CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Center for Improving Value in Health Care

Payer Submission Compliance Policy

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Revision History

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CIVHC Payer Submission Compliance Policy

I. Purpose

To outline payer submission requirements, exceptions, and penalties for non-compliance. Non-compliance with payer submission requirements could cause data quality issues and gaps in the CO APCD. Non-compliance may include unreasonable delays to a payer's onboarding period, inconsistent or nonresponsive communication, continual failing of file submissions without evidence of attempted reconciliation, submitting under incorrect versions of the DSG, not submitting files regularly, or lack of technology or capability to submit correctly.

II. Scope

This policy applies to all payers required to submit data to the Colorado All Payer Claims Database, except as outlined under Exemptions.

III. Definitions

"Alternative Payment Model file" or "APM file" means the group of files that include data about payments made to providers outside of the traditional fee-for-service model.

"Annual file" means the Alternative Payment Model files and Drug Rebate files that are due on an annual basis.

"CIVHC" means the Center for Improving Value in Health Care, including those individuals acting within the scope of their duties as Workforce Members of that organization. CIVHC was appointed as the CO APCD Administrator in August of 2010.

"Claim" or "Health Insurance Claim" means a specific set of information generated when a medical provider or patient submits a request for payment or reimbursement to their health insurer for the cost of health services rendered or provided.

"Claims Data" means structured information submitted by a data provider to the CO APCD according to the specifications established in the submission guide.

"CO APCD Administrator" is the entity appointed by the Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF) to manage operations of the CO APCD. CIVHC was appointed as the CO APCD Administrator in August of 2010.

"Colorado All Payer Claims Database" or "CO APCD" is a secure database, authorized by statute, which aggregates claims data from public and private payers and serves as a comprehensive source of health claims information for the state of Colorado.

"Data provider" means a public or private health insurer or health plan that submits Claims Data to the CO APCD as required by statute, or an employer, Third Party Administrator (TPA), Administrative Services Only (ASO) or any other insurer or health plan that submits Claims Data to the CO APCD on a voluntary basis.

"Data" means structured information received, transmitted, exchanged, stored, or otherwise managed on CIVHC information technology systems.

“Director” means the Executive Director of the Colorado Department of Health Care Policy and Financing.

“Drug rebate data file” means a file that includes data about total rebates, compensation, remuneration, and any other price concessions provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided fair market value bona fide service fees.

“Eligibility data file” means a file that includes data about a person who receives health care coverage from a payer, according to the requirements contained in the submission guide.

“ERISA” means the Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. ch. 18.

“Law” means any applicable statute, ordinance, rule, legislation, constitution, common law, resolution, interpretation, ordinance, code, treaty, decree, directive, pronouncement or other law of any federal, state, local, or other governmental authority.

“Medical claims data file” means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

“Monthly files” means the Medical Claims, Pharmacy Claims, Member Eligibility, and Medical Provider files that are due on a monthly basis.

“Payer” or “Carrier” or “Submitter” means a private health care payer and a public health care payer.

“Pharmacy claims data file” means a file that includes data about prescription medications and claims filed by pharmacies, according to the requirements contained in the submission guide.

“Private health care payer” means an insurance carrier as defined in C.R.S. § 10-16-102(8) covering an aggregate of 1,000 or more enrolled lives in health coverage plans as defined in C.R.S. § 10-16-102(34). For purposes, of this regulation, “private health care payer” includes carriers offering health benefits plans under C.R.S. § 10-16-102(32)(a) and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. For the purposes of this regulation, a “private health care payer” also means a self-insured employer-sponsored health plan covering an aggregate of 100 or more enrolled lives in Colorado. It does not include a self-insured employer-sponsored health plan, if such health or pharmacy plan is administered by a third-party administrator, administrative services only organization, or pharmacy benefit manager (“TPA/ASO/PBM”) that services less than an aggregate of 1,000 enrolled lives in Colorado; carriers offering accident only; credit; benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage issued as a supplement to liability insurance; worker’s compensation or similar insurance; or automobile medical payment insurance, specified disease, or hospital indemnity and other fixed indemnity insurance.

