Assessing the Feasibility of a Sustainable Alaska All-Payer Claims Database

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Table of Contents

Executive Summary 3
Introduction 10
Chapter One: Solidifying Stakeholder Support and Generating Value 12
Chapter Two: Data Management 20
Chapter Three: Data Submission, Quality and Access 30
Chapter Four: Development and Maintenance Costs and Funding 44
Chapter Five: Moving Forward 54
Appendix A: Vendor Contact Information for APCDs in Full Operation 65
Appendix B: Procurement Tasks 67
Appendix C: Detailed Project Plan and Risks 70

Executive Summary

The Problem: Healthcare in Alaska is the most expensive in the United States. These high healthcare costs put pressure on Alaska employers and strain the state's budget, which must cover the cost of medical benefits for state employees, retirees and Medicaid recipients. Meanwhile, a lack of reliable, timely information makes it impossible to know whether Alaskans are getting good value for their money.

Efforts to measure the rate of increase in healthcare costs and understand the causes have been hampered by the lack of comprehensive spending information. In the absence of timely state data, Alaska stakeholders have had to rely on national data sources that do not reflect the state's distinct market conditions, landscape or population. Current, detailed and complete data about Alaska's healthcare marketplace will be critical to efforts seeking to improve cost, quality and access to care. [1]

A Path Forward: In more than 20 states, consumers, physicians, hospitals, employers, health insurers, policymakers and researchers are using healthcare claims data to better understand the health of their residents and quality and cost of their medical care.

In these states, health insurance companies, state Medicaid agencies, Medicare and some employers contribute claims data – the same information used for billing – to develop a broad and deep dataset ready to generate actionable information. These datasets, known as all payer claims databases ("APCDs"), provide accurate, timely and reliable information to inform policy, quality improvement efforts and purchasing decisions.

Questions APCDs Can Answer:

- How much do Alaskans spend on healthcare?
- How often do Alaskans receive recommended care?
- Which Alaska regions need more primary care providers?
- What percentage of Alaskans have a specific diagnosis or health condition?
- How often are Alaskans leaving the state for medical care and for which services?

Roadmap for Alaska: This report presents a roadmap for the development of an Alaska APCD. It builds on the work of the Alaska Healthcare Transformation Project in 2019-2020 and customizes the experience of more than 20 states to offer a roadmap for an Alaska APCD that reflects state values and needs. This report offers recommendations for how Alaska should approach the development, funding and operations of an APCD and includes standalone chapters on key topics of development for readers interested on specific aspects of the APCD. This Executive Summary offers highlights and summarizes recommendations.

Key Themes:

- Shape the program with input from Alaska's healthcare experts, providers, patients and state leaders

[1] Available online at: https://secureservercdn.net/198.71.233.179/9vg.8fc.myftpupload.com/wp-content/uploads/2019/12/Roadmap-FINAL10-28-2019.pdf, page 103.

- Work with an experienced, successful APCD administrator to manage this project
- Adopt state of the art patient privacy protections at every step of the way
- Ensure diverse funding sources to get started and stay running
- Work collaboratively and transparently to build a trusted data source

System-wide Information in All Payer Claims Databases

APCDs collect information about payments for all kinds of healthcare services, known generally as "claims data." Twenty states now have state authorized APCDs in operation or development and several others are actively moving forward (see Figure 1).

RECOMMENDATION:

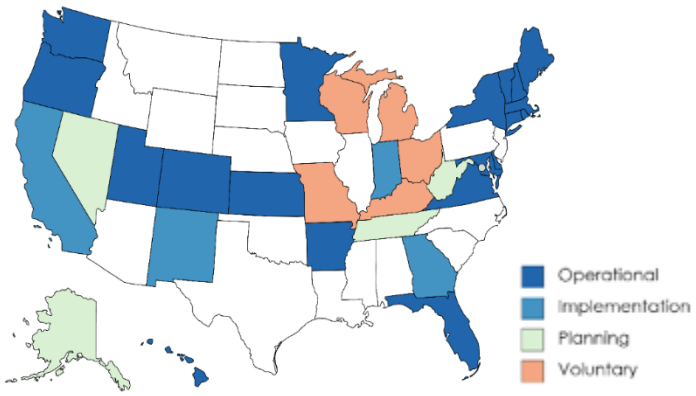
Require commercial health insurance plans, Medicaid, Medicare Advantage, Medicare Fee-for-Service (FFS), and pharmacy benefit managers (PBMs) to securely send this information to a well-qualified data manager.

APCDs for Insight into Healthcare Value, Effectiveness and Quality

Successful APCDs have taken deliberate and careful steps in designing their programs to align with state data needs, stakeholder preferences, legal authority and efficient data collection methods. Chapter 1 includes examples of reports built from APCD data on topics such as:

- Immunization and prevention
- Primary care and specialty services
- Costs of care for specific services
- Public health intervention needs
- System-wide healthcare spending

Figure 1: APCDs in the US



RECOMMENDATIONS:

- Convene an advisory group to discuss the types of data and reports that will be produced to address Alaska's needs.
- Gain input from the advisory group to create a tiered reporting plan that offers a timeline for what will be produced. The plan recognizes that the database needs to be carefully checked before making information public.
- Use the plan and other communications to let healthcare professionals know what to expect and how they will be consulted before the APCD publishes reports that contain detailed information about them.

Health Data for Alaskans

An **Alaska APCD state mandate would generate claims data for approximately 68% of the state's population**, based on available information and current federal law. This would include traditional Medicare files (provided under a special program for APCDs).

RECOMMENDATION:

Go beyond issuing a state mandate and work with self-insured employers to gain access to data submitted voluntarily for another 10% of all Alaskans, bringing the potentially available covered lives to more than 75% of the state's population.

Table 1: Types of Coverage

Type of Coverage	Covered Lives	% of Alaska Population
Medicaid and CHIP	235,000	32%
Medicare FFS	104,000	14%
Dual Eligibles[1]	(18,000)	(2%)
Fully Insured Commercial Plans	60,000	8%
State Employee Plans	114,000	16%
Total (minus Dual Eligibles to avoid double counting)	**498,000**	**68%**

[1] Dual eligible lives may be counted in multiple categories; this adjustment avoids double counting of approximately 18,000 Alaskans who are eligible for both Medicare and Medicaid.

Managing an APCD: State Role

In other states, legislation authorizing the APCD program typically designates a responsible state agency that is directed to issue rules and engage in whatever contracts are needed.

RECOMMENDATION:

Stakeholders suggested that the Alaska Department of Commerce, Community, and Economic Development's Division of Insurance (DOI) is the logical regulatory "home" for the Alaska APCD based on its statutory authority for oversight of commercial health insurance plans. DOI would be responsible for issuing rules for data submission and access to reports and contracting with a lead organization for hands-on data management. As the regulator, DOI could collaborate with the Department of Health and Social Services (DHSS), which includes Alaska's single Medicaid Agency, as both a data contributor/user and – importantly - a key partner in seeking federal funding.

Managing an APCD: Contracting with a Lead Organization to Jumpstart Alaska's APCD

Several states contract with a nonprofit entity to serve as lead organization (LO). These organizations serve as the state's representative for day-to-day, hands-on technical data management services and may also serve as the APCD's liaison to the healthcare community. LO responsibilities are often described in state law (WA, VA, AR) or developed in regulation and under contract with the state regulatory authority (CO).

RECOMMENDATIONS:

- Alaska stakeholders consulted in the course of developing this report strongly recommend contracting for the technical tasks with a capable data management organization (a "lead organization") that runs a successful, fully operational APCD, thereby allowing Alaska state agencies to focus on the administrative and oversight activities.
- Utilize this partnership to streamline the start-up process with the benefit of deep experience in leading a successful program. Other potential advantages include leveraging established relationships with data submitters and economies of scale realized by "bolting on" to an existing program. For example, the LOs in WA, VA and CO have existing data collection operations in place and offer expertise in healthcare claims data collection, data quality monitoring, analysis and structuring public reports.
- To ensure that an out-of-state LO understands and prioritizes Alaska's needs, an in-state non-profit organization should oversee the LO's tasks. This should include stakeholder engagement/advisory committee facilitation, reporting plan design and monitoring and supporting formal data access processes. The Alaska-based non-profit would be responsible for all Alaska-specific aspects of the project, including stakeholder engagement, communications, reporting plan development, data reports and data products and sustainability.

Cost Estimates and Funding Sources

The annual cost of operating an APCD includes administrative services and technical management services. Other APCDs vary considerably in both the allocation of responsibility between state agency staff and contracted services as well as the specific costs for services. APCDs typically have a start-up period for regulatory and contracting processes. The proposed plan for Alaska to contract with another state's lead organization is a first-in-the-nation approach. The estimated annual contract costs for the LO include data collection, processing, data quality control and reporting as well as Alaska-based stakeholder engagement support. At full operation, these contracted services have an estimated annual cost of $1.75M to $3M. Alaska state agencies may require additional resources to manage the regulatory process and LO contracting processes. Across all state agencies that will participate in oversight of the APCD, this additional work is estimated to require a total of 1 to 2 FTEs across several functional roles in different organizations.

Common Sources of APCD Funding:

- State appropriations help start up the APCD and subsequently provide stability and focus on state priorities.
- Philanthropic support, if available, for startup and ongoing operations would be of great value to the project while a more durable plan is created. Consider whether there is an opportunity to use these funds for "state match" to qualify for federal funding (FFP).
- At full operation, data licensing fees can provide some additional revenue.

RECOMMENDATIONS:

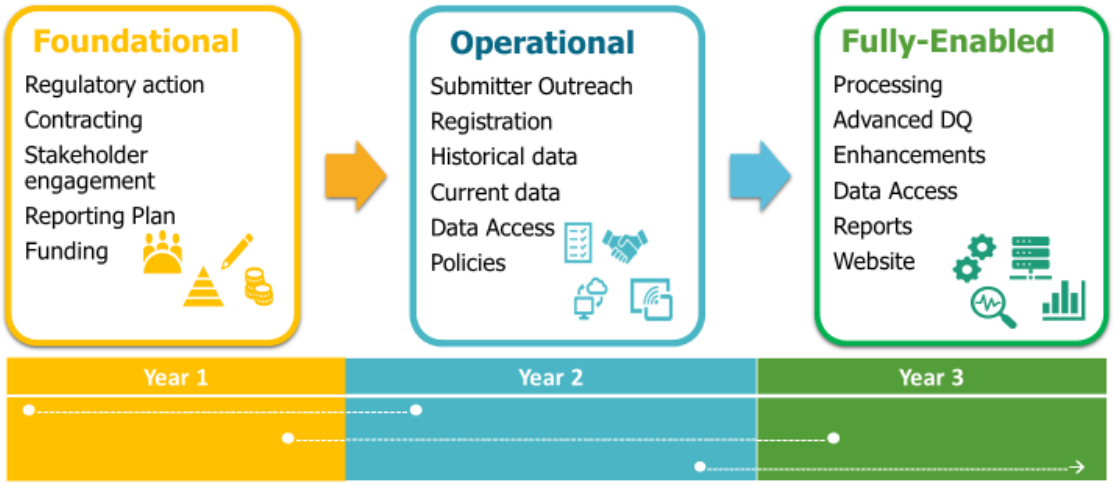
- The APCD planning effort has been fortunate to receive support from Alaska's philanthropic community, including the Mat-Su Foundation and the Rasmuson Foundation. The APCD should explore whether these organizations would provide initial funding for the project as operations get underway.
- The federal Centers for Medicare and Medicaid Services (CMS) has now approved 10 states' requests to cover both costs associated with implementing a new APCD and/or maintaining an existing APCD if the proposed work meets conditions described in federal regulations. Most recently, CMS awarded California two years of enhanced federal funding of $7.5M, representing up to 90% of the Medicaid portion of the program cost. Other states with approved enhanced matches include Rhode Island and Delaware. Alaska should seek this funding.

Timeline

APCDs generally have three phases of development, as shown in Figure 2. The Foundational Phase covers the legal and procedural tasks needed to get the project underway, including regulatory actions, contracting for administrative and data management services, stakeholder engagement to develop a reporting plan and building a funding plan. This phase may be shorter or longer depending on state rule making processes and state agency workloads. During the Operational phase, the contracted LO begins outreach to submitters and begins collecting data. This phase may include developing data access

policies and procedures for certain types of data. This phase may also vary in length depending on data submitters' familiarity with data formats and the data management team's timeline for any system changes that might be needed. Once the initial data load is completed, the APCD enters its Fully Enabled phase during which reports and data become available to users. The first reports typically become available during the third year of activity.

Figure 2: APCD Phases



RECOMMENDATION:

Utilize the experience of other APCDs to revise and refine the workplan provided in Appendix C: Detailed Project Plan and Risks and allow the workplan to serve as a basis for resource planning, funding requests and budgeting.

Measuring Outcomes

Early stage APCD supporters are often pressed to quantify a "return on investment" for the project, a connection between the expenditure in one area and a specific, quantifiable impact on some aspect of the healthcare system. An APCD does not have a traditional ROI: an APCD is not a pure price control or policy tool. Rather, the insights that can be gained through analysis of the database stretch across multiple areas: healthcare policy, enhancing public health and helping employers and consumers find high value care.

RECOMMENDATION:

Track how APCD data is being used, document its impact and ask how it could be made more useful. Share findings broadly to generate additional interest in the dataset and ongoing support for its operations.

Conclusion

With the data and reports from the Alaska APCD, Alaskans will have the opportunity to make thoughtful, directed investments into programs and services that help drive towards the Quadruple Aim. In times of resource constraints, Alaska APCD data will provide a window into progress toward achieving health system transformation goals and support program effectiveness review and course correction. With input from diverse groups informing its creation, the Alaska APCD will provide essential support to building a more efficient and equitable healthcare system for Alaska.

Introduction

Problem Statement: Alaska's Need for Health Data

In Alaska and in states across the nation, healthcare is too often unaffordable and inaccessible. Driving change requires access to detailed data on Alaska health system performance which stakeholders have noted is currently lacking. Recognizing the need for an organized approach to lead change, the Alaska Healthcare Transformation Project (AHTP) was formed to improve Alaskans' health, enhance both patients and health professionals' experience of care, and lower the per capita healthcare cost growth rate – the Quadruple Aim. Towards that end, AHTP has worked over the past two and a half years with a cross sector collaboration of payers, providers, policymakers, and patient advocates to transform Alaska's healthcare system. During this time, AHTP has gathered information through reports prepared by the National Opinion Research Center (NORC) and through a multitude of discussions with the AHTP Project Management Committee (PMC), stakeholder groups, strategy development teams, and topic-specific work groups. Approximately 175 people or organizations have been engaged at varying levels since the project's inception.

Stakeholder feedback and NORC analysis confirmed that state-specific health system data has been scarce, dated and incomplete. In its 2019 report entitled *Alaska Healthcare Transformation Project: A Roadmap for Reform,* NORC noted that current, detailed and complete data about Alaska's healthcare marketplace will be critical to efforts seeking to improve cost, quality and access to care, but that this type of data was currently limited.[2] In the absence of timely statewide data, Alaska stakeholders have had to rely on national data sources that do not reflect the state's distinct market conditions, landscape or population.

The last PMC meeting held in July 2019 resulted in consensus on developing plans for the collection of cost and quality data, a formal project leadership and governance process, and agreement on a core set of quality measures to track progress in creating a value-based payment structure. Work groups continued meeting throughout the fall of 2019 and their discussions highlighted the need for creating an All-Payer Claims Database (APCD).

APCDs contribute to a better and more timely understanding of state and local healthcare cost, quality, and utilization - as well as many aspects of population health - across payer types and settings of care (e.g., hospitals, outpatient clinics, EDs, medical offices). An APCD builds upon and complements other datasets, enabling a deeper understanding of the health care system and providing insights that can inform policy choices.

In healthcare, as in any industry, trusted and shared information is necessary to support a well-functioning market. APCDs have demonstrated their ability to serve as this information source. With aggregation and standardization of comprehensive data, and the insights of stakeholders, APCDs have influenced provider-purchaser contracting, inspired regulatory changes, prompted action to reduce use

[2] Available online at: https://secureservercdn.net/198.71.233.179/9vg.8fc.myftpupload.com/wp-content/uploads/2019/12/Roadmap-FINAL10-28-2019.pdf, page 103.

of low-value care, held payers and providers accountable for rising costs, and changed consumer behavior. APCDs also support states in conducting a wide range of analyses to identify specific opportunities for improvement, prioritize resources and move closer to realizing the Quadruple Aim.

An Alaska APCD would support in-depth analysis of healthcare cost, utilization, quality and population health based on comprehensive, state specific data. Insights gleaned from APCD analysis and reporting would identify specific opportunities for improvement, support more informed policy discussions and help Alaska realize meaningful and lasting health system change.

Chapter One: Solidifying Stakeholder Support and Generating Value

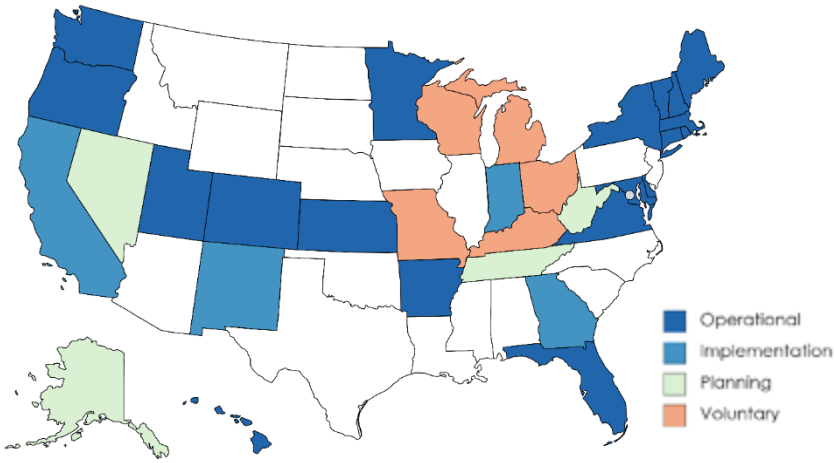
This chapter discusses how APCDs can generate value, click here for additional information on operationalizing an Alaska APCD. APCDs are large-scale databases that collect healthcare claims data from multiple payers. Commercial health insurance plans, Medicaid, Medicare Advantage, Medicare Fee-for-Service (FFS), and pharmacy benefit managers (PBMs) provide data to APCDs. These data typically include medical claims and encounters, pharmacy claims, enrollment data, provider information, and in some cases claims and encounters for dental, vision, and behavioral health services. Although other data sources provide similar important information, they have limitations that APCDs do not. For example, hospital discharge data are limited to facility-provided inpatient and outpatient procedures and services and do not include information on actual payments, disease registries are limited to specific health conditions, and health plan-specific databases are limited to a single payer.

Existing APCDs share common features, yet each reflects the unique health care delivery systems in its state, and as such, reflects the characteristics of the local healthcare market.

