



STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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February 5, 2016

To: The House Committee on Health

H.B. 2481 - Relating to Health

Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair
Committee on Health

Monday, February 8, 2016, 1:45 pm, State Capitol, Conference Room 329

From: Sue Radcliffe, Administrator
State Health Planning & Development Agency

Agency's Position: Support

Chair Belatti, Vice Chair Creagan and Committee Members:

Thank you for this opportunity to provide testimony in support of H.B. 2481 Relating to Health.

My name is Sue Radcliffe, Administrator of the State Health Planning & Development Agency (SHPDA).

Since 1975, SHPDA has been the State's principal agency charged with the duty of promoting accessibility for all the people of the State of Hawai'i to quality health care services at reasonable cost. To accomplish our objectives we:

- Conduct studies and investigations regarding the causes of health care costs
- Promote the sharing of facilities or services by health care providers to achieve economies of scale and restrict unusual costly services
- Conduct coordinated health planning activities and determine health needs of the State.
- Administer the State's Certificate of Need (CON) program
- Serve as staff in the preparation, revision, and implementation of the State's Health Services and Facilities Plan

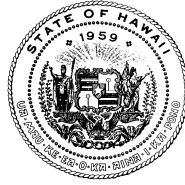
I and my staff support the passage of H.B. 2481 because it will reinvigorate the Agency and strengthen our potential to succeed in our mission. The bill will promote transparency in the health care sector and support public policy decision making.

Importantly, H.B. 2481 clarifies existing language making it clear that the State needs the original *data* not merely summaries and statistical reports. The bill designates SHPDA as the point of centralized authority tasked with directing health care data to technical analytical resources within the State.

Furthermore, H.B. 2481 confirms the intent and desire by this legislature, on behalf of the people of Hawai'i, for SHPDA to orchestrate and direct the analysis of health care claims payment data to promote quality health care services at reasonable cost in the most transparent public way possible.

State Health Planning & Development Agency looks forward to this opportunity of modernizing our capacity to serve Hawai'i's people. Leveraging the new capabilities now available to us, we will help the people, you, our legislature, our sister state agencies, and further empower the people and their accessibility to the greatest quality of health care at the most reasonable cost.

Thank you, again, for this opportunity to testify in support of H.B. 2481.



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
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**Testimony in SUPPORT of HB2481
RELATING TO HEALTH**

REPRESNATIVE DELLA BELATTI, CHAIR
HOUSE COMITTE ON HEALTH

Hearing Date: February 8, 2016

Room Number: 329

1 **Fiscal Implications:** None for Department of Health.

2 **Department Testimony:** A centralized and accessible repository of health care services claims
3 will be invaluable to statewide health planning efforts and likely augment Certificate of Need
4 analyses. The department recommends identifying a general state agency's data center or
5 potentially a state agency designee's data center, as opposed to the University of Hawaii
6 specifically, to maximize the future flexibility of an analytics program.

7 **Offered Amendments:** Page 3, Bill Section 2, line 17:

8 (b) The state agency shall submit acquired data to a
9 [~~University of Hawaii~~] state-designated data center that shall
10 comply with the conflict of interest provisions of section
11 2794(d)(2) of the federal Patient Protection and Affordable Care
12 Act that requires a data center established under section
13 2794(c)(1)(C) of the federal Patient Protection and Affordable
14 Care Act to adopt by-laws ensuring that the center and all
15 members of the center's governing board are independent and free
16 from all conflicts of interest."

17



UNIVERSITY OF HAWAII SYSTEM

Legislative Testimony

Testimony Presented Before the
House Committee on Health
Monday, February 8, 2016 at 1:45pm

By
Robert Bley-Vroman, Chancellor
And
Denise Eby Konan, Dean
College of Social Sciences
University of Hawai'i at Mānoa

HB 2481 – RELATING TO HEALTH

Chair Belatti, Vice Chair Creagan and members of the committee:

Thank you for the opportunity to provide testimony on HB 2481. We appreciate the opportunity to testify in strong support of HB 2481 intended to promote accessibility to quality health care to the people of Hawai'i at a reasonable cost.

We request that the bill be amended to specifically name the CSS Social Sciences Research Institute (SSRI) Pacific Health Informatics Center as the host of the "University of Hawai'i data center" described in SECTION 2.b.

As the Dean of the College of Social Sciences and an economist, I have also been personally aware of the APCD from many conversations over the past two years with Dr. Kameoka, who has been a Principal Investigator on many health related grants from the National Institutes of Health and other federal agencies; and, Dr. Okamura and Christina Higa who are the Principal Investigators on the agreement between the State of Hawai'i and the University of Hawai'i and funded through the Center for Consumer Information and Insurance Oversight (CCIO) of the Centers for Medicare and Medicaid Services (CMS).

The CSS-SSRI has significant capacity, expertise, and track record to serve as the State of Hawai'i health data repository. CSS-SSRI will develop the Pacific Health Informatics Center (PHIC) for this purpose. CSS-SSRI currently serves as the data repository for the Commonwealth of the Northern Mariana Islands (CNMI) through their Telecommunications and Social Informatics (TASI) research program, under the direction of Dr. Norman Okamura, Director. CSS-SSRI also runs the Telehealth Resource Center. CSS-SSRI has analytical expertise in data analytics and economic analyses through the University of Hawai'i Economic Research Organization (UHERO), of which Dr. Konan is a founding member, as well as a network of scholars with relevant expertise. We would be honored to undertake the responsibilities set forth in HB 2481.

We understand the importance of claims data to the State of Hawai'i. We are aware that the Health Committees of both the Senate and the House of Representatives value an All Payer Claims Database (APCD) to health care and have held joint informational meetings on the subject over the years. We respect that the Health Committees are fully aware of importance of an APCD to understanding the cost of care, quality of care, population health, health disparities, health care service utilization and gaps, and oversight of health insurance premiums and Medical Loss Ratios in Hawai'i. We too believe in the importance of data to improving care, population health, identifying issues with access to care, and to lessen the cost of care through actionable information and insight into health care.

