

**WAC 82-75-020 Definitions required by chapter 43.371 RCW.** The following definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Allowed amount" means the maximum dollar amount contractually agreed to for an eligible health care service covered under the terms of an insurance policy, health benefits plan or state labor and industries program.

"Billed amount" means the dollar amount charged for a health care service rendered.

"Claim file" means a data set composed of health care service level remittance information for all nondenied adjudicated claims under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, covered medical services files, pharmacy files and dental files.

"Covered medical services file" means a data set composed of service level remittance information for all nondenied adjudicated claims for Washington covered persons that are authorized under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, member demographics, provider information, charge and payment information including facility fees, clinical diagnosis codes and procedure codes.

"Data file" means a data set composed of member or provider information including, but not limited to, member eligibility and enrollment data and provider data with necessary identifiers.

"Dental claims file" means a data set composed of service level remittance information for all nondenied adjudicated claims for dental services for Washington covered persons including, but not limited to, member demographics, provider information, charge and payment information including facility fees, and current dental terminology codes as defined by the American Dental Association.

"Member eligibility and enrollment data file" means a data set containing data about Washington covered persons who receive health care coverage from a payer for one or more days of coverage during the reporting period including, but not limited to, subscriber and member identifiers, member demographics, plan type, benefit codes, and enrollment start and end dates.

"Paid amount" means the (~~actual~~) dollar amount paid for a health care service rendered under the terms of an insurance policy, health benefits plan or state labor and industries program for covered services, excluding member copayments, coinsurance, deductibles and other sources of third-party payment. This dollar amount includes incentive payments that are captured in the claims financial fields in the WA-APCD Data Submission Guide; such incentive payments include, but are not limited to, withholds, shared savings payments, case or episode payments, and pay-for-performance amounts. For capitated services the fee-for-service equivalent is to be reported as the paid amount.

"Pharmacy claims file" means a data set containing service level remittance information for all nondenied adjudicated claims for pharmacy services for Washington covered persons including, but not limited to, enrolled member demographics, provider information, charge and payment information including dispensing fees, and national drug codes.

"Provider data with necessary identifiers" means a data file containing information about health care providers that submitted claims for providing health care services, equipment or supplies, to subscribers or members and such other data as required by the data submission guide.

AMENDATORY SECTION (Amending WSR 17-08-079, filed 4/4/17, effective 5/5/17)

**WAC 82-75-030 Additional definitions authorized by chapter 43.371 RCW.** The following additional definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Capitation payment" means a payment model where providers receive a payment on a per "covered person" basis, for specified calendar periods, for the coverage of specified health care services regardless of whether the patient obtains care. Capitation payments include, but are not limited to, global capitation arrangements that cover a comprehensive set of health care services, partial capitation arrangements for subsets of services, and care management payments.

"Claim" means a request or demand on a carrier, third-party administrator, or the state labor and industries program for payment of a benefit.

"Coinsurance" means the percentage or amount an enrolled member pays towards the cost of a covered service.

"Copayment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

"Data management plan" or "DMP" means a formal document that outlines how a data requestor will handle the WA-APCD data to ensure privacy and security both during and after the project.

"Data release committee" or "DRC" is the committee required by RCW 43.371.020 (5)(h) to establish a data release process and to provide advice regarding formal data release requests.

"Data submission guide" means the document that contains data submission requirements including, but not limited to, required fields, file layouts, file components, edit specifications, instructions and other technical specifications.

"Data use agreement" or "DUA" means the legally binding document signed by the lead organization and the data requestor that defines the terms and conditions under which access to and use of the WA-APCD data is authorized, how the data will be secured and protected, and how the data will be destroyed at the end of the agreement term.

"Deductible" means the total dollar amount an enrolled member pays on an incurred claim toward the cost of specified covered services designated by the policy or plan over an established period of time before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.

"Director" means the director of the office of financial management.

"Fee-for-service payment" means a payment model where providers receive a negotiated or payer-specified rate for a specific health care service provided to a patient.

"Health benefits plan" or "health plan" has the same meaning as in RCW 48.43.005.

"Health care" means care, services, or supplies related to the prevention, cure or treatment of illness, injury or disease of an individual, which includes medical, pharmaceutical or dental care. Health care includes, but is not limited to:

(a) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(b) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

"Lead organization" means the entity selected by the office of financial management to coordinate and manage the database as provided in chapter 43.371 RCW.

"Member" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

"Office" means the Washington state office of financial management.

"PFI" means the proprietary financial information as defined in RCW 43.371.010(12).

"PHI" means protected health information as defined in the Health Insurance Portability and Accountability Act (HIPAA). Incorporating this definition from HIPAA, does not, in any manner, intend or incorporate any other HIPAA rule not otherwise applicable to the WA-APCD.

"Subscriber" means the insured individual who pays the premium or whose employment makes him or her eligible for coverage under an insurance policy or member of a health benefit plan.

"WA-APCD" means the statewide all payer health care claims database authorized in chapter 43.371 RCW.

"Washington covered person" means any eligible member and all covered dependents where the state of Washington has primary jurisdiction, and whose laws, rules and regulations govern the members' and dependents' insurance policy or health benefit plan.