State-mandated APCD adoption has increased significantly since 2005 when only three states (ME, NH and MD) had data collection efforts underway. Twenty states now have APCDs in operation or development and several others are actively moving forward (see Figure 3) States with APCDs offer a rich history of successes and lessons learned, all of which can help guide Alaska as it explores building a sustainable APCD, ready to generate value for the state and its stakeholder partners.

States' interest in APCDs has grown as their peers have achieved success with a variety of governance models, improved the efficiency of data aggregation and standardization, demonstrated high-impact use cases and discovered new revenue streams to support sustainability. Successful APCDs have taken deliberate and careful steps in designing their APCD programs to align with state data needs, stakeholder preferences, appropriate legal authority and efficient data collection methods.

Figure 3: Mandatory and Voluntary State APCDs



Identifying Opportunities and Driving Change: APCDs support states in a wide range of analyses to identify opportunities for improvement, prioritize resources and move closer to the Quadruple Aim. Table 2: APCD Use Cases, Impacts and Examples suggests the range of potential use cases for an APCD, discusses their impact and provides links to examples from other states.

Table 2: APCD Use Cases, Impacts and Examples

Topic	Sample Analyses	Impact	Sample Outputs
Quality & Access to Care	• Preventive screening and immunization rates • Preventable hospitalization and emergency department visits • Chronic care management and care coordination • Number of primary care or behavioral health providers offering services in a particular geographic region	• Identify peers who have implemented best practices • Drive quality improvement initiatives across health systems • Inform consumers about variation in quality	• Center for Improving Value in Health Care Reports • Emergency Department Use in Delaware • Washington Health Alliance Community Check Up
Cost & Utilization	• Healthcare utilization, cost and total cost of care by population, provider, and health system • Cost of low-value care and avoidable complications	• Understand variation in cost and care delivery across populations and providers • Illuminate opportunities for multi-stakeholder, collaborative projects	• New Hampshire HealthCost website • Total Cost of Care Multi-State Analysis • 2018 CO APCD Annual Report • Florida Price Finder • First Do No Harm
Coverage & Access to Coverage	• Health insurance coverage trends • Premiums, deductibles, and out-of-pocket spend • Medical, specialty, dental, and behavioral health care access across populations; network adequacy	• Identify changes in the insurance market and their impact on consumers • Identify opportunities to improve access and population health	• New Hampshire Network Adequacy Report
Population & Public Health Surveillance	• Chronic conditions risk factors, prevalence, and costs • Cancer, infectious disease, and behavioral health trends • Opioid prescribing rates • Firearm injuries, incidence, and cost	• Prioritize state resources to prevent disease and promote health	• Chronic Disease Prevalence and Costs in Minnesota • Opioid Prescribing Patterns in New York State • Emergency Department Visits for Opioid Overdose in Delaware

Health System Performance	• Impact of system consolidation on cost, quality, access, and equity • Impact of new models of care and payment • Enhanced care coordination costs and ROI • Alternative payment models prevalence, trends • Primary care investment and other affordability standards	• Inform state policy and market regulations to ensure equitable access to high quality affordable care and allow for the measurement of progress towards health care system transformation goals.	• Massachusetts Annual Healthcare System Performance Report • California Regional Health Care Cost and Quality Atlas • Midwest Health Initiative Community Scorecard

Successfully achieving many of these use cases depends on a combination of factors including trusted governance, multi-stakeholder collaboration, legal authority to collect and appropriately share sensitive data, and efficient, standardized data collection, aggregation and quality assessment.

Principles for Success:

Trusted Governance: Information derived from APCDs can impact healthcare payment and professional reputations. It's often said that, "Data moves at the speed of trust." Data submitters and data users must have confidence in the technical ability and objectivity of the organization overseeing the data set for the information to be effectively shared and used to drive improvements in cost and quality. Governance for a state mandated APCD can reside within a state or quasi-state agency that is transparent in its policies and held accountable for its decisions. This entity is responsible for building a data collection, aggregation and analytics team with the right mix of internal and external support to meet its needs with appropriate oversight.

ACTION FOR ALASKA

Identify a state or quasi-state agency that can serve as an administrative and governance home for the APCD. Then determine the combination of internal and external supports necessary to achieve the vision for data collection, processing and analytics. This could include contracting with another APCD which would serve as the lead organization (LO) responsible for managing day to day operations and participating in stakeholder engagement. The responsibilities of the LO could include oversight of an external data management vendor that manages data collection, quality assurance, analytics and data access.

Multi-Stakeholder Collaboration: Developing strategic approaches to data collection and use requires technical knowledge as well as expertise in convening stakeholders to guide policy decisions, developing

technical specifications and analyzing results for a wide range of use cases (e.g., comparative quality, cost and utilization, substance use disorder, primary care spending, Medicaid analytics). Providing opportunities for input at all stages of APCD development is essential for addressing stakeholder concerns and building trust.

ACTION FOR ALASKA

AHTP has a strong track record of convening stakeholders and reaching agreement on complex issues. Its input was clearly reflected in House Bill 229 of the 31st Alaska State Legislature (HB 229). These foundational efforts can expand to encompass the development and implementation of the APCD. In other states, APCDs benefit from engaging stakeholders who can serve as ambassadors for the APCD. AHTP can leverage its rich history of healthcare stakeholder engagement to achieve consensus and build an effective and sustainable APCD while partnering with the state agency housing the APCD, a LO, and the data management vendor. Alaska's APCD stakeholders should have opportunity to participate in all aspects of APCD development and implementation, both technical and policy related. Engagement can be sustained through creation of multi-stakeholder advisory, data access and other committees.

Legal Authority and Policies Regarding Collection and Appropriate Sharing of Sensitive Data: APCDs need legal authority to collect data from payers. APCDs also need legal authority to collect certain personal protected health and payer financial information to bring value to the states and stakeholders they serve. Successful APCDs have statutory authority to collect this sensitive information and implement programs for secure data use and access. These programs, typically overseen by multi-stakeholder committees with a diverse range of perspectives and expertise, emphasize how users can access aggregated, de-identified information and ensure only appropriate, secure access to confidential information.

ACTION FOR ALASKA

Convene a data access committee early and engage this committee in developing regulations, data collection specifications, and data access policies that support the Alaska's use cases while protecting sensitive information.

Efficient, Standardized Data Collection, Aggregation and Quality Assessment: There are several technical capacities that undergird high-value APCDs. These APCDs have processes in place that support efficient data collection, a standardized approach to aggregation and multi-layered quality assessment. While each data set has its own nuances, the most frequently occurring challenges are well known with a range of ready solutions.

ACTION FOR ALASKA

Identify a state oversight team and hire an experienced lead organization and data management vendor. Experienced organizations and vendors can speed implementation and avoid or anticipate many common pitfalls such as missing data or processing incorrect submissions that adversely impact the accuracy of reports. Over time, as use cases require and budgets allow, layer on various data enhancements such as clinical care groupers, provider attribution methodologies and risk adjustment software.

Develop a Strategic Approach to Data Use

Many states compile features of desired APCD use cases and prioritize them in a comprehensive reporting plan. The plan lays out a tiered or phased data collection process paired with a reporting strategy that moves along a continuum from aggregated, summary level reports highlighting variation to progressively more detailed analyses. In doing so, stakeholder concerns regarding perceived "misuse of the data" can be mitigated through emphasis on establishing principles of data quality and plans for documentation to support actionable analytics and reporting. A tiered reporting plan also helps the APCD determine which data elements it will need to collect to achieve its goals, when certain data enhancements (e.g., groupers, attribution, risk adjusters) need to be applied, and when certain use cases are supported given available data elements, data quality or populations of interest. These reporting plans are often organized into three phases as shown in Table 3, a draft reporting plan recently released by California.

Tier One: The first tier typically focuses on summary statistics based on analysis of aggregated data, with a range of population-based reports that allow data users to view results by age, gender and intrastate geography such as by county/borough, census area or zip code.

Tier Two: Second tier reports offer more complex analytics which stakeholders, such as collaborating state agencies, may gain access to electronically or via a data extract. Or, they may be shared with a broader audience via an interactive website or as a static report. These reports may include information by payer type (e.g., Medicare, Medicaid, commercial) and some show comparisons by provider group. They may also integrate or layer data from other sources such as a hospital discharge or public health data sets. These reports often inform policymaking.

Tier Three: Third tier reports are the most sophisticated and require a more mature data set that has been tested and refined with time and use. These reports typically layer on multiple data enhancements and may look at patient care longitudinally or group services across multiple care settings to create an episode of care. In states with mature Health Information Exchanges (HIEs) or other opportunities for clinical data exchange, clinical and claims data can be integrated to support comparative effectiveness and outcomes-based analysis and reporting.

Table 3: California's Tiered APCD Data Collection and Reporting Plan

	Tier 1: Core	Tier 2: Expansion	Tier 3: Maturity
Data Categories	• Claims and encounters (medical and pharmacy) • Member enrollment • Provider information	• Alternative payment models (APMs), e.g., capitation, pharmacy rebates, pay for performance, etc. • Dental claims, encounters, member enrollment, and provider information	• Lab values and other clinical information through electronic medical records (potentially)
Leveraging Other Data Sources: Examples	• Census data elements (such as race/ethnicity, income, and housing)	• Hospital discharge data (OSHPD)[1] • Vital statistics (birth and death records) • Surveys (e.g., California Health Interview Survey,[2] Behavioral Risk Factor Surveillance System[3]) • CA's open data portal, e.g., air and water quality[4] • Other public sources[5]	• Immunization registries • Chronic disease registries (e.g., CA Parkinson's[6]) • CA Reportable Disease Information Exchange (infectious disease, CalREDIE[7]) • California Cancer Registry[8] • Controlled Substance Utilization Review and Evaluation System (CURES)[9]
Output Examples	• Web displays, including maps and dashboards • Predefined reports based on de-identified aggregate data	• Interactive reports • Access to data by application through a data enclave • Custom datasets (one-time data extracts)	• Web or enclave-enabled data analysis
Reporting Level and Capabilities	Summary statistics, statewide and regional by age, gender, race/ethnicity	By payer (Medi-Cal, Medicare, commercial) and product (HMO, PPO, ACO)	Patterns of care at the individual level over time, such as episodes of care, longitudinal analyses (e.g., cost in last six months of life)
Use Case Examples	1.1 Utilization, Spending, and Total Cost of Care (utilization and spending components); most common or costly	1.1 Utilization, Spending, and Total Cost of Care (total cost of care component) 1.2 Identify and Reduce Low-Value Care	More complex analysis and sophisticated reporting on all use cases, e.g., episodes of care for diabetes (Use Case Example 4.1).

diagnoses and procedures 2.1 Quality Comparisons 3.1 Coverage Trends by Region and Payer (region component) 3.2 Regulatory Oversight of Insurance 4.1 Prevalence, Management, and Cost of Diabetes (prevalence component)	2.2 Quality and Continuity of Care Through Coverage Transitions 3.1 Coverage Trends by Region and Payer (payer component) 4.1 Prevalence, Management, and Cost of Diabetes (management and cost components) 4.2 Understanding the Opioid Epidemic 5.1 Report on Statewide System Performance 5.2 Effect of Consolidation on Quality and Cost

Sources: Reprinted from the California Office of State Health Planning and Development, "The Health Care Payments Data Program: Report to the Legislature," published March 9, 2020, page 21, https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Legislative-Report-20200306-ADA.pdf

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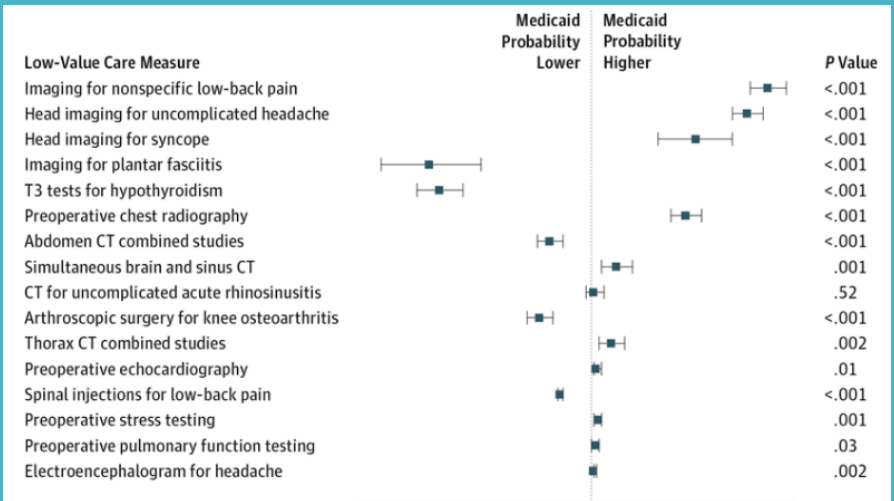
ACTION FOR ALASKA

Use the stakeholder engagement process to develop a tiered reporting plan that fits Alaska's needs, priorities and cadence. This reporting plan should reflect the data most likely to be collected, the time needed to develop the database, the available budget and the plan for keeping the healthcare community informed about progress and reporting schedules. Ongoing engagement allows stakeholders to share their concerns and builds trust and confidence in the database. Data access, reporting and other policies should be consensus based; documentation, including information on policies and data quality, must satisfy the needs of various audiences.

Case Study One: Medicaid Benchmarking

Comparison of Low-Value Care in Medicaid vs Commercially Insured Populations

In 2016, as reported in the Journal of the American Medical Association, a cross-sectional study of Medicaid and commercial insurance claims in Oregon found no consistent association between insurance type and use of low-value care. Low-value care refers to services routinely provided to patients that generate little or no medical or health benefit. Medicaid patients were more likely to receive some low-value services but less likely to receive others. For 7 of 11 low-value care measures, Medicaid patients were significantly more likely to receive low-value care if they resided in an area with a higher rate of low-value care for commercial patients.



[3]

Recap - Principles for Success:

- Use cases drive the design and operation of the APCD.
- The purpose of the state's role in overseeing governance is to build trust.
- Continue and expand existing stakeholder collaboration efforts to encompass APCD policy and technical approach.
- Frame legal authority with care to ensure that the APCD can support the projected use cases.
- Identify effective, efficient data collection and access strategies.
- Develop a tiered reporting plan that prioritizes identified use cases, keeping in mind the data elements, completeness or quality thresholds and enhancements necessary to achieve the analyses.

[3] Charlesworth et al., 2016. Comparison of Low-Value Care in Medicaid vs Commercially Insured Populations. Available online at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2525419

Chapter Two: Data Management

This chapter discusses APCD data management, click here for additional information on operationalizing an Alaska APCD.

What is Data Management?
Data management in the context of APCDs has two components: first, the set of technical tasks related to collecting, processing and producing datasets and second, the administrative and oversight requirements governing those technical functions. This chapter describes input to date, key tasks, choices to be made and options for collaborating with other West Coast APCDs.

To date, supportive stakeholders suggest that an Alaska APCD would benefit from a collaboration with an established APCD, especially one located in the western US. This collaboration could take many forms depending upon Alaska's needs and the interest and capability of a potential collaborating entity or lead organization. Benefits could include:

- Minimizing submitter burden for Alaska's largest commercial insurers that already submit APCD files in Washington and Oregon
- Leveraging experienced claims data infrastructure, technical expertise and data analytics resources
- Reducing the amount of time needed for implementation

The purpose of APCD data management is to ensure that the data is submitted on time and in the correct format from all designated submitters, is credible, and that timely reports and analytic files contain meaningful and useful data. A sharp attention to detail is needed because claims data are generated by disparate systems, each with their own structure and processes. When all these data sources are compiled into a single APCD, data management vendors standardize the information so that reports and analyses produce consistent and reliable results. Throughout the process, effective data management maintains data security and confidentiality. The goal is to collect and deliver aggregated, high quality data to support a wide range of use cases with appropriate documentation and technical support.

States have successfully implemented and operated their APCDs under the authority of different state agencies with various models of managing the administrative/governance functions of the data, and different methods of data collection, production and dissemination. Each state finds its own array of champions, funding sources and data analytics resources.

Administrative/governance functions create the process around technical data management, including:

- Issuing regulations that govern who must submit data, when, in what format, and how that data can be shared and with whom
- Stakeholder engagement on advisory and data access committees
- Active participation in oversight of the database.

Regulatory Authority: To date, most states have placed authority for an APCD within a health-related agency such as a health department, Medicaid or health policy agency, all of which often

have an organizational mission to improve the health of state residents. Often, these agencies seek to develop and use data assets to inform program and policy decisions (WA, OR, HI, CO, UT). Some states opt for placing the authority within the insurance department to build on existing regulatory authority and relationships with commercial data submitters. For these agencies, the data may be used to inform rate review, market oversight or mandated benefits proposals (MA, NH). Regardless of which agency has regulatory authority, successful state APCDs grant data access to other state agencies and in some cases, external stakeholders, to allow the data to support a wide variety of use cases.

Looking ahead to requesting federal financial support from the Centers for Medicare and Medicaid Services (CMS), the success of such requests is not dependent on whether the Medicaid agency regulates the APCD. Whichever agency ultimately has regulatory oversight of the APCD and contracts for an external lead organization/data management vendor, close collaboration with the Medicaid agency is essential for working with CMS regional staff and assisting with required financial reporting.

Responsibility for Stakeholder Engagement: Recent APCD legislation around the country (WA, NM, FL, VA, IN, GA) typically includes at least one, and sometimes two, formal stakeholder bodies to provide ongoing input into APCD operations. An overarching advisory committee is often convened to provide general guidance and feedback on APCD operations. Membership typically includes (but is not limited to) payers, providers, hospitals, trade associations, patient advocates, state agencies and legislative representatives. These committees offer insights from diverse perspectives and can become champions of the project in the healthcare community. Typical topics include providing input regarding data collection, guidelines for data access, and the type of reports that will be developed using the data. When the APCD data outputs have sufficiently matured, a second committee may be convened to review and advise on formal requests for data and reports. This data access committee may be a subset of the advisory committee or operate independently within established regulatory and policy guidelines. The data access committee makes determinations about the fee schedule for outputs and data products approved for external users.

Active Participation in the Oversight of the Database: APCD regulatory agencies demonstrate a wide range of engagement in participating in the day-to-day operations of the APCD. The regulator typically holds an *ex officio* seat on any advisory committee along with representatives from other state agencies that may have an interest in the data. Some regulators directly oversee the data management vendor's (DMV) contract and monitor performance and outputs (examples include ME, MD, NH, OR, UT, DE), and may augment agency insight with project management and subject matter expertise. In four active states (AR, CO, WA, VA) regulators delegate those functions via contractual agreement to an external entity such as a lead organization.

Factors to consider in identifying a regulatory "home" for the APCD include:

- Agency's interest in using the data to advance an agency mission or priority. A desire to inform some aspect of the agency's own operations or business needs helps move the project forward.
- Agency's current regulatory model for oversight of commercial health plans. Options include adding conditions and penalties for noncompliance or creating new authority.
- Availability of existing agency staff resources to provide, at a minimum, assistance during regulatory development, contracting for overall data management services, budgeting and

financial reporting. Any APCD operational arrangement will require some amount of the agency's attention.

