

ARKANSAS



**All-Payer Claims
Database**

ARKANSAS APCD BEST PRACTICES REPORT

November 25, 2014

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.



1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

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State Data Collection Processes and Best Practices

All-payer claims databases (APCDs) in other states have different approaches to data collection. The majority of existing APCDs have a statutory or regulatory mandate requiring payers to submit data to the APCD. A few states have been able to maintain a functional APCD by relying on voluntary data submission.

As a part of its project with the Arkansas Insurance Department, Health Insurance Rate Review Division (HIRRD), the Arkansas APCD team at the Arkansas Center for Health Improvement (ACHI) researched approaches and best practices in other states to collect health care claims data. For purposes of this assessment, states were selected based upon the longevity of the existence of the state's APCD, national recognition for the state's APCD, and APCD attributes that reflect information gleaned from our stakeholder survey.¹ This summary provides an independent assessment of what practices have proven workable, and has also drawn on information presented in two reports, the APCD Council's "APCD Legislation: Review of Current Practices and Critical Elements" and Milliman's "Best Practices for Launching and Operating an All-Payer Claims Database."^{2,3}

The APCD Council assessment outlines important features of APCD legislation and provides state examples of each, including:

1. **Purpose.** The purpose section of the legislation explains the reasons to create an APCD, the scope of the legislation, and the APCD direction.
2. **Governance.** APCD legislation typically identifies which entity will be given authority to direct APCD operations and enforce provisions outlined in legislation or rules. It may also designate an entity responsible for collecting and reporting information.
3. **Scope.** APCD legislation may include a list of data submitters required to report information, the type of files to be collected, a schedule of submission, and exceptions.
4. **Privacy and confidentiality.** The intent of this section is to protect the privacy of patient information. It may direct identifiable information to be de-identified or limit how the data is transferred or linked between entities.
5. **Funding and penalties.** Funding sources are typically identified in the legislation or direct the responsible entity to obtain funding before the development of the APCD. Another component often included is penalties for non-compliance by the data submitters.
6. **Reporting requirements.** Legislation often includes specific reports that must be produced using the APCD. Requirements may include frequency of reporting and the intended audience that will receive the report (e.g., consumers, providers, or legislators).
7. **Access.** This section identifies the thresholds required for data use and parameters for allowing outside users access to the data.

The Milliman report identifies similar key APCD elements and considerations for APCDs but focuses its best practice analysis on the technical components of an APCD.

While the Arkansas APCD team will be addressing technical components in the stakeholder process, this report is intended to give an overview of the legislative framework for APCDs in other states and note successful approaches to APCD data collection. The information compiled from these activities will be used to develop a mandatory transition plan in 2015 that the state can deploy when appropriate.

This report includes:

- a survey of states' voluntary data collection processes;
- a survey of states' mandatory data collection requirements and identification of best practices; and
- an analysis of Arkansas state laws and regulations to assess authority to collect health data and barriers to collection and use.

¹ Stakeholder feedback from the survey and in response to the Best Practices Summary is in Appendix A.

² [https://www.nahdo.org/sites/nahdo.org/files/publications/APCD%20Council%20APCD%20Legislation%20November%202013%20\(1\).pdf](https://www.nahdo.org/sites/nahdo.org/files/publications/APCD%20Council%20APCD%20Legislation%20November%202013%20(1).pdf)

³ <http://publications.milliman.com/publications/healthreform/pdfs/all-payor-claims-database-best-practices.pdf>

Survey of States' Voluntary Data Collection Processes

In the early stages of this project, the APCD team will collect data as it becomes available through a voluntary submission process. Although most states with successful data collection practices benefit from mandatory authority to collect information, a few states have adopted a voluntary collection strategy. The following section describes these voluntary processes.

Virginia

In 2012, Virginia passed a statute creating an all-payer claims database, which allows voluntary submission of claims data to a nonprofit organization.⁴ The Virginia Department of Health (VDH) oversees APCD operations and has contracted with the Virginia Health Information (VHI) to be the entity charged with the storage, collection, analysis, and evaluation of the data submitted.⁵ The APCD statute requires the state health commissioner to appoint an advisory committee to assist in the development of the APCD. The statute also details the process to ensure data accuracy, release, and reporting and ensures the information is exempt from disclosure by the Virginia Freedom of Information Act.

Wisconsin

The Wisconsin Health Information Organization (WHIO) is a non-profit, member-based organization that leads a voluntary initiative to collect claims information. Members include providers, employers, payers, and the state, with a governing board comprised predominately of purchasers. WHIO collaborates with state agencies to collect claims data on health care cost and quality measures. The structure of the Wisconsin APCD is intended to provide expanded functionality by offering two tiers of access. Restricted access to identified data sets will be used to link to the health information exchange for personal health records, physician access, and advance research. Access to de-identified data is given to members (data submitters) and subscribers (data users) for analyses. The data warehouse uses a snapshot of data to identify gaps in care for treatment of chronic conditions and provide data about the costs per episode of care, population health, preventable hospital readmissions, and variations in prescribing generic drugs. The APCD is funded by grants and membership and subscription fees from payer groups, providers, and other health care organizations.

Michigan

The Michigan Data Collaborative (MCD), part of the University of Michigan, collects claims and eligibility data from Medicare, Medicaid, Blue Cross Blue Shield Michigan, and Blue Care Network. Data submission is voluntary. MCD built the database to support the three-year Michigan Primary Care Transformation (MiPCT) demonstration project. MCD provides summary level and physician organization-specific reports, allowing physicians to view reports through a secure web portal.

The Michigan legislature introduced—but has not yet passed—a bill in April 2013, that would create the Michigan Healthcare Transparency Act and give the Department of Insurance and Financial Services the authority to promulgate rules that “provide for the electronic submission of data and submission and transfer of uniform claim forms.”⁶

⁴ VA Code Ann. § 32.1-276.7:1

⁵ https://www.nahdo.org/sites/nahdo.org/files/Resources/Data_Enhancement_and_Linkage/VHI%20data%20linkage%203%2019%2009.pdf

⁶ <http://www.legislature.mi.gov/documents/2013-2014/billintroduced/senate/htm/2013-SIB-0333.htm>

Survey of States' Mandatory Data Collection Processes

Best practices for mandatory data collection are in a state of evolution due to state-specific considerations (e.g., technical capacity, political environment, funding options, and authority for data collection, use, and release) and the limited number of APCDs that have reached maturity. Mandatory data collection typically entails both enabling statutory authority and regulations to further define the process. Generally, enabling statutes provide an entity with the authority to collect the data and provide the basic framework for the APCD, while subsequent regulations set forth the details about gathering, managing, and using data. The levels of detail within enabling statutes varies from state to state, but, as noted above, typically include the APCD's purpose, governance structure, scope of data reporting and release, privacy and security requirements, and funding mechanisms. APCD statutes may grant authority to a governing body to promulgate rules and regulations that are necessary to carry out the operation of the database.