AMENDATORY SECTION (Amending WSR 16-22-062, filed 11/1/16, effective 12/2/16)

**WAC 82-75-240 Data release.** (1) Upon approval of a request for data, the lead organization must provide notice to the requestor. The notice must include the following:

(a) The data use agreement (DUA). The DUA will include a confidentiality statement to which the requesting organization or individual must adhere.

(b) The confidentiality agreement that requestors and all other individuals who will have access to the released data, whether an employee of the requestor, subcontractor or other contractor or third-party vendor including data storage or other information technology vendor, who will have access to or responsibility for the data must sign. At a minimum, the confidentiality agreement developed for recipients must meet the requirements of RCW 43.371.050 (4)(a).

(c) Requestors must comply with the requirements for data release in WAC 82-75-500 through 82-75-520.

(2) A person with authority to bind the requesting organization must sign the DUA; or in the case of an individual requesting data, the individual must sign the DUA.

(3) All employees or other persons who will be allowed access to the data must sign a confidentiality agreement.

(4) No data may be released until the lead organization receives a signed copy of the DUA from the data requestor and signed copies of the confidentiality agreement.

(5) The lead organization must maintain a record of all signed agreements and retain the documents for at least six years after the termination of the agreements.

(6) Data fees, if applicable, must be paid in full to the lead organization. Itemized data fees assessed for each data request are subject to public disclosure and should be included in the approval that is posted on the WA-APCD web site.

## FORMAT FOR THE CALCULATION AND DISPLAY OF DATA

### NEW SECTION

**WAC 82-75-500 Additional definitions related to the format for the calculation and display of data.** The following additional definitions apply throughout this chapter unless the context clearly indicates another meaning. These definitions are related to the rules regarding the format for the calculation and display of cost data.

(1) "Aggregate cost data" means data collected from individual-level records that are maintained in a form that does not permit the identification of individual records.

(2) "Arithmetic mean" means the sum of a set of values, divided by the number of values in the set.

(3) "Average" means the arithmetic mean.

(4) "Cell size suppression" means a method used to report data that restricts or suppresses disclosure of subsets of data to protect the identity and privacy of data subjects and to avoid the risk of identification of individuals or providers in small population groups.

(5) "Median" means the middle value of a list of values where the values have been sorted in size order. If the list has an even number of values, the median is the arithmetic mean of the two middle values.

(6) "Outlier" means an observation that is well outside of the expected range of values in a study or experiment, and which is often discarded from the data set.

(7) "Proportion" means a comparative relation between things or magnitudes as to size, quantity, number, or ratio.

(8) "Range" is the largest value in the set of numbers minus the smallest value in the set. Often, a range is expressed to denote a particular span, e.g., 25th to 75th percentile range. Note that as a statistical term, the range is a single number, not a range of numbers.

NEW SECTION

**WAC 82-75-510 Data formatting rules apply to proprietary financial information.** (1) The format rules apply to all proposed uses of proprietary financial information submitted to the WA-APCD. The format rules apply to three categories of users for which proprietary financial information may be disclosed in accordance with chapter 43.375 RCW:

- (a) Lead organization;
- (b) Federal agencies, Washington state agencies, and units of Washington local government; and
- (c) Researchers with IRB approval.

(2) The lead organization shall assess a data requestor's proposed methods submitted in compliance with RCW 43.371.050 (1)(c) and WAC 82-75-210(2), which require the data requestor to submit a description of the proposed methodology for data analysis. The lead organization's assessment shall include evaluating the data requestor's methodology as it pertains to the calculation and presentation of cost information that rely upon proprietary financial information.

(3) To evaluate data requestor methodology, the lead organization shall adopt criteria to prevent the disclosure or determination of proprietary financial information to any third party.

(4) The data release advisory committee shall advise the lead organization on the criteria to be adopted.

(5) Nothing in this rule shall contravene the authorized uses of proprietary financial information as provided in RCW 43.371.050.

NEW SECTION

**WAC 82-75-520 Elements to safeguard the use of proprietary financial information.** All reports, analytics or other information drawn from the WA-APCD that an approved WA-APCD data user as defined in WAC 82-75-510(1) shares with any third party shall comply with the following restrictions.

- (1) Allowed amount data may be made available for public use.
- (2) Allowed amount data shall be provider or payer deidentified.
- (3) Provider-specific allowed amount data shall be suppressed if that payer accounts for more than fifty percent of that provider's patient market share that payer deidentified data could readily be payer reidentified.
- (4) Absolute or relative allowed cost information shall be communicated in ways that mitigate the potential to mislead data users including, but not limited to:
  - (a) Median cost mitigates the impact of outlier cases;
  - (b) Cost variation statistics (ranges, confidence intervals) illustrate the typical distribution of costs around a point estimate;
  - (c) Categorization, stratification or risk-adjustment techniques make like-comparisons of patient populations;
  - (d) Minimum case volume rules and/or reporting of volume alerts users to the universe or sample underlying the cost result; and
  - (e) Cell size suppression rules are followed whereby cells containing cost data based on a number of patients or providers that is below a minimum threshold count is suppressed.