All Payer Claims Database Advisory Group

NOTICE OF MEETING AND AGENDA

Date:	Thursday, July 10, 2014
Time:	9:00 a.m. to 11:00 a.m.
Location:	Legislative Office Building, Room ID 300 Capitol Avenue, Hartford, CT 06103
Conference:	(877) 716-3135 Participant Code: 23333608
Directions:	http://www.cga.ct.gov/olm/directions2.asp

I. Call to Order and Introductions

II. Public Comment

III. Approval of April 10 and June 12, 2014, Meeting Minutes

IV. CEO / ED Updates

V. Development Planning for APCD

VI. Medicaid Data Usages – Examples from other States' APCDs

VII. Update on Medicaid Data from DSS

VIII. Status of Subcommittees

IX. Next Steps

X. Future Meetings

XI. Adjournment

Public comment of the agenda is limited to two minutes per person and is not to exceed the first 15 minutes of each meeting. A sign-in sheet will be provided.

Access Health CT is pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Christen Orticari at (860) 241-8444.

Meeting materials will become available at: www.ct.gov/hix following each meeting.

For further information concerning this meeting, please contact Christen Orticari at (860) 241-8444 or **Christen.Orticari@ct.gov**.

Connecticut Health
FOUNDATION
Changing Systems, Improving Lives.

July 9, 2014

Access Health Analytics All Payer Claims Database (APCD) Advisory Group, Executive Director Ahmed, and staff, my name is Elizabeth Krause. As VP of Policy and Communications, I am providing public comment on behalf of the Connecticut Health Foundation (CT Health), the state's largest independent health philanthropy.

CT Health is a health equity funder dedicated to improving the lives of Connecticut residents through systemic change. As such, we have long held that Connecticut's APCD is an exciting new mechanism that will enable us to more transparently measure care across payers with an eye toward improvement. In 2012, CT Health made a $50,000 grant to the then state Office of Health Reform and Innovation. This grant supported some of the formative APCD research and planning that Freedman Health Care conducted in the state. In 2012 and 2013 CT Health provided a total of $50,000 in grant funding to the Connecticut Center for Patient Safety in conjunction with the Connecticut Health Policy Project resulting in the report "The Power of Data: Consumer Involvement and Accountability for Connecticut's All Payer Claims Database" and a well-attended October 2013 expert roundtable.

The foundation was concerned to recently learn that Medicaid may not be included in Connecticut's APCD. CT Health had operated under the assumption that all payer would mean all payer and we had been following other states that have included Medicaid in their APCDs, as will be discussed on today's agenda.

We believe it is imperative that Medicaid be included in Connecticut's APCD for several reasons:

- Connecticut will not maximize the APCD's potential as a resource and tool without claims data from the state's largest payer, which now covers over 740,000 lives.
- Including Medicaid, which provides medical, behavioral, and dental services to vulnerable populations (with regard to income, race/ethnicity, and disability), is essential for monitoring and comparing the extent to which various payers are providing more access to better quality care for populations that have long experienced health inequities.
- Many children who are covered by HUSKY have family members who are commercially insured.

(Over)

- Growing concerns about consumer enrollment volatility ("churn") between public and private insurance makes having uniform and integrated eligibility and claims data sets all the more important. Ben Sommers from the Harvard School of Public Health published a national survey in Health Affairs that estimated 35% of adults will have a change in eligibility in 6 months and 50% will have a change over a 12 month period.
- The APCD is noted as a key enabling initiative in the current draft of the State Innovation Model ("SIM") test grant application, in which Medicaid now has a more prominent role.
- Providing claims data to the APCD will provide Medicaid with the opportunity to improve program administration. The Department of Social Services (DSS) has many important priorities and there is an understandable limit to the agency's resources to consistently conduct data analysis on all aspects of the program. To allow Medicaid claims data to go into APCD will benefit DSS as more resources will be brought to bear around understanding how Medicaid is performing and how it can be improved.