- Prior experience with procurement and management of complex data projects. An understanding of data management processes helps inform contract management and regulatory enforcement.

Table lists the agency responsible for regulatory affairs in selected APCD states and indicates whether the agency plays an active role in stakeholder management (advisory and data access committees) and/or engages directly in day to day APCD operations. The table also identifies the type of entity responsible for managing operations and data access. Many states also directly supervise the data management vendor's activities. Together, these elements provide an overview of data governance and highlight variation that exists across state APCDs.

Table 4: Regulatory Roles for Selected APCDs

State	Regulator	Regulator Engaged in		Who Manages Operations?*	Who Manages Data Access?
		Stakeholder Mgmt.	Day-to Day Oversight		
Arkansas	Insurance			University	University
Colorado	Medicaid			Lead Org & DMV	Lead Organization
Connecticut	Policy Agency	●		DMV	Policy Agency
Delaware	Health Information Exchange	●	●	Health Information Exchange & DMV	Health Information Exchange
Florida	Medicaid	●		DMV	Medicaid
Hawaii	Medicaid	TBD	TBD	University	TBD
Kansas	Insurance	N/A		Medicaid & DMV	Insurance
Maine	Data Agency	●	●	DMV	Data Agency
Maryland	Data Agency	●	●	DMV	Data Agency
Massachusetts	Data Agency	●	●	Data Agency	Data Agency
Minnesota	Health	●	●	DMV	N/A
New Hampshire	Insurance & Medicaid	●	●	DMV	Medicaid
New York	Health	●	●	DMV	Health
Oregon	Health	●	●	DMV	Health
Utah	Health	●	●	DMV	Health
Rhode Island	Health	●		DMV	Health
Vermont	Policy Agency	●		DMV	Policy Agency
Virginia	Health			Lead Org & DMV	Lead Organization
Washington	Medicaid			Lead Org & DMV	Lead Organization

*DMV = data management vendor

Some of the core functions of a state mandated APCD must be assigned to certain entities, although there is flexibility in determining how to assign responsibility.

Options for the Alaska APCD include the choice of a regulatory "home," the amount of responsibility to delegate to an external partner and the essential characteristics of that external partner.

Principles for Success: The Regulatory "Home:" Stakeholders have suggested that the Alaska Department of Commerce, Community, and Economic Development's Division of Insurance (DOI) is the logical regulatory "home" for the Alaska APCD based on its statutory authority for oversight of commercial health insurance plans. As the regulator, DOI could collaborate with the Department of Health and Social Services (DHSS), which houses Alaska's Medicaid Agency, as both a data contributor/user and – importantly - a key partner in seeking federal funding.

- The regulator must issue the rules for data submission and data access and support compliance actions as recommended by the administrator.
- The regulator is likely to be statutorily responsible for contracting with a lead organization.
- The regulator may delegate responsibility for stakeholder engagement, data collection, processing and access policies, operations, reporting plans, Medicare data acquisition, voluntary submitters and fulfilling requests by approved data users.

Oversight of data collection, processing and dissemination

Most APCDs and all lead organizations contract with a data management vendor (DMV). Services typically provided by the DMV include:

- ***Data collection***: The set of processes created to allow secure transmission of required files from designated submitters, often aligning with national data collection standards to minimize burden on submitters and communicating with submitters about data collection issues and/or data quality thresholds.
- ***Data processing***: The tasks around creating the aggregated database by integrating commercial, Medicare and Medicaid files to allow cross payer analysis, including extensive data quality reviews, application of business rules and enhancement methodologies, adding reference data tables, and patient and/or provider identity management.
- ***Analytics/Data dissemination***: This work includes creating reports, custom and standardized data files, secure access mechanisms, and developing robust documentation and transparency about data strengths and limitations.

Most APCDs contract with external DMVs for all three functions. Some states have enough internal analytic capacity to manage data dissemination using fully processed files created during the data processing phase. Moreover, States with robust analytic and data management infrastructure can also bring some of the data collection and data processing functions "in house" onto a state managed data platform.

DMVs are experts in providing efficient and specialized technical services to ensure that data are handled securely and are processed within a reliable analytic platform. DMVs work with data submitters to clarify requirements and resolve data quality issues and will inform regulators or contract monitors

about data submission or quality issues. Over the past decade, two APCDs contracted with multiple DMVs to obtain "best in class" services for each phase of the process - data collection, processing and dissemination. In one case, state staff became the go-betweens when data quality issues emerged.

Most DMVs have tools to add enhancements during the data processing phase. These tools include enhancements such as condition categories, episode of care groupers, prescription drug classifications, patient-provider attribution, illness burden scores ("risk assessment") and adding geographic area detail. Some states have contracted directly with DMVs to produce topic specific analytic files based on the state's data, such as Milliman's Waste Calculator and Remedy Partners' hospital episode grouper.

To increase visibility and access to the data, APCD regulators began requiring DMVs to provide permissions-based access to the fully processed data through business intelligence (BI) tools and data enclaves. States and DMVs are also building cloud-based analytic environments that provide access for credentialed users to files or "data marts" created *specifically* for certain use cases or analytic projects. These curated files and datasets have limited or no protected health information and allow users to easily develop custom queries using data elements that "play well together", and then export de-identified data and analytic results from the secure environment. APCDs have also delivered successful results through specialized, project-specific analytic contracts.

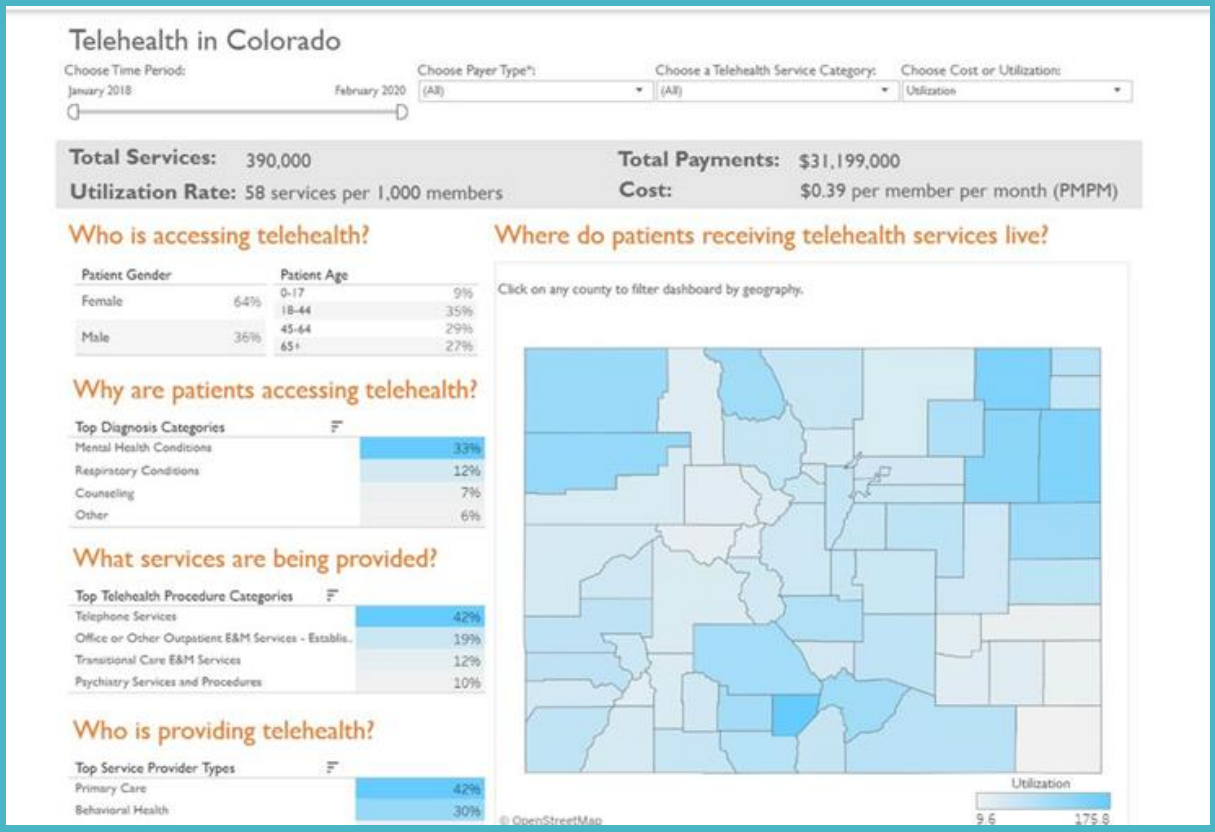
In contrast to the role of the state regulator or a lead organization, DMVs are typically observers in APCD stakeholder discussions about policy, direction and data release. Among the currently operating APCDs, none of the DMVs manage communications to the broader stakeholder community, develop tiered reporting plans, perform initial outreach to voluntary and federal government data sources, or control the data access process. Lead organizations and/or state regulators perform these tasks.

Appendix A: Vendor Contact Information for APCDs in Full Operation lists the DMVs and contact information for state mandated APCDs in full operation.

Case Study Two: Telehealth Usage

CO APCD Evaluated Use of Telehealth Services in Colorado

In August 2020, the Center for Improving Value in Health Care used Colorado's APCD to provide benchmark information on telehealth services before the COVID-19 pandemic. Data shows the use of telehealth rose before the onset of the pandemic. Updates to this report will track telehealth usage before, during and after the pandemic.



4

Role of a Lead Organization

Several states contract with a nonprofit entity to serve as lead organization (LO). These LOs add an intermediate layer by serving as the state's representative for day-to-day, hands-on technical data management services. Responsibilities of LOs are often described in state law (WA, VA, AR) or developed in regulation and under contract with the state regulatory authority (CO). LOs bring well-established reputations in the state's health care policy community through projects that emphasize collaboration and consensus to, in general, work towards better value, affordability and quality in their state. For those that are concerned about a state's direct access to the APCD data, the LO can add an

[4] Available online at: https://www.civhc.org/get-data/public-data/focus-areas/co-apcd-out-of-network-data/

important buffer, and allow for stakeholder input about the reports and data that will be disseminated. Perhaps most importantly, the LOs in WA, VA and CO have existing data collection operations in place and offer expertise in healthcare claims data collection, data quality monitoring, analysis and structuring public reports.

LOs may also manage certain functions on behalf of the regulatory oversight agency, including stakeholder engagement, data request processes and review committees and delivering outputs and reports to approved users. The WA and CO LOs are also responsible for generating a portion of the funding to support the database operations. In CO, AR and VA, the LO manages all aspects of the DMV, including procurement and oversight of day-to-day operations. In WA, state law calls for the LO to contract with the state's specified DMV.

For Alaska's APCD, partnering with a LO with an established relationship with a DMV may create an opportunity to streamline the start-up process with the benefit of deep experience in leading a successful program. Other potential advantages include leveraging established relationships with data submitters and economies of scale realized by "bolting on" to an existing program.

Organizations contacted for this report expressed interest in learning more about the opportunity and a willingness to continue discussions as an Alaska APCD moves forward. At a minimum, an out-of-state LO should have an established data collection and processing operation with the capacity to add inputs for all of Alaska's covered lives.

TableTable 5 compares characteristics of three West Coast LOs for voluntary and state-mandated projects. In selecting a partner, an Alaska APCD might consider the extent to which the LO can provide:

- Streamlined data submission processes for Alaska's commercial submitters that also submit data in the LO's state, thereby reducing the submission burden and timeline for producing outputs and data products
- Data outputs that are aligned with an Alaska APCD's vision for level of detail, suitability for linkages to other data sources and timing of data collection, processing and timing of updated outputs and data products.
- Experience with data collection under a regulatory model and enforcing timeliness and adherence to established data quality standards
- Analytic and data quality processes that reflect both best practices and knowledge of Alaska's health care landscape
- "Boots on the ground" resources to ensure that Alaska's preferences and requirements are accurately reflected in processes, outputs and data products
- Capacity to manage a new startup within existing commitments
- Alignment with organizational mission
- Stable financial outlook

Table 5: Characteristics of Three Lead Organizations

	Washington Health Alliance	Center for Improving Value in HealthCare	Integrated Healthcare Association
Type of APCD	Voluntary	Mandated	Voluntary
State	Washington	Colorado	California
State Regulator	N/A	Medicaid	N/A
Compliance Model	Collaboration	Penalties	Voluntary Provider Quality Ratings
Advisory Group	✓	✓	✓
Data Management Vendor (DMV)	Milliman	HSRI/NORC	Onpoint Health Data
Current Data Output Frequency	Quarterly	Every other month	Annual
Funding Source	Member fees, state contracts	General Fund, Medicaid Match, Data Use Fees	Member fees, state contracts
Types of products	• Community Checkup • Reports	• Reports • Data extracts	• Reports

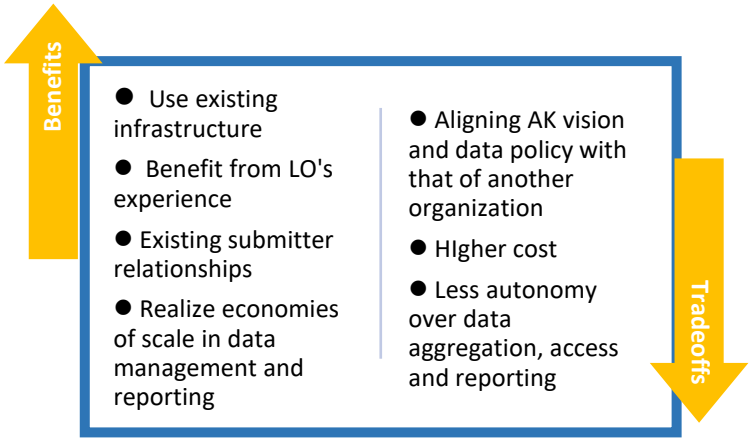
Considerations for Alaska

Role of the Lead Organization: An experienced non-profit health policy organization with a solid track record in multi-payer claims data collection and processing could jump start the Alaska APCD. Leveraging existing data collection structures, submitter and stakeholder communications processes, data quality techniques and advanced analytic resources would all be advantageous. Further conversations with West Coast and western US LOs are recommended to explore mutually beneficial avenues. In addition, commercial payers that operate in Alaska and a LO's state may be able to come up to speed quickly for an Alaska APCD if the intake and data quality requirements are identical for both states. Figure 4 outlines key benefits and tradeoffs of working with a LO.

- The LO may serve as the administrative arm of the regulatory authority and ensure that all data operations are consistent with regulations. The LO may also lead on stakeholder engagement, recruiting voluntary submitters, data quality activities, data request processing and fulfillment, and public reporting

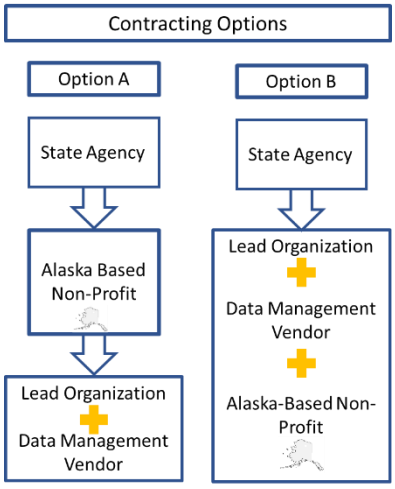
- The LOs in operation today typically work with analytic data files and do not intake nor process the submitted data directly. Rather, they partner with a DMV to perform the data intake and processing.

Figure 4: Benefits & Tradeoffs of Contracting with a Lead Organization



Ensuring that Alaska's Needs and Goals Drive the Project: To date, LOs have concentrated their work in their home state. They understand that a successful APCD fosters and maintains fluent communication with stakeholders across the healthcare system and that two-way communication about the inputs and the outputs are essential. Alaska could ensure that the LO will create and maintain this critical communication channel. Figure 5 shows examples of potential structures. In Option A, Alaska's regulatory authority could work with an Alaska-based non-profit organization as the "face" of the project. The non-profit organization is then responsible for contracting with a LO and its data management vendor for all technical and operations services. The Alaska-based non-profit would be responsible for all Alaska-specific aspects of the project, including stakeholder engagement, communications, reporting plan development, data reports and data products and sustainability. Option B shows an alternative structure where the regulatory authority contracts directly with a LO/DMV and requires contracting with an Alaska-based non-profit for state specific tasks.

Figure 5 Contracting with a LO



As conversations with potential LOs continue, it will be important to evaluate alignment with the LO's existing structure and data use priorities as well as long-term vision and willingness to collaborate on key decisions. This alignment will be necessary to maximize economies of scale for both states. If Alaska decides to pursue an APCD with a LO partner, a next step would be to develop a Request for Information or a Request for Proposal, which would offer potential partners the opportunity to share details on which roles and responsibilities would be held the by the LO, which would be reserved for the regulatory authority and which would be completed by the data management vendor.

ACTION FOR ALASKA

A request for information prior to the upcoming legislative session is recommended to collect information that can inform drafting of an APCD bill. A framework of potential roles and responsibilities is included in Chapter 2. While it is assumed Alaska would use

the same data management vendor as the chosen LO, a separate contract and scope of work will likely be needed for the work specific to Alaska. Should Alaska choose to contract with a LO based in another state, it would be the first instance of an APCD's LO being based in a state other than the APCD. Therefore, it may be necessary to rethink the division of responsibilities typically undertaken by the LO. Engagement of legislators and other stakeholders, particularly regarding revenue generation, is often best guided by individuals within the state that have long-standing relationships with those stakeholders.

Data Management Vendor: LOs can also manage the selection and oversight of the DMV (See Appendix A: List of Vendor Contacts for list of states and vendors). Several DMVs have extensive track records in supporting state APCDs and voluntary regional efforts. As Alaska considers its choice of a LO and its DMV services, its review should explore the types of reports that have been produced to date, the potential for future data linkages and the costs associated with fulfilling data or report requests. Alaska data submitters could be consulted to learn more about how the DMV should intake and process data files and how to provide timely feedback. State agencies that have contracted with a DMV may also be a source of insight on performance, collaboration and perception of data produced.

Appendix B: Procurement Tasks includes a summary of best practices in developing a request for proposal for an APCD scope of work and a checklist for evaluating responses.

Recap - Principles for Success:

- Select a regulatory authority or "home" with an interest in using reports and data products as well as capacity to move forward with regulations, contracting for operations and interagency collaboration.
- Look to established, successful LOs and DMVs in other states to manage the technical operations of data collection, processing and analytics/data products.
- Require that an in-state non-profit organization guide the LO's output to achieve Alaska-specific reporting and data access goals. Such work should include stakeholder engagement/advisory committee facilitation, reporting plan design and monitoring and supporting formal data access processes.