We believe that the information is important to the State of Hawai'i not only because health matters, but also because the State is a major funder of health care programs and services; and because the costs of health care continue to rise for state and county governments and employees, the State Medicaid program, the Hawai'i Health Systems Corporation, and the Department of Health. Data on the conditions and costs of care is critically important to understanding how the state expends resources for health care.

There are several reasons why the UH College of Social Sciences within the University of Hawai'i is positioned to support both the data management and research.

First, the UH TASI works with payer/provider claims data. UH TASI has developed this experience by assisting health care providers in Commonwealth of the Northern Mariana Islands and Guam to implement the RPMS Electronic Health Record Systems (EHR) and electronically billing with payers such as CMS and Aetna. UH TASI is intimately familiar with electronic transactions and data structures of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) Designated Standards Management Organizations (DSMOs) for claims data.

UH TASI is collaborating with the State Enterprise Technology Services (ETS) on the Hawai'i All-Payer Claims database. Within the UH TASI research program, an organized unit of the Social Science Research Institute, a program we call the Health Care Cost, Value, and Quality Project has been established to analyze retrospective claims data.

UH TASI is also assisting the CNMI Medicaid Agency to establish a claims data repository and to analyze Medicaid claims data for the CNMI Medicaid program for the same purposes. UH TASI in the CNMI is also working on a clinical data repository from the EHR system that includes a hospital, HRSA Section 330 Community Health Center, remote island clinics, and the Division of Public Health. The integration of clinical data will not only enable the understanding of interventions and costs, but also the outcomes of services. Please see the endorsements of the CNMI and Guam Departments of

Public Health and Healthcare Services in having the UH TASI receive Research Identifiable Files (RIF) data for Medicare populations in these territories.

Second, the UHM College of Social Sciences firmly supports and is committed to the objective of providing information to the many stakeholders, including consumers, policymakers, government agencies, and businesses. The UH plan is not only to provide information in the form of data briefs and reports, but also through a web portal that will enable access to information.

Third, the Health Care Cost and Value Project of the UH TASI Research Program within the Social Science Research Institute (SSRI) is also well-positioned to undertake such work with integrity and independence. The statutory requirements for a “Data Center” is clear in its directive that there be no conflicts of interest in the analysis and reporting of data. Specifically, the statute states that:

SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

To ensure that there are no conflicts of interest in the analysis or reporting of the data, Section 2794 of the U.S. Public Health Service Act requires that the data center have no conflicts of interest.

“(2) Conflicts of interest.

A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center’s analysis of health care costs.”

CMS Guidance

“To clarify, there are statutory requirements that apply to Data Centers established or enhanced through the Rate Review Grant Program. Specifically, section 2794 of the Public Health Service (PHS) Act requires that Data Centers must be located at academic or other non-profit institutions.

...

In addition, Data Centers must adopt by-laws that comply with the conflict of interest requirements established by section 2794 of the PHS Act. Appendix F of the Funding Opportunity Announcement contains new guidance in order to assist states seeking to comply with the requirements established by section 2794.”

The UH completely supports the need for independence in the data analysis as provided for in Section 2794. The UH believes that it is best positioned to provide such

independent analysis to *both involve and to inform* the many stakeholders. The UH has explicit conflict of interest requirements that apply to all faculty and staff. Finally, all faculty and staff are required to annually certify that there are no conflicts of interest.

Fourth, with respect to the types of healthcare analytics that will be conducted, there are two program components: Standard Analytics and Special Studies.

Standard Analytics: The UH TASI will undertake a standard set of healthcare analytics that replicate useful studies and methodologies from the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention, and the APCDs and academic institutions that share their methodologies and algorithms. The standard analytics will be in the form of reports that are generated on an ongoing basis by UH TASI.

Special Studies: To encourage and ensure that the data is capable of being used by the many stakeholders, the UH plan is to establish Working Groups (WGs) that are open to participation by all stakeholders.

The members of the WGs will be asked to collaboratively:

- Identify and define health matters that can be informed through APCD data;
- Develop and review the analytic methodology from the other federal agencies and APCDs (e.g. indicators, measurements) for cost, health conditions, quality, services, and the like;
- Develop and test the statistical and/or other software algorithms with test data;
- Review the integrity of the algorithm; and,
- Once the algorithms have been tested and evaluated, UH TASI will execute the algorithms against the encrypted full database.

The approach will help to ensure that there is integrity and openness in the process. It will also ensure the security of the data.

The reports and website will be valuable to the stakeholders; and, credit will be given to individuals who invest effort and time in the healthcare analytics.

To further specific studies of interest to stakeholders, the State ETS and UH TASI has developed a process for the WGs to work with the data. The ETS and UH TASI plan to establish Working Groups that will collaborate to:

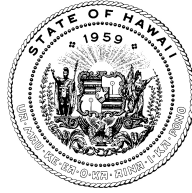
Finally, it is important to note the UH is both committed and legally bound by the HIPAA to protect the privacy and to safeguard ePHI data. UH is a Business Associate of the State of Hawai'i ETS; the Commonwealth Healthcare Corporation and State Medicaid Agency of the CNMI; the Guam Department of Public Health and Social Services and the Guam Northern and Southern Region Community Health Centers. UH TASI

complies with the Health Insurance Portability and Accountability Act and will protect the confidentiality of the PHI. UH TASI systems and networks complies with HIPAA; and, as appropriate, the recommendations of the National Institute for Standards and Technology (NIST).