In closing, the Connecticut Health Foundation asks the APCD Advisory Committee and Access Health Analytics to partner with DSS to allow Medicaid claims data to be incorporated into Connecticut's APCD, which will increase opportunities for program enhancement.

Please do not hesitate to contact me at 860.724.1580.

Special Meeting of the All Payer Claims Database Advisory Group

Draft Meeting Minutes

Date: Thursday, June 12, 2014
Time: 9:10 a.m. – 11:00 a.m. EST
Location: Legislative Office Building, Room 1E

Members Present

Tamim Ahmed, Robert Aseltine, Robert Tessier, Mary Ellen Breault for Thomas Leonardi, Kimberly Martone, Jean Rexford, Matthew Katz, Dr. Robert Scalettar, James Iacobellis, Victor Villagra (phone), Mary Taylor, Vicki Veltri, Michael Michaud for Patricia Rehmer , Barbara Parks Wolf for Ben Barnes, Joshua Wojcik for Kevin Lembo

Members Absent

Kevin Counihan, Roderick Bremby, Anne Melissa Dowling, Jewel Mullen, Dr. Mary Alice Lee, Dean Myshrall, Thomas Woodruff

Other Participants

Phyllis Hyman, Virginia Lamb, Robert Blundo, Matthew Salner, Christen Orticari

---

I. Call to Order and Introductions

Tamim Ahmed called the meeting to order at 9:10 a.m. and members introduced themselves.

II. Public Comment

There was no public comment.

III. Approval of April 10th, 2014 Meeting Minutes

Mary Taylor requested the removal of the sentence fragment under Section X on Next Steps, which included her name. Matthew Katz suggested formatting changes and asked that his motion, during the Section VII on Legal Issues Concerning Various Aspects of the APCD, be further clarified. Acceptance of the minutes was tabled until the next meeting.

IV. CEO/ ED Updates

Mr. Ahmed provided an overview of the procurement process for a data management vendor and explained work continued on the contract. Virginia Lamb stated that information from the contract's statement of work could be shared with members in the future. Mr. Ahmed reported that various data privacy and security issues were being addressed in the Data Privacy and Security Subcommittee, and commented that the denied claims use cases and dental data intake processes were in consideration by the Policy and Procedure Enhancement Subcommittee. Mr. Ahmed said that AHA was in discussions regarding partnership on the State Innovation Model (SIM) grant. Mr. Ahmed briefed the group on the security audit of the data management vendor.

DRAFT

V. DSS

Mr. Ahmed introduced Phyllis Hyman, an attorney for the Department of Social Services (DSS), and stated that at the last Advisory Group meeting, members expressed interest in learning more about DSS plans to submit Medicaid data to the APCD.

Ms. Hyman summarized state and federal laws regarding submission of Medicaid data. She said that the APCD enabling legislation (CGS Section 38a-1091) did not require the reporting of Medicaid data to the APCD. Ms. Hyman also cited federal Medicaid regulations (42 CFR 431.300 to 431.307, inclusive) which allowed Medicaid data disclosure for purposes directly related to Medicaid plan administration. Members discussed whether the proposed uses of APCD data would meet the definition of "plan administration" under these regulations. Vicki Veltri mentioned that other state APCDs incorporate Medicaid data. **Mr. Katz made a motion to formally request that DSS provide a written explanation, by the next APCD Advisory Group meeting, of whether it is possible to submit Medicaid data to the APCD, and that DSS work with the APCD Advisory Group to justify this data submission with regard to the federal regulations concerning Medicaid plan administration. Ms. Veltri seconded the motion.** Dr. Scalettar proposed an amendment which would require AHA staff to work with DSS to research the submission of Medicaid data to other state APCDs. Mr. Katz said that the amendment was not friendly, because it was the responsibility of DSS to make a decision on this matter. Dr. Scalettar withdrew his amendment. Mr. Ahmed called for a vote on Mr. Katz's motion. **Motion was passed unanimously without abstention.**

VI. Procurement Overview

Mr. Ahmed reported on the data management vendor procurement. A summary was provided on the Request for Proposals (RFP) review and evaluation process. Out of the five vendors who met the criteria for an internal review, the top three were invited to give oral presentations. One of the three vendors was unable to present at the scheduled time. AHA is working with legal counsel to develop the contract and will begin negotiations with the selected vendor in the near future.