While much of the mechanisms and operational features of APCDs differ greatly, the Arkansas APCD team has identified the following consistent practices among the states with mandatory data submission requirements.

- All APCDs have some level of state agency involvement to enable rulemaking, whether the agency houses the APCD or not.
- Few enabling statutes set forth all of the APCD data submission, use, and reporting requirements. Most details regarding these requirements are developed via regulation.
- Many enabling statutes provide for a funding source or sources.
- Most enabling statutes require data submission from public and private payers, as well as third-party administrators.
- All enabling statutes include privacy and security requirements, and a few include specific provisions regarding Freedom of Information Act exemptions.
- Many enabling statutes require the development of a data release committee to review certain types of data request and provide recommendations.
- A few states post a summary of data request applications on a public website and offer a public comment period.
- Many enabling statutes require consumer-facing information.

The following sections summarize successful practices in other states.

Colorado

The Colorado APCD is included in this summary for two main reasons. First, the Colorado APCD administrator, the Center for Improving Value in Health Care (CIVHC), received the 2013 Innovation in Data Dissemination Award from the National Association of Health Data Organizations (NAHDO) for effectively communicating health data to the public. Secondly, Colorado has a unique governance structure, creating a public-private partnership that allows for an organization familiar with data management to join forces with a state agency that maintains data collection authority.

Statutes/Regulations

Private and public health care payers are required by statute to submit data to the Colorado APCD.⁷ Payers must submit eligibility, medical, and pharmacy claims, and provider data files to the APCD pursuant to the submission guide developed by CIVHC. The APCD statute went into effect in 2010, which established a 25-member advisory committee to make recommendations about the development and implementation of an

⁷ Private health care payer is defined as any carrier that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and rules of Colorado.

APCD.⁸ The committee met monthly and devised three subgroups to provide insight to the advisory committee. This process generated the framework and approach to establish an APCD in the state.

Upon recommendation by the advisory committee, final APCD rules were adopted by the Colorado Department of Health Care Policy and Finance (HCPF) in August 2011. The rules detail the reporting requirements of the APCD.⁹ The APCD statute required funding to be secured by an established date before the database could be created. CIVHC met the required deadline, and funding was secured through grants from Colorado foundations to support development and implementation through spring of 2016.

In summary, the 2010 statute addresses the following:

- Directs the executive director of HCPF to appoint the APCD administrator and advisory committee
- Describes the recommendations needed from the advisory committee regarding the database
- Requests a report to the governor and general assembly on the status of funding
- Allows the APCD to be created if funding is secured through gifts, grants, and donations by an established date
- Directs the APCD administrator to determine the data submission requirements, method of collection, data elements, and reports made publically available with recommendations of the advisory committee
- Requires the APCD administrator to ensure patient privacy in compliance with state and federal laws
- Allows the APCD administrator to contract with outside parties
- Gives HCPF authority to promulgate rules necessary for the implementation of the APCD including the ability to collect fines for noncompliance

Administration and Governance

Under the authority of the 2010 statute, HCPF appointed the CIVHC—an independent, non-profit organization in Colorado—as the administrator. The advisory committee is comprised of providers, carriers, researchers, health policy advocates, employers, health information technology experts, legislators, and consumers advises and makes recommendations to CIVHC concerning data collection, quality improvement, consumer decision-making, data analysis, alignment with existing data sources, sustainability, privacy and security.

Data Submission

The submission process is detailed in the Colorado APCD Submission Guide (DSG).¹⁰ Payers must submit eligibility, medical claims including charged and paid amount, pharmacy claims, and provider data monthly. Files may be submitted using a secure file transfer protocol (SFTP) client or web upload formatted as a standard text file.

Data Use

CIVHC is required to issue reports at an aggregate level to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns, and utilization of services.¹¹ These reports are provided on a consumer facing websites.¹² CIVHC expects to report comparative cost and utilization information at the facility and provider group level in 2014 after processes and procedures are vetted with the stakeholders.¹³

Data Release

An entity interested in obtaining data from the Colorado APCD must submit an application that describes the purpose, methodology, qualifications of the organization and staff, capacity to maintain data confidentiality

⁸ C.R.S. § 25.5-1-204

⁹ 10 CCR 2505-5 Section 1.200.2

¹⁰ http://www.civhc.org/getmedia/c4071074-ecc4-457b-bd40-72fee47ee639/Data-Submission-Guide-V6-March-2014-FINAL_1.pdf.aspx/

¹¹ 10 CCR 2505-5 Section 1.200.4.A.

¹² 10 CCR 2505-5 Section 1.200.4.B.

¹³ <http://www.civhc.org/All-Payer-Claims-Database/FAQs.aspx/>

and security, and experience with similarly complex data sets.¹⁴ The Data Release Review Committee (DRRC) reviews applications and advises CIVHC whether release of the data is consistent with the statutory purpose. Types of data release include custom reports or de-identified data sets. The APCD is prohibited from releasing individually identifiable information such as name, street address, or social security number.

Implementation Timeline

The development and implementation of the Colorado APCD—marked by the release of the first reports in November 2012—took approximately two years from the initial meetings of the advisory committee in 2010. The initial launch of the APCD focused on providing meaningful information for public health activities and supporting health care policies. Information is currently presented to the public at an aggregate level. As the database becomes more robust and reports are developed and validated, the APCD will release reports that are more sophisticated.

Maine

The Maine APCD received the Award of Excellence in 2007 by NAHDO for successful implementation of the first APCD in the nation, serving as a model for other states. The following summary examines Maine's transformation and identifies key features that have made their APCD successful.

Statutes/Regulations

The Maine Health Data Organization (MHDO) was established in 1995 by statute as an independent agency. The statute granted the organization authority to collect data from health care facilities. As indicated by the statute, the goal of MHDO was to establish a comprehensive database inclusive of health care claims data.

In 2001, the legislature established the Maine Health Data Processing Center (MHDPC), a public-private organization between MHDO and OnPoint (previously the Maine Health Information Center), to facilitate the collection of claims information. OnPoint, a non-profit organization, partially funded the APCD and was primarily responsible for data management and health analytics. The partnership has since dissolved and MHDO has taken on many functions once performed by MHDPC. The existing statutes were revised to expand the APCD's authority to collect data from carriers and third-party administrators.¹⁵ APCD rules require each "third-party payer, third-party administrator, Medicare health plan sponsor, or pharmacy benefits manager" to submit a data set for Maine residents and include definition files for payer-specific provider specialty codes.¹⁶

Administration and Governance

The Maine APCD is currently administered by MHDO. MHDO is governed by a board of directors made up of consumers, providers, employers, third-party administrators, and a representative from the Department of Health and Human Services and the Department of Professional and Financial Regulation.¹⁷ The board has the authority to:

- adopt rules for administration and enforcement of the APCD;
- enter into contracts;
- develop, implement, and modify policies and procedures for the collection, processing, storage and analysis of clinical, financial, quality and restructuring data;
- establish a schedule for compliance with the required uniform reporting systems; and
- provide data analysis upon request.