Chapter Three: Data Submission, Quality and Access

This chapter discusses APCD data submission, quality and access, click here for additional information on operationalizing an Alaska APCD. The value of an APCD depends on the completeness and quality of the claims data collected and ability to access this information to produce meaningful analyses and reports. This chapter will explore several topics that states must consider in planning for – and running – a successful APCD. These include:

- Design data collection processes with anticipated use cases in mind to ensure the necessary data elements will be available to support meaningful analysis and reporting.
- Understand the expected data sources and use cases to determine the technology and support resources necessary.
- Build thorough processes to evaluate data quality. Share information on data quality with stakeholders to understand appropriate uses and build trust and confidence in the database.
- Develop data access policies in collaboration with stakeholders to ensure that their concerns are addressed while balancing the need to support use cases that generate value to maximize APCD benefits across consumers, providers, payers and policymakers.

This chapter provides an overview of these topics, provides examples of best practices used in other states, and points to opportunities for an Alaska APCD to build on that experience.

What is the Anticipated Size of the Alaska APCD?

An estimate of the number of covered lives in the Alaska APCD is necessary to support planning for use cases and information technology (IT) to support the database. Based on analysis of the information available, *an Alaska APCD might eventually collect claims data for 68% of the state's population.*

Alaska population: According to the US Census Bureau, the estimated Alaska population was 731,545 in 2019.

Payers and Covered Lives:

- ***Medicaid:*** As of September 2020, about 235,000 people were covered under Alaska's Medicaid and CHIP programs, representing approximately 32% of the population.[5]
- ***Medicare:*** Medicare enrollment in Alaska as of mid-2020 was 103,889 and represented about 14% of the state's population. All beneficiaries are covered under Medicare fee for service (FFS) because Medicare Advantage plans are not available for purchase in Alaska.[6] Medicare FFS data must be obtained from the Centers for Medicare and Medicaid Services (CMS) through one of two request processes. Several states have obtained Medicare FFS data for their APCDs through these CMS programs.

[5] Alaska Department of Health and Social Services, Division of Public Assistance, Services Dashboard. Available online at: http://dhss.alaska.gov/dpa/Documents/dpa/Dashboard/DPA-Dashboard.pdf.
[6] Healthinsurance.org, Medicare in Alaska. Available online at: https://www.healthinsurance.org/alaska-medicare/#:~:text=Medicare%20enrollment%20in%20Alaska%20stood,those%20filing%20for%20Medicare%20benefits.

- ***Dual Eligibles:*** Dually eligible beneficiaries are persons enrolled in both Medicare and Medicaid. There is a risk of double counting dual eligibles because they may have services paid for under both programs and thus appear twice in claims data. There were just over 18,000 dual eligibles in Alaska as of September 2019 at risk of being double counted in this analysis.[7]
- ***Fully Insured Commercial Plans:*** The Alaska Division of Insurance 2019 Annual Report indicates that about 60,000 persons (8%) were covered under fully insured commercial health plans in 2018. State Employee Plans, including state and local governments and school districts, covered another 114,000 lives (16%) in 2017.[8]

Other Insurance Types:

- Due to the US Supreme Court decision in the case of *Gobeille vs. Liberty Mutual,* states cannot require submission of claims data from self-funded commercial plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA).
- ***Military and Indian Health Service:*** State APCDs have been unsuccessful in obtaining claims from the Veterans Administration, TRICARE and IHS; it is unlikely Alaska can collect this data.
- ***Uninsured:*** Because no claims are generated for individuals without insurance, information on care received by uninsured Alaskans will not be collected. Information regarding utilization and the cost of healthcare for the uninsured is not collected by other APCDs.

Estimate of Alaska APCD Covered Lives: Combining this information suggests that an Alaska APCD could eventually collect information for about 498,000 lives (68%) of the 2019 estimated population. This calculation of total lives removes the 18,000 dual eligibles who are covered under both Medicare and Medicaid to avoid double counting.

Table 6: Summary of Potential Alaska APCD Covered Lives

Type of Coverage	Covered Lives	% of Alaska Population
Medicaid and CHIP	235,000	32%
Medicare FFS	104,000	14%
Dual Eligibles	(18,000)	(2%)
Fully Insured Commercial Plans	60,000	8%
State Employee Plans	114,000	16%
Total (minus Dual Eligibles to avoid double counting)	**498,000**	**68%**

Note: Dual eligible lives may be counted in multiple categories.

A note on uncertainty: These estimates are based on data for commercial insurance, Medicare and Medicaid; the three most common sources for an APCD. Some uncertainty exists due to missing or incomplete data. Detailed analysis will be required to better understand the number of lives covered

[7] Medicare-Medicaid Dual Eligible Enrollment Snapshot: Quarterly Release (06/2015-09/2019). Available online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

[8] Estimate of the Potential Value of Consolidating Alaska State, Local and School District Public Employee Health Plans, Mark A. Foster and Associates (MAFA), August 24, 2017. Available online at: http://doa.alaska.gov/pdfs/MAFAReport.pdf.

under ERISA self-funded plans, the Tribal Health System and the extent to which individuals have multiple sources of coverage and may be double counted. These estimates can be used to support planning for use cases and information technology (IT) to support the database and reflect what may be possible; not a guarantee of what an Alaska APCD would collect upon implementation.

What does an APCD need to support Use Cases?

Chapter 1 presents use cases, example analyses, impacts and links to reports produced by other APCD states. Categories of use cases summarized in Chapter 1 that Alaska should consider include: Quality and Access to Care, Cost and Utilization, Coverage and Access to Coverage, Population and Public Health Surveillance and Health System Performance.

Tiered Reporting: Chapter 1 also discusses a strategic approach to APCD data use including a tiered reporting plan for release of information to support a better understanding of health system performance that identifies and informs opportunities for policy to reduce costs and improve quality, population health and provider experience of care.

Data Enhancements: Enhancements applied to claims data during processing increase the number and complexity of use cases an APCD can support. These include grouping claims into condition categories (asthma, diabetes), episodes of care for common procedures (knee and hip replacements, vaginal and cesarean births), prescription drug classifications, patient to primary care provider attribution, health status or illness burden scores (risk adjustment) and adding regional groupings.

Tier 1 reports typically include summary statistics based on analysis of aggregated data that is readily available in claims processing systems, is minimally processed and does not require data enhancements. Tier 2 and Tier 3 reports require additional data from non-claims sources and application of grouping and other data enhancement tools. Table 7 presents use case topics and sample analyses from Chapter 1, assigns these to reporting Tiers and identifies the enhancements and non-claims data necessary to support them.

Table 7: Sample Use Case Topics, Sample Analyses and Enhancements by Tier

Topic	Sample Analyses	Reporting Tier	Enhancements or Data Required
Quality & Access to Care	• Preventive screening and immunization rates	Tier 1	• None
	• Number of primary care or BH providers offering services in a geographic area	Tier 1 or 2	• Tool to identify preventable hospitalizations and ED visits
	• Preventable hospitalization and emergency department (ED) visits	Tier 2 or 3	• Method or tool to identify and group claims by chronic condition
	• Chronic care management and care coordination	Tier 2 or 3	

			• Grouping of claims by geographic region based on zip code, county, etc.
Cost & Utilization	• Cost and utilization for specific services • Total cost of care by population, provider, and health system • Cost of low-value care and avoidable complications	Tier 1 Tier 3 Tier 3	• None • Requires patient to primary care provider attribution and total cost of care software • Low-value care software. Avoidable complications method or tool
Coverage & Access to Coverage	• Health insurance coverage trends • Premiums, deductibles, and out-of-pocket spend • Medical, specialty, dental, and behavioral health care access across populations • Network adequacy	Tier 1 Tier 1 or 2 Tier 1 or 2 Tier 3	• None – if reported by payer type • Requires detailed data on payments made by patients • Depends on level of reporting detail desired • Requires detailed network info
Population & Public Health Surveillance	• Firearm injuries, incidence, and cost • Chronic condition risk factors, prevalence, and costs • Cancer, infectious disease, and behavioral health trends • Opioid prescribing rates	Tier 2 Tier 1 or 2 Tier 1 or 2 Tier 1 or 2	• Method or tool to identify and group claims by chronic condition • Depends on level of reporting detail desired • Drugs grouped by class for Tier 2 • Procedure and Diagnosis codes must be present in the data
Health System Performance	• Impact of system consolidation on cost, quality, access, and equity • Impact of new models of care and payment • Enhanced care coordination costs and ROI • Alternative payment models prevalence, trends	Tier 3 Tier 3 Tier 2 Tier 2 or 3	• Requires detailed information on merger and acquisition activity • Requires data on Alternative Payment Methods (APMs) • Requires data on care coordination programs • Requires data on Alternative Payment Models (APMs)

	• Primary care investment and other affordability standards	Tier 2 or 3	• Requires data on primary care investment and other affordability programs

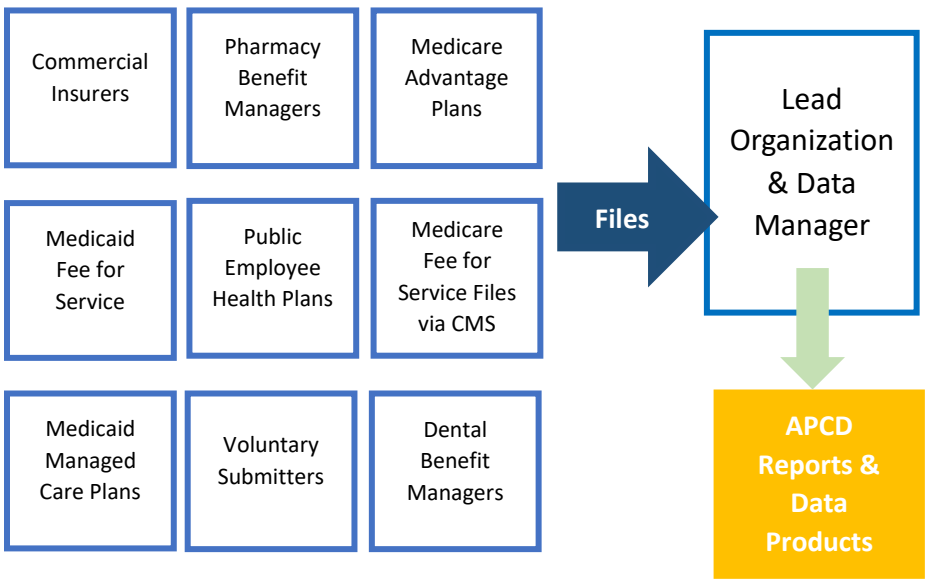
Principles for Success:

- Pursue a tiered reporting strategy to help manage stakeholder expectations, demonstrate early value and generate confidence in the APCD data, analysis and reporting.
- High-level Tier 1 reports presenting summary statistics based on analysis of aggregated data that highlight variation in cost, utilization and quality are early wins and demonstrate APCD value in informing opportunities for health system improvement.
- More complex Tier 2 and 3 use cases can be added as the database matures, enhancements are applied, non-claims data sources are added and confidence in the accuracy and completeness of the data develops.
- Determinations regarding which use cases to pursue and when should be made based on an understanding of stakeholder needs and priorities and the readiness of the data to support them.

Data Submission Process and Timeline

Claims data for an APCD are collected from public and private payers offering health insurance coverage in a state. These include private commercial health plans and insurers, and publicly funded Medicaid and Medicare programs. Claims files are submitted by payers to the LO/ DMV and processed, stored in a standardized format and then made available to support analysis and generation of reports and other APCD data products. The sources and flow of claims data into an APCD are summarized in Figure 6.

Figure 6: The Sources and Flow of APCD Data Submissions



Claims data includes information on health care services provided to patients, also referred to as members. Medical and pharmacy claims files contain information on the person receiving services, providers rendering the services, details regarding the specific services delivered (procedure and diagnosis codes), the dates of

service, place of service where care was delivered and payment information. Eligibility files include information on each member who had insurance through that payer, including the payer and insurance type, coverage period, and information about the member (name, age, address, primary care provider, whether they are the primary subscriber, etc.). Provider files include information on the health care facilities, physicians and other providers rendering services and may include information on provider relationships, e.g., larger health systems or provider groups. There is some overlap in the data in these files to support linking to create a complete record of care delivered to patients.

Claims data files do not include information on patient clinical outcomes such as lab test results or information from Electronic Medical Records (EMRs). Claims data also does not include payments for services not delivered under fee for service (FFS) reimbursement. The latter are referred to as Alternative Payment Models (APMs) and include capitation payments (where a fixed payment is made for some or all services delivered to patients), bundled payments (for a set of related services), provider performance incentives or penalties, prescription drug rebates and health insurance premium information. These data are not available in claims processing systems and must be obtained from actuarial or finance departments or other sources.

What's the difference between a claim and an encounter?

Claims are transactions used to request payment for health care services rendered. A claim is generated when an insured person (also referred to as a member) visits a doctor, is admitted to a hospital, receives care in an emergency department (ED), fills a prescription, undergoes a lab test, or receives other health care services.

Encounters include similar information to claims but are distinguishable because they are records of service, not requests for payment and do not include payment information.

Data Submission Process

Commercial Payers: A secure data submission process must be developed to facilitate payer transmission of claims data files containing confidential and potentially sensitive information to the APCD in a manner that satisfies all federal and state requirements regarding data privacy and security. At the federal level, HIPAA and HITECH establish data privacy and security requirements that apply to information collected by APCDs, and many states have additional requirements that are, in some cases, more restrictive and must be adhered to as well. Essential elements and best practices for establishing a secure data submission process include:

- Establish a process for registering submitters and maintaining current contact information
- Create a web-based portal to receive encrypted files from payers and store/process them in a secure environment. Each payer submitting data should have a unique link and log-in credentials for purposes of secure file submission
- Implement and maintain a Data Submission Guide (DSG) that provides detailed data file specifications and other information necessary to support payers in creating conforming files
- Create detailed documentation and provide technical support resources for all data submission related activities

Timing of Submissions: Many APCDs require commercial and/or Medicaid data submissions on a monthly basis, whereas others collect data quarterly, semi-annually or even yearly. The frequency of submission is often determined based on analytic needs or use case priorities and in collaboration with

data submitters. More frequent data submissions mean timelier data and create additional costs for data collection and processing that must be balanced against the available APCD budget.

- ***Commercial Payers*** securely submit data files according to processes and schedules established by the regulatory authority or LO and in the formats specified in the DSG.
- ***State Medicaid Agencies*** generally submit data on a similar schedule and in the DSG format. The Medicaid agency often submits data for services it reimburses directly as well as those provided by contracted Managed Care Organizations (MCOs). This reduces the number of Medicaid data submissions coming directly into the APCD.
- ***Medicare claims data submission:*** Medicare FFS claims data files are available on an annual or quarterly basis and are delivered on a schedule and in formats determined by CMS. The APCD data manager must map the CMS Medicare FFS data files into the DSG format.

Building Relationships with Payers: Successful states work closely with payers in designing their data submission requirements and to address data quality and other issues. Building and maintaining good relationships with payers is a best practice and key to success. Regular and ongoing communications to discuss data submission and quality issues builds trust, contributes to a smooth data collection process and helps minimize the need for correction and resubmission of files.

Principles for success:

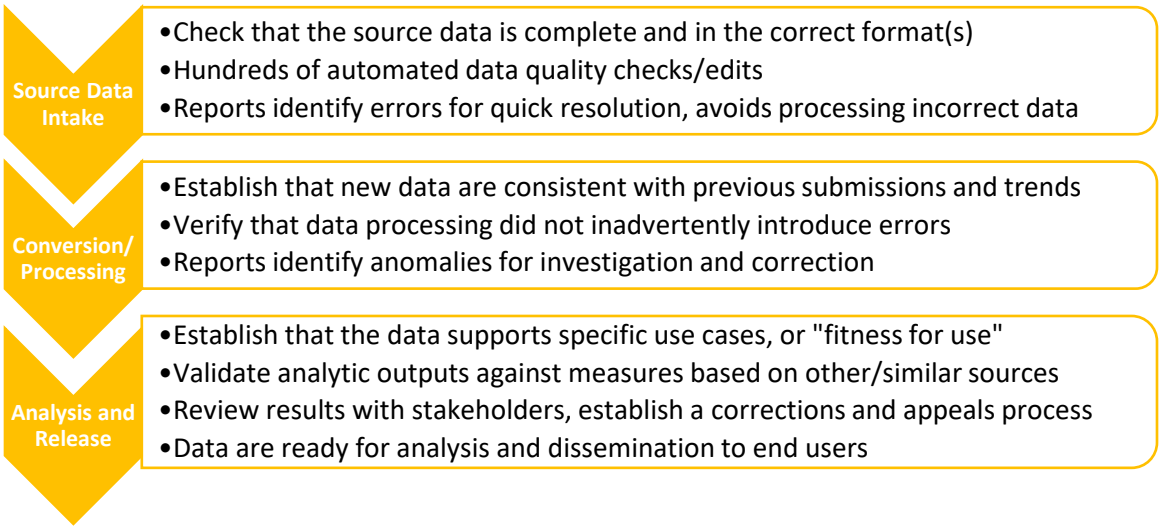
- Establish legal authority in APCD statute and specific data submission requirements in regulations and detailed policies and procedures
- Design data submission requirements in collaboration with payers that align with emerging formats in other states to minimize the compliance burden and time to report production
- Work closely and maintain regular, ongoing communications with payers and the DMV to discuss data quality and other submission related issues.
- Provide detailed documentation and technical support for all data submission related activities.

Data Quality Through the Life Cycle

The importance of carefully evaluating APCD data quality at all stages of the life cycle cannot be overstated. Analysis of inaccurate or incomplete data will produce results of questionable validity and reliability that will be inconsistent with similar information generated based on other sources. This will cause stakeholders to question the value of the APCD in supporting a more complete understanding of health system performance and informing opportunities related to cost and quality improvement. This section describes essential elements of a comprehensive APCD data quality program that the LO and DMV should have in place and can extend to Alaska's APCD.

The Life Cycle Approach: Data must be carefully evaluated for accuracy and completeness at each stage of the life cycle to establish "fitness for use" to support various use cases. Before data is accepted into the database, it must be checked to ensure that it conforms with the data submission guide and is in an acceptable format. Once ingested, data must again be reviewed to make sure it is logical and consistent with what a state would expect to see from a similar payer. Additional data quality checks must also be applied to enhanced data to prevent errors from persisting in the database and adversely impacting analysis and reporting. Steps in the life cycle approach to APCD data quality are summarized in Figure 7.