VII. Update on Proposed Timeline for Data Collection

Robert Blundo briefed members on the AHA proposal for an updated timeline for data intake. Mr. Blundo reviewed the newly proposed submission timeline for planning purposes following the contract effective date. The proposed revised timeline was contingent on the date of the first kick off meeting with the vendor onboard and all submitters.

VIII. Status of SIM Project and APCD Collaboration

Mark Schaefer, director of the SIM Program Management Office, presented an overview of the SIM Initiative and discussed potential opportunities to collaborate with the APCD. Mr. Schaefer described the funding announcement, goals, and timeline for the new four-year SIM grant opportunity. The high level goals targeted triple aim initiatives, which support the creation of a "whole person" centered system with increased access to care and reduced costs. The SIM PMO is presently developing plans to accomplish nine requirements throughout the four year timeframe allotted by CMS.

Mr. Schaefer discussed ways that SIM may be able to collaborate with the APCD to facilitate the accomplishment of operational and data intake requirements. If DSS is unable to share Medicaid data with the APCD, SIM may be able to support the inclusion of this data in through an edge server, which is being procured. Mr. Schaefer said that the APCD could play in integral role in helping SIM to produce claims extracts, and suggested that the SIM test grant funds may be available to support APCD implementation and contribute to sustainability. Ms. Veltri commented that one of the roles of the SIM Initiative is to facilitate and coordinate efforts for improving data access within the state to assist in health care system transformation.

DRAFT

IX. Update on Focus Group Findings

Mr. Ahmed reviewed the purpose and findings from focus group research facilitated recently by AHA. Mr. Ahmed reviewed the focus group methodology, summarized factors that appear to influence consumer shopping, provided findings, and discussed next steps. Christen Orticari stated that the purpose of the research was to gather consumer input on consumer decision support tools, and that AHA intended to convene additional focus groups in the future.

X. Status of Various Subcommittees

Dr. Scalettar reported that the Data Privacy and Security Subcommittee last met on April 1, and planned to meet on June 26 to discuss aspects of the RFP and the vendor security audit. Mr. Katz said that the Policy and Procedure Enhancement Subcommittee met on May 5 to discuss the potential future submission of denied claims data and dental data. Mr. Katz said that the subcommittee would continue discussing these topics at their meeting on June 27.

XI. Next Steps

No next steps were discussed at this time.

XII. Future Meetings

Mr. Ahmed announced that the next regular meeting of the APCD Advisory Group would be held on July 10 from 9:00 a.m. until 11:00 a.m. at the Legislative Office Building in room 1D.

XIII. Adjournment

Dr. Scalettar motioned to adjourn the meeting. Mr. Katz seconded the motion. Motion passed unanimously. The meeting was adjourned at 11:00 a.m.

DRAFT

Special Meeting of the All Payer Claims Database Advisory Group
Draft Meeting Minutes

Date: Thursday, April 10, 2014
Time: 9:08 a.m. – 11:00 a.m. EST
Location: The Hartford Hilton, Ballroom East,
315 Trumbull Street, Hartford, CT 06103

Members Present
Tamim Ahmed, Kevin Counihan (phone) Robert Tessier, Mary Ellen Breault for Thomas Leonardi, Olga Armah for Kimberly Martone, Jean Rexford, Matthew Katz, Dr. Robert Scalettar, James Iacobellis (phone), Dr. Mary Alice Lee, Mary Taylor, Michael Michaud for Patricia Rehmer, Josh Wojcik for Kevin Lembo