¹⁴ <http://www.civhc.org/getmedia/9117f876-d23d-49bf-94b1-a1326bf1d0e3/APCD-Annual-Report-March-1-2014-with-Cover-Letter.pdf.aspx/>

¹⁵ http://www.shadac.org/files/shadac/publications/StateDataSpotlight_ME_May2011.pdf

¹⁶ 90-590 C.M.R. ch. 243

¹⁷ 22 M.R.S. § 8703

Data Submission

Maine was the first state to launch an APCD in 2003 and the first to integrate public and private payer data sources.¹⁸ Data submission guidelines are outlined in detail via statute in a section titled, “Uniform Reporting System for Health Care Claims Data Sets.”¹⁹ The APCD collects claims data from commercial carriers, third-party administrators, pharmacy benefits managers, dental benefits administrators, Maine Medicaid (MaineCare), and the Centers for Medicare and Medicaid Services.¹⁹ Filing periods are determined by the total number of members. Payers with more than 2,000 members are required to submit claims monthly, while payers with 200 to 1,999 members are required to submit quarterly. Payers with less than 200 members are not required to submit claims.

Data Use

MHDO’s governing statute requires quality, payments, comparison, and physician services reports. Maine’s APCD utilizes an externally facing consumer website called Maine HealthCost to provide information on quality and medical pricing by insurance plan and average procedure cost by facility.²⁰ In addition, MHDO must produce an annual report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals and health care facilities. An annual report of 10 services and procedures most often provided by osteopathic and allopathic physicians must also be provided.

Data Release

The APCD has separate sets of rules regarding data submission, use, and release. The data release rule describes the extent to which data will be made available to the public and establishes the procedures for data requests. Confidential or privileged information is prohibited from release. Procedures to review of data claimed to be confidential or privileged are outlined in the rule.

Implementation Timeline

The establishment of the MHDPC in 2001 began the process to create an APCD. MHDO became the first in the nation to build and house an APCD and has been collecting claims since 2003. A successful linking of the APCD and the state health information network (HIN) was performed in 2013. MHDO continues to refine these processes to ensure a high quality of exchange of data.

Massachusetts

The Massachusetts APCD is among the earliest of APCDs with efforts beginning in 2006 with the state's broader health care reform law. The Center for Health Information and Analysis (CHIA), the agency responsible for the Massachusetts APCD, has been working to enhance its ability to support the Affordable Care Act premium stabilization programs including risk adjustment. In addition to its longevity and risk adjustment support, the regulations for data release are well-developed and noteworthy as an example of a more structured approach on the regulatory spectrum.

Statutes/Regulations

The Division of Health Care Finance and Policy (DHCFP) was given broad authority to collect health care data including claims information in 2008, and in 2010 adopted regulations to establish an APCD and require mandatory data submission. The DHCFP transitioned into CHIA by statute and acts as an information hub for other agencies to promote administrative simplification.²¹ CHIA was given authority to mandate submission from each private health care payer offering small or large group health plans, public health care payers, and payers using alternative payment contracts (e.g., a contract between a provider and payer that utilizes alternative payment methodologies).

¹⁸ http://www.onpointcdm.org/newsletters/newsletter_articles.php?id=23

¹⁹ <https://mhdo.maine.gov/claims.htm>

²⁰ <https://mhdo.maine.gov/healthcost2014/CostCompare>

²¹ M.G.L. ch. 12C § 10

Administration and Governance

In addition to maintaining the Massachusetts APCD, CHIA is the state agency responsible for monitoring the health care system. The agency supplies data sources for various health care improvement efforts. In 2013, CHIA convened the Data Intake Governance Committee, which considers data intake changes and waiver requests from payers with final approval given by CHIA. The Data Privacy Committee reviews requests for compliance with state and federal privacy and security laws and screens the data release. CHIA's Data Release Committee provides additional screening procedures to certain applications to ensure release is in the public interest.

Data Submission

Data is submitted using a web-based transaction service of CHIA. CHIA regulations guide the submission process and require collection of medical claims, encounter data, pharmacy claims, dental claims, eligibility data, provider files, and product files with most files submitted monthly to maintain a current dataset. Each submission must be a variable field length asterisk delimited file as outlined in the APCD data submission guide.

Data Use

The APCD statute authorizes CHIA to promulgate regulations that allow it to analyze:

- changes over time in health insurance premium levels;
- changes in the benefit and cost-sharing design of plans offered by payers;
- changes in measures of plan cost and utilization for comparison; and
- changes in type of payment methods for comparison.²²

CHIA regulations allow the sale of APCD data to approved users, discussed in more detail below. Established fees reflect the cost of analysis, program development, and other costs related to the production of the requested data.²³

Data Release

As noted above, all data release must be screened by the Data Privacy Committee, but CHIA regulations provide a specific path for all data requests. Government agencies may have access to datasets containing protected health information if the agency has a public purpose for acquiring the data. Requests for Medicaid data must be directly connected with the administration of the Medicaid program. Payers, providers, or researchers may receive de-identified data for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis and research. Payers and providers may seek direct patient identifiers for treatment and coordination of care, but patient consent may be required. All other data release requests are discretionary.

Implementation Timeline

APCD efforts began in 2006 with the creation of the Health Care Quality and Cost Council. Receipt of data did not occur until 2009, when the DHCFP began receiving claims data from payers. The first reports were released in 2012 based on payer data from 2008 – 2010. Release 2.0 reports were made available in January 2014.²⁴

Utah

The Utah Department of Health, the agency that manages the state's APCD, was awarded the Ventana Research Leadership Award in 2011 for effectively implementing an APCD in Utah.

²² Massachusetts General Laws, Chapter 12 section 10(a).

²³ <http://www.mass.gov/chia/docs/g/chia-ab/1311.pdf>

²⁴ <http://www.mass.gov/chia/docs/r/pubs/14/chia-annual-report-2014.pdf>

Statutes/Regulations

Pursuant to legislation passed in 2007, work on the Utah APCD began in 2008 with policy planning, drafting rules, and releasing requests for proposals for data management and analysis vendors. The enabling statute established the Health Data Committee (HDC) to “direct a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care.”²⁵ Funding for the APCD was established by statute in 2008. HDC’s health insurance claims reporting rule went into effect in 2009.²⁶ The rule requires carriers that have more than 2,500 covered lives to submit health care claims data described in the technical specifications.²⁷ Carriers must notify the Office of Health Care Statistics (OHCS) if required data elements are not available to the carrier.

Administration and Governance

The Utah APCD is managed by the Utah Department of Health (UDOH), Center for Health Data (CHD), Office of Health Care Statistics (OHCS). The CHD oversees the HDC, which works closely with the OHCS and has rulemaking authority to administer the APCD.