In the past year, the physical and technical security safeguards of UH TASI were enhanced by moving the primary Data Center servers for ePHI systems to the UH Information Technology Services (ITS) Data Center. UH TASI has prepared a System Security and Data Management Plan to meet the requirements of the agreement with the State ETS. UH TASI has also submitted a Data Management Plan for the CMS as well.

The University of Hawai'i stands ready to support HB2481 Related to Health and firmly believes in its importance to transform healthcare in State of Hawai'i.

DAVID Y. IGE
GOVERNOR



TODD NACAPUY
CHIEF INFORMATION
OFFICER

OFFICE OF ENTERPRISE TECHNOLOGY SERVICES

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INFORMATION AND COMMUNICATION
SERVICES DIVISION

OFFICE OF INFORMATION MANAGEMENT
AND TECHNOLOGY

Testimony of
TODD NACAPUY
Chief Information Officer, State of Hawai'i

Before the

HOUSE COMMITTEE ON HEALTH
Monday, February 8, 2016; 1:45 p.m.
State Capitol, Conference Room 329

HOUSE BILL NO. 2481
RELATING TO HEALTH

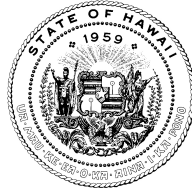
Chair Belatti, Vice Chair Creagan and Committee Members:

Thank you for this opportunity to provide testimony on House Bill No. 2481, Relating to Health. My name is Todd Nacapuy, Chief Information Officer (CIO) of the State of Hawai'i.

The CIO-led Office of Enterprise Technology Services (ETS) supports the intent of this bill as it would facilitate the State's ability to take full advantage of the current availability of federal funding for the Hawai'i Health Data Center (HHDC).

HHDC is a federally funded special collaborative project between ETS, which manages the funds, and the University of Hawai'i's Telecommunications and Social Informatics Research program, which is the project's technical partner. By leveraging modern health data technologies, the project has the potential to break down silos and other barriers to the integration and analyzing of data that would prove useful in improving health outcomes for Hawai'i residents.

In view of this, ETS supports the intent of this measure.



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INFORMATION AND COMMUNICATION
SERVICES DIVISION

OFFICE OF INFORMATION MANAGEMENT
AND TECHNOLOGY

Testimony of
BRYAN FITZGERALD
Project Director, Hawai'i Health Data Center Project

Before the

HOUSE COMMITTEE ON HEALTH
Monday, February 8, 2016; 1:45 p.m.
State Capitol, Conference Room 329

HOUSE BILL NO. 2481
RELATING TO HEALTH

Chair Belatti, Vice Chair Creagan and Committee Members:

Thank you for this opportunity to provide testimony in support of House Bill No. 2481, Relating to Health.

My name is Bryan FitzGerald, Project Director of the Hawai'i Health Data Center (HHDC), a federally funded special collaborative project between the Office of Enterprise Technology Services (ETS) and the University of Hawai'i's Telecommunications and Social Informatics Research (UH TASI) program. The objective of the HHDC is to establish a *public* Health Data Center for the State of Hawai'i. We intend to compile health insurer claims data and analyze and integrate the information with clinical quality and outcome data streams. The resulting unbiased reports will empower the people of Hawai'i, their representatives, and the State with long-needed information to make the best choices to improve personal and entire population health outcomes. That means living longer, better lives, and spending less money to do so.

The first phase in standing up this data center is to establish a "*State's All Payers Claims Database*," pursuing data the State already has from Med Quest, Medicare, and the Employer-Union Health Benefits Trust Fund (EUTF). Once we have established a proof of concept, we aspire to expand our analysis to integrate diverse data sets.

Even though we are just beginning on this project, we would like to share some facts about the status of health data in Hawai'i that may help you in evaluating H.B. 2481. We have discovered a general State-wide dearth of data centralization, manifesting in:

1. Disparate, isolated and deeply siloed databases with very useful information.

2. Departments within the State were reluctant or unwilling to share data without an all-embracing data authority giving them comfort in doing so.
3. Analysis that, although being well done, is program-specific and also siloed.
4. There has not in the State evolved an entity with a comprehensive, enterprise wide view. What's needed is to intelligently assemble and direct data. It should be collected and centrally analyzed. This will make for more meaningful decisions regarding the cost and effectiveness of our health programs and interventions.
5. The State should have the ability to see all of the data sources and direct them to be aggregated and analyzed to maximum effect.
6. The State Health Planning and Development Agency (SHPDA):
 - a. has a long standing mission to promote accessibility for all people of the State to quality healthcare services at reasonable cost;
 - b. should be responsible for coordinating and directing all across-department and statewide health data requests and analysis;
 - c. is the natural home to establish the HHDC's governance board within the Executive Branch; and
 - d. has some existing authorities that require updating to fully meet its potential and actualize its mission.
7. To provide the highest level of integrity and transparency for the people of Hawai'i, SHPDA must have a reliable State technology partner, free from conflicts, to warehouse the data and provide unimpeded, impartial data analysis, free from corporate interests.
8. The TASI program at the University of Hawai'i:
 - a. is an existing, internationally respected health data asset within the State;
 - b. is experienced, trusted, free from conflicts, and steadfastly committed to impartiality; and
 - c. is the best choice to partner with SHPDA to provide data warehouse and analytics services, and to help it fulfill its mission.

By passing H.B. 2481:

1. This bill reinvigorates our health planning agency SHPDA with the authority needed to satisfy their original mandate of promoting accessibility for all the people of the State to quality health care services at reasonable cost. SHPDA will be updated and better positioned to take advantage of the available 21st Century health data technologies. It will be able to provide more comprehensive plans and reports to help the people of Hawai'i, and will itself be a more valuable asset for the State.
2. The silos and barriers to sharing and analyzing the data will be eliminated.
3. The State can take full advantage of the current availability of federal funding to support the establishment of an unbiased publicly owned and operated All Payers Claims Database.