Members Absent
Robert Aseltine, Roderick Bremby, Victor Villagra, Anne Melissa Dowling, Jewel Mullen, Dean Myshrall, Damien Fontanella for Vicki Veltri, Thomas Woodruff, Barbara Parks Wolf for Ben Barnes

Other Participants
Joan Feldman, William Roberts, Robert Blundo, Christen Orticari, Matthew Salner

---

I. Call to Order and Introductions

Tamim Ahmed called the meeting to order at 9:08 a.m. and members introduced themselves. Mr. Ahmed introduced Christen Orticari, the new Analyst at Access Health Analytics, as well as Attorney Joan Feldman and William Roberts from Shipman and Goodwin, who serve as the legal consultants for Access Health Analytics (AHA).

II. Public Comment

There was no public comment.

DRAFT

III. Approval of January 9th, 2014 Meeting Minutes

Mr. Ahmed requested a motion to approve January 9, 2014 meeting minutes. Mary Ellen Breault asked that Thomas Leonardi not be marked absent for the meeting. Ms. Breault stated her attendance was on behalf of Mr. Leonardi. Ms. Breault motioned to accept the minutes. Robert Tessier seconded. The motion passed unanimously.

IV. CEO/ ED Updates

Kevin Counihan informed the group that he needed to conference into the meeting due to an extenuating circumstance.

V. RFP Process Status, TimeLine

Mr. Ahmed stated that the RFP process was complete. The name of the vendor could not be disclosed until the end of the contracting process.

Matthew Katz referred to a previous APCD Advisory Group discussion concerning a responsibility to support or recommend the vendor to the Access Health CT Board. Mr. Katz was concerned that the APCD Advisory Group was unaware of the vendor who was in contract negotiations with AHA and expressed that this indicated a tacit approval made without input from the APCD Advisory Group. Mr. Katz remarked that this approach would not allow the members to have any input until after the signing of a contract, which seemed to be inconsistent with previous discussions in the APCD Advisory Group. Mr. Ahmed thanked Mr. Katz for stating his concern and responded by indicating that the involvement and consent of the group was specifically requested by AHA during the creation of the vendor selection work group. Mr. Ahmed continued to explain that AHA did not limit the number of volunteers who could serve in this group, and only one AHCT Board member, who was also a member of the APCD Advisory Group, volunteered to assist with this process. Mr. Katz recalled that the APCD Advisory Group had a discussion about the creation of a subgroup for vendor selection who would report back to the APCD Advisory Group for a specific vote or recommendation as part of its charge to the Exchange Board, who would ultimately have the authority of making these decisions. Mr. Katz inquired regarding whether the AHCT Board voted to approve for AHA to engage in the contract process. Matthew Salner replied that the AHCT Health Board was not required to vote to approve, or not approve contracts, and indicated that the CEO makes the final approval.

Mr. Katz asked for more information on the voting and decision making process within the APCD Advisory Group. Mr. Ahmed stated that the comments by Mr. Katz would be taken into consideration. Robert Tessier reminded members that approximately two years ago, Access Health CT (AHCT) hired and authorized the CEO to run the organization making decisions about hiring vendors, as well as the hiring of the APCD legal consultants, which were not board decisions. Mr. Tessier remarked that the board had been kept up to date on the process, invited to be part of the process, and noted that he and Dean Myshrall, APCD Advisory Group members, responded to the request for participation to serve on the RFP committee, which was the group to that ultimately recommended the finalist to Mr. Counihan.

DRAFT

Mr. Ahmed reviewed the project timeline and updated members on the status of vendor onboarding provided that AHA would provide updates regarding the anticipated date of contract finalization. Ms. Feldman responded briefly to two comments made by committee members. Ms. Feldman indicated in her experience it was rare for contracts to be approved at a board level. Ms. Feldman assured that the contract was on the fast-track to completion.

Mr. Katz responded by conveying the importance of understanding and receiving clarification on the fiduciary responsibilities of the APCD Advisory Group, and requested that members receive a form of written document from the legal counsel outlining their fiduciary responsibilities from a perspective of the group's statutory requirements to make recommendations associated with the ongoing operation of the APCD. Mr. Ahmed replied that he appreciated and understood the concerns raised by Mr. Katz.