Data Submission

The submission process is detailed in the Utah APCD Data Submission Guide.²⁸ In general, eligibility, medical claims, pharmacy claims, and provider data must be submitted monthly. Files may be submitted using a SFTP client or web upload.

Data Use

APCD data supports research of health care cost, quality, access, health promotion programs, or public health issues.²⁹ The APCD statute limits the use of data beyond these purposes.

Data Release

A data use subcommittee manages data request applications and the HDC approves applications. Limited data or limited time access is given at varying levels either as public (contains no identifiable data) or research (contains identifiable data) data sets.

Implementation Timeline

APCD efforts took approximately three years from the initial planning in 2006 to the final administrative rule effective in 2009.

²⁵ Utah Code Ann. § 26-33a-104

²⁶ Utah Admin. Code R428-15

²⁷ Utah Admin. Code R428-15-4

²⁸ http://health.utah.gov/hda/apd/UT_APCD_DSG_v2.0.pdf

²⁹ Utah Admin. Code R. 28 – 2

Analysis of Arkansas State Laws and Regulations

The APCD team explored statutory and regulatory mechanisms in Arkansas for collecting health care information. Existing Arkansas statutory provisions that provide authority for the state to collect claims information are outlined in Table 1 below. Also noted are the restrictions on use of the data collected.

Related Agency/Organization	Arkansas Statute	Collection Authority	Limitation
Arkansas Department of Health (ADH)	A.C.A. § 20-7-301	Authorized to collect data, claims information to establish a base of health care information for patients, providers, and hospitals	Prohibited from releasing data that could identify providers, institutions, or health plans*
Health Services Permit Agency	A.C.A. § 20-8-110	Authorized to collect utilization statistics, claims data, and other health data to review applications for new or expanding health care facilities	Prohibits the release of information that can identify individual patients or be linked with any third-party payer
Office of Health Information Technology	A.C.A. § 25-42-106	Houses and shares patient-specific protected health information with participating health care providers	Requires patient authorization, information exchange is limited to participating or subscribing providers non-disclosable
Arkansas Insurance Department	A.C.A. § 23-61-108	Insurance Commissioner can issue rules necessary for the regulation of insurance or as required to be in compliance with federal laws	Limited uses, not inclusive of systems research
Arkansas Center for Health Improvement (ACHI) and the Health Data Initiative	A.C.A. § 20-8-401 <i>et seq.</i>	Authorizes ACHI to have access to any data the state owns or contracts for that could inform health policy	Needs permission of the agency responsible for the data, data use is limited to research and to inform health policy decisions
*ADH must provide data to the AR Hospital Association for its price transparency and consumer-driven health care project that will make price and quality information about Arkansas hospitals available to the public.			

Importantly, none of these statutes enabling data collection affects work on the APCD going forward, except to the extent that data collection for the APCD relies upon one or more of these authorities, which have restrictions tied to them. For example, if the APCD relies upon the mandatory collection authority of the Arkansas Department of Health, reports could not identify individual providers, institutions, or plans, because such information is statutorily restricted from release. Similarly, if the APCD relies upon the voluntary collection authority of the Health Data Initiative, analyses would be limited for policymaking and research: no consumer-facing information could be generated under that authority.

Under a voluntary or mandatory submission requirement, the APCD will be guided by state and federal privacy and security laws and regulations, such as the federal Health Insurance Portability and Accountability Act (HIPAA). APCD public reports will be at an aggregate level to protect individual-level information. Any release of APCD data to qualified requestors, such as researchers or public health officials, will follow structured data release protocols and controls and will comply with all HIPAA requirements.

With respect to the collection of data, a state requirement via statute would provide a clear path for payers to disclose claims, including protected health information, for APCD purposes.³⁰ Absent a mandate for submission to the APCD—as is the status in Arkansas—the path is less clear for payers. A state agency with authority for “health oversight activities” as defined by HIPAA,³¹ could potentially use state authority to compel the disclosure of claims information. Permitted disclosures under this HIPAA provision, however, are nonetheless limited to activities for which the agency is legally authorized. In other words, the HIPAA provision does not expand state agency’s authority to conduct activities beyond those that it is authorized to do under state statute.

Conclusion

In this report, the Arkansas APCD team has focused on operational features of APCDs with either voluntary or mandatory data submission practices. Throughout the engagement process, the Arkansas APCD team will learn more from stakeholders about the data sources and the demand for reports and increased health care transparency.³² With that knowledge, the team will formulate a mandatory data submission transition plan that will incorporate many of the practices used by the states highlighted in this report as well as stakeholder input. Should the state deploy the plan, it will provide guidance on components suggested by the APCD Council and Milliman (i.e., APCD governance, data submission requirements—including scope of data, frequency of submission, data format, privacy and security protections, funding, and data use, including required reports and limitations).

³⁰ A more comprehensive rationale for mandatory data collection is in Appendix B.

³¹ 45 CFR § 164.501

³² The Community Support Plan, Appendix C, identifies the educational materials and events the APCD team plans to deploy as part of the communication process. The team will work with stakeholders to further refine the plan.

Appendix A

Stakeholder Input

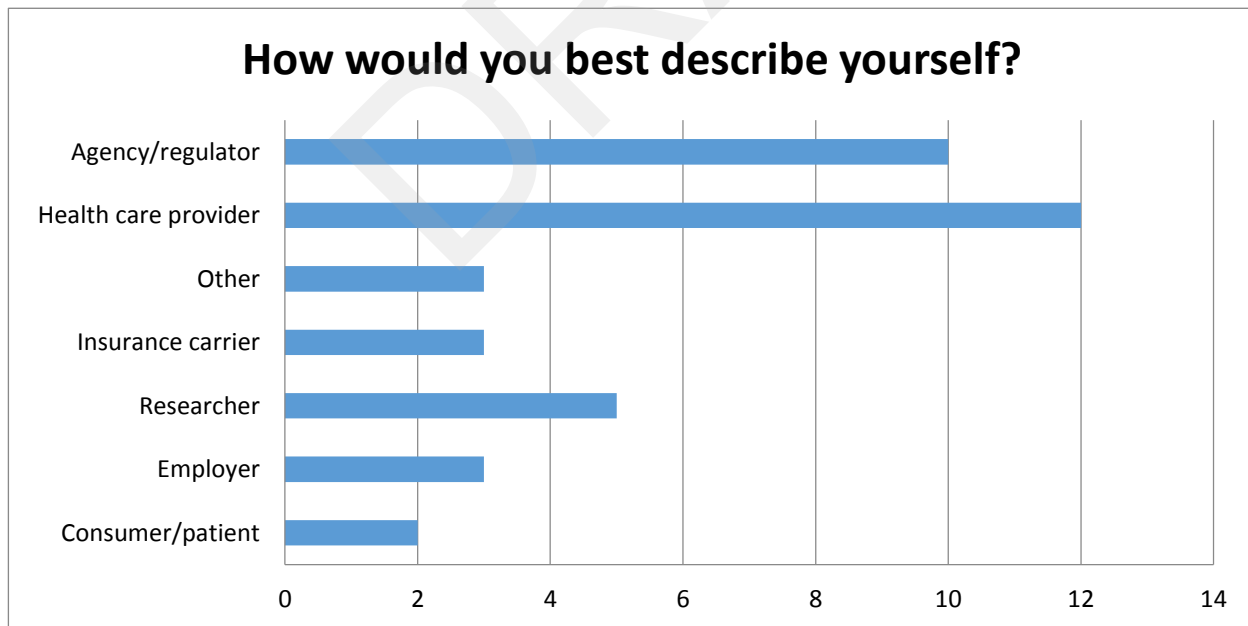
The stakeholder engagement process is key to optimal APCD utility and long-term sustainability. The APCD team recognizes the importance of candid stakeholder input, expertise, and guidance as the state proceeds toward developing a more robust platform for transparency. Should the state deploy a mandatory data transition plan, in order to advocate effectively, learning and understanding stakeholder needs will be essential for buy-in and developing a clear message. The APCD team will capitalize on the valuable perspective of each stakeholder and encourage stakeholders to build interest and promote value to external individuals and groups that may have a significant impact on the project.