Thank you, again, for this opportunity to provide testimony in support of H.B. 2481.



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

P. O. Box 339
Honolulu, Hawaii 96809-0339

February 8, 2016

TO: The Honorable Della Au Belatti, Chair
House Committee on Health

FROM: Rachael Wong, DrPH, Director

SUBJECT: **HB 2481 Relating to Health**

Hearing: Monday, February 8, 2016, 1:45 pm
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the intent of the bill and provides comments.

PURPOSE: The purpose of the bill is to facilitate greater transparency in the health care sector by broadening the scope of data, including health care claims data, reported to the State Health Planning and Development Agency (SHPDA).

The Department of Human Services (DHS) supports the intent of the bill to increase transparency through data and analysis of health care claims and payment data. We respectfully suggest some clarifications for the Committee's consideration. First, in order to share Medicaid claims' data, a Medicaid purpose to the use of the data must be stated in order to comply with federal Medicaid regulations (42 CFR Part 431, Subpart F). Also, Medicaid, like all other payers, must be able to satisfy all applicable privacy and security requirements before release of the data.

Finally, the collection, compiling and analysis of the data will require not only informational systems to support the stated purpose, but complex health analytics. We defer to SHPDA regarding implementation of the proposal as it will be essential for SHPDA to have adequate resources to be able to use the data for the intents and purposes of the bill.

Thank you for the opportunity to testify on this bill.



**TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-EIGHTH LEGISLATURE, 2016**

ON THE FOLLOWING MEASURE:
H.B. NO. 2481, RELATING TO HEALTH.

BEFORE THE:
HOUSE COMMITTEE ON HEALTH

DATE: Monday, February 8, 2016 **TIME:** 1:45 p.m.
LOCATION: State Capitol, Room 329
TESTIFIER(S): Douglas S. Chin, Attorney General, or
Angela A. Tokuda, Deputy Attorney General

Chair Belatti and Members of the Committee:

The Department of Attorney General offers the following comments on this measure.

This measure would amend section 323D-18, Hawaii Revised Statutes (HRS), to require all payers of claims for payment for health care services delivered to any person, including providers of public and private health insurance doing business in this State, to submit "[h]ealth care services claims and payment data" to the State Health Planning and Development Agency, which in turn is required to submit the data to a University of Hawai'i data center (page 3, lines 9 to 17).

Health care services claims and payment data contain a variety of sensitive and confidential information including, but not limited to, protected health information, personal information, and information regarding recipients of medical assistance. This measure in its current form does not address safeguards and protections for that information. Yet the State must comply with all relevant federal and state privacy, security, and confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996, federal Medicaid regulations, state confidentiality statutes such as section 346-10, HRS, and other applicable laws if this measure is implemented. For clarity, we recommend that the phrase "consistent with all federal and state privacy, security, and confidentiality laws" be added on page 2, line 11, after the word "submit."

This measure also incorrectly cites, in two places, a section of the federal Patient Protection and Affordable Care Act (ACA). First, on page 3, line 18, the correct citation should be 42 USC § 300gg-94(d)(2). Second, on page 3, line 20, the correct citation should be 42 USC § 300gg-94(c)(1)(C).

We recommend that, if the Committee passes this measure, it include the proposed reference to federal and state privacy, security, and confidentiality laws, and that it correct the references to the ACA.

Representative Della Au Bellati, Chair
Representative Richard Creagan, Vice Chair
House Committee on Health
Hawaii State House of Representatives
Hawaii State Capitol, Room 426
Honolulu, HI 96813

Dear Chair Bellati and Vice Chair Creagan,

RE: HB2481 Relating to Health

The Hawaii Health Information Corporation supports the intent of HB2481, to better inform policy makers, consumers and the whole healthcare community of healthcare trends in Hawaii using data on healthcare services and costs. In the rapidly changing world of healthcare, current and meaningful data is increasingly used by the healthcare community to improve the quality of healthcare services, to address costs and to inform decision-makers and the public of important issues and trends. To provide such information, HB2481 proposes to establish an All Payer Claims Database (APCD) for Hawaii. We have serious reservations that the measure as it is currently drafted will not achieve its intended goal.

First, the resources available to carry out the project are limited. Second, the complexity and scope of the project are significant. Third, the conflict of interest provisions of a temporary grant are inserted into permanent Hawaii law in a manner that will lead to confusion. Finally, the organization that HB2481 proposes to use to effectuate this project has not manifested the capabilities to carry out such a project. I will elaborate on each of these points.

First, developing a database of private insurance claims is a major effort requiring significant resources over an extended period of time to achieve. Successful APCDs such as those of New Hampshire, Maine and Colorado have required 3-5 years of effort to start up and have had development/operating costs of over \$2M/year.

From HHIC's understanding, the current resources available to fund the proposed effort are contained in two Health Insurance Rate Review grants (Cycle III and Cycle IV) totaling approximately \$4.2M, which the State received beginning in September 2013. These grants are slated to expire in September of 2016 (with the possibility of extending the grant[s] for another year). As we understand, the two grants are funded through the authority of Section 2794 of the Affordable Care Act, which allocated \$250M nationwide for this effort. The funding, however, is for a "5-year period, beginning with fiscal year 2010". Federal funding will not be available to permanently fund the intended activity. State general funds will be required to continue this activity on a permanent basis at a roughly \$2-3M/year level, based on experience from other APCDs.

While some APCDs are located within government and are entirely subsidized by general funds, others are set up as non-profits within the private sector. Under this model, some general fund subsidy to these organizations is augmented by the sale of reports and datasets to minimize the public cost burden. Attached is an example of one such model, that of the Commonwealth of Virginia.