Figure 7: Data Quality Through the Life Cycle



To evaluate and establish data quality, checks or edits must be applied to data submissions, both before and after data conversion and processing and in assessing fitness for use. These levels of data quality assessment are described below:

- ***Data File Intake***: The first step in a comprehensive APCD data quality program involves applying checks or edits to incoming files submitted by payers. These data quality checks establish that incoming files include all required data elements and are in the correct format. The goal is to prevent processing of incomplete or inaccurate data that will create errors and require greater levels of effort to correct in the future. Files that do not pass initial quality checks will be rejected and must be corrected by payers and resubmitted. States have adopted best practices including providing payers with a detailed list of data intake quality checks so they understand the standards against which their files will be evaluated. Data intake systems automatically generate detailed data quality reports that identify specific reasons for file failures. This provides valuable information for both the APCD and payers, helps to minimize submission errors and facilitates timely correction of data quality issues.
- ***Data Conversion and Processing, Part 1:*** The second set of quality checks establish that new data files are consistent with previous submissions and historical trends. These include comparing volumes of claims, members, total dollars and per member per month spending over time to establish consistency and stability in the data. Anomalies discovered at this stage are investigated, root causes identified, and corrections made so that errors do not persist in the data and adversely impact analysis. Best practices include careful review of data quality reports and sharing this information with payers for error correction and resubmission of conforming files.
- ***Data Conversion and Processing, Part 2:*** Quality checks applied at this stage establish that application of enhancements, including identity management, claims groupings, primary care provider attribution and risk adjustment, produced reasonable results and did not inadvertently introduce errors that will persist and adversely impact analysis and reporting. These checks also assess the distribution of diagnosis, procedure and other codes for consistency with historical trends and sources of similar information including Medicaid and Department of Public Health

datasets. The goal is to establish that data quality can support the more advanced Tier 2 and 3 use cases.

- ***Fitness for Use:*** The final phase of data quality evaluation assesses fitness for use or the ability of the processed data to support specific use cases and generate results that are as valid and reliable as possible. While it is not possible to validate an APCD *per* se, it is a best practice to evaluate data quality and completeness in the context of specific use cases. Determining fitness for use involves assessment of whether the required data elements are present at levels of completeness and accuracy necessary to support *the intended use*. If not, the results of analyses may not be valid, reliable or compare favorably to similar information generated based on other sources. For internal analyses, states typically review reports with affected stakeholders for accuracy prior to public release. This is an essential element of a collaborative approach that builds trust in the database and confidence in the results of analysis. Some APCDs also require review of results generated by external data users to ensure accuracy and for consistency with established data release policies and other requirements.

Assessing and improving data quality is an evolving and ongoing process; careful attention must be paid to data quality at each phase of the life cycle. This section described elements of an APCD data quality program used by qualified LOs and DMVs. The most successful states are committed to a program of continuous data quality improvement that builds trust and confidence in the data and contributes to positive stakeholder perceptions and APCD sustainability.

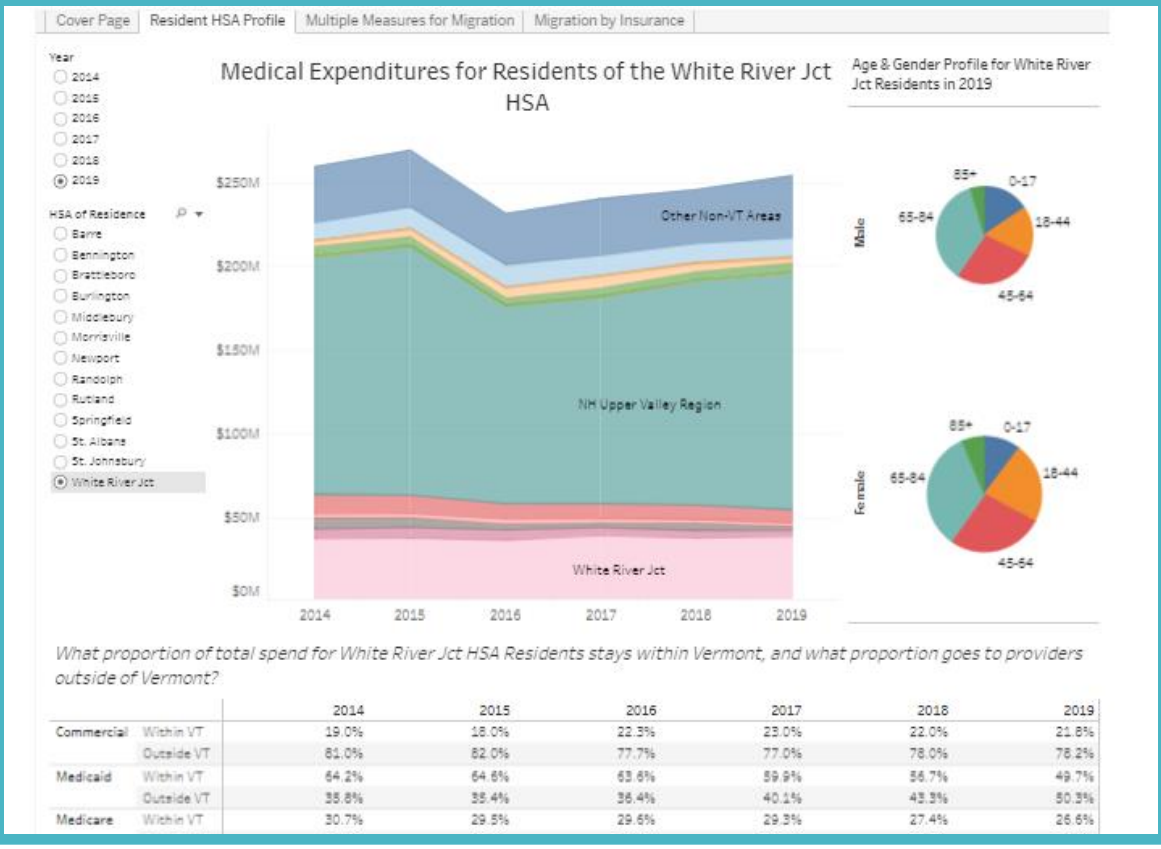
Principles for Success:

- Data quality is a shared responsibility. The regulatory authority, LO and DMV vendor must all be actively engaged in reviewing data quality reports to identify and correct errors on an ongoing basis.
- As part of LO and DMV selection, reach out to other APCD states for information on the robustness and success of data quality evaluation and improvement efforts.
- Build comprehensive data quality processes that address all phases of the life cycle.
- Ensure payers understand the data quality process that will be used to assess their data.
- Provide transparent and detailed information on data quality that is accessible for various stakeholder audiences.
- Be transparent about known quality issues and their implications for analysis and reporting.

Case Study Three: Assessing Medical Tourism

Patient Migration Analysis

In 2020, the State of Vermont's Green Mountain Care Board issued a report on Vermont Health Service Areas (HSA), the proportion of services staying in HSA, other in-state HSA and out of state HSA. The report provides a state resident perspective on where the patient is going for care. The subset of data below answers the question: What proportion of total spend for White River Junction HSA Residents stays within Vermont and what proportion goes outside of Vermont? Alaska policymakers and other stakeholders have identified an interest in better understanding the extent to which Alaskans are traveling out of state for medical care and which services they are going out of state to receive.



What proportion of total spend for White River Jct HSA Residents stays within Vermont, and what proportion goes to providers outside of Vermont?

		2014	2015	2016	2017	2018	2019
Commercial	Within VT	19.0%	18.0%	22.3%	23.0%	22.0%	21.8%
	Outside VT	81.0%	82.0%	77.7%	77.0%	78.0%	78.2%
Medicaid	Within VT	64.2%	64.6%	63.6%	59.9%	56.7%	49.7%
	Outside VT	35.8%	35.4%	36.4%	40.1%	43.3%	50.3%
Medicare	Within VT	30.7%	29.5%	29.6%	29.3%	27.4%	26.6%

9

Data Access and Release: Policy and Process

The value of an APCD will be greater if qualified users capable of generating meaningful and actionable analyses to inform policy can access the data. Data access and release policies, consistent with statutory and regulatory requirements and designed in collaboration with stakeholders, may generate revenue to partially support ongoing database operations and sustainability.

[9] Available online at: https://public.tableau.com/profile/state.of.vermont#!/vizhome/Patient-Migration_2014-2019_v6/CoverPage

APCD Data Access: APCDs vary in their approach to data access for research and other allowable uses. Some states are limited by statute and regulations or take a conservative approach, whereas others provide access to data through multiple mechanisms.

The highest level of data access is release of public reports based on internal analysis and nearly all APCDs provide this to some extent. These public reports, like the Tier 1 reports described in this report, are informative but do not allow stakeholders to perform their own analyses. It is a best practice to review reports with affected stakeholders prior to public release. Reports that include payer specific results should be reviewed with Medicaid to ensure results align with similar information provided by the agency to the legislature and Governor's office or released publicly. Reports that include cost and quality measures for named facilities or provider groups should be shared in advance for their review, verification and correction of any errors. The regulatory authority should work closely with the LO, DMV and stakeholders to create reporting principles that address concerns and establish clear policies for the public release of information based on the APCD.

Access to de-identified data allows stakeholders to perform hands on analysis and generate reports that can inform a variety of healthcare issues. De-identified data contain no patient level information and do not create significant data privacy or security concerns. Potentially sensitive information, including provider identifiers, sensitive diagnoses (HIV, substance use disorder treatment) and detailed payment data may be removed or aggregated. Access to de-identified data does not allow users to perform in-depth analyses (Tier 2 or 3 use cases) which may help to assuage some stakeholder concerns.

Some states provide access to what is defined under HIPAA as a Limited Data Set. These data include indirect patient identifiers including dates specific to individuals with month and day level detail and patient 5-digit zip codes. Data at this level of detail supports more sophisticated analysis of specific patient populations, disease categories and regional comparisons.

A few states allow access to patient identifiable data that facilitate linkages to Electronic Medical Records and other data sources at the patient level and support sophisticated research use cases including analysis of patterns of care for specific populations or population subgroups.

Policies and Documentation to Support Data Access: Broad parameters regarding who may access the data and for what purposes are often defined in APCD statute, with rules established in regulations and specific requirements detailed in policy documents. States typically define APCD data access policies in collaboration with their multi-stakeholder Advisory and/or Data Access Committees (more on this below).

APCD statute and regulations, along with detailed policies and procedures, create a comprehensive framework for data use and access. States develop detailed policy documents that summarize legislative and regulatory provisions, define who can request data and for what purposes and identify the information that must be provided in a data request. An application form is created to collect the required information and guide applicants through the request process. A Data Use Agreement defines specific terms and conditions that apply to data recipients including limits on how the data can be used

or shared. Once signed by the recipient, the Data Use Agreement is a binding contract and violation of any terms or conditions may be subject to legal action.

How Data Access Decisions are Made: The Data Access Committee reviews applications, considers the appropriateness of requests and advises the APCD Administrator about the application's alignment with established data access requirements. The APCD Administrator typically agrees with the committee's findings.

Principles for Success:

- Establish clear authority for data access in APCD statute and provide specifics in regulation and detailed policy and process documentation.
- Engage multi-stakeholder groups, such as an Advisory and/or Data Access Committee, in the development of data access policies to ensure that multiple perspectives are represented.
- Provide opportunities for multi-stakeholder input to share data analytic and reporting needs, priorities and concerns.
- Create a multi-stakeholder Data Access Committee to review applications and advise on the appropriateness of data requests.
- Be transparent and provide periodic reports to ensure accountability regarding data use, access and release decisions.

Special Considerations for Alaska

Alaska is exploring partnering with an existing APCD to access experienced LO and DMV resources, shorten implementation time and reduce costs by leveraging existing infrastructure. This chapter has explored several topics that Alaska should consider in the context of a potential partnership.

- Physical data collection, processing, storage, analysis, etc. would be managed by an external DMV. The regulatory authority, with help from the LO, would be responsible for building and maintaining good relationships with Alaska payers and coordinating ongoing meetings and communications to ensure a smooth data submission process.
- The regulatory authority will have to work closely with the LO and DMV to develop reporting principles and a tiered approach that satisfies the needs of Alaska stakeholders and addresses their concerns. Reporting principles and approaches developed for other states may not be acceptable or satisfy Alaska's needs. Contracts and similar agreements should require that external entities satisfy Alaska's needs and comply with unique requirements in the event of any conflicts.
- Data quality is necessarily a shared responsibility between the regulatory authority, LO, DMV and submitters. The regulatory authority will play a lead role in coordinating data quality assessment and improvement efforts to build and maintain trust and confidence in the database. Alaska should reach out to other APCD states for information on the robustness and success of data quality evaluation and improvement efforts as part of LO and DMV selection.
- Data access policies will be determined by statutory provisions, regulations and specific policies and procedures developed in collaboration with Alaska stakeholders. The regulatory authority will manage data access processes in collaboration with the LO and DMV.

Recap - Principles for Success:

Planning for Reporting

- Pursue a tiered reporting strategy to help manage stakeholder expectations, demonstrate early value and generate confidence in the APCD data, analysis and reporting.
- High-level Tier 1 reports presenting summary statistics based on analysis of aggregated data that highlight variation in cost, utilization and quality are early wins and demonstrate APCD value in informing opportunities for health system improvement.
- More complex Tier 2 and 3 use cases can be added as the database matures, enhancements are applied, non-claims data sources are added and confidence in the accuracy and completeness of the data develops.
- Determinations regarding which use cases to pursue and when should be made based on an understanding of stakeholder needs and priorities and the readiness of the data to support them.

Data Submission

- Establish legal authority in APCD statute and specific data submission requirements in regulations and detailed policies and procedures.
- Design data submission requirements in collaboration with payers that align with emerging formats in other states to minimize the compliance burden and time to report production.
- Work closely and maintain regular, ongoing communications with payers and the DMV to discuss data quality and other submission related issues.
- Provide detailed documentation and technical support for all data submission related activities.

Data Quality

- Data quality is a shared responsibility. The regulatory authority, LO and DMV must all be actively engaged in reviewing data quality reports to identify and correct errors on an ongoing basis.
- As part of LO and DMV selection, reach out to other APCD states for information on the robustness and success of data quality evaluation and improvement efforts.
- Build comprehensive data quality processes that address all phases of the life cycle.
- Ensure payers understand the standards against which data quality will be assessed.
- Provide transparent information on data quality that is accessible for various stakeholder audiences.
- Be transparent about known quality issues and their implications for analysis and reporting.

Data Access

- Establish clear authority for data access in APCD statute and provide specifics in regulation and detailed policy and process documentation.
- Engage multi-stakeholder groups, such as an Advisory and/or Data Access Committee, in the development of data access policies to ensure that multiple perspectives are represented.
- Provide opportunities for multi-stakeholder input to share data analytic and reporting needs, priorities and concerns.

- Create a multi-stakeholder Data Access Committee to review applications and advise on the appropriateness of data requests.
- Be transparent and provide periodic reports to ensure accountability regarding data use, access and release decisions.

Chapter Four: Development and Maintenance Costs and Funding

This chapter discusses APCD costs and funding, click here for additional information on operationalizing an Alaska APCD. As the Alaska APCD develops its path to sustainability, it will have the benefit of learning from and potentially, building on, the work of others. A significant learning from established APCDs is the tendency for these datasets to evolve in phases, and operational costs and funding opportunities often reflect where the APCD is in its lifecycle. In developing a financial outlook for the Alaska APCD, it is important to keep these "lifecycle" factors in mind. This chapter will provide an overview of development and operating costs, potential funding sources and a summary of cost ranges for each phase of the lifecycle. It will also discuss potential economies of scale and tradeoffs of partnering with an existing APCD as an LO.

Estimating the Cost of Developing and Operating an APCD

While there are some common themes and learnings, no two states' APCDs are exactly alike, and neither are the contracted DMV scopes of work, budgets, data systems and oversight services that comprise each program. Differences stem in part from volume and workload -- the number of submitters and covered lives, the frequency of submission and the number of data files collected.

Another area of difference is the complexity and sophistication of the use cases pursued, and the data enhancements required to support those use cases. Examples of enhancements include provider attribution, risk adjustment and the use of groupers and other software tools to organize the data for analysis of care delivery, quality and cost.

In addition to data collection and management services, the APCD program also relies on a state regulatory authority or a LO to provide administrative and governance services . For example, DMVs typically do not draft regulations, select reports to publish, manage the data release process, provide public information about the project or engage with stakeholders. Staff to support these strategic, project management and analytic functions are the responsibility of the state regulatory authority or LO and impose additional costs that vary by APCD.

The combination of LO, DMV and other supports determine the total cost of operating the APCD. Below is a range of cost estimates for APCD data management and support services in three lifecycle phases. These estimates are intended to offer an understanding of expected Alaska APCD costs. Final costs will depend on many factors including LO and DMV partnerships and the use cases selected. The three APCD lifecycle phases include:

- **Foundational**: Key tasks in the Foundational phase include strategic planning and oversight, project management and stakeholder engagement, and identification of a LO and/or DMV. This phase begins after APCD legislation is passed and may require a year to two years to complete**.**
    - Foundational 1: In this phase, the first six to 12 months of this phase will be focused on contracting and regulatory activity, with the lower end of that estimate assuming the Legislature approves pursuing a contract with a LO and provides a state appropriation sufficient to launch. The timeframe will lengthen if the state decides to seek Medicaid Match funding at the outset.

- Foundational 2: This phase begins as soon as initial data collection begins at the point that regulations are in place, the DMV is on board and the submitters have been engaged. This phase includes submitter registration, training, historical and current data submission, quality assurance testing and high-level analysis will begin after a DMV is under contract.

- **Operational:** The Operational phase, which typically lasts for approximately 2 years, begins after up to three years of historical commercial, Medicaid and Medicare data are available for analysis and regular submissions and database refreshes are underway. In addition to ongoing Foundational services, costs for data aggregation and management and analytic support and tools increase. Additional costs for data enhancements are likely depending on the use cases selected. Tier 1 reports are generated and released and development of more advanced, Tier 2 use cases occurs. Some data access fee revenues are realized beginning with implementation of the data release process.

- **Fully Enabled**: In the Fully Enabled phase, ongoing costs are incurred in all five categories. Costs for analytic tools and data enhancements will decrease over time as the database matures and the need for additional services in these categories diminishes. Commercial and Medicaid data are refreshed on a regular basis and robust access is available to a broad array of users. Tier 2 reports are fully implemented, and Tier 3 use cases and reports are developed over time.

As described in Chapter 2, APCD Data Management functions typically require support and services from in-state and external organizations. Table 8 shows how these functions are distributed during the three life cycle phases.