As the first step to facilitate the conversation regarding mandatory submission, on September 29, 2014, the APCD team presented the Best Practice Summary (discussed above) to the APCD Advisory Committee. The APCD team gave each stakeholder a copy of the summary and prepared a presentation to review highlights. Stakeholders were encouraged to give feedback on the summary and on how these practices may be incorporated moving forward. Though no direct feedback has been given at this time, ACHI will continue to discuss these practices with stakeholders in conjunction with data submission, data use, and data release strategies. In addition, best practices discussions will continue through the carrier engagement process to ease concerns relating to privacy and security, release of information, and governance.

Stakeholder Survey

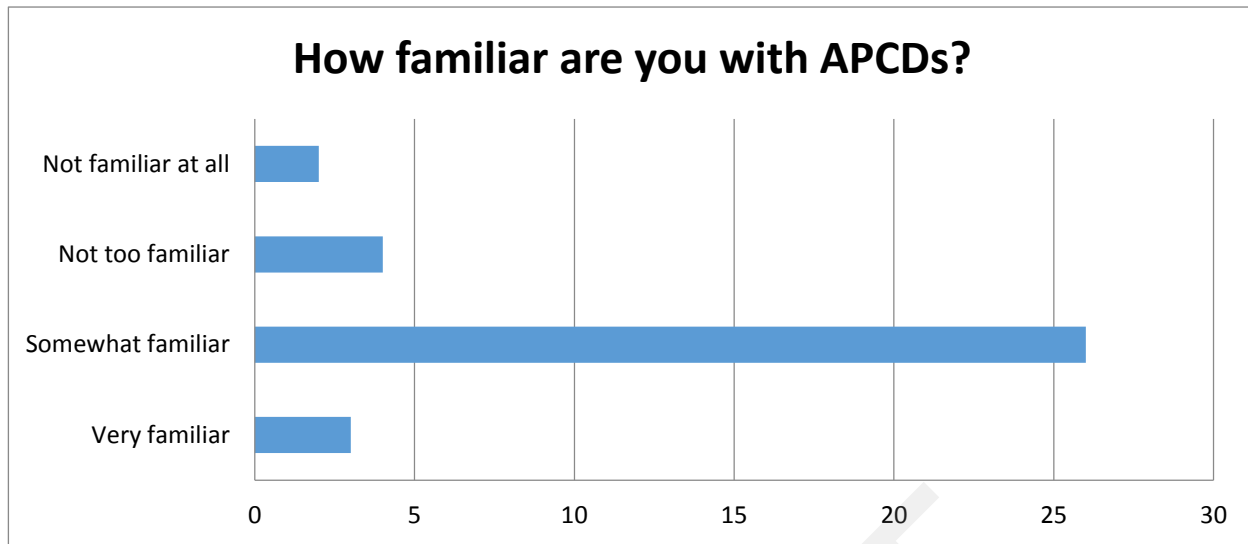
The APCD team administered a survey at the first APCD stakeholder meeting and subsequent policy and technical workgroup meetings. The survey consisted of eight questions; the results of each represented graphically below.

Question 1



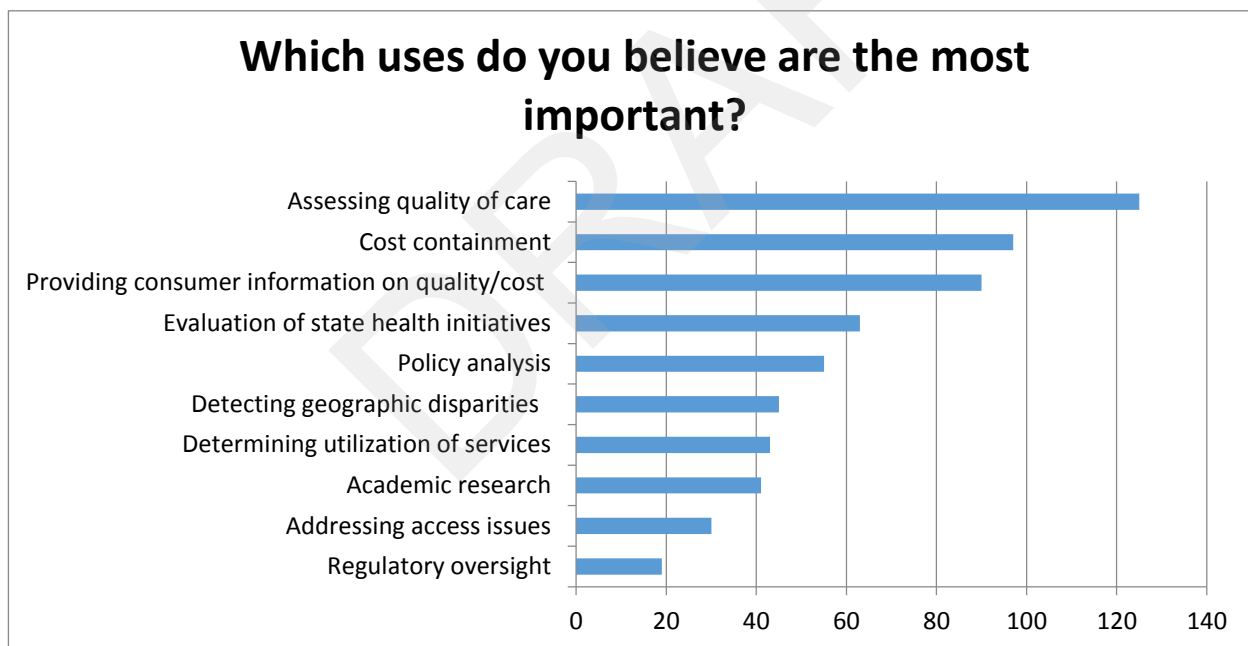
Note: Results were calculated by simple counts of votes in each category.