VI. Address Member Opt-Out from APCD Data Collection

Mr. Ahmed addressed the topic of member consent in regard to the APCD, as it was promulgated by the language included in public law for APCD development and implementation. Mr. Ahmed indicated that the question of whether the APCD could allow for member opt-out was raised during the last meeting of the Data Privacy and Security Subcommittee. Mr. Ahmed stated that the when the original APCD legislation was debated in 2012, a proposed amendment regarding allowing for opt out was overwhelmingly defeated.

VII. Legal Issues Concerning Various Aspects of APCD

Ms. Feldman provided an overview of issues related to privacy and security of data reported to the APCD. Ms. Feldman informed members that the FAQ document provided to members was included for the purpose of answering questions related to data privacy and security. Mr. Katz remarked that the quasi-governmental status of this agency imposed challenges with identifying data policies related to ownership, and requested clarification on the APCD policy for data maintenance and ownership, and requested confirmation that a reporting entity would not be able to extract or declare exclusive ownership of data already submitted to the APCD database. Ms. Feldman ensured that AHA would uphold the highest standards and policies to preserve data privacy, security and confidentiality, and informed members that the delineation of responsibility with the preferred vendor would be excruciating in terms of encryption, accessibility, auditing, monitoring, and ultimately will have standards that exceed federal standards. Mr. Tessier asked for and received confirmation from Ms. Feldman that there was no federal regulation tying APCD's use of federal dollars to HIPAA standards. Joshua Wojcik requested that members receive a breakdown of how the standards match up to HIPAA in terms of where they would be compliant, exceed, or fall short of HIPAA standards. Ms. Feldman responded to the request by Mr. Wojcik with agreement to provide this information as a future deliverable, and added that although the APCD was not held to HIPAA by state law, the enabling legislation, to an extent, self-imposed HIPAA on the APCD in terms of its policies and regulations

DRAFT

regarding information disclosure. Dr. Dr. Robert Scalettar suggested that the Data Privacy and Security Subcommittee be incorporated into the process to help determine privacy and security standards, financial terms, among other related policies, by way of providing recommendations and receiving information regarding the inclusion of standards to resolve challenges associated with lack of communication. Dr. Scalettar noted that the preferred vendor likely provided a response for handling sections of the RFP related to data privacy and security, and that the subcommittee would likely benefit from information of these sections moving forward in collaboration. Mr. Katz expressed his agreement with the recommendation supported communications of the related subsections with the Data Privacy and Security Subcommittee for this purpose. Ms. Feldman closed her commentary on the FAQ document by reviewing applicable privacy laws that could, but are not required to be imposed within the APCD standards. Mary Taylor recommended that behavioral health laws be researched for their applicability to the APCD. Mr. Tessier requested that Ms. Feldman confirmed that the vendor would not be considered a business associate under HIPAA. Mr. Katz recommended that the Data Privacy and Security Subcommittee appraise and assess the standards and processes for data privacy and security through communication with the future vendor throughout the development and implementation of the initiative to enable members of the subcommittee to provide valuable policy and procedure recommendations. Mr. Ahmed concurred that policies and procedures needed to evolve over time, and encouraged the Data Privacy and Security Subcommittee are kept abreast of data security elements in the contract, pending legal approval. Dr. Scalettar encouraged that recommendations from Data Privacy and Security Subcommittee members be taken into account with regard to the importance of inclusion and transparency. **Mr. Katz made a motion for the Data Privacy and Security Subcommittee to be delegated the responsibility to raise questions, comments and concerns with regard to data privacy and security through correspondence with the preferred vendor, pending legal approval, and or, contract finalization. Mr. Ahmed made the motion. Dr. Scalettar seconded. The motion passed unanimously**. Mr. Ahmed concluded the discussion by indicating that AHA would provide the subcommittee a proposed plan for how this data could be shared with its members, and commented that the vendor would be available for more communication upon onboarding.