Table 8: Estimated Annual APCD Cost Ranges by Development Phase

	State Agency Strategic Planning and Oversight	Data Aggregation, Management Services	Project Management, Stakeholder Engagement	Analytic Support and Tools	Data Enhancements
Foundational *(0-12 months)*	$150,000 - $300,000 **Assumptions:** 1.0 FTE – 2.0FTE May be split across several professionals from sponsoring state agency and lead organization In AK, led by DOI or DHSS in collaboration	Expected to be very low assuming that contract begins at Year 2.	$200,000- $350,000 **Assumptions:** 1 to 1.5 FTE, i Includes stakeholder engagement resources for “boots on the ground” in Alaska and oversight of Lead Organization/Data Management vendor performance	Expected to be very low assuming that contract begins at Year 2.	Not applicable in Year 1.

	with Department of Law to support regulatory, procurement, funding strategy, interagency coordination, stakeholder engagement. Assisted by: In-state non-profit (Lead Organization role will depend on contracting timing				
Foundational *(12-24 months)*	$150,000-$250,000 **Assumptions:** 1.0 FTE - 1.5 FTE May be split across several professionals from sponsoring state agency and lead organization. Supports ongoing funding strategy, contract oversight, interagency coordination, stakeholder engagement. May be assisted by: In-state non-profit and/or Lead Organization, depending on contracting timing	$500,000-$600,000 **Assumptions:** Covers Lead Organization, Data Management Vendor work. Low end of range assumes "bolting onto" existing APCD's contract with a data management vendor with few customizations. In AK, the services will be engaged by the Lead Organization with a contracted Data Manager	150,000-$300,000 **Assumptions:** 1 to 1.5 FTE Includes stakeholder engagement resources for "boots on the ground" in Alaska and oversight of Lead Organization/Data Management vendor performance; develops and manages design of data access processes per regulatory guidance	$75,000-$100,000 **Assumptions:** 0.5 to 1 FTE, to start scoping business requirements for reports. Staff may be at state agency, lead organization or included in the data vendor contract and the tool chosen to support analytics.	$25,000+ **Assumptions:** Tableau or other tools to analyze and present results of data quality analyses.
Operational *(24-36 months)*	$150,000-$250,000 **Assumptions:** 1.0 FTE – 1.5 FTE May be split across sponsoring state agency and lead organization; responsibilities continue from Foundational 2.	$500,000-$750,000 **Assumptions:** Same as Foundational 2, except for growing complexity in reporting and data access options even as certain aspects of the project become more standardized	$200,000-$400,000 **Assumptions:** 1.5 FTE to 2.5 FTE Same as Foundational 2, expanded to encompass assistance to data requesters and to approved data users.	$150,000 - $500,000 **Assumptions:** 0.5 FTE to 3.0 FTE, APCD seeks more frequent, complex analytics and begins to respond to stakeholders' requests for data; Staff from state	$60,000-$100,000 **Assumptions:** Assumes APCD chooses to implement 2-3 data enhancements (e.g., attribution, risk adjustment, episode groupers) in this phase. Some data management vendors bundle certain

		and less resource intensive over time.		agency may assigned or can be from lead organization or included in the data vendor contract.	enhancements such as risk adjusters or attribution into their contracts which may require an earlier investment
Fully Enabled	$150,000-$250,000+ **Assumptions:** 1 FTE - 2 FTE Same responsibilities as Operational.	$500,000-$750,000 **Assumptions:** Same responsibilities as Operational.	$400,000+ **Assumptions:** Two or more FTE's, may be a combination of state agency, lead organization staff and AK contracted support. Same responsibilities as Operational.	$500,000+ **Assumptions:** 3 FTE, APCD seeks more frequent, complex analytics and begins to respond to stakeholders' requests for data; some staff may be at state agency, some at lead organization. Same responsibilities as Operational.	$100,000-$350,000+ **Assumptions:** Assumes APCD maintains license to data enhancements (e.g., attribution, risk adjustment, episode groupers) acquired in Operational phase and adds 1-3 additional. High end range anticipates working to integrate APCD with other data sources. Some data management vendors bundle certain enhancements such as risk adjusters or attribution into their contracts which may require an earlier investment

Developing Diverse, Sustainable Revenue Streams to Support an Alaska APCD

The most successful APCDs secure and retain diverse revenue streams that maximize opportunities for state agencies and other partners to access the dataset and minimize reliance on a single funding source. To be successful, the Alaska APCD will need to develop a plan that includes several stable and predictable revenue streams that will vary with phase of development. Figure 8: Funding Sources provides an overview of the revenue opportunities seen in many of the mandatory APCDs.

State Funds: The majority of APCDs receive some level of core funding from general state appropriations in exchange for the benefits lawmakers, agencies and departments derive from access to data, reports and other information products. Examples include:

- Identify specific opportunities for improvement and support policy discussions informed by objective and reliable data about variation in utilization, cost and access
- Satisfy CMS reporting requirements and contribute to more efficient program administration
- Identify highly effective programs and services
- Quantify utilization and revenue flowing out-of-state due to "medical tourism" and travel to other states for care.

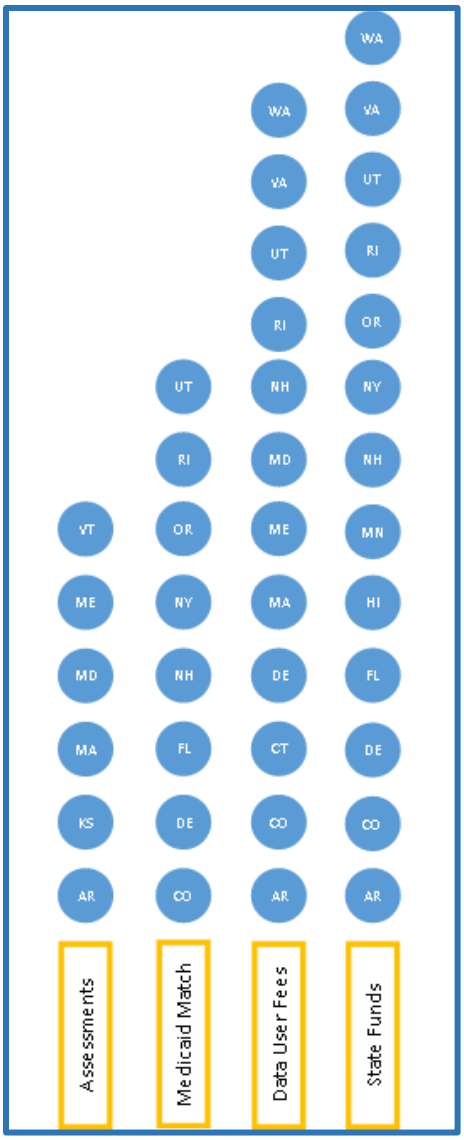
- Calculate and monitor population health measures that assist public health departments in designing interventions and making informed resource allocation decisions
- Identify areas of need and informs the design and evaluation of health system reform initiatives and market analysis.

Like many states, Alaska is facing significant budget challenges. High health care costs impose a heavy fiscal strain on the state budget, state employers and state residents. While developing an APCD will likely require some investment of state general funds, that likely investment is a minute fraction – ***less than 0.0125% of the state's more than $3.2 billion healthcare budget***.

Assessments: Five states currently support their APCDs through special fund sources such as industry assessments. Except in Kansas, these assessments are levied by the state health agency responsible for the APCD, rather than the APCD itself. The practice of levying industry assessments to support APCDs has become less common in recent years as states have found it more useful to leverage limited general appropriation funds to drawn down federal financial support or matching funds.

Medicaid Match: Recognizing the value of APCDs to support state Medicaid agencies understanding of cost, efficiency, utilization, quality, care patterns, and geographic differences, in 2016, CMS began encouraging states to pursue Federal Financial Participation (FFP) for their APCDs. Funds obtained through FFP, also referred to as "Medicaid Match" funds, are available both for costs associated with implementing a new APCD and/or maintaining an existing APCD if the proposed work meets conditions described in federal regulations. The application for FFP must be submitted by the state Medicaid agency however, there is no requirement that the APCD reside within that agency to qualify for federal matching funds.

Figure 8: Funding Sources



Access to APCD claims and encounter data allows state Medicaid agencies to produce multi-payer and Medicaid specific reports in a timely, efficient, and cost-effective way, evaluate the impact of Medicaid programs and initiatives, and measure progress toward state health system goals. Specific ways an Alaska APCD could support the Medicaid program include:

- Enhanced ability to meet CMS monitoring and reporting requirements which require comparing Medicaid rates to those of commercial payers and Medicare
- Provide comprehensive views of healthcare cost, utilization, and quality for Medicaid members across payers and over time
- Contribute to development of provider and health system performance benchmarks
- Provide data for dually eligible members that can help identify specific opportunities to improve care coordination and reduce costs

- Allow assessment of the impacts of churn (people changing coverage or becoming uninsured) on cost, quality, and continuity of care
- Support the design, implementation, and evaluation of state healthcare reform initiatives.

States use the Advance Planning Document (APD) process to request Medicaid Match funds from CMS and the process involves extensive collaboration among multiple entities and may require many months to complete. No other sources of federal dollars may be used to cover the state's share of costs.

FFP provided in support of APCD programs is available through two channels, Administrative Match and Enhanced Match.

Administrative Match – provides regular FFP (50% match rate) to offset expenditures for general Medicaid program administration (Social Security Act, § 1903(a)(7)). Some states (e.g., Utah) have obtained federal reimbursement via an administrative match for specific tasks and services provided by the APCD to the Medicaid program, e.g., development of Medicaid dashboards or reports.

Enhanced FFP – provides 90% FFP for design, development, and implementation (DDI) activities related to developing a claims processing module such as when setting up a new database to support Medicaid uses or business needs that can't otherwise be met, or re-orienting or configuring an existing database to support Medicaid, and 75% FFP for ongoing maintenance and operations (M&O) of these activities. In contrast to administrative match, other states have demonstrated that, in line with recent CMS guidance, the entire APCD claims processing module is eligible for enhanced match due to the value of the data and analysis that Medicaid will be able to access through the APCD. States have also secured resources for the Medicaid agency to prepare APCD data submissions and to use the reports and data products that are created by the APCD operation.

Table 9 shows the experience of four states in obtaining federal Medicaid match for FFP activities. Colorado and Utah chose an Administrative match while Rhode Island and Delaware opted for the Enhanced match.

Table 9: Medicaid Match Experience in Four States

	Colorado	Utah	Rhode Island	Delaware
Type of FFP	Administrative	Administrative	Enhanced	Enhanced
APCD Housed w/in Medicaid	No	No	Yes	No
Source of State Match	State Funds, Grants	State Funds	State Funds, Data User Fees, Grants	State Funds
Other APCD Funding Sources	All leverage Data User Fees and State Funds. None rely on Assessments			
% Federal Match	50/50	50/50	90/10 Year 1 75/25 Years 2-5	90/10 Year 1 75/25 Years 2-5
Start Date	2018		2018	2019
Total FFP Awarded	$890,000 year 1 Ongoing FFP amount TBD	$185,000/year	$1.8M/year 1 $1.4M/years 2-5	$3.65M Year 1 $3.6M Years 2-5

Level of Support or Share of APCD Costs Covered by FFP	Medium 41% of total CO APCD budget	Small Custom analysis and reporting only	Significant All APCD operating costs, including salaries and analytic enhancements
Purpose	Enhanced reporting capabilities to support Medicaid 41% share is based on the APCD budget attributed to Medicaid members	Produce up to 2 Medicaid-specific reports per year Provide Medicaid access to episode of care data, including cost and quality measures	APCD as a module within the Medicaid data warehouse and analytic layer – RI APCD provides data extracts to be incorporated as a module within the Medicaid data warehouse – DE Support Medicaid operational, reporting, and evaluation needs Support new federal Medicaid reporting requirements

An Alaska APCD will be a new implementation and likely qualify for enhanced match (90/10) funding to support design, development and implementation (DDI) activities for one or more years. Enhanced match would then be available to support maintenance and operations (M&O) for several years after that. Other APCD states have been successful in securing multiple rounds of Match funding to support expansion of data and analytic capabilities that benefit their Medicaid programs.

Data Access User Fees:

States with the most successful data use programs establish processes, in partnership with their multi-stakeholder Advisory and/or Data Release Committees, that allow a variety of stakeholders to access the data while maintaining appropriate privacy and security protections. As part of their data request process, most states charge a cost-based data use fee. While data use fees can help offset the cost of generating data products and operating the APCD, data use fees' contributions to total revenues tend to be modest and should be considered a supplemental revenue source only. It is also important to note that APCDs rarely generate data use fees in the first one to two years of operations.

There is substantial variation in how states set user fees for APCD data access. A number of factors contribute to APCDs' pricing strategies for data products. Colorado, for example, identifies indirect costs including legal fees, labor costs/time required, number of unique and specific data elements, output type (e.g., Tableau reports, Excel spreadsheet), and additional professional services/consultation required as factors that influence pricing. Each Colorado data extract is different, as are the costs. Some states charge for the creation of a specific dataset or report or offer subscriptions or licenses to support multiple users or uses.

As shown in Table 10, fees for data files and reports range from a few hundred dollars up to $300,000, depending on the number and types of files and the entity obtaining the data. Several states vary pricing based on the entity making the request and many states offer collaborating state agencies free or heavily discounted access to the dataset, only charging fees when the request includes analytic work in addition to data files. For example, Connecticut charges different prices for commercial, nonprofit or educational, state agencies, and assessed entities including hospitals and insurance companies. Washington has four fee tiers—reduced for nonprofits and state agencies, standard for data suppliers or

reportable entities, premium for single general users, and premium+ for multiple users within the same organization. Financial aid for applicants is available in two states (Arkansas and Colorado).

Table 10: Comparison of State APCD Data Access and User Fees

State	Price Per File	License or Subscription	Price Varies by Applicant?	Start of Data Release	Applicants Paying Fees Last Year
AR[1]	$2,800 - $3,800 annually	$200,000 - $300,000	✓	Not available	Not available
CO[2]	$10,000 +	$30,000 - $50,000	✓	2013	69
CT[3]	$3,000 - $12,000		✓	2017	7
ME[4]	$3,500 - $10,000		✓	Not available	20
MD[5]	$4,000 - $8,000		✓	2014	3
MA[6]	$7,500 - $37,500		✓	2013	9
OR[7]	$500 - $1,000			Not available	Not available
RI[8]		$25,000 - $87,500		2016	12
UT[9]	$20,000	$150,000	✓	Not available	Not available
WA[10]	$7,500 +	$40,000 - $107,500	✓	2018	2

Source: Reprinted from the California Office of State Health Planning and Development, "The Health Care Payments Data Program: Report to the Legislature," published March 9, 2020, page 84, https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Legislative-Report-20200306-ADA.pdf.

State APCDs typically create a restricted revenue fund that is authorized to accept revenue from non-government sources (e.g., data users) and restrict its use for a specified purpose (e.g., APCD-related costs). Without such a fund, revenue could be directed away from the APCD and to other state needs. For state agency data users, the APCD can utilize an interagency transfer process to move dollars from one agency to another in exchange for data access or services.

A Note about Grant Funding: Grants have been a source of temporary, short-term APCD funding for several APCDs. In past years, states were able to use federal grants from the Center for Medicare and Medicaid Innovation initiatives (SIM grants) and the Center for Consumer Information and Insurance Oversight (CCIIO) to start and enhance APCD programs. These grant programs have since expired, and CMS is not currently running any relevant grant programs.

Philanthropic funding has supported APCD development or expansion in a few states. Such funding tends to be time limited or project specific. Colorado's APCD notably received over $4M in startup funding to support general operations from local foundations. Subsequently, ***additional grant funds were provided for the "state match" portion of FFP*** and for specific reports that supported agency priorities. An example of a project-focused grant is Arnold Venture's recent three-year support for Virginia's statewide pilot to reduce utilization of low-value care. VA APCD data help drive this initiative and receive support for the cost of the related licenses and reporting that will support the project. The California Health Care Foundation has a history of supporting price transparency efforts in the state and provided support for the recent California APCD process by sponsoring research briefs to help stakeholders in developing a state-specific approach. APCD managers informally report that concentrating on specific reports can be challenging when core operations are under-resourced. While grant funding can be a helpful contributor to early development costs, foundations are more likely to

fund specific projects that have defined objectives and timeframes, rather than core operations. APCDs should not rely on grant funding as a stable, sustainable source of operational funding.

Alaska's APCD may be of interest to several foundations with an interest in supporting improvements in health and healthcare across the state. Generous support from foundations and nonprofits in the state, including the Rasmuson Foundation, have allowed the Alaska Healthcare Transformation Project to move forward, and the Mat-Su Health Foundation supported development of this report. An Alaska APCD may wish to pursue conversations with these organizations around ongoing support for operating costs that could serve as the "state match" under an enhanced FFP request, as well as for enhancements that expand the database's functionality for all users.

Funding Sources and Annual Cost Range Estimates by Phase: Table 11 recaps how other APCDs have approached creating a diversified and sustainable plan for continued operation of the program. APCD planners must recognize that data use fees can only be generated when the database is fully operational and ready to offer controlled access to new users through an appropriate review process. Experienced APCD administrators also caution that the volume of data use fees will not cover the entire operating budget and that a reliable funding stream is essential.

Table 11: Funding Sources by Phase of Development

Foundational (~12-24 months)	Operational (~24 months+)	Fully Enabled (Ongoing)
Medicaid Match (DDI)	Medicaid Match (DDI and M&O)	Medicaid Match (M&O and DDI)
State General Fund	State General Fund	Data Access or User Fees
Philanthropy and Grants	Data Access or User Fees	State General Fund
	Philanthropy and Grants	Philanthropy and Grants

Summary of Cost Ranges: Table 12 provides estimated cost ranges by phase of APCD development. These ranges are based on publicly available information and the experience of other states. No existing APCD has opted to partner with a LO and DMV from another state so more precise cost range estimates are unavailable. Actual APCD costs by phase of development will vary based on factors including the numbers of data submitters, files collected, covered lives and frequency of data submissions. Data submissions and database refreshes occur monthly, quarterly, semi-annually or annually depending on the information needs of the state and its stakeholders. While this does not significantly impact overall APCD IT expenses, personnel costs for quality assurance and other "hands-on" activities increase with greater frequency and vary by state. The use cases selected, and enhancements required are additional factors that will impact actual Alaska APCD development and operating costs.

Table 12: Annual Cost Range Estimates by Development Phase

Phase	Low	High
Foundational 1 (~12 months)	$450,000	$600,000
Foundational 2 (~12 months)	$900,000	$1.2 million
Operational (~24 months)	$1 million	$2 million
Fully Enabled (Ongoing)	$1.6 million	$2.3 million +

Recap - Principles for Success:

- Pursue a diversified APCD funding model that leverages multiple sources, as appropriate and by phase of development.
    - State appropriations provide stability and allow focus on state priorities.
    - Philanthropic support, if available, for startup and ongoing operations would be of great value to the project while a more durable plan is created. Consider whether there is an opportunity to use these funds for "state match" for FFP.
    - Set expectations around volume and timing of revenue from data use fees.
- Recognize participating agencies' level of effort when developing an overall funding plan.
- Plan for additional analytic tools and resources as the database matures.

Chapter Five: Moving Forward

This chapter describes the plan for moving forward, including activities needed to get the APCD established and the developmental phases of the project, click here for additional information on APCDs.

Getting Started via Legislative Action

HB 229 included some foundational principles for an APCD, notably the purpose of the database and some vision around the use cases. Going forward, the bill focusing on a mandatory APCD should answer the following questions:

- What is the public interest in collecting and using this data?
- Who must submit data?
- For what purposes may the data be used?
- Who is responsible for oversight, administration and monitoring sustainability?

States have continued to innovate in APCD governance since the publication of the APCD Council's "Model Legislation" in 2015[10]. Recent legislation for mandatory APCDs suggests that states are increasingly interested in delegating many of the necessary functions to experienced health data organizations operating outside state government. Enabling statutes that require the state to contract with a LO include Colorado, Virginia, Washington, Indiana and Georgia.