Question 2



Note: Results were calculated by simple counts of votes in each category.

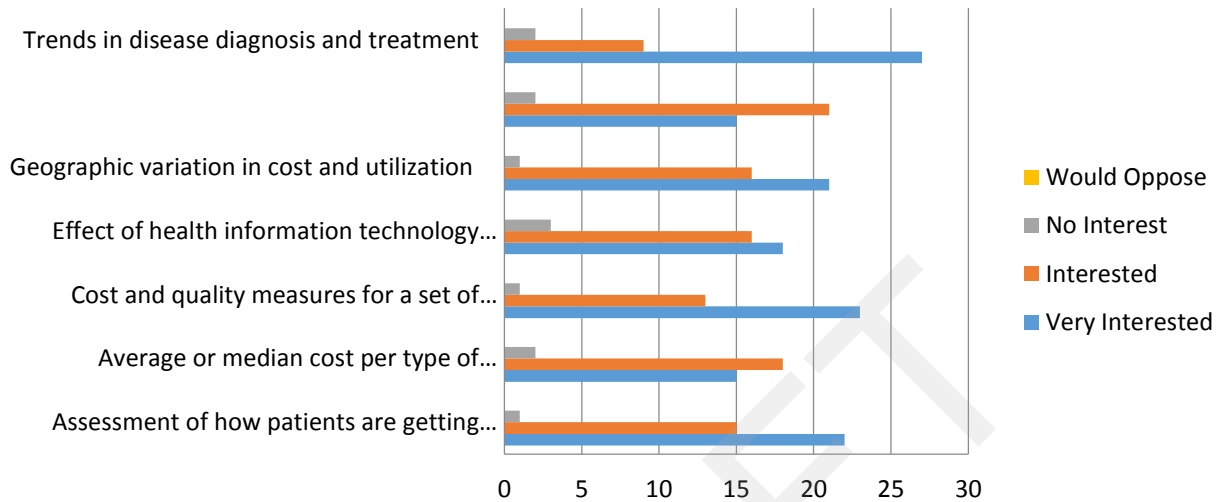
Question 3



Note: Results were calculated by assigning a weight to each ranking. A rank of 1 was assigned a weight of 5; 2 was assigned a weight of 4; 3 was assigned a weight of 3; 4 was assigned a weight of 2; and 5 was assigned a weight of 1.

Question 4

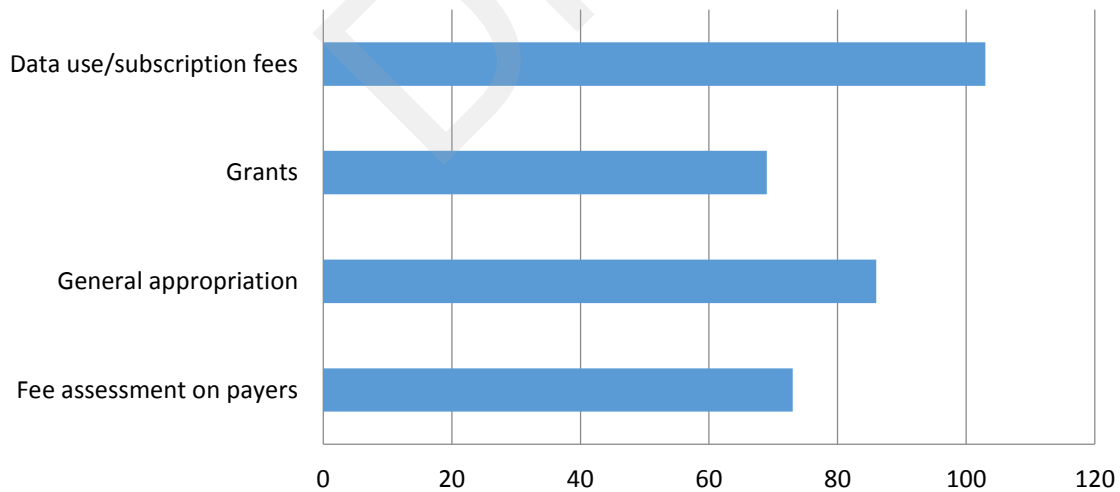
What level of interest do you have for the following APCD reports?



Note: Results were calculated by simple counts of votes in each category.

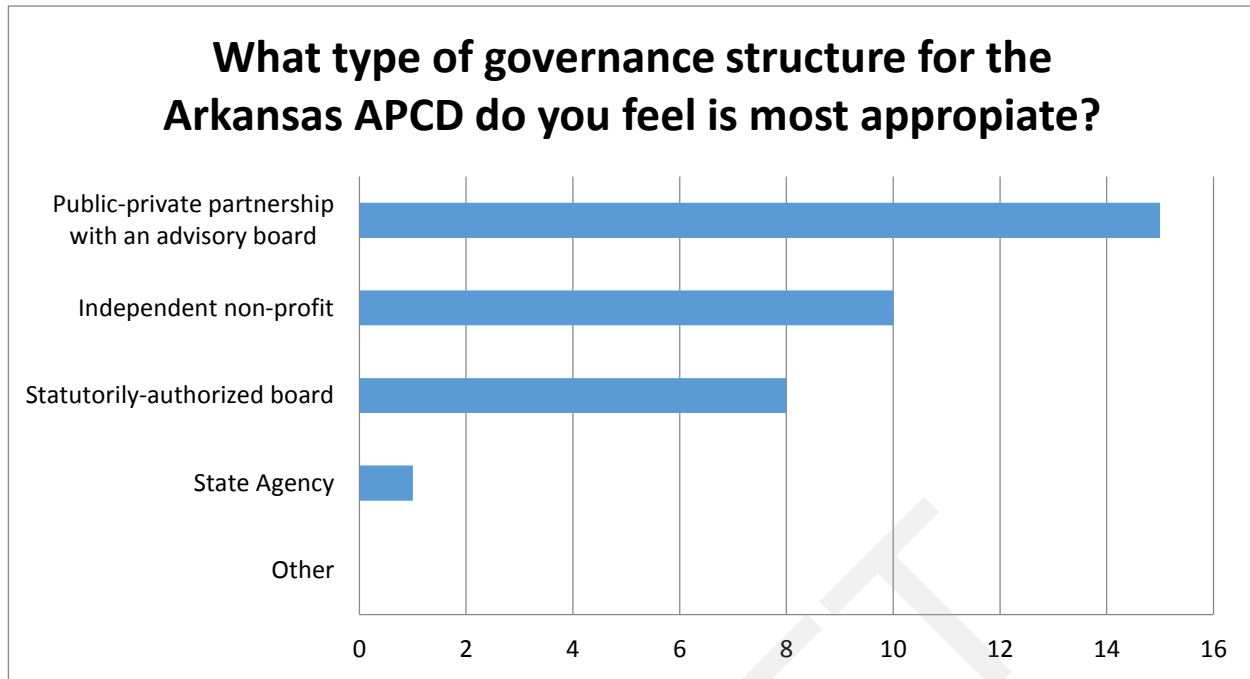
Question 5

How do you rank the following funding sources?



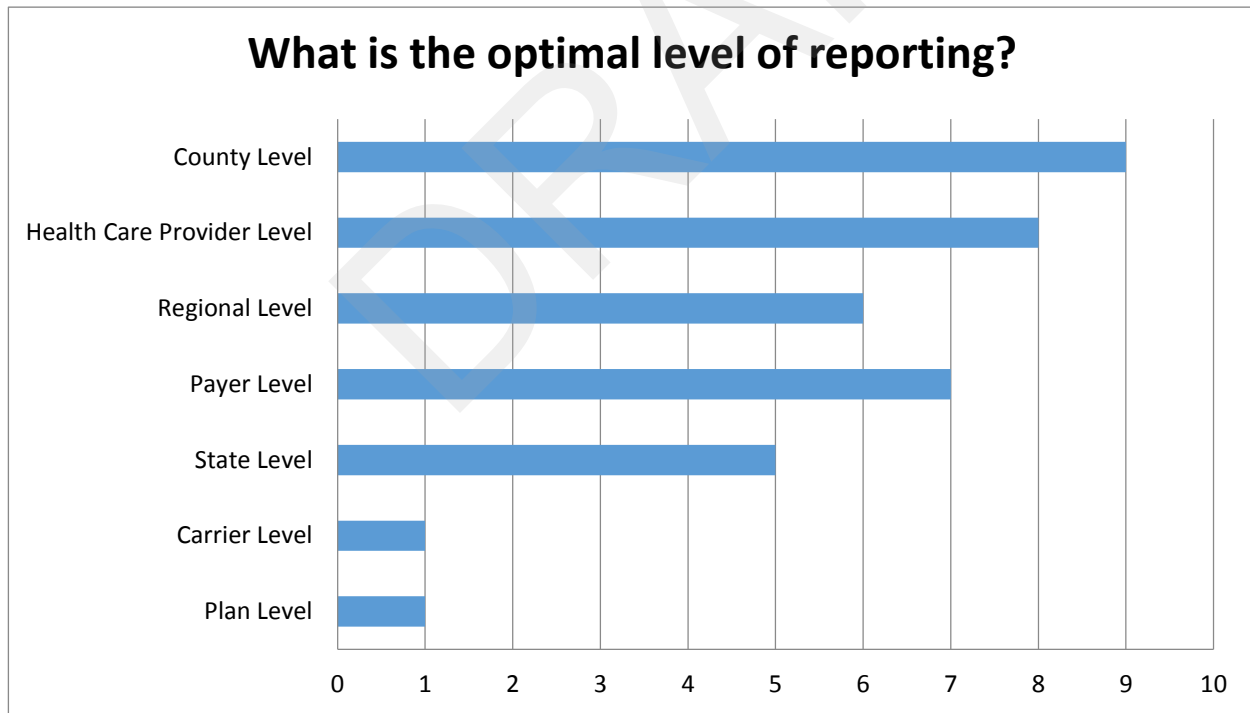
Note: Results were calculated by assigning a weight to each ranking. A rank of 1 was assigned a weight of 4; 2 was assigned a weight of 3; 3 was assigned a weight of 2; and 4 was assigned a weight of 1.

Question 6



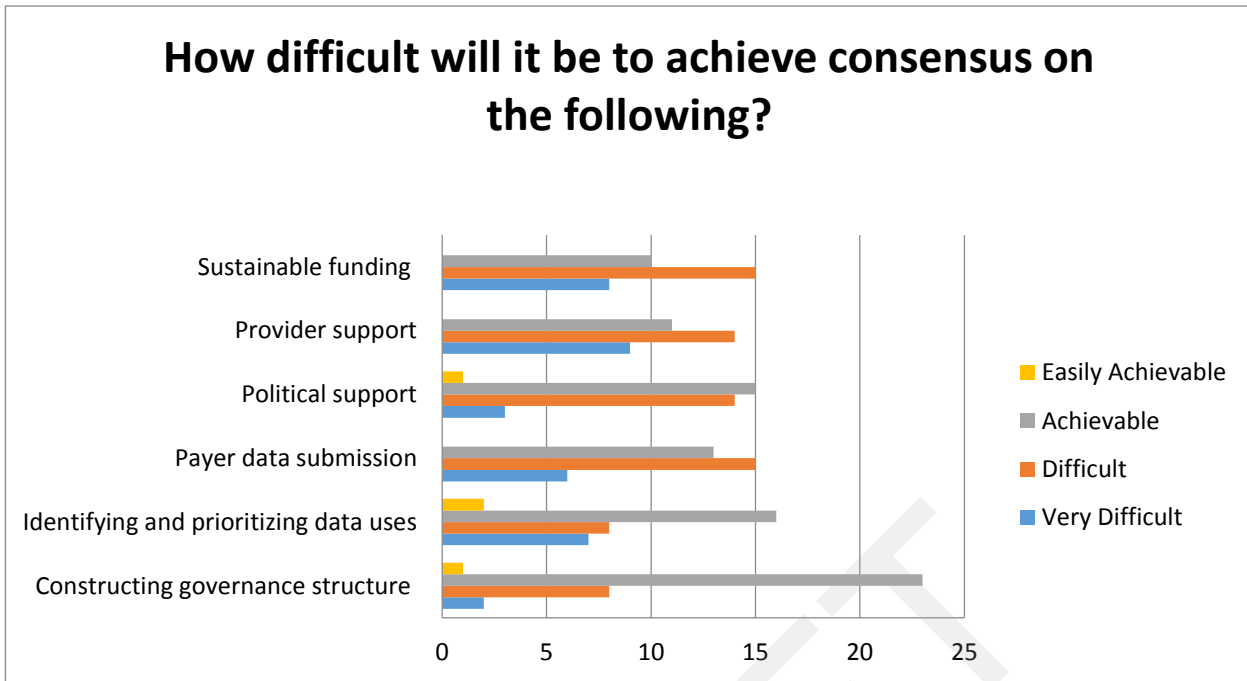
Note: Results were calculated by simple counts of votes in each category.

Question 7



Note: Results were calculated by simple counts of votes in each category.

Question 8



Note: Results were calculated by simple counts of votes in each category.

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Appendix B

Rationale for Mandatory Submission

A mandatory requirement for Arkansas APCD data submission may be necessary if minimum sufficient data cannot be acquired through a voluntary process. The Arkansas APCD will have minimum sufficient data when it has acquired comprehensive data—inclusive of individual identifiers to allow linking across datasets and price information—that represents greater than 75 percent of the Arkansas population. In addition, data should be examined for sufficiency with respect to geography, gender, age, race, and ethnicity.

