ARKANSAS APCD
BEST PRACTICE SUMMARY

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

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Summary of 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 awards or recognition for the state's APCD, and APCD attributes that reflect information gleaned from our stakeholder survey. 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 Payor Claims Database."[1,2]

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).

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 summary is intended to give an overview of the legislative framework for APCDs in other states and note successful approaches to APCD establishment. Following stakeholder review and comment, the Arkansas APCD team will incorporate stakeholder input in a final report to HIRRD. 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 summary document includes:

- a survey of states' voluntary data collection processes;
- a survey of states' mandatory data collection requirements and identification of best practices; and

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[1] .https://www.nahdo.org/sites/nahdo.org/files/publications/APCD%20Council_APCD%20Legislation_November%202013%20(1).pdf

[2] http://publications.milliman.com/publications/healthreform/pdfs/all-payor-claims-database-best-practices.pdf

- an analysis of Arkansas state laws and regulations to assess authority to collect health data and barriers to collection and use.

Survey of States' Voluntary Data Collection 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.[3] 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.[4] 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) 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.

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. MDC 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."[5]

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[3] VA Code Ann. § 32.1-276.7:1

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

[5] http://www.legislature.mi.gov/documents/2013-2014/billintroduced/senate/htm/2013-SIB-0333.htm

Colorado

The Colorado APCD is included in this summary for the following reasons: (1) The Center for Improving Value in Health Care (CIVHC), the APCD administrator, received the 2013 Innovation in Data Dissemination Award from the National Association of Health Data Organizations (NAHDO) for their work of effectively communicating health data to the public; and (2) Colorado has a unique governance structure creating a public-private partnership allowing 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.[6] 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 APCD.[7] 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.[8] 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, which is 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,

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[6] 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.

[7] C.R.S. § 25.5-1-204

[8] 10 CCR 2505-5 Section 1.200.2

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).[9] 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.[10] These reports are provided on a consumer facing websites.[11] 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.[12]

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 and security, and experience with similarly complex data sets.[13] 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

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

[10] 10 CCR 2505-5 Section 1.200.4.A.

[11] 10 CCR 2505-5 Section 1.200.4.B.

[12] http://www.civhc.org/All-Payer-Claims-Database/FAQs.aspx/

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

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.[14] 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.[15]

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.[16] 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.

Data Submission

Maine was the first state to launch an APCD in 2003 and the first to integrate public and private payer data sources.[17] Data submission guidelines are outlined in detail via statute in a section titled, "Uniform Reporting System for Health Care Claims Data Sets."[18] 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.[21] 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 privilege information is prohibited from release. Procedures to review of data claimed to be confidential or privileged are outlined in the rule.

Implementation Timeline

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[14] http://www.shadac.org/files/shadac/publications/StateDataSpotlight_ME_May2011.pdf

[15] 90-590 C.M.R. ch. 243

[16] 22 M.R.S. § 8703

[17] http://www.onpointcdm.org/newsletters/newsletter_articles.php?id=23

[18] https://mhdo.maine.gov/claims.htm

[19] https://mhdo.maine.gov/claims.htm

[20] https://mhdo.maine.gov/healthcost2014/CostCompare

[21] https://mhdo.maine.gov/rules.htm

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. [22] 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).

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 applies 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: (1) changes over time in health insurance premium levels; (2) changes in the benefit and cost-sharing design of plans offered by payers; (3) changes in measures of plan cost and utilization for comparison; and (4) changes in type of payment methods for comparison.[23] 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.[24]

Data Release

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[22] M.G.L. ch. 12 § 10

[23] Massachusetts General Laws, Chapter 12 section 10(a).

[24] http://www.mass.gov/chia/docs/g/chia-ab/1311.pdf

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.[25]

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.

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."[26] Funding for the APCD was established by statute in 2008. HDC's health insurance claims reporting rule went into effect in 2009.[27] The rule requires each carrier to submit health care claims data described in the technical specifications.[28] 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.[29] 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.[30] The APCD statute limits the use of data beyond these purposes.

Data Release

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[25] http://www.mass.gov/chia/docs/r/pubs/14/chia-annual-report-2014.pdf

[26] Utah Code Ann. § 26-33a-104

[27] Utah Admin. Code R428-15

[28] Utah Admin. Code R428-15-4

[29] http://health.utah.gov/hda/apd/UT_APCD_DSG_v2.0.pdf

[30] Utah Admin. Code R. 28 – 2

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.

Analysis of Arkansas State Laws and Regulations

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

Table 1: Data Collection Related Statutes in Arkansas

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 *et seq.*	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.**

Conclusion

In this summary, the Arkansas APCD team has focused on operational features of APCDs with either voluntary and mandatory data submission practices. Should stakeholders decide to move forward with mandatory data submission for the Arkansas APCD, it is anticipated that the regulatory and advisory frameworks from the states highlighted in this summary will serve as the best guides for the development of an Arkansas-specific framework.

As a part of the Arkansas APCD project, the APCD team will be developing a mandatory data submission transition plan that will incorporate many of the practices used by the states highlighted in this summary. Should the state wish to 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). Stakeholder input will be critical to the development of the transition plan.

While much of the regulatory 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 and the utilization of that committee to authorize—not just inform—the release of data.
- Many enabling statutes require consumer-facing information.

Throughout the engagement process the Arkansas APCD team will learn more from the stakeholders about the data sources that will become available on a voluntary basis and demand for reports and increased health care transparency. With that knowledge the team will formulate a transition plan for the state that incorporates stakeholder input and observes lessons learned by other states.