VIII. Status Update on Date for Submission

Robert Blundo provided a status update of data collection efforts, bottlenecks and challenges with that process, and discussed the processes of onboarding the vendor while simultaneously communicating with submitters. Mr. Blundo continued to explain challenges associated with accommodating a variety of vendors into the submission process and informed members that AHA was attempting to answer questions to the degree possible without impacting the submitter in the future, and triaging questions to be answered within an FAQ document tabling those unable to be answered until vendor onboarding. Ms. Taylor commented that ongoing, regular communication, in monthly calls, has been critical beyond the initial APCD implementation in other states to troubleshoot and address anomalies in submissions. Mr. Blundo agreed by responding that AHA planned to maintain open lines of communication, and expected an increase in discussions during pre-submission preparations for the test data feed. Mr. Blundo highlighted that the policies and procedures set the first data test feed submission date for May 5, 2014, and clarified that AHA planned to communicate to submitters an accurate estimate for when

the vendor would ideally be on board since this would permit the timeline to resume and the rescheduling of the test submission date. Mr. Blundo suggested that AHA planned to release a revised proposed timeline with the start date contingent on the enactment of the vendor contract. Ms. Taylor requested that the FAQ document inclusive of the open questions be shared with carriers when available, and asked that information on threshold variances be provided to the carrier allowing for proactive measures to be taken to then avoid failed submissions. Mr. Blundo stated that AHA would take a common sense approach to discussing threshold challenges with the vendor as soon as possible. Mr. Blundo stated that RESDAC confirmed the Connecticut APCD could receive Medicare data, however they were not compliant with the data submission guide (DSG), and the vendor would need to transform the data into acceptable feeds. Mr. Blundo informed members that AHA was to meet with DSS in May for a discussion on Medicaid data collection. Mr. Blundo noted the active engagement process with commercial carriers was expected to be a six to 12 month process to prepare for data collection, making it a priority from a collection standpoint, whereas Medicare, for instance, was a shorter collection process, which consisted of an audit and certification. Jean Rexford reported on the importance of cost to Medicare members with regard to out-of-pocket costs, stated that the recent availability of Medicare data was groundbreaking since it would enable the identification of outliers in various health care service circumstances. Ms. Rexford also opined that Medicare data was integral to the APCD in order to ascertain cost and quality information for the general public in the state, and from a public health perspective to identify best practices. Mr. Ahmed and Mr. Tessier expressed agreement with the comments by Ms. Rexford. Mr. Tessier stated that the incorporation of Medicare data would enhance consumer empowerment through price transparent information, support consumer buy-in to this initiative, and be used for public health research. Dr. Scalettar noted that commercial and governmental information was valued most within the context of the discussion, and stated his agreement with the staged approach to move forward with intake in a timely manner. James Iacobellis remarked that Medicare data, as well as Medicaid, were invaluable and appeared to be important for the purpose of all reports, and highlighted the challenge of prioritizing data intake without knowing the focus of the initial reports AHA planned to produce. Mr. Iacobellis requested that Mr. Blundo provide more information about the conversations with DSS on the provision of Medicaid data. Mr. Katz asked whether Commissioner Bremby was able to attend meetings or if a representative would be present on his behalf, particularly to discuss the provision of Medicaid data to support the planning process for APCD intake and integration. Dr. Mary Alice Lee suggested that an overview of how APCDs in other states handle Medicaid data, and highlights from the May meeting planned with DSS be provided at the next meeting. Dr. Lee remarked that in order to portray the health of the public longitudinally, Medicaid data must be included to avoid large gaps in coverage information for services across the continuum of care and time. Brenda Shipley asked whether Medicare provided one year of data in one submission, and Mr. Ahmed replied that annual and quarterly options were available for the same price. Mr. Ahmed noted that AHA applied to receive Medicare data for the next three years and indicated that a revised approach in consideration was to receive the data for two years through to the most recent data available. Mr. Katz received confirmation from Mr. Blundo that the Medicare Part C and D data was to come in through the plans and not through Medicare.