“Production files” means the set of files submitted by carriers that are meant to be used in final analyses. These files include all monthly files submitted to the CO APCD Administrator each month. It also includes the annual files that are due on September 30th each year.

“Provider file” means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file; and is submitted according to the requirements contained in the submission guide.

“Public health care payer” means the Colorado Medicaid program established under articles 4, 5 and 6 of title 25.5, C.R.S., the children’s basic health plan established under article 8 of title 25.5, C.R.S. and Cover Colorado established under part 5 article 8 of title 10, C.R.S.

“Rule” means 10 CCR 2505-5 Section 1.200 All Payers Claims Database.

“Submission guide” means the document entitled “Colorado All-Payer Claims Database Data Submission Guide” developed by the CO APCD Administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical, dental and pharmacy claims data files and provider data files to the APCD dated Version 11.5 April 2020, which document is hereby incorporated by reference.

“Test files” means the set of files submitted by carriers that are meant to allow carriers to understand if the structure, quality, and content of their files meet expectations. Carriers can submit monthly test files as often as desired. The administrator may require carriers to submit test files when a new DSG is implemented to ensure new formats are properly accounted for. Test files for the annual file process are required from submitters and must be sent in by July 15th of each year.

IV. Payer Reporting Requirements

Payers shall submit complete and accurate eligibility data files, medical claims data files, pharmacy claims data files, and provider files to the APCD pursuant to the data submission guide (DSG), including reconciliation of any data quality issues.

The CO APCD Administrator may amend the submission guide and shall provide notice of the revisions to payers. Any revision to the submission guide will be effective only when incorporated into the Rule and issued in compliance with the requirements of C.R.S. § 24-4-103 (12.5). Reports submitted 120 days following the effective date of the revision of the Rule and the submission guide shall follow the revised submission guide.

Onboarding:

- The onboarding process applies to submissions from a new payer and begins once contact has been made between the payer and the CO APCD Administrator.
- The payer will go through an orientation process with the CO APCD Administrator and the data vendor that oversees the data warehouse.
- Once the submission system training is held, submitters are allotted approximately 6 weeks to submit their first set of test files and address all structural and failure level validation issues. Submitters are then allotted approximately 12 weeks to submit historical files and then begin regular monthly submissions on the 1st of the following month. Note that this standard timeline may be adjusted to align with annual DSG update timelines.
- Payers shall submit test files of its eligibility data, medical and pharmacy claims data and provider files to the CO APCD Administrator.
- After addressing issues with any test files that interfere with the quality of the CO APCD, payers shall submit complete and accurate historical data to the CO APCD administrator that conforms to submission guide requirements. The CO APCD Administrator will decide, in consultation with the payer, on the time period for which the payer should submit historical files.

- Please refer to the Monthly File Submission Process section below for detailed information surrounding file quality and content expectations.

Ongoing Monthly Reporting and Submission Process:

- For each month thereafter, files shall be submitted no later than 30 days after the end of the reporting month.
- The CO APCD Administrator shall provide any time extension to payers in writing at least 30 days prior to established deadlines.
- Monthly files submitted to the CO APCD undergo a series of quality checks upon submission. These quality checks, also known as intake validations, are meant to validate the files against a set of expected criteria. Thresholds for the various fields submitted in the files are established based on reasonable metrics of what can be expected to be included in the files. For example, 99.5% of records in a file must have a valid Member Date of Birth.
- If a file does not meet the expected thresholds, carriers can follow one of two steps:
    - Fix the issue and resubmit
    - Request an exemption override for the CO APCD Administrator to review
- The CO APCD Administrator reserves the right to deny an exemption override and require further details in the exemption request or require a complete resubmission.
- A file is not considered complete until all intake validation failures are addressed and the file is in a status of "Validation Passed".
- Data submissions are due 30 days after the end of the reporting month as outlined in the submission guide. This equates to files being submitted on the 1st day of the month and passing all intake validations in the CO APCD portal by the 15th day of the month. Automated reminder emails are sent via the CO APCD Portal throughout the month.

Annual Reporting and Submission Process:

- Each year following onboarding, active payers must submit complete and accurate APM and Drug Rebate files for the most recent and complete three calendar-year periods no later than September 30th of the following year.
- Before the September deadline, payers are required to submit test files by July 15th of each year containing one year's worth of data.
- Payers who are exempt from submitting either a Drug Rebate or APM file must submit a waiver each year on or before July 1st. A list of exempt criteria can be found in the Exceptions section.
- Annual files undergo a series of quality checks completed manually by CIVHC. Results are distributed via email with details surrounding the file's performance against a set of quality measures. For example, the total spending reported in the file must align within a +/- 20% margin when compared to the calculated spending in the CO APCD.
- The CO APCD Administrator reserves the right to require resubmission of a file if quality measures are not met.
- A file is not considered complete until the CO APCD Administrator officially sends an email confirming that a file has passed the annual file quality criteria.
- The test files are due on July 15th of each year and are meant to give payers an understanding of file expectations and identify any quality issues that must be addressed for the production file deadline of September 30th.
- Annual files are due on September 30th of each year. Test files for the annual files are due on July 15th of each year. CIVHC will validate the September 30th files within a week of receipt. Payers must

address any quality issues identified in the files by October 30th in order for their data to be included in the Division of Insurance's Primary Care Spending report.

V. Exceptions

This policy does not require the following payers to submit claims data to the APCD but they may continue to submit claims data or elect to submit claims data at any time in accordance with the procedures described in Sections 1.200.2.A and 1.200.3 of the Rule:

1. A private health care payer subject to the provisions of ERISA;
2. Self-insured employer-sponsored health plans, if such health plan is administered by a third-party administrator or administrative services only organization ("TPA/ASO") that services less than an aggregate of 1,000 enrolled lives in Colorado;
3. Carriers offering accident only;
4. Credit;
5. Benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10;
6. Disability income insurance;
7. Liability insurance including general liability insurance and automobile liability insurance;
8. Coverage issued as a supplement to liability insurance;
9. Worker's compensation or similar insurance; or
10. Automobile medical payment insurance, specified disease, or hospital indemnity and other fixed indemnity insurance.

Active submitters to the CO APCD are not required to submit an Alternative Payment Model file if any of the following apply:

1. Carrier provides prescription drug only benefits
2. Carrier provides Medicare Supplemental only benefits
3. Carrier provides dental only benefits
4. 100% of carrier's reimbursements to providers fall under a fee-for-service model

Active submitters to the CO APCD are not required to submit a Drug Rebate file if any of the following apply:

1. Carrier provides medical only benefits
2. Carrier provides dental only benefits

If a carrier is exempt from submitting APM or Drug Rebate files, the carrier must submit a waiver (see Appendix 1) each year on or before July 1st.

VI. Data Quality Issues

Data quality issues can be any issues that impact the integrity or accuracy of the data within the CO APCD. Quality issues can range from not meeting an intake threshold (e.g. less than 99.5% of records do not have a valid member Date of Birth) to a foundational issue with how claims are versioned (e.g. a voided claim is not properly removed from the data set due to faulty logic).

Once a data quality issue has been identified by CIVHC, the data vendor, or the payer, the payer must work diligently with CIVHC to reconcile the files. Reconciliation of data quality issues should be completed in a timely manner. If a payer has not demonstrated a substantive effort to reconcile the identified data quality issues within 30 days, the payer must submit in writing to CIVHC their plan for reconciliation including a timeline for compliance.