Based on the experience of the states that have implemented this model, Alaska's legislative language for the APCD should cover the following:

- *Providing a broad statement of purpose that the data may be used to help Alaska drive towards the Quadruple Aim of lower costs, better population health and improved quality and provider experience of care, without limiting future options. This might include categories of potential uses for an Alaska APCD, including transparent analytics to help Alaskans make informed choices about care, support benchmarking and value-based purchasing and promote competition based on quality and value. These are well-framed and appropriate goals for an APCD and should be reflected in the program going forward.*
- *Designating a state regulatory authority to oversee the APCD by:*
    - *issuing regulations,*
    - *contracting with the LO and DVM,*
    - *appointing the advisory committee and*
    - *collaborating with other state entities on funding arrangements*
- *Establishing an advisory committee comprising stakeholders representing consumers, policy makers, payers (private and public), providers, hospitals, trade organizations and state agencies to obtain feedback on plans for reports and data access.*
- *Authorizing required mandatory submission of data from commercial insurers (including Medicare Advantage), state-specific public payers (Medicaid, state employee benefits), dental and pharmacy claims and legal authority to accept voluntary data submissions, notably from private self-insured plans.*

[10] Hodder, Lucy et Al, "Model All-Payer Claims Database Legislation," APCD Council, 2015, accessed October 7, 2020 at https://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation

- *Requiring acquisition of Medicare FFS data from CMS.*
- *Authorizing PHI collection and maintaining it in a secure environment to promote longitudinal studies and alignment and linkages with other data files to support more nuanced analysis such as geographic variation and the impact of social determinants of health.*
- *Explicit direction to make the data available in appropriate formats, with review of requests containing sensitive data by a data access committee convened under regulation and comprised of knowledgeable stakeholders with diverse perspectives.*
- *Exempting the database from freedom of information or open records requests.*
- *Specific directive to contract with a LO and, through that agreement, empower the LO to collect data on behalf of the state and act as its agent in applying state regulations on data collection and access.*
    - *A further consideration is whether to allow a waiver of competitive bidding processes and permit the state to enter a sole source contract, allowing a single bidder to fulfill contract requirements, with one of the handful of LOs with experience in running a mandatory APCD.*
- *Delegating authority for establishing a data use fee schedule to the LO working in consultation with the state regulatory authority.*
- *Establishing an appropriation, ability to accept and spend grant funds, and create a retained revenue account with spending authority if data use fees are deposited in a state account.*

Some states require specific updates or an annual report on the status of the project to promote transparency and stakeholder awareness and engagement. A more effective strategy is to develop contractual requirements for the LO to produce various types of reports and data products to demonstrate the breadth, success and value of the project. Information about the database, including capabilities, access and data quality should be routinely distributed via publications on an Alaska APCD website.

Principle for success:

APCD planners should review recent successful legislation from other states to inform a conversation about the provisions that are the right fit for an Alaska APCD statute. While no state's law can be an exact "copy and paste" for another, California's recent law[11] is the product of extensive stakeholder discussions and research into national best practices and would be a useful starting point for discussion.

Foundational Tasks

Once the legislation is passed, the responsible state regulatory authority should initiate the regulatory process, prepare a funding strategy, contract with a LO paired with its DMV and develop a plan for stakeholder engagement. These tasks are divided into two Parts. Some states require that all Part 1 tasks be complete before starting Part 2. Other states allow some concurrent or overlapping activity in

[11] See https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=8.5.&article=

order to compress the timeline. This section describes a completely sequential process, where all Part 1 tasks must be completed before starting any Part 2 tasks.

Foundational Tasks, Part 1

Regulations: The formal regulatory process begins on the legislation's effective date. If the legislation is passed earlier in the session, an informal regulatory development process can begin with research into other states' approaches and discussions with prospective LO's, data submitters and potential data users. Initial indication from the Department of Law suggest that all phases of the regulatory process require 6 months to complete. The regulations address two parts of the process: data collection and data access.

Data submission processes (and the burden on submitters) may be streamlined if Alaska's data submission format is the same as the LO's other state. However, Alaska-specific regulations will still be needed to address unique features of the state's population and healthcare environment.

Key features of data collection regulations include:

- Thresholds for required submitters (usually based on the number of covered lives in the state)
- Timelines for initial and ongoing data submissions
- A submitter registration process and requirements to ensure data privacy and security are protected
- References to a detailed Data Submission Guide which includes required data submission formats, quality standards for acceptable files and exception and resubmission processes for files that do meet the standards.

Key elements of data access regulations include:

- Policies and procedures for public reporting and secure access to deidentified data and more detailed files in appropriate formats for state agencies, academic researchers and others
- Ideally, creation of a multi-stakeholder data access committee that will provide advice on the processes and procedures for making different types of data products available, including topics such as application information requirements, criteria for evaluation and data use fees. The data access committee may also advise on the data use fee schedule
- Terms and conditions of a state-approved data use agreement and a data privacy and security plan for approved requests for sensitive data.

Principles for success:

- At a minimum, data collection regulations should offer additional clarity on which entities must submit data, timelines for submission and processes for payer registration
    - Regulations should identify detailed data submission formats, quality standards, resubmission requirements and an exceptions process. At the same time, regulations should not confine the program to a specific DMV or proprietary process that will constrain future ability to update and modernize.
    - Submitters will welcome a statement of intent to limit changes to formal submission standards to once per year with compliance dates that reflect submitters' processes to update and test these changes.

- Data access regulations should provide additional clarity on requirements for public reporting and who can access the data and for what purposes. Regulations should require formation of a multi-stakeholder data access committee to develop specific policies and procedures, review requests and advise on alignment with statutory, regulatory and other requirements.

Funding and Sustainability: Chapter 4 identified four types of potential funding sources for Alaska's APCD: general fund appropriations, philanthropic and other grants, federal financial participation and data use/licensing fees.

To date, Alaska's philanthropic community has provided generous support for APCD planning and engagement activities. Additional grants would support continued development in the "Foundational" phase as the state regulatory authority turns to the task of writing regulations and a developing a scope of work for a LO. If DOI and DHSS are directed to collaborate on the project, these funds could support short term efforts to coordinate activity, research specific best practices in other states and develop draft documents as requested. These funds could also support stakeholder communications and feedback gathering processes.

Over the long term, states offer some support to APCDs through general appropriations, in part, to secure federal matching funds. Data use fees may offset a small portion of the total project cost and may grow over time as awareness of the database increases. These revenues become available only after the project is in full operation and the data are sufficiently credible. Moreover, initial demand is often higher than ongoing requests, so fee revenue can taper off if resources are not devoted to educating stakeholders on how the APCD can be used to support their work and how to access the data.

> *Emerging Opportunity - Federal Financial Participation: In close collaboration with DHSS, the APCD project could seek significant federal financial participation.*

As described in Chapter 4, since 2016, CMS has invited state proposals for augmenting Medicaid data resources with information drawn from aggregated claims data. Nine states –including Utah, Delaware, Colorado and Rhode Island -- have successfully demonstrated how APCD data and analytics can contribute to the Medicaid program. Topics noted in Chapter 4 include:

- Enhanced ability to meet CMS monitoring and reporting requirements
- Comprehensive views of healthcare cost, utilization, and quality for Medicaid members across payers and over time
- Provider and health system performance benchmarks
- Insight into patterns of care for future dually eligible populations that can help identify specific opportunities to improve care coordination and reduce costs
- Impacts of churn (people changing coverage or becoming uninsured) on cost, quality, and continuity of care
- Design, implementation, and evaluation of state healthcare reform initiatives.

States have requested support under two CMS FFP models: the traditional administrative match and newer guidance that makes claims processing modules like APCDs eligible for enhanced match. The latter option has generated significant support for APCD operations at an initial 90/10 rate, followed by

75/25 for maintenance and operations. States have also secured resources for the Medicaid agency to prepare APCD data submissions and to use the reports and data products that are created by the APCD operation. With respect to cost allocation, some states have successfully demonstrated that the entire APCD module supports Medicaid.

Principle for success:

The APCD should request an initial modest appropriation in combination with a request for philanthropic support to allow the project to move forward. As part of this initial phase, planners should give careful thought to seeking federal financial participation and determine which pathway is more advantageous. Over time, data use fee revenue could serve as a portion of the match funding requirement, further limiting the state's general fund contribution.

Foundational Tasks, Part 2

Contracting with a Lead Organization/Data Management Vendor: Alaska stakeholders have expressed a preference for working with a nonprofit health organization and its DVM that together operate an APCD in another state, making Alaska a national leader in pioneering a multi-state APCD model. Three such organizations (CO, VA, DE) currently operate state-mandated[12] APCDs, a fourth, the Washington Health Alliance, is currently in negotiations with the state to assume a similar role. The advantages of working with an experienced LO would allow the Alaska APCD to capitalize on an established infrastructure that has capacity for:

- Collecting and processing claims data files from commercial submitters, pharmacy benefit managers, dental carriers, Medicaid agencies and Medicare
- Evaluating the credibility of the resulting aggregated data assets
- Producing effective reports and data products to demonstrate value and drive change
- Insightful outreach and engagement with data submitters' technical staff
- Faster start up and shorter time to report production
- Applying lessons learned, avoiding pitfalls and expediting full implementation of the Alaska APCD.

At least two organizations have expressed interest in learning more about this opportunity to work with the state of Alaska and manage the operation of the state's APCD. Issues that need additional exploration include:

- Assessing whether another state's data collection format will fully support Alaska's desired use cases and how differences or deficiencies would be addressed
- How will the LO gain insight into Alaska's unique health care system, diverse payers and geographic factors to inform creation of meaningful, credible reports and data products?
- Who will lead continuous engagement with Alaska's advisory committee and other stakeholder groups?
- Does the LO have capacity to rapidly scale up to meet Alaska's needs?

[12] Many other organizations in the western US collect health care claims data on a voluntary basis and have not needed to consider state regulatory requirements, interpreting paid amounts or providing structured access to approved data users.

- Can the LO pivot to a client service model and hold firm to meeting the Alaska APCD timelines and priority reporting needs?
- Is the LO financially stable? Is there a plan for continuity of Alaska's data operations if the LO experiences an interruption in other revenue streams?

To clarify a LO's capability and capacity, Alaska might consider issuing a Request for Information (RFI) to gauge interest from the LOs identified to date and to learn whether others may have relevant experience. RFIs may request information about the estimated cost of the project. This process could begin in the near term, would elicit a prospective LO's approach to the issues needing further exploration and allow Alaska to develop customized language for the overall contract.

Stakeholder engagement: During the foundational stage, advisory groups can provide a forum for stakeholders to come together to share concerns and learn more about the process and progress of the APCD. Discussions about how the data will be used are typically of high interest once data collection has been authorized. Stakeholders will want to understand who will decide on the types of reports that are published, criteria for prior review and how sensitive data will be handled. These discussions may support development of a "comprehensive reporting plan" that lays out what will be reported and when. For example, as shown in the table in Chapter 1, the state created a three-tier structure[13], where Tier 1 reports would show aggregated information and summary statistics highlighting variation in utilization and spending on a population basis statewide and by region, payer type, age group and gender. Tier 2 reports could add claims-based quality measures and information on prevalence and costs to treat chronic conditions. Tier 3 reports could reflect the addition of analytic enhancements such as episodes of care and utilization and cost of low value services.

Operational

When the project moves into the data collection phase, the LO assumes responsibility for day-to-day operations of the database. The state regulatory authority maintains oversight for compliance with contract terms and any formal liaison roles with state budget or Medicaid offices. In addition, the regulatory authority may help shape the reporting agenda to generate data and analysis that supports critical agency functions and tasks, as described in Chapter 1's Use Cases.

The Road Forward

Figure 9: One Option for Process Flow describes the major next steps in bringing the Alaska APCD into operation. The process begins with legislation that directs a state regulatory authority to begin implementation and includes other key provisions regarding data collection and data access. During the Foundational phase, the regulatory authority must promulgate more detailed regulations regarding data collection and data access. The regulatory authority may also make provisions for contracting with a LO to provide day-to-day operational support such as data collection, stakeholder engagement and a data access strategy. The regulatory authority may also serve as the liaison to other state agencies with administrative responsibilities (e.g., OMB, DHSS) as well as those that have an interest in obtaining insights from reports and analysis of the database. The LO and its DMV assume responsibility for all

[13] See page 21, California Office of Statewide Planning and Development Health Care Payments Data Program Report to the Legislatures, March 9, 2020, https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Legislative-Report-20200306.pdf,

matters related to data collection, processing, enhancement, quality assurance, producing reports and distribution of all data products. A qualified LO will have extensive experience in enhancing the data, developing accurate and informative reports and providing insight into expanding the user community through appropriate channels.

Figure 9: One Option for Process Flow

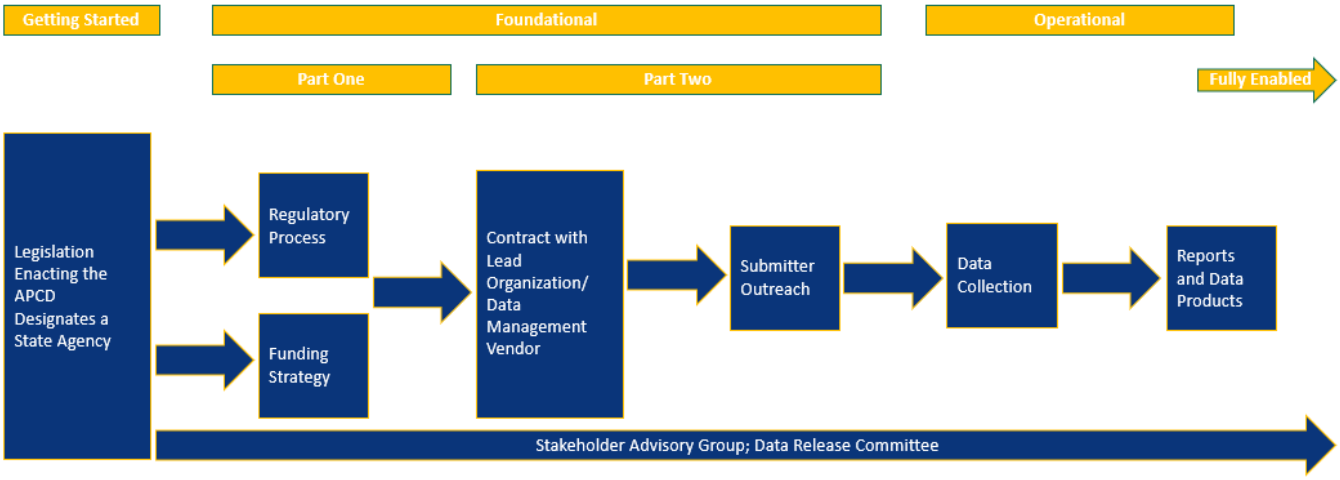


Table 13: Activity Phases provides additional detail about the tasks required during each phase. It is important to note that states handle the sequencing of the LO contract in different ways. Washington completed its regulatory process before engaging its LO in 2017. Colorado was able to use philanthropic grants to engage the LO at an early stage to support the regulatory process, planning for implementation and development of a longer-term funding strategy. The choice stems from an assessment of the state agency's bandwidth and resource availability.

Table 13: Activity Phases

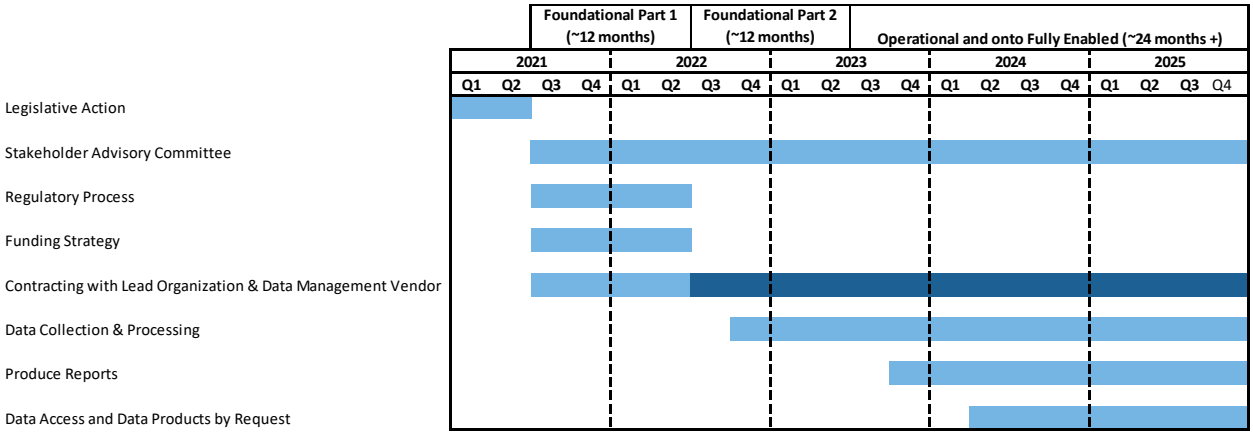
	State	In-State Nonprofit	Lead Organization & Data Management Vendor		Estimated Annual Cost Range
			Data Collection & Processing	Reports and Data	
Legislative Phase	• Work with supporters to create shared understanding of roles and responsibilities during legislative session • Recommend language that promotes the agency's vision for its role and use of the data	Assist as needed with communication strategy	No activity, not yet under contract		TBD
Foundational – Part 1 Approximately 12 months	• Convene Advisory Committee: discuss implementation issues; develop preliminary reporting plan • Develop and issue regulations • Pursue Federal Match with state appropriation and/or private philanthropy	Facilitate meetings; assist with regulatory process, LO contracting, funding strategy including grant and FFP planning	No activity, not yet under contract		$450,000-$550,000
Foundational - Part 2 Approximately 12 months	• Contract with LO: Depending on legislation, competitively procure or sole source contract	• Outreach to submitters • Develop tiered Reporting Plan • Develop access policies and procedures including an advisory group to review data use requests • Oversee data quality	• Advise on data submission formats • Use processes established for other state APCDs • Obtain Medicare data from CMS		$900,000 - $1.2 million

	State	In-State Nonprofit	Lead Organization & Data Management Vendor		Estimated Annual Cost Range
			Data Collection & Processing	Reports and Data	
Operational Approximately 24 months	• Annual rule updates, if necessary • Monitor contract performance; issue payments • May assist with coordinating data use by sister state agencies • Federal Match with state appropriation and/or private philanthropy offset by initial data use fee revenue	• Periodic meetings with Advisory Committee to refine Reporting Plan • Manage data access plan and requests for data • Continue monitoring data quality of inputs and reports • Support revenue generating activity with marketing and outreach	Continue: • Engage submitters on data quality • Ongoing data collection and processing	• Provide and then refine Tier 1 reports (e.g. add drilldowns) and develop Tier 2 reports • Facilitate access to appropriate data for approved users; may include appropriate public data • Access for researchers	$1 million -$2 million
Fully Enabled Ongoing	• Increased offset of state funding and support federal match with data use fee revenue	Coordinate/ facilitate periodic meetings with Advisory Committee to refine Reporting Plan	Continue to: • Engage submitters on data quality • Ongoing data collection and processing	• More sophisticated and longitudinal analysis • Build out Tier 3 advanced analytics and reports	$1.6 million - $2.3 million

The road to an Alaska APCD begins with legislative action that starts in January 2021 and results in a mandated APCD with an effective date of July 1, 2021. Figure 10: Development Timeline assumes that the regulatory authority will need approximately one year to develop data collection regulations, develop a funding strategy and contract with a LO/DMV. Assuming that regulations are effective on July 1, 2022, data collection would then proceed with outreach to submitters followed by file submissions beginning in late 2022. In this scenario, high level, aggregated reports could be available in the latter part of 2023 with the ability to fulfill data requests starting in mid-2024.

