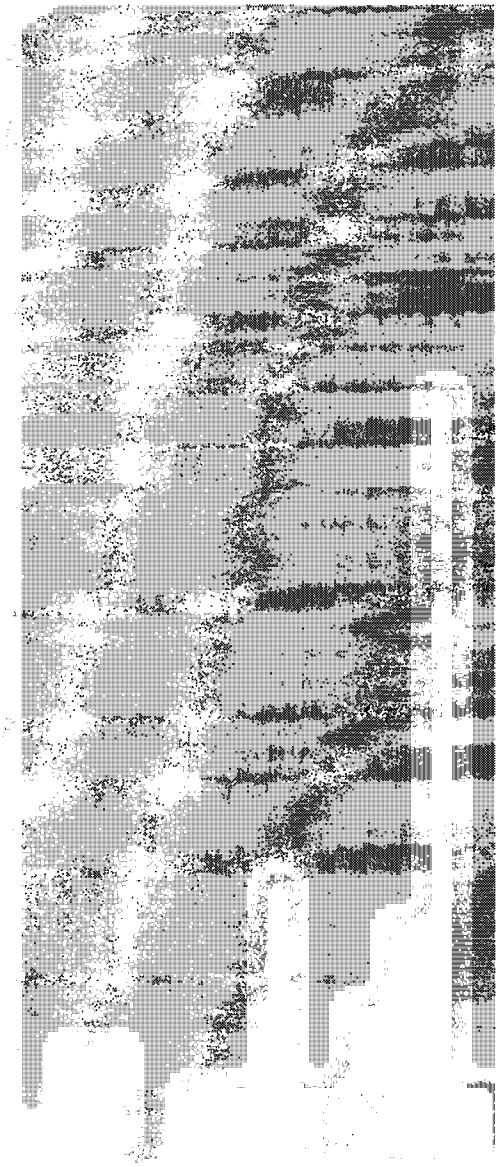
H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

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

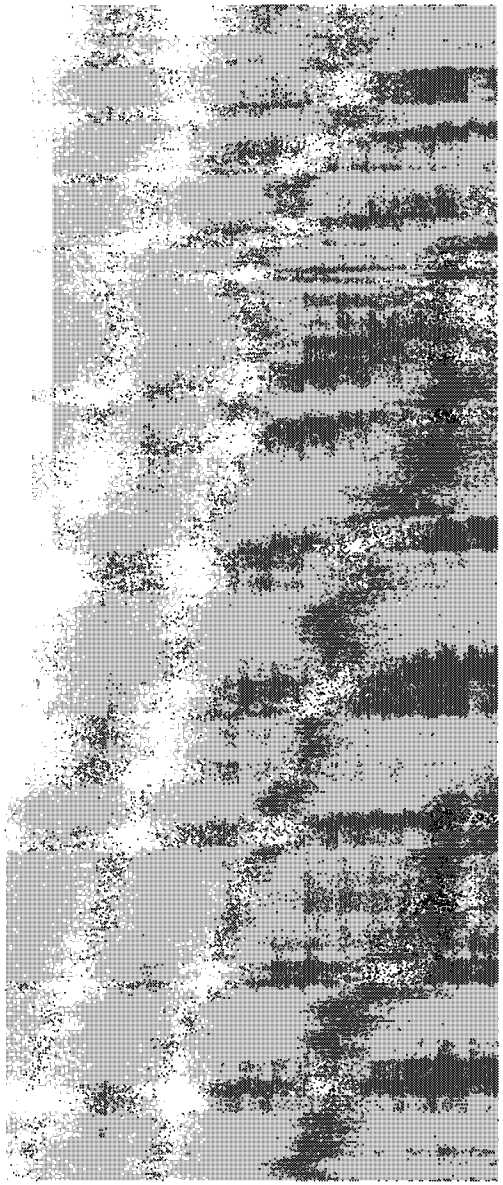


Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME003					Insurance Type Code/Product
		1/31/2007	Text	2	12
					Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
					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
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 GS2 for policies sold and issued directly to employers having between two and nine employees

Appendix C-1: Member Eligibility File Specifications

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

Appendix D1: Medical Claims File Specifications

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

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

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type Maximum Length	Description/Codes/Sources
				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
MC020	Admission Type	1/31/2007	Integer	1	Required for all inpatient claims. Refer to Appendix A.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
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) 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
MC023 (Cont'd)	Discharge Status (Cont'd)				

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. 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.

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.
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 6 Intermediate Care

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Start Date	Length	Type Maximum Description/Codes/Sources
				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 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgery Center
MC037 (Cont'd)	Site of Service - on NSF/CMS 1500 Claims (Cont'd)			

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					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 03 Processed as tertiary

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
					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.
MC049	Other Diagnosis – 8	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
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. CCYYMMDD

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
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. CCYYMMDD
MC070	Service Provider Country Name	1/31/2007	Text	30	Code US for United States.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
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.
MC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
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	20/19	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; 4/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Site of Service – on NSF/CMS 1500 Claims	N/A	N/A	24B	EA0-07.0, 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

Appendix D2: Medical Claims File Mapping to National Standards

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 Maximum Type 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	804-6B
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 200 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 date 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 SSL 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?

_____ CD-ROM _____ DVD-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?

_____ CD-ROM _____ DVD-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: ______________________________

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: ______________________________

[1] 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 #:

D.B.A.:

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 Specifics Named Disease

Medicare Supplemental (Medigap): Limited Benefit
Behavioral Health Student Policy

Substance Abuse Workers Compensation

Long Term Care Accident Only or AD&D

Disability Stop Loss

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 Health	Pharmacy	Behavioral	Medicare Supplement	Major Medical
Collect and handle 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 Health	Pharmacy	Behavioral	Major Medical

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 INFORMATION

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 19 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: _____

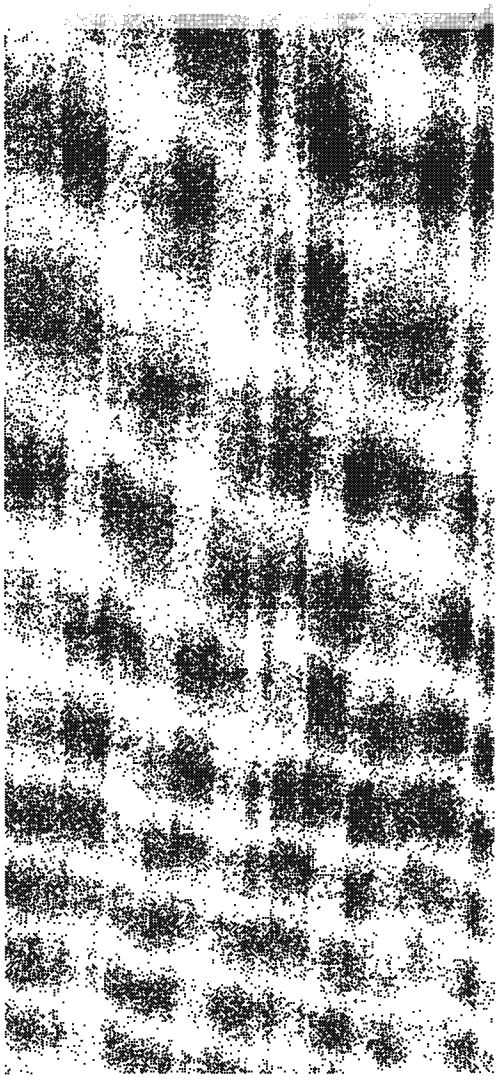
P.O. Box and/or Street: _____

City: _____

State: _____

ZIP or Postal Code: _____

County: _____



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

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

DATA ELEMENT NUMBER	[redacted] FILE ELEMENT NAME

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

[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

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

ME001 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

DATA ELEMENT NUMBER ELEMENT NAME

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

PE001 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)

PE901 Payer
PE902 National Plan ID
PE906 Insured Group or Policy Number
PE915 Member City Name
PE917 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

PE903 Insurance Type/Product Code
PE908 Encrypted Subscriber Social Security Number
PE909 Plan Specific Contract Number PE910 Member Suffix or Sequence Number
PE911 Member Identification Code
PE912 Individual Relationship Code PE914 Member Date of Birth
PE918 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

Derived or calculated from submitted data

PE903 BISHCA Extract Date PE904 Unique Member ID
PE906 Submission ID#
PE913 Duplicate Member Flag

Appendix J-4: Data Release Schedule

DATA RELEASE SCHEDULE: MEDICAL CLAIMS FILE

DATA ELEMENT NUMBER	ELEMENT NAME

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

Appendix J-4: Data Release Schedule

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#~~

Appendix J-5: Data Release Schedule

DATA RELEASE SCHEDULE: PHARMACY CLAIMS FILE

ELEMENT NAME

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

Appendix J-5: Data Release Schedule

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 Teble)
* 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
PC999 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.

DATA ELEMENT NUMBER	

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.

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

ELEMENT [illegible]	ELEMENT NAME

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 Files

UNAVAILABLE FOR RELEASE

PCSP904	Pharmacy Tax ID Number

Appendix J-9: Data Release Schedule

DATA RELEASE SCHEDULE: PHARMACY MASTER FILE

ELEMENT	ELEMENT NAME
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

DATA ELEMENT NUMBER	ELEMENT NAME	
		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)

HCPT901	Procedure Code
HCPT902	Payer Code
HCPT903	Procedure Code Description
HCPT904	Date HCPT 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

DATA ELEMENT NUMBER	ELEMENT NAME

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.

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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

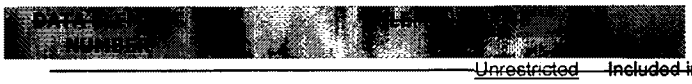
UNAVAILABLE FOR RELEASE

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

Appendix J-12: Data Release Schedule

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 Include[redacted] 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.

DATA ELEMENT NUMBER	ELEMENT NAME

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

~~9~~.703 Effective Date

This rule shall become effective _____.

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
Rule 9.000: Data Release

9.100 General Provisions

9.101 Authority

The Board adopts this Rule pursuant to 18 V.S.A. §§ 9404 and 9410.

9.102 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 in Vermont and to Vermont residents in other states. 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.

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. This rule establishes processes by which the Board will make data in the health care database available to support legitimate and beneficial research and analysis.

9.103 Definitions

For purposes of this rule:

(1) "Analytic table" means a file developed to answer specialized questions with detailed information related to claims, patients, health insurers, or health care providers.

(2) "Authorized User" means a person authorized by the Board to access restricted data under the terms of a data use agreement.

(3) "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.

(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 use agreement" or "DUA" means a written agreement detailing an Authorized User's commitment to data privacy and security and setting forth restrictions, limitations, and conditions on the use and disclosure of data from the health care database.

(8) "Data Use and Disclosure Manuals" means the publicly available manuals created and maintained by the Board that specify procedures for the submission and review of applications for data from the VHCURES and VUHDDS data sets, limitations on the availability of such data, and requirements that persons seeking or receiving such data must comply with to ensure that the privacy and security of the data is maintained.

(9) "Data Release Schedules" means the documents created and maintained by the Board that classify data elements based on the risk that release would pose for identification of individuals and disclosure of proprietary or other sensitive information.

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

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

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

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

(14) "Individual user affidavit" means the form created and maintained by the Board for Principal Investigators and any individual who will be allowed to access data under a DUA acknowledge and affirm that they have read, understand, and agree to abide by the DUA's terms and conditions.

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

(16) "Limited data set" has the same meaning as in 45 C.F.R. § 164.514(e)(2).

(17) "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.

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

(19) "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.

(20) "Principal Investigator" means the individual designated by an Authorized User to be responsible for ensuring compliance with the requirements in a DUA. An Authorized User may also be a Principal Investigator.

(21) "Secure Analytic Environment" or "SAE" means a secure, virtual remote desktop, server, or other portal that provides access to restricted data in a data set through individual accounts provided to Authorized Users as specified in their Individual User Affidavit.

(22) "Standard report" means a recurring report derived from the VHCURES or VUHDDS data sets that is intended to provide information pertaining to claims, members, patients, health insurers, health insurance, health care providers, and/or health care services.

(23) "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.

(24) "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.

(25) "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.

9.200 Release of Data

9.201 Availability of Data in the Health Care Database

(a) The Data Release Schedules shall classify data elements in the health care database as "unrestricted," "restricted," or "unavailable" based on the level of risk that release of the data would pose for identification of individuals and disclosure of proprietary or other sensitive information.

(b)(1) Data elements classified as "unrestricted" may be available for general use and public release under section 9.203 of this rule.

(2) Data elements classified as "restricted" shall not be available for use or release outside the Board unless permitted under the terms of an executed DUA.

(3) Data elements classified as "unavailable," including any data element not classified as unrestricted or restricted, shall not be available for use or release outside the Board in any circumstance.

(c) The Data Use and Disclosure Manuals may specify additional restrictions or limitations on the availability of data in the health care database, such as restrictions or limitations required by the agreements under which the Board obtains the data and the laws that apply to the data.

9.202 Modes of Access; Secure Analytic Environment

(a) Persons with access to VHCURES or VUHDDS data sets may receive extracts generated from the data or permission to access the data set through the Secure Analytic Environment.

(b) No person outside the Board may access the Secure Analytic Environment unless permitted under the terms of an executed DUA.

9.203 Release of Public Use Data, Analytic Tables, and Standard Reports

(a) If beneficial to the public, usable, and technically feasible, the Board may from time to time publish unrestricted data elements and information derived from unrestricted data elements in public use data files, analytic tables, or standard reports.

(b) Public use data files, analytic tables, and standard reports published under subsection (a) of this section shall:

(1) be made available upon request for no or minimal cost by Web-based electronic data download; and

(2) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, underlying methodology, and other disclaimers that provide appropriate context.

9.300 Data Use Agreements; Application and Review

9.301 Application

(a) A person may request authorization to access the Secure Analytic Environment or data sets or analytic tables that include restricted data elements by applying for a limited data set on forms maintained by the Board.

(b) The Board may require a prospective applicant for access to the Secure Analytic Environment or data sets or analytic tables that include restricted data elements to complete and submit a pre-application review form.

(c) The Board will create and maintain one or more Data Use and Disclosure Manuals that specify procedures for the submission and review of applications. The Board's procedures may require review and approval of applications by agencies other than the Board and may specify different procedures for different types of requests and requestors.

9.302 Review of Applications

(a) The Data Governance Council shall approve or deny applications submitted under section 9.301(a) of this rule on behalf of the Board. The Council shall solicit and consider public comment relating to applications.

(b) The Data Governance Council may approve applications submitted under section 9.301(a) of this rule only when satisfied as to the following:

(1) The application submitted to the Council is complete and has been signed by the Principal Investigator(s) and a person with authority to bind the applicant, or, if the applicant is an individual, by the individual;

(2) Procedures to ensure the confidentiality of any patient data or other confidential data are documented;

(3) The qualifications of the investigators and staff, as evidenced by:

(A) credentials, training and previous research; and

(B) an affiliation with a university, private research organization, health care facility, state agency, or other qualified institutional entity;

(4) No state or federal law or regulation prohibits release of the requested information; and

(5) The data will be used in a way that aligns with GMCB's statutory responsibilities; federal and state data protection and privacy requirements; and the data stewardship policies adopted and amended from time to time by the Data Governance Council, which the Board shall make available on its website.

(c) If the Council denies an application submitted under section 9.301(a) of this rule, it shall give written notice of the basis for denial and give the applicant an opportunity to resubmit or supplement the application to address the Council's concerns. Any adverse decision regarding an application made by or on behalf of the Council may be appealed to the Board within 30 days by filing a notice of appeal to the Chair of the Board.

(d) A decision by the Board to deny an appeal filed under subsection (c) of this section shall be a final decision that is appealable pursuant to 18 V.S.A. § 9381.

9.302 Data Use Agreements

(a) To access the Secure Analytic Environment or data sets or analytic tables that include restricted data elements, an Authorized User and Principal Investigator must execute a data use agreement with the Board.

(b) The Board will create and maintain standard data use agreements that set forth the restrictions, limitations, and conditions on the use and disclosure of data from the health care database.

(c) The Principal Investigator and any individual who will be allowed to access data under a DUA must sign an individual user affidavit.

(d) An Authorized User and the Principal Investigator must comply with the terms of the DUA. Failure to do so will be cause for immediate recall of the data or revocation of permission to use the data and may be grounds for sanctions under section 9.601 of this rule.

9.400 Costs of Data and Services

9.401 Analytic and Information Services

Upon request, the Board or its designated vendor may provide analytic and information services for members of the public.

9.402 Costs and Fees

(a) Data sets containing restricted data elements approved for release under this rule shall be made available to an Authorized User at the cost charged by the Board's designated vendor to program and process the requested data set. An Authorized User must pay these costs directly to the designated vendor within thirty days of receipt of the data set.

(b) Access to the Secure Analytic Environment access will be provided to an Authorized User at the cost charged by the Board's designated vendor. An Authorized User must pay these costs directly to the designated vendor prior to receiving access to the SAE.

(c) Analytic tables approved for release under this rule and analytic and information services shall be made available at the maximum allowable rate under law for time spent extracting data and performing similar tasks necessary to create the table or provide the services. Payments are due within thirty days of receipt of the analytic tables or receipt of an invoice for the analytic or information services.

9.403 Cost and Fee Waivers

Subject to budgetary limitations of the Board, the Data Governance Council may grant full or partial cost or fee waivers or may enter into alternative payment arrangements with applicants who can demonstrate that: (1) the requested data will be used to fulfill a public purpose, and (2) the payment of the costs or fees would constitute an undue financial hardship. Costs and fees shall be waived for any department, agency, or subdivision of the State of Vermont.

9.500 Special Considerations

9.501 Data Linkage

(a) No person outside the Board may link VHCURES or VUHDDS data, including public use data, with any data sources containing personally identifiable information or other data sources that could result in the identification of individuals in the data set without the express written consent of the Board. For purposes of this section, data linkage means the merging of two or more unique data sets or files to connect common identifiers across the data sets.

(b) If necessary to conduct research that would otherwise not be practicable, a person may request authorization to link VHCURES or VUHDDS data with identifiable record data sources using forms created and maintained by the Board. Requestors must provide a list of data sources to which the data would be linked and identify which data sources include personally identifiable information, including the specific identifiers within those data sources, as well as any other information specified by the Board.

(c) Any data set linked to VHCURES or VUHDDS data must, at a minimum, adhere to the protections, constraints and requirements set forth in the underlying GMCB data use agreement.

(d) If the Board denies a data linkage request, it shall provide a written explanation to the requestor identifying reasons for the denial.

9.502 Data Redisclosure

(a) An Authorized User may not redisclose VHCURES or VUHDDS data or extracts generated from the data to third parties or external agents such as contractors, subcontractors, grantees, and subgrantees without the express written approval of the Board or the Council.

(b) An Authorized User may request authorization to redisclose VHCURES or VUHDDS data. Requestors must provide a full list of individuals who will have access to the data upon the effective date of an approved redisclosure and assurances that the recipient of the redisclosed data will be bound by a written agreement to the same restrictions and conditions that apply to the Authorized User under its DUA with the Board. Requests for redisclosure can be made as part of an application under section 9.301(b) of this rule.

(c) The Principal Investigator(s) identified in the Board's DUA with the Authorized User shall ensure that individual user affidavits are submitted to the Board for all data users prior to granting access to VHCURES or VUHDDS data under a redisclosure.

9.600 Enforcement

9.601 Sanctions for Violations

(a) A person who knowingly fails to comply with the requirements of 18 V.S.A. § 9410 or this rule may be subject to sanction by the Board as set out in 18 V.S.A. § 9410(g) after written notice and an opportunity to be heard. The Board's authority to sanction individuals shall be 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 DUA.

(b) Hearings under this section shall be conducted by the Board in accordance with 3 V.S.A. §§ 809, 809a, 809b, and 810. Decisions of the Board under this section shall comply with the requirements of 3 V.S.A. § 812 and may be appealed pursuant to 18 V.S.A. § 9381.

9.700 Other Matters

9.701 Waiver of Rules

In order to prevent unnecessary hardship or delay, in order to prevent 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.

9.702 Conflict

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

9.703 Severability

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

9.703 Effective Date

This rule shall become effective _____.

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

Proposed Rules Postings
A Service of the Office of the Secretary of State

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:	21P020
Title:	Rule 9.000: Data Release.
Type:	Standard
Status:	Proposed
Agency:	Green Mountain Care Board
Legal Authority:	18 V.S.A. §§ 9404 and 9410
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.
Persons Affected:	Any entity that requests access to the data contained in the database would be affected by the rule. The rule restricts access based on intended use of the data, not the identity of the person requesting access. The most frequent entities that seek access to the database are: State agencies and instrumentalities Research and academic institutions Commercial entities
Economic Impact:	The rule facilitates the legitimate and responsible use of health care data for valuable research and analysis into health care utilization, expenditures, and performance in Vermont. The research and analysis can be used by Vermont regulators, policymakers, insurers, health care providers, and health care consumers to improve the quality, cost, and coverage of health care in the state. The Board contracts with a vendor to administer the databases and make restricted data sets available to approved users. The cost of making restricted data sets available or providing access to approved users that are not state entities is paid directly by the approved users. There is no cost to other state entities. The Board's budget covers the management of the database. The economic impact will not be materially different than the existing rule and is positive to the state, as the benefits of the research and analysis completed with the data outweighs the costs to administer the database.
Posting date:	Jun 30,2021

Hearing Information

Information for Hearing # 1

Hearing date:	08-02-2021 3:00 PM [redacted]
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 meeting.

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
Address: 144 State Street
City: Montpelier
State: VT
Zip: 05602
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
Name: Kathryn O"Neill
Agency: Green Mountain Care Board
Address: 144 State Street
City: Montpelier
State: VT
Zip: 05602
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Fax:
Email: kathryn.oneill@vermont.gov

Keyword Information

Keywords:

VHCURES
VUHDDS
Healthcare database
All payer claims database
Hospital discharge database
Data use agreement

OFFICE OF THE SECRETARY OF STATE

VERMONT STATE ARCHIVES & RECORDS ADMINISTRATION (VSARA)

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	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	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.

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