Minimum sufficient data is necessary to perform analyses and develop reports that are meaningful to consumers and to develop products that will be valuable to data users. Minimum sufficient data is the foundation for Arkansas APCD sustainability. Acquiring this level of data is crucial for the Arkansas APCD to be responsive to questions from policymakers in a rapidly changing environment. The inclusion of individual identifiers in the minimum sufficient data definition is critically important, because it enables:

- Healthcare utilization reporting that can account for patient migration among payers and providers.
- Linking of patients in claims to clinical records for outcome-based quality assessment.
- Reporting on the prevalence of and costs to treat chronic diseases (e.g., asthma and diabetes, analysis of cost drivers, and comparison of observed to expected values based on underlying health status).
- Assessment of where patients seek care in relation to where they reside.

A mandatory data submission requirement would be an important tool to create equity among entities that are reluctant to submit data in a voluntary environment. The APCD team's conversations with potential data submitters have surfaced concerns about a voluntary framework—particularly about individual entity exposure, the lack of a formal governance structure, the existence of contractual restrictions on data disclosure in provider contracts, and the absence of a clear path to disclose data under the Health Insurance Portability and Accountability Act (HIPAA). A mandatory data submission process would offer an opportunity for data submitters to address these concerns. In addition, it would offer the APCD team the opportunity to establish more formality and uniformity to the data submission process with respect to submission timing and data format.

A mandatory data submission process would present an opportunity for agency leaders responsible for state initiatives to assess and streamline ongoing data submission practices. For example, officials at the Arkansas Department of Human Services leading State Innovation Model efforts to assess the success of episodes of care and patient-centered medical homes, and officials at the Arkansas Insurance Department seeking to assess the quality of qualified health plans could require payer data to be funneled to the Arkansas APCD for those assessment activities. This could result in lessening the administrative burden for those submitting data by limiting the number of data requests and number of locations for data warehousing.

Perhaps most importantly, a mandatory data submission requirement would assist the Arkansas APCD to fulfill its mission to be a trusted, reliable source of information for Arkansans. As Arkansas and many other states extend coverage to additional individuals with the help of state and federal financial support, lawmakers will increasingly demand transparency with respect to the use of those funds and, as they demand heightened individual responsibility, they will press for individuals to have access to more information to promote more informed health care decision-making.

In sum, the Arkansas APCD would benefit from a mandatory data submission requirement:

- to support efforts to acquire minimum sufficient data if it cannot be garnered through a voluntary process;
- to create equity among data submitting entities and establish formality and uniformity to the process;
- to promote streamlining of multiple ongoing data submission processes; and
- to ensure that the Arkansas APCD has the ability to fulfill its mission to be a reliable, trusted source of information that can be sustained over time.

As noted in the main text, the APCD team will be developing a more comprehensive Mandatory Data Submission Transition Plan. However, the following is a high-level description of stakeholder engagement and other activities that we anticipate will occur if the state moves forward with mandatory submission.

- Continue to meet with APCD stakeholder groups to gain support and guidance
- Meet with the Arkansas Insurance Commissioner under a new administration to develop a strategy and define roles for legislative advocacy to advance the issue
- Meet with the chairperson of both the Arkansas Senate and House of Representatives Public Health, Welfare, and Labor committee
- Meet with the Arkansas Speaker of the House and President Pro Tempore
- Meet with individuals of groups that oppose and support mandatory submission to assess concerns and reach a compromise to influence support

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Community Support Plan

ACHI has prepared its Community Support Plan as a guide to public education regarding the Arkansas APCD. ACHI will implement public education in a two-phase approach. The strategy in phase one incorporates a soft launch of the Arkansas APCD website and provides education materials for legislators and other stakeholders. The purpose of the soft launch is to introduce the APCD in a less aggressive manner while Version 1.0 reports are beta tested and finalized. This will also allow ACHI time to make changes based on public feedback and adapt materials where needed to use in phase two for consumers. Phase two will have a loader approach with the focus on consumers. There is a strategy behind the delayed rollout of consumer education materials. Until useful and credible information is available to consumers, there is a chance of consumer turn-away if directed to a website with limited function. This may cause difficulty enticing consumers to use the public reporting tools once available. The goal of phase two is to create excitement about the new reports on the website and to get information in the hands of consumers, allowing them to see the value in the APCD.

Public Education Materials

There is limited funding allocated to public outreach for the early implementation of this project. In order to reach target audiences and build anticipation for the APCD tools, ACHI will be innovated in its approach to utilize existing resources. ACHI anticipates collaborating with the University of Arkansas for Medical Sciences (UAMS) Center for Health Literacy to develop educational materials for readability and formatting based on plain language guidelines.

In phase one, ACHI will develop education materials designed for targeted stakeholders, provide demonstrations, and continue stakeholder engagement activities. Educational materials and activities will include:

- a transparency brief that focuses on the potential benefits of increased health care transparency, the status of information on the health care system in Arkansas, and initiatives that are creating opportunity and driving the need for a more transparent health care environment;
- an information sheet available for legislators during the 2015 legislative session that details the purpose and value of the APCD and provides the status of the project;
- targeted material for stakeholders that will describe unique opportunities and value for their particular needs;
- provide demonstrations to existing stakeholder groups for various statewide health care initiatives and current and future workforce groups; and
- prepare press releases to provide information to the media about the project and status.

In phase two of the Community Support Plan, phase one materials will be adapted and distributed to communities around the state with the aid of the UAMS Center for Health Literacy and demonstrations will be targeted to support consumer use of the APCD tools.

Public Education Series of Events

Schedule of Events	Description
90th General Assembly	The 90th general assembly will convene January 12, 2015. Throughout the regular session, ACHI will have resources available to provide information and answer questions regarding the APCD.
Employer Advisory Council (EAC)	The EAC is an advisory council established to recruit self-insured companies to participate in the Arkansas Health Care Payment Improvement Initiative to maximize pressure on the health care system to achieve the necessary changes to contain costs and improve quality. ACHI will leverage the quarterly meeting to provide APCD information and demonstrations.
Arkansas Hospital Association (AHS)/Arkansas Medical Society (AMS) meeting	The purpose of this monthly meeting is to provide system transformation updates, inclusive of the APCD, to the AHA and AMS.
Arkansas Employee Benefits Division (EBD)	ACHI supports EBD on several projects through technical assistance and program implementation. ACHI will meet will EBD monthly to discuss ongoing projects and continue engagement regarding the APCD.
Multi-payer Executive Committee	A multi-payer executive committee meets monthly to discuss AHCPII progress and alignment on design parameters. As a participant, ACHI will use these meeting opportunities to provide updates on the APCD and demonstrations where appropriate.
APCD Stakeholder Meetings	ACHI will continue stakeholder engagement for advice and recommendations on issues brought before them. Arkansas Medicaid and private carriers are among the stakeholders.
Media Relations	APCD team will work the ACHI communication specialist leverage existing earned media channels.