This schedule assumes that the regulatory authority will be able to take on the regulatory, funding and contracting work within a 12-month period. The regulatory authority may determine that the LO may have specialized knowledge and should assist with regulations development and building out a longer-term funding strategy. In this case, the start times for data collection and report production will move forward into a later year.

Figure 10: Development Timeline



Appendix C: Detailed Project Plan and Risks shows the tasks, intervals and predecessors and identifies risks and mitigation strategies.

Measuring Outcomes

Early stage APCD supporters are often pressed to quantify a "return on investment" for the project, a connection between the expenditure in one area and a specific, quantifiable impact on some aspect of the healthcare system. An APCD does not have a traditional ROI: an APCD is not a pure price control or policy tool. Rather, the insights that can be gained through analysis of the database stretch across multiple areas: health care policy, enhancing public health and helping employers and consumers find high value care. Alaskans can learn where there are opportunities to reduce low value care and see the rates at which recommended care is being provided, with the goal of improving population health and slowing the progression of chronic illness. Availability of comparative cost, utilization and quality information helps identify specific opportunities for improvement and supports more informed policy discussions.

With the data and reports from the Alaska APCD, Alaskans will have the opportunity to make thoughtful, directed investments into programs and services that help drive towards the Quadruple Aim. In times of resource constraints, Alaska APCD data will provide a window into progress toward achieving health system transformation goals and support program effectiveness review and course correction. With input from diverse groups informing its creation, the Alaska APCD will provide essential support to building a more efficient and equitable healthcare system for Alaska.

Recap - Principles for Success:

- Legislation: Review recent successful legislation from other states to inform a conversation about the provisions that are the right fit for an Alaska APCD statute. While no state's law can be an exact "copy and paste" for another, California's recent law[14] is the product of

[14] See https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=8.5.&article=

extensive stakeholder discussions and research into national best practices and would be a useful starting point for discussion.
    - Pursue a state appropriation
    - Pursue "Enhanced Federal Match"
- Data Collection: At a minimum, data collection regulations may define the entities who must submit data, the timelines for submission and the processes for payer registration
    - Regulations should identify detailed data submission formats, quality standards, resubmission requirements and an exceptions process. At the same time, regulations should not confine the program to a specific vendor or proprietary process that will constrain future ability to update and modernize.
    - Submitters will welcome a statement of intent to limit changes to formal submission standards to once per year with compliance dates that reflect submitters' processes to update and test these changes.
- Data access regulations should provide additional clarity on requirements for public reporting and who can access the data and for what purposes. Regulations should require formation of a multi-stakeholder data access committee to develop specific policies and procedures, review requests and advise on alignment with statutory, regulatory and other requirements.

Appendix A: Vendor Contact Information for APCDs in Full Operation

State	Mandatory or Voluntary	State Agency or Lead Organization	Data Management Vendor	Contact	Email
Colorado	M	Center for Improving Value in Health Care	HSRI/NORC	Leann Candura	lcandura@hsri.org
Maine	M	Maine Health Data Organization			
Oregon	M	Oregon Health Authority	In transition From: Milliman To: HSRI/NORC		
Delaware	M	Delaware Health Information Network	Medicasoft	Mike O'Neill	mike.oneill@medicasoftllc.com
Missouri	V	Midwest Health Initiative	Milliman	Al Prysunka	Al.Prysunka@milliman.com
New Hampshire	M	Department of Insurance			
Utah	M	Department of Health			
Virginia	M	Virginia Health Information			
Washington	V	Washington Health Authority			
California	V	Integrated HealthCare Association	Onpoint	Jim Harrison	jharrison@onpointhealthdata.org
Connecticut	M	Office of Health Strategy			
Minnesota	M	Department of Health			

Rhode Island	M	Health Department			
Vermont	M	Green Mountain Care Board			
Washington	M	Washington Health Alliance*			
Wisconsin	V	WI Health Information Organization	SymphonyCare	Sal Braico	Sal.braico@symphonycare.com

*Contract in progress.

Appendix B: Procurement Tasks

A. **Getting ready for procurement**

1. Envision final products
    a) Define reporting needs
    b) Confirm data submitters

B. **Consider using a Request for Information to gauge lead org interest**

C. **Use another state's RFP as a model where services and requirements are similar**

1. Ensure that RFP addresses any state-specific special provisions that are created by the rules
2. Establish clear and measurable deliverables and expectations

D. **Define foundational tasks that must be done by state agency**

1. Legislation
2. Issue rules (rules may be drafted by Lead Org, which may also draft public comment responses, etc.)
3. Funding strategy
4. Coordinate interagency collaboration

E. **Lead Organization/Project Manager: Scope of Work**

1. Funding plan

2. Facilitation Tasks
    a) Liaison to state regulator and other state agencies; "face" of the project
    b) Stakeholders –periodic meetings, informational materials, talking points
        (1) Reporting Plan: how the data will be used
        (2) Definitions of mandatory submitters
        (3) Data to be reported
        (4) Timeline for data submission
        (5) Data access process, including fees for access to data products
        (6) Alternative payment data submission
    c) Reporting plan design and execution
    d) Data access process – design, review applications, facilitate committee discussions, send approved files out, collect fees
    e) As directed, design methodology for collecting and reporting alternative payment methodology data

3. Project budgeting and cash flow; financial reports and budget requests as needed
    a) Liaison to Medicaid agency; may assist with drafting FFP requests

b) Review/approve data management vendor invoices; determine SLA compliance

4. Monitor data management vendor performance

a) Review and approve data submission documentation
b) Monitor data quality through reports and, if necessary, hands on access to raw data
c) Review operational dashboards
d) Review all deliverables and documentation archives

5. Lead report design and analytics (Lead organization may produce the reports itself or oversee the work of the DMV or another company).

6. Lead consumer facing website design, rollout, UAT, social media etc.

F. **Data Management Vendor Scope of Work Requirements**

1. Data collection

a) Payer registration and credentialing
b) Intake Medicaid and Medicare files
c) Establish a secure data submittal portal; provide training and technical assistance to submitters
d) Establish and maintain a submitter variance process
e) Maintain a compliance process for data at intake, including timely notification of acceptance or rejection for submitters; provide data quality checks to submitters
f) Collect test, historical and periodic files, checking for initial compliance and allowing for resubmission
g) Track and report on all activity

2. Data Processing

a) Collect and Integrate data from all sources
(1) Crosswalk Medicare FFS data to APCD format
(2) Ensure that Medicaid encounter and FFS data is correctly loaded
(3) Assign Master Patient identifier
(4) Resolve cross payer member identities (accounting for Medicare/Medicaid duals and Medicaid beneficiaries with limited coverage)
b) Perform extensive data quality processes
c) Identify and align final paid versions of claims
d) Enhance data – examples –not a complete inventory
(1) Groupers – episodes, hospital inpatient stays
(2) Reference data –drug names, categories
(3) Geographic data
(4) Patient-provider attribution
e) Store raw and processed data

3. Data Product Delivery

a) Public facing reports according to Reporting Plan

b) Fulfill approved data requests with standard and custom extracts or via access to a data enclave

4. Consumer facing website – data delivery only – design services by Lead Org
5. Project management
    a) Tracking and operational dashboards
    b) Documentation of business rules, technical specifications archive, standardized processes

G. **Evaluation Criteria for a Lead Organization and Data Management Vendor**

1. For both Lead Organization and Data Management Vendor
    a) Experience
    b) Capacity for additional projects – physical, "mental energy"
    c) Financial stability
2. Evaluation Criteria for Lead Organization
    a) Knowledge of healthcare policy, data and public data projects
    b) Established stakeholder relationships
    c) National perspective on innovation and emerging data uses
    d) Experience managing a data access process
    e) Capacity to build relationships with providers
    f) Demonstrated experience in overseeing data quality processes
    g) Provides leadership in creating and expanding the market for multi-payer claims data through diverse strategies

H. **Evaluation Criteria for Data Management Vendor**

1. Minimum Qualifications:
    a) At least five (5) years of experience collecting claims information from multiple health insurers in a prescribed data submission format;
    b) At least five (5) years of experience in claims validation and at least five (5) years of experience in quality assurance;
    c) At least five (5) years of experience in the secure management, storage, and transmission of HIPAA protected data that is compliant with federal rules and regulations;
    d) At least five (5) years of experience designing and delivering data extracts that support analytic or research projects;
    e) At least five (5) years of experience in medical claims analytics.
2. Understanding of the scope of the project and Alaska's needs
3. Prior experience with voluntary data submissions
4. Robust, well documented data quality processes at all phases of data collection, processing, analytics, reports and data access.

Appendix C: Detailed Project Plan and Risks

A. Detailed Project Plan

ID	Outline Number	Task Name	Start	Finish	Predecessors
1	**1**	**Getting Started**	**Mon 1/4/21**	**Wed 6/30/21**	
2	1.1	Preliminary budget and supporting documentation	Mon 1/4/21	Mon 2/1/21	
3	1.2	Legislation filed and passed	Tue 1/19/21	Wed 6/30/21	
4	**2**	**Foundational Tasks Part 1**	**Thu 7/1/21**	**Mon 1/31/22**	**3**
5	2.1	Stakeholder Advisory Committee to develop Reporting Plan (Tier 1, 2, 3)	Thu 7/1/21	Wed 12/15/21	
6	2.2	Regulatory Process	Thu 7/1/21	Wed 12/15/21	
7	2.3	Meet with "sister" state agencies to develop state agency data needs	Thu 7/1/21	Wed 8/25/21	
8	**2.4**	**Funding in Place**	**Thu 7/1/21**	**Mon 1/31/22**	
9	2.4.1	Confirm budget and funding schedule	Thu 7/1/21	Wed 8/25/21	
10	2.4.2	Create Appropriation Accounts and LO spending authority	Thu 8/26/21	Thu 9/23/21	9
11	**2.4.3**	**Philanthropic Opportunity**	**Thu 7/1/21**	**Fri 10/22/21**	
12	2.4.3.1	Determine interest	Thu 7/1/21	Wed 7/28/21	
13	2.4.3.2	Develop request	Thu 7/29/21	Thu 9/23/21	12
14	2.4.3.3	Receive funds	Fri 9/24/21	Fri 10/22/21	13
15	**2.4.4**	**Obtain FFP "Medicaid Match"**	**Thu 7/1/21**	**Mon 1/31/22**	

ID	Outline Number	Task Name	Start	Finish	Predecessors
16	2.4.4.1	Planning -- approach and use cases	Thu 7/1/21	Wed 8/25/21	
17	2.4.4.2	Develop P-APD	Thu 8/26/21	Thu 9/23/21	16
18	2.4.4.3	Develop IAPD	Fri 9/24/21	Mon 11/22/21	17
19	2.4.4.4	CMS Review	Tue 11/23/21	Mon 1/31/22	18
20	2.4.4.5	Earliest Draw Down	Mon 1/31/22	Mon 1/31/22	19
21	**3**	**Foundational Tasks Part 2**	**Thu 7/1/21**	**Tue 5/24/22**	
22	**3.1**	**Contract with LO/DMV (Competitive Bid)**	**Thu 7/1/21**	**Tue 5/24/22**	**1**
23	3.1.1	Draft preliminary scope of work	Thu 7/1/21	Wed 8/4/21	
24	3.1.2	Draft and issue request for Information to answer questions about LO role	Thu 8/5/21	Thu 9/9/21	23
25	3.1.3	Receive responses to RFI and review	Thu 9/9/21	Thu 9/9/21	24
26	3.1.4	Draft request for proposal and refine scope of work	Fri 9/10/21	Fri 10/22/21	24
27	3.1.5	Internal reviews	Mon 10/25/21	Mon 11/22/21	26
28	3.1.6	CMS Contract Review	Tue 11/23/21	Wed 12/22/21	27
29	3.1.7	Issue RFP	Mon 11/22/21	Mon 11/22/21	27
30	3.1.8	LO Prepares and submits response	Tue 11/23/21	Mon 1/31/22	29
31	3.1.9	Evaluate proposals	Tue 2/1/22	Tue 3/1/22	30
32	3.1.10	Conduct negotiations	Wed 3/2/22	Tue 3/29/22	31

ID	Outline Number	Task Name	Start	Finish	Predecessors
33	3.1.11	State completes internal reviews	Wed 3/30/22	Tue 5/24/22	32
34	3.1.12	Sign contract	Tue 5/24/22	Tue 5/24/22	33,20
35	**3.1.13**	**Stakeholder Engagement**	**Thu 7/1/21**	**Thu 9/23/21**	
36	3.1.13.1	Advise on reporting plan	Thu 7/1/21	Thu 9/23/21	
37	3.1.13.2	Advise on data access plan	Thu 7/1/21	Thu 9/23/21	
38	3.1.13.3	Advise on framework for reviewing applications for reports and data products	Thu 7/1/21	Thu 9/23/21	
39	**4**	**Operations: Collect Data and Produce Analytic Files**	**Wed 5/25/22**	**Fri 5/8/26**	
40	**4.1**	**Lead Org/DMV**	**Wed 5/25/22**	**Fri 5/8/26**	
41	4.1.1	LO Ready to begin operations, including DMV data portal, etc	Wed 5/25/22	Thu 7/21/22	34
42	**4.1.2**	**Ongoing LO operations**	**Fri 7/22/22**	**Fri 5/8/26**	
43	**4.1.2.1**	**Data Submitter Outreach and Registration**	**Fri 7/22/22**	**Thu 12/15/22**	**41**
44	4.1.2.1.1	Establish data collection formats/re-use those used by LO	Fri 7/22/22	Thu 8/4/22	34,6
45	4.1.2.1.2	Contact and register commercial submitters	Fri 7/22/22	Thu 8/18/22	
46	4.1.2.1.3	Request & receive Medicare Data via ResDac	Fri 7/22/22	Thu 12/15/22	34,20
47	4.1.2.1.4	DHSS Files Mapped, Extracted, Tested	Fri 8/5/22	Thu 12/1/22	44
48	**4.1.2.2**	**Data Collection**	**Fri 8/19/22**	**Fri 7/11/25**	
49	4.1.2.2.1	Commercial submitters test data	Fri 8/19/22	Fri 9/16/22	44,45,6

ID	Outline Number	Task Name	Start	Finish	Predecessors
50	4.1.2.2.2	Commercial submitters' historical files (2019-2021)	Mon 9/19/22	Mon 10/17/22	49
51	4.1.2.2.3	Commercial submitters year to date	Tue 10/18/22	Tue 11/15/22	50
52	4.1.2.2.4	Commercial files Regular production begins (monthly or quarterly)	Wed 11/16/22	Mon 1/23/23	51
53	4.1.2.2.5	DHSS Files – Historical	Fri 12/2/22	Fri 1/6/23	47
54	4.1.2.2.6	DHSS Files -- year to date	Mon 1/9/23	Mon 2/6/23	53
55	4.1.2.2.7	DHSS Files Regular Production begins (monthly or quarterly)	Tue 2/7/23	Fri 7/11/25	54
56	4.1.2.2.8	Medicare Data Mapped and loaded	Fri 12/16/22	Mon 2/6/23	46
57	**4.1.2.3**	**Data Processing**	**Mon 1/9/23**	**Fri 5/8/26**	
58	4.1.2.3.1	Data Quality Reviews -- Historical data	Mon 1/9/23	Tue 3/7/23	53
59	4.1.2.3.2	Data Quality Reviews - Year to date	Wed 3/8/23	Tue 4/4/23	54,58
60	4.1.2.3.3	Production files ready	Wed 4/5/23	Wed 5/31/23	53,54,59,58
61	4.1.2.3.4	Production files ongoing updates	Thu 6/1/23	Thu 6/12/25	60
62	**4.1.2.3.5**	**Enhancements**	**Thu 6/1/23**	**Fri 5/8/26**	**60**
63	4.1.2.3.5.1	Example Enhancement 1 -- test, run, QA, load to production	Thu 6/1/23	Thu 7/27/23	60
64	4.1.2.3.5.2	Example Enhancement 2 -- test, run, QA, load to production	Fri 7/28/23	Fri 9/22/23	63
65	4.1.2.3.5.3	Example Enhancements ongoing	Thu 6/1/23	Fri 5/8/26	
66	**5**	**Fully Enabled: Produce Reports**	**Fri 7/28/23**	**Thu 6/12/25**	

ID	Outline Number	Task Name	Start	Finish	Predecessors
67	**5.1**	**Public Report production**	**Fri 7/28/23**	**Thu 6/12/25**	
68	**5.1.1**	**Tier 1 Reports**	**Fri 7/28/23**	**Mon 4/22/24**	
69	5.1.1.1	Tier 1 First Round of Reports	Fri 7/28/23	Mon 10/23/23	60,63
70	5.1.1.2	Tier 1 Second Round of Reports	Mon 1/29/24	Mon 4/22/24	69FS+60 days
71	5.1.2	Tier 2 Reports	Fri 9/13/24	Fri 11/8/24	70FS+100 days
72	5.1.3	Tier 3 Reports	Thu 4/17/25	Thu 6/12/25	71FS+100 days
73	**6**	**Fully Enabled: Data Access and Data Products by Request**	**Thu 12/16/21**	**Thu 6/12/25**	
74	6.1	Data Review Committee -- initially convened to shape process	Thu 12/16/21	Tue 5/17/22	6
75	6.2	Processes and criteria developed	Tue 1/25/22	Tue 3/22/22	74FS-80 days
76	6.3	Accept applications for data & fulfill requests	Tue 10/24/23	Thu 6/12/25	75,60,69

B. Risks to the Project Plan and Timeline

Risk	Mitigation
Legislation does not pass in 2021	• Develop and execute communication plan, informed by 2020 feedback
Alaska stakeholders are not engaged	• Lead Organization contract requires Alaska “boots on the ground” regardless of where Lead Organization is based
Regulatory process is extended beyond time in plan	• Review regulations in Lead Organization’s state and align to the greatest extent possible • Prepare communication plan including outreach to and updates for data submitters (often a workgroup)
Delays in acquiring funding	• Use philanthropic funds to bridge while state or federal funding is in progress

	• Use funding for lead organization to get ready for data collection with essential but relatively low-cost activities such as stakeholder engagement around a reporting plan and access to data.
Data submissions are delayed	• Regulations direct Lead Organization to use a common data layout • Align Alaska APCD data quality standards with the Lead Organization's other states