VII. Non-Compliance Remediation Process

Should payers not meet the timelines outlined in sections IV and VI above, CIVHC will implement the following non-compliance remediation process:

1. **CIVHC intake staff send non-compliance notification email**. This email notifies the payer of their non-compliance status and is a venue for CIVHC and the payer to work together to develop a reasonable remediation timeline.
2. **CIVHC compliance staff issue first compliance letter**. A formal compliance letter is sent if the payer does not meet the remediation timeline developed with CIVHC intake staff or does not respond to the non-compliance notification email within 2 weeks. This letter provides a due date for the payer to provide an action plan and is sent to executive-level staff.
3. **CIVHC compliance staff issue second compliance letter**. A second compliance letter is sent if the payer does not respond to the first compliance letter within 2 weeks or fails to meet the deadline in the action plan. The second letter notifies the payer that they must be in a compliant status within one month or CIVHC will escalate their non-compliance to the Colorado Department of Health Care Policy and Financing (HCPF) to impose fines. This letter is sent to executive-level staff.
4. **CIVHC escalation of non-compliance to HCPF**. A formal letter is sent to HCPF, with a copy to the payer's executive team, notifying HCPF of the payer's noncompliance and recommendation to impose fines in accordance with the Rule.
5. **HCPF Issues Fines.** HCPF will issue fines to the payer based on section VIII below if they are not in a compliant status within one month of CIVHC sending a second compliance letter.

VIII. Penalties for Non-Compliance

If the payer fails to provide the required information within the thirty days, the CO APCD Administrator shall provide the payer with notice of the failure to report and will notify the Director of the payer's failure to report.

The HCPF Director shall assess a penalty of up to $1,000 per week for each week that a payer fails to provide the required data to the APCD up to a maximum penalty of $50,000. Fines may be calculated retrospectively to the beginning of non-compliance with the Rule.

In determining whether to impose a penalty, the Director may consider mitigating factors such as the size and sophistication of a payer, the reasons for the failure to report, and the detrimental impact upon the public purpose served by the APCD.

INSTRUCTIONS TO REQUEST A DATA SUBMISSION WAIVER for the COLORADO ALL PAYER CLAIMS DATABASE – APM AND DRUG REBATE FILES

CIVHC will work collaboratively with APCD data submitters to ensure that required submissions achieve the intent of the rules. These rules have been put in place to deliver a high quality, reliable source of health care data for Colorado. The APCD Program will engage in a Continuous Quality Improvement (CQI) process intended to achieve ever higher levels of data quality and completeness as the APCD Program evolves.

Consistent with the CQI process, the APCD will consider requests from data submitters to provide file exemptions for their Alternative Payment Model (APM) and Drug Rebate files. This policy is intended to recognize the special circumstances for each payer (see section 4 of the Data Submission Manuals) and document their exempt status for APM or Drug Rebate submissions.

Data submitters may request a one-year waiver from submitting required file types.

<u>For waivers of a particular file type:</u>

- The year for which the file exemption is requested.
- The file type for which the file exemption is requested.
- An explanation as to why the data submitter is unable to submit the file.
- An original signed certification by the organization's Chief Information Officer or Regulatory Compliance Office that includes the above information and asserts that the data submitter cannot meet the requirements because the requested information is not available and cannot be derived from the data submitter's information systems.

A template for the request for waiver is attached for your convenience. Please attach additional pages of narrative as needed to provide a full explanation of the reasons that the data submitter cannot comply. Please submit all documentation electronically to **submissions@civhc.org**. Questions may also be directed to **submissions@civhc.org**.

Colorado APCD Data Variance Submission Request for [Year]:______

Name of Submitter:	Date Submitted:
Contact Name, Email and Phone:	

Data File Name (AM, CT, DR, etc)	Detailed description of reason

Certification: On behalf of ____________________________________, I certify that this data submitter cannot submit the files listed because the required information is not available and cannot be derived from the data submitter's information systems.

Submitted by: ____

Name Title

_________________________________ _________________________________

Signature Date