Second, the complexity of insurance claims is one of the reasons for the extended development and implementation period required for an APCD. Each insurance payer's claim system is unique, with its own rules of operation, definitions and processes. Pulling all payers into one database requires substantial learning on the part of the implementing organization. Interpreting the meaning of each organization's claims in comparison with those of other organizations is a difficult task. Finding the metrics that fairly compare payers requires considerable dialogue before, during and after the implementation of the database. Procedures for sharing initial results with parties affected are important, as substantial misinterpretations of the data are possible. Substantial staff with specialized knowledge of insurance claims must be engaged and the significant concerns of payers and providers with definitions, processes and public reporting must be addressed. These aspects are also present for public payers as well. Most importantly, defining the questions all parties want to have answered is critical to the success of such an effort. Reports are structured by providing the information in such a form as to accurately and objectively answer the questions those using the system want to have answered. Otherwise, "data" is gibberish.

Successful states have had substantial periods of dialogue with both providers and payers to address such issues. Involvement with consumers and public officials is also important since the information must also be understandable to those using the data as well. Such dialogue takes extended periods of time but results in defining the meaningful questions that policy makers, consumers and the healthcare community ask and the reports that answer those questions.

HHIC has worked with hospital claims data since 1995 and, in fact is the reliable and recognized All Payer Claims Database for hospital data (both inpatient and ER) for Hawaii. Our Board includes hospitals, physicians, a payer, the UH system and representatives of the community. In addition, we have already developed a healthcare database for Medicare Fee For Service (FFS) payments in a partnership with the Hawaii Health Systems Corporation (HHSC) and the John A. Burns School of Medicine (JABSOM). We are well positioned to examine claims data for reporting. There is no need to duplicate for our small state what our partnership has already invested development time and substantial resources in bringing into existence.

Third, HB2481 further writes into permanent Hawaii statute "conflict of interest" language that refers to a federal grant program that officially expired at the end 2015. On the surface, this language implies that a data center (funded by the grants) cannot function unless "members of the [data] center's governing board are independent and free from all conflicts of interest". However, Appendix F of the grant standards spells out HHS' application of the ACA provision in which this phrase originated; this is a much different, and more practical, policy than that implied by the language above. Specifically, according to the HHS interpretation, when there is a conflict of interest, a member of a Board must "recuse him or herself from the matter and notify a compliance official, the chairman of the board or other official appointed to address conflicts of interest." Thus, the federal grant standards do not rule on the composition of Board members, but instead provides guidelines to govern what happens when a Board member has a conflict. The wording as written in HB2481 implies something completely different from the true intent of HHS. A Board, however constituted, will not be able to have members without a conflict of interest at some point. The very people needed to provide expertise and knowledge to govern an organization are most often those with possible conflicts. The State has statutes governing conflict of interest in its public boards and commissions. Similarly, the IRS requires that each Board



member on a non-profit board reveal their conflicts and commit to reporting these conflicts. The "conflict of interest" provisions in HB2481 thus unduely restrictive and unclear. They should be removed.

Finally, the proposed subsection (b) designates a University of Hawaii data center as the data repository. HHIC looks at the results from the current grants, which utilized the UH data center proposed in HB2481. That arrangement has used up 2 1/2 years of grant time, and, to our knowledge, has achieved none of the data milestones established by the State's grant application. We believe that a different approach is needed.

In summary, we believe that the effort will lack the long-term financial resources to produce useful information for its intended audiences without significant infusion of State general funding, that the complexity of the APCD process requires extensive time and engagement of all parties for a successful implementation and that the effecting organization in the measure has not achieved the products required by the existing grant. Codifying this unsuccessful effort in statute would be a mistake.

To conclude, HHIC supports the goals of this bill. We suggest an alternative course of action for legislative consideration. Successful state APCDs across the country have developed through an extended period of public information and industry engagement. We believe that the State would be well served by having an organization familiar with healthcare database efforts such as the APCD Council, AHRQ's Health Care Utilization Project, and the AHRQ MONAHRQ effort nationally and with data development in Hawaii lead an effort to define the requirements for an APCD. This effort would involve payers, providers and other healthcare interests in a process of information/engagement among the many parties involved. Resources from the Cycle III and IV grants could be used to fund the effort, and a report formulated with the involvement of the entire community. Such a report would inform the legislature and governor of the ongoing costs of such a system on the appropriate next steps if the process is to go forward.

We look forward to working with your committee to provide a solution that delivers high quality healthcare data and analysis to Hawaii. Thanks for providing the opportunity to provide testimony to you on this issue of significant importance to our State.

Sincerely,



Peter A. Sybinsky, Ph.D.
President and CEO
Hawaii Health Information Corporation

Attachment



Chapter 7.2. Health Care Data Reporting.

§ 32.1-276.2. Health care data reporting; purpose.

The General Assembly finds that the establishment of effective health care data analysis and reporting initiatives is essential to improving the quality and efficiency of health care, fostering competition among health care providers, and increasing consumer choice with regard to health care services in the Commonwealth, and that accurate and valuable health care data can best be identified by representatives of state government and the consumer, provider, insurance, and business communities. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, shall administer the health care data reporting initiatives established by this chapter.

1996, c. 902;2010, c. 416;2012, cc. 693, 709.

§ 32.1-276.3. Definitions.

As used in this chapter:

"Board" means the Board of Health.

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

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

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

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health

and Developmental Services for the care and treatment of individuals with mental illness, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

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

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

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

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

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

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

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

"System" means the Virginia Patient Level Data System.

1996, cc. 902, 905, 1046; 1999, c. 764; 2000, cc. 720, 897; 2001, c. 541; 2003, c. 466; 2009, cc. 813, 840.

§ 32.1-276.4. Agreements for certain data services.

A. The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit

organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter; for the operation of the All-Payer Claims Database pursuant to § 32.1-276.7:1; and for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Such nonprofit organization shall be governed by a board of directors composed of representatives of state government, including the Commissioner, representatives of the Department of Medical Assistance Services and the Bureau of Insurance, health plans and health insurance issuers, and the consumer, health care provider, and business communities. Of the health care provider representatives, there shall be an equal number of hospital, nursing home, physician, and health plan representatives. The articles of incorporation of such nonprofit organization shall require the nomination of such board members by organizations and associations representing those categories of persons specified for representation on the board of directors.

B. In addition to providing for the compilation, storage, analysis, and evaluation services described in subsection A, any contract or agreement with a nonprofit, tax-exempt health data organization made pursuant to this section shall require the board of directors of such organization to:

1. Develop and disseminate other health care quality and efficiency information designed to assist businesses and consumers in purchasing health care and long-term care services;
2. Prepare and make public summaries, compilations, or other supplementary reports based on the data provided pursuant to this chapter;
3. Collect, compile, and publish Health Employer Data and Information Set (HEDIS) information or reports or other quality of care or performance information sets approved by the Board, pursuant to § 32.1-276.5, and submitted by health maintenance organizations or other health care plans;
4. Jointly determine with the Board of Medicine any data concerning safety services and quality health care services rendered by physicians to Medicaid recipients that should be identified, collected, and disseminated. The board of directors shall further determine jointly with the Board of Medicine the costs of requiring physicians to identify, submit, or collect such information and identify sufficient funding sources to appropriate to physicians for the collection of the same. No physician shall be required to collect or submit safety and quality of health care services information that is already identified, collected, or submitted under this chapter; or for which funds for collection are not appropriated;
5. Maintain the confidentiality and security of data as set forth in §§ 32.1-276.7:1 and 32.1-276.9;
6. Submit a report to the Board, the Governor, and the General Assembly no later than October 1 of each year for the preceding fiscal year. Such report shall include a certified audit, including an analysis of the efficacy and value of the All-Payer Claims Database, and provide information on the accomplishments, priorities, and current and planned activities of the nonprofit organization;
7. Submit, as appropriate, strategic plans to the Board, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying data elements for collection under this chapter. In developing strategic plans, the nonprofit organization shall incorporate similar activities of other public and private entities to maximize the quality of data

nonprofit organization shall also evaluate the continued need for and efficacy of current data initiatives, including the use of patient level data for public health purposes. The approval of the General Assembly shall be required prior to the implementation of any recommendations set forth in a strategic plan submitted pursuant to this section;

8. Competitively bid or competitively negotiate all aspects of all data projects, if feasible; and

9. Fulfill all funded requirements set forth for the nonprofit organization in this chapter.

C. The Department shall take steps to increase public awareness of the data and information available through the nonprofit organization's website and how consumers can use the data and information when making decisions about health care providers and services.

D. Except as provided in subdivision A 2 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Commissioner authorized by this section. Funding for services provided pursuant to any such contract or agreement shall come from general appropriations and from fees determined pursuant to § 32.1-276.8 and from such fees and other public and private funding sources as may be authorized by this chapter.

1996, c. 902;2000, c. 897;2006, c. 426;2010, c. 416;2012, cc. 693, 709.

§ 32.1-276.5. Providers to submit data.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section.

Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

C. Every medical care facility as that term is defined in § 32.1-102.1 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.

The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

D. Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data.

E. The Board shall evaluate biennially the impact and effectiveness of such data collection.

1996, c. 902;2000, c. 897;2006, c. 426;2009, c. 175;2013, c. 515.

§ 32.1-276.5:1. (Contingent repeal -- see Editor's note) Disclosures of contractual arrangements to be made publicly available.

A. In order to advance transparency in health care and provide patients and families with better information on which to judge value among their treatment options, the Commissioner shall negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for an annual survey of carriers offering private group health insurance policies, which are subject to HEDIS reporting, to determine the reimbursement that is paid for a minimum of 25 most frequently reported health care services which may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases. Each carrier shall report the average reimbursement paid for a specific service from all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices. The survey shall also include, when available, the average reimbursement rates for the same services provided for reimbursement by fee-for-service Medicare and Medicaid. The survey shall be managed by the Commissioner to insure that when such information is reported it will provide the aggregate information so that readers will be able to determine the average amount of reimbursement paid for specific healthcare services. No provider, facility or carrier specific reimbursement information shall be included in the public survey reports. Such specific information shall be deemed proprietary and shall not be disclosed to the public; only the Commissioner will have access to the underlying survey data. The public survey reports shall be made available to the public through an Internet Website operated by the contracting organization.

The Commissioner, in conjunction with stakeholders working through the non-profit organization, shall work to (i) incorporate existing service quality data and guidance to the price information to further assist informed consumer choice to the extent it is practical and consistent with generally accepted national guidelines, and (ii) seek over time to display price and quality information for episodes of care in a manner which is consistent with generally accepted national guidelines.

B. The information acquired in the survey and provided to the Commissioner shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 21 of § 2.2-3705.6.

§ 32.1-276.6. Patient level data system continued; reporting requirements.

A. The Virginia Patient Level Data System is hereby continued, hereinafter referred to as the "System." Its purpose shall be to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions.

B. Every inpatient hospital shall submit to the Board patient level data as set forth in this subsection. Every general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title and every physician and every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709.1 performing surgical procedures in his office shall also submit to the board outpatient surgical data as set forth in this subsection. Every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709 shall submit to the Board outpatient surgical data as set forth in this subsection for only those procedures for which certification is required pursuant to § 54.1-2709.1.

Any such hospital, facility, physician or oral and maxillofacial surgeon, as defined in § 32.1-276.3, may report the required data directly to the nonprofit organization cited in § 32.1-276.4. Unless otherwise noted, patient level data elements for hospital inpatients and patients having outpatient surgery shall include, where applicable and included on standard claim forms:

1. Hospital identifier;
2. Attending physician identifier (inpatient only);
3. Operating physician or oral and maxillofacial surgeon identifier;
4. Payor identifier;
5. Employer identifier as required on standard claims forms;
6. Patient identifier (all submissions);
7. Patient sex, race (inpatient only), date of birth (including century indicator), street address, city or county, zip code, employment status code, status at discharge, and birth weight for infants (inpatient only);
8. Admission type, source (inpatient only), date and hour, and diagnosis;
9. Discharge date (inpatient only) and status;
10. Principal and secondary diagnoses;
11. External cause of injury;
12. Co-morbid conditions existing but not treated;
13. Procedures and procedure dates;
14. Revenue center codes, units, and charges as required on standard claims forms; and

15. Total charges.

C. State agencies providing coverage for outpatient services shall submit to the Board patient level data regarding paid outpatient claims. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;
2. Patient identifier;
3. Physician or oral and maxillofacial surgeon identifier;
4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and
5. Other related information.

The Board shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 32.1-276.4.

1996, c. 902;2001, c. 341;2003, c. 466;2009, c. 652.

§ 32.1-276.7. Methodology to review and measure the efficiency and productivity of health care providers.

A. Pursuant to the contract identified in § 32.1-276.4, and consistent with recommendations set forth in strategic plans submitted and approved pursuant to § 32.1-276.4, the nonprofit organization shall administer and modify, as appropriate, the methodology to review and measure the efficiency and productivity of health care providers. The methodology shall provide for, but not be limited to, comparisons of a health care provider's performance to national and regional data, where available, and may include different methodologies and reporting requirements for the assessment of the various types of health care providers which report to it. Health care providers shall submit the data necessary for implementation of the requirements of this section pursuant to regulations of the Board. Individual health care provider filings shall be open to public inspection once they have been received pursuant to the methodology adopted by the Board as required by this section.

B. The data reporting requirements of this section shall not apply to those health care providers enumerated in (iv) and (v) of the definition of health care providers set forth in § 32.1-276.3 until a strategic plan submitted pursuant to § 32.1-276.4 is approved requiring such reporting and any implementing laws and regulations take effect.

1996, c. 902.

§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.

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

B. The Commissioner, in cooperation with the Bureau of Insurance, may collect paid claims data for covered benefits. Pursuant to data submission and use agreements as specified in subsection

C, from entities electing to participate as data suppliers, which may include:

1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing a health care plan for health care services;
2. Third-party administrators and any other entities that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, Virginia residents;
3. The Department of Medical Assistance Services with respect to services provided under programs administered pursuant to Titles XIX and XXI of the Social Security Act; and
4. Federal health insurance plans, if available, including but not limited to Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

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

1. Protection of patient privacy and data security pursuant to provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115);
2. Identification of the type of paid claims to be collected by the All-Payer Claims Database, and the entities that are subject to the submission of such claims as well as identification of specific data elements from existing claims systems to be submitted and collected, including but not limited to patient demographics, diagnosis and procedure codes, provider information, plan payments, member payment responsibility, and service dates;
3. Geographic, demographic, economic, and peer group comparisons;
4. Identification and comparison of health plans by public and private health care purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers, and providers with regard to their provision of safe, cost-effective, and high-quality health care services;
5. Use of existing national data collection standards and methods, including the electronic Uniform Medical Claims Payer Reporting Standard, as adopted by The Accredited Standards Committee X12 (ASC X12) and APCD Council, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created pursuant to subsection D;

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

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

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

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

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

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

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

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

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

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

all necessary corrections, the report may be released.

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

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

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

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

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

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

2012, cc. 693, 709.

§ 32.1-276.8. Fees for processing, verification, and dissemination of data.

A. The Board shall prescribe a reasonable fee for each affected health care provider to cover the costs of the reasonable expenses of establishing and administering the methodology developed pursuant to § 32.1-276.7. The payment of such fees shall be at such time as the Board designates. The Board may assess a late charge on any fees paid after their due date.

In addition, the Board shall prescribe a tiered-fee structure based on the number of enrollees for each health maintenance organization to cover the costs of collecting and making available such data. Such fees shall not exceed \$3,000 for each health maintenance organization required to provide information pursuant to this chapter. The payment of such fees shall also be at such time as the Board designates. The Board may also assess a late charge on any fees paid by health maintenance organizations after their due dates.

B. Except for the fees assessed pursuant to subsection A, the nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 shall not assess any fee against any health care provider that submits data under this chapter that is processed, verified, and timely in accordance with standards established by the Board. The Board shall establish penalties for submission of data in a manner that is inconsistent with such standards.

C. State agencies shall not be assessed fees for the submission of patient level data required by subsection C of § 32.1-276.6. Individual employers, insurers, and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative analysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

D. The nonprofit organization providing services pursuant to an agreement or contract with the Commissioner of Health shall be authorized to charge and collect reasonable fees for the dissemination of patient level data and Health Employer Data and Information Set (HEDIS) data or other approved quality of care or performance information set data; however, the Commissioner of Health, the State Corporation Commission, and the Commissioner of Behavioral Health and Developmental Services shall be entitled to receive relevant and appropriate data from the nonprofit organization at no charge.

E. The Board shall (i) maintain records of its activities; (ii) collect and account for all fees and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid; and (iii) enforce all regulations promulgated by it pursuant to this chapter.

1996, c. 902;1999, c. 764;2000, c. 897;2001, c. 341;2003, c. 472;2009, cc. 813, 840.

§ 32.1-276.9. Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected pursuant to this chapter shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this chapter; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which may be released solely for research purposes if otherwise permitted by law and only if such identifier is encrypted and cannot be reasonably expected to reveal patient identities. No report published by the nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient. The nonprofit organization, in its discretion, may release physician and employer identifier information. Outpatient surgical charge data shall be made publicly available only pursuant to a review by the Joint Commission on Health Care.

B. No person or entity, including the nonprofit organization contracting with the Commissioner, shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

C. Any disclosure of information made in violation of this chapter shall be subject to a civil penalty of not more than \$5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this article shall be entitled to initiate an action to recover actual damages, if any, or \$500, whichever is greater, together with reasonable attorney's fees and court

1996, c. 902;2001, c. 341.

§ 32.1-276.9:1. Health information needs related to reform; work group.

A. The Commissioner shall direct the nonprofit organization to establish a work group to study continuing health information needs and to develop recommendations for design, development, and operation of systems and strategies to meet those needs. The work group shall include representatives of the Department of Health, the Department of Medical Assistance Services, the Department of Health Professions, the State Corporation Commission's Bureau of Insurance, the Virginia Health Reform Initiative, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, health care providers, and other stakeholders and shall:

1. Identify various health information needs related to implementation of health care reform initiatives, including those associated with development and operation of an all-payer claims database, the Virginia Health Information Exchange, the Virginia Health Benefit Exchange, and any other health reform initiatives. In doing so, the work group shall identify the clinical and paid claims information required and the purposes for which such information will be used; and
2. Identify opportunities for maximizing efficiency and effectiveness of health information systems, reducing duplication of effort related to collection of health information, and minimizing costs and risks associated with collection and use of health information.

B. The Commissioner shall report on activities, findings, and recommendations of the work group annually to the Governor and the General Assembly no later than December 1 of each year, beginning in 2014.

2012, cc. 693, 709.

§ 32.1-276.10. Chapter and actions thereunder not to be construed as approval of charges or costs.

Nothing in this chapter or the actions taken by the Board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care provider.

1996, c. 902.

§ 32.1-276.11. Violations.

Any person violating the provisions of this chapter may be enjoined from continuing such violation by application by the Board for relief to a circuit court having jurisdiction over the offending party.

1996, c. 902.



An Independent Licensee of the Blue Cross and Blue Shield Association

February 8, 2016

The Honorable Della Au Belatti, Chair
House Committee on Health
The Honorable Richard Creagan, Vice Chair
House Committee on Health

Re: HB 2481 – Relating to Health

Dear Chair Belatti, Vice Chair Creagan, and Committee Members:

The Hawaii Medical Association (HMSA) respectfully opposes HB 2481, which broadens the scope of health and health care data and other information submitted to SHPDA.

HMSA appreciates and shares the Committee's interest in ensuring that health care services offered in our state are both reasonably affordable and high quality. However, HB 2481, does not advance that interest and may pose serious risk to our members.

We therefore would ask the Committee to consider our following concerns before advancing is measure:

- Proprietary information that helps HMSA negotiate for the best rates for our members could potentially be in jeopardy.
- Subsection (7) needs further clarification with regard to the types, frequency, and level of claim data being requested.
- Currently there are no qualifications within this bill to ensure that the data being requested from issuers is properly deidentified according to any state or federal standard.
- We have serious reservations with provisions in this measure that would require HMSA to release and store any claims data to the University of Hawaii (UH). Protecting our members personal health data and preventing undue cause for identity theft is utmost importance to HMSA. This bill does not adequately address the security concerns or requirements for the type of relationship being required.
- HMSA currently submits aggregated claims and utilization data to meet mandated state and federal transparency requirements. Should this measure ultimately be enacted in its current form, it would require plans to provide significantly more, and different, data which mean incurring significant cost for the plan and ultimately our members.

We share the Committee's interest in efforts around transparency in order to better serve members and policymakers alike and look forward to continuing ongoing meetings with state officials on these issues. Earlier in this process there was discussion of creating a stakeholder



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advisory council to focus on these types of complex and sensitive data sharing issues; we would support that effort and urge the Committee to consider deferring HB 2481 and instead establish a formal task force or working group to report back to the legislature with recommendations.

Thank your allowing us to testify in opposition to HB 2481.

Sincerely,

A handwritten signature in black ink, appearing to read "JD", with a long horizontal flourish extending to the right.

Jennifer Diesman
Vice President, Government Relations



February 8, 2016 at 1:45 PM
Room 329

House Committee on Health

To: Chair Della Au Belatti
Vice Chair Richard P. Creagan

From: George Greene
President and CEO
Healthcare Association of Hawaii

Re: Submitting comments
HB 2481, Relating to Health

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 180 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

We would like to thank Chair Belatti, Vice Chair Creagan and members of the House Committee on Health for the opportunity to **submit comments** on HB 2481. We support efforts to help policy-makers and other stakeholders gain access to data needed to make informed decisions. However, we would respectfully request that your committee establish a working group to help better inform all stakeholders about the particulars of this project, discuss the details of an all-payers claims database in Hawaii, and make recommendations as necessary on enabling legislation.

According to the All-Payers Claims Database (APCD) Council—a national collaborative focused on developing APCDs across the country—"stakeholder engagement...is essential to the success of a state APCD initiative." While this project has been considered for many years, a detailed plan for Hawaii's version of an APCD has not been widely developed and shared. There are a number of issues to work through, including how data will be stored, analyzed and disseminated. Creating a working group to discuss these issues would enable stakeholders from across the health care continuum to fully engage with one another to discuss and make recommendations on the various barriers and opportunities an APCD provides and also to determine the sustainability of any project.

While we appreciate the intent of this legislation, we would ask that your committee defer this measure and consider establishing a working group on the development of Hawaii's APCD. Thank you for your time and consideration of this matter.