DRAFT

Mr. Tessier noted the second circuit court decision in the Vermont APCD with regard to its relevance to the data submission challenges. Mr. Tessier referred to a specific exemption in the Connecticut statute of these plans that required the full submission of their data, and indicated his interest in learning more as it may help the APCD anticipate potential future challenges. Ms. Feldman explained that AHA was reaching out for information from neighboring states in the second circuit with existing APCDs. Ms. Feldman commented on her communication with the Federal Government Department of Labor regarding their filing of an amicus brief in the Vermont statute, and informed members of AHA's efforts to work with other states for a unified approach to handle any resulting impact.

IX. Status of Various Subcommittees

Mr. Katz provided a status update for Policy and Procedure Enhancement Subcommittee, and noted that it was initially charged with providing policy and procedures recommendations regarding the incorporation of denied and dental claims. Mr. Katz explained that the subcommittee set forth goals, a timeline to accomplish these tasks, and sought review use cases tied to denied claims for the purpose of understanding the impact and practical implications of setting forth a policy for denied claims. Mr. Katz proceeded to explain that the subcommittee planned to make reasonable timeline recommendations for modifications to the dental claims aspects of the policy and procedures, and noted that members were reaching out to identify and invite dental claims stakeholders to meetings for their input. Mr. Katz announced that the subcommittee was planning the next meeting, and hoped to provide updates on denied claims use cases, a proposed timeline for dental claims incorporation and recommendations for appropriate modification of the dental content within the policies and procedures.

Dr. Scalettar provided a status update for the Data Privacy and Security Subcommittee with reference to slides 15 and 16. Dr. Scalettar indicated that at the first meeting, members received information of ongoing APCD practices and challenges in data privacy and security, and welcomed Ms. Feldman and Mr. Roberts, as the legal counsel for the APCD initiative, and for their legal expertise to clarify topics, including that the Connecticut APCD was not a HIPAA entity. Dr. Scalettar noted that the subcommittee was working with AHA staff and legal counsel on the acquisition side of data to support the determination of data privacy protocol for APCD data based on information shared regarding industry standards and best practices. Dr. Scalettar remarked that as the subcommittee moved forward, it intended to contribute to the development of the data review and release process and policies based on a foundational awareness of existing statutes in operation; and the creation of data use agreements as they continue to explore data use cases from various stakeholders. Dr. Lee recommended that the measures taken to avoid privacy breaches in working with the particularly aggregate data, under the purview of the subcommittee, be thoroughly considered in the development process of rules and regulations for data review and release. Mr. Ahmed echoed that these recommendations were being considered by the subcommittee and commented that the Data Privacy and Security Subcommittee should discuss measures to take for the protection of aggregate data in future meetings.

Ms. Taylor mentioned that other states focused initial reporting efforts by selecting one main focus for their initial out of the box reporting to help shape some of the discussions and work done. Ms. Taylor

DRAFT

indicated centralizing reporting efforts by maintaining a consistent focus facilitated APCD implementation and improved the effectiveness of content in comparison to maintaining a broader, open approach. Mr. Katz stated his agreement with the suggestion by Ms. Taylor and opined that the vendor to be on-boarded could provide productive insight for best practices from previous APCD experience. Ms. Rexford made a recommendation for a report on the initial efforts of other states and whether they would have focused their efforts differently. Dr. Scalettar commented in response to the recommendation that the Connecticut APCD was intended to be consumer-focused and supported by cost and quality information, whereas other APCDs had been developed with more of a research or policy focus and have recently started to focus on the patient stakeholder in their reporting.

X. Next Steps

Mr. Ahmed asked for next steps by the APCD Advisory Group to include polling member responses with regard to rescheduling the next meeting for June since the proposed vendor would not be able to be in attendance due to ongoing contract negotiations. Mr. Katz requested also that the May eighth meeting of the Advisory Group be delayed to involve the vendor in meeting discussions to optimize meeting effectiveness, and suggested the APCD Advisory Group meet prior to the July meeting depending on the perspective held by AHA staff regarding timeline and deliverables. Mr. Katz remarked that a meeting to deliberate the issues raised during this meeting would not be efficient because they involve the vendor and require input on their part moving forward.

XI. Future Meetings

Mr. Ahmed recommended that the decision for the next meeting of the Advisory group be delayed to June eighth or a similar date to allow time to address the variability inherent to contract negotiations. Dr. Lee requested that a report of national Medicaid data use cases be provided to members, and asked AHA staff to address the status of their communication with DSS in lieu of discussing vendor-related issues. Mr. Ahmed conveyed that the deliberation with respect to the upcoming meeting pointed to the importance of holding the May eighth meeting or delaying it by one month to discuss various topics. Mr. Ahmed offered to hold special meetings upon completion of contract negotiations.

XII. Adjournment

Mr. Ahmed moved to adjourn the meeting. Mr. Katz seconded the motion. The motion was passed unanimously. The meeting was adjourned at 11:05 a.m.

DRAFT

All-Payer Claims Database Advisory Group Meeting

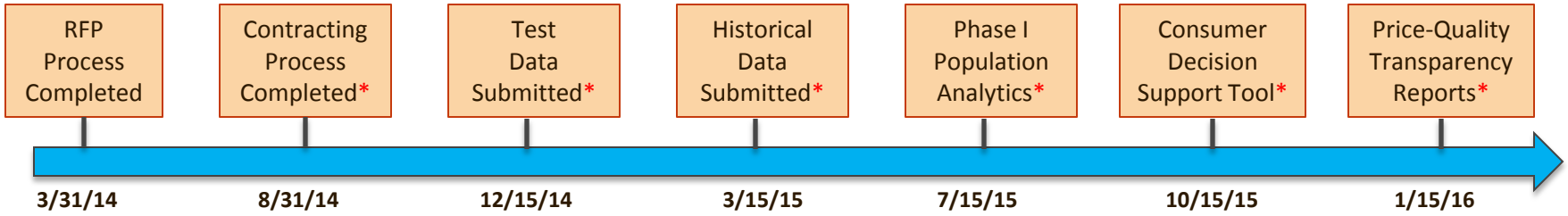
Created By: Access Health Analytics
7/8/2014

Presentation Overview

- Development Planning for APCD
- Medicaid Data Usages – Examples from other States' APCDs
- Update on Medicaid Data from DSS
- Subcommittee Updates
- Next steps

Development Planning for APCD - Timeline

- RFP process for vendor selection for developing & managing APCD completed March 31, 2014
- Vendor negotiation in progress and expected to be completed by August, 2014
- Data in-take infrastructure will need to be created by the data submitters to link with the APCD vendor for automated submissions and retrievals via secured web-based transmissions, Sept. – Nov., 2014
- Test data is expected to be submitted in December, 2014
- Pending data quality validation tests, historical data is expected to be submitted in March, 2015
- Phase I reporting – population analytics – is expected to be available in July, 2015
- Consumer Decision Support Tool, i.e., enabling Exchange enrollees to choose the right plan, is targeted to be released in October of 2015
- Price/Quality transparency tools is expected to be launched in Jan 2016



Note: '*' expected; timeline will slip if contract is not finalized by 8/31/2014

access health CT

Development Planning for APCD – Core Components

The following capabilities and components have been deemed absolutely necessary for a well functioning APCD. Some of these elements in the scope are explicitly included in the Policy & Procedure document. Other elements are needed to complement the primary scope.

- ✓ Collection of medical & pharmacy claims data from various carriers, including ASO data
- ✓ Collection of Medicare data
- ✓ Collection of Medicaid data
- ✓ Developing data validation process for collected data
- ✓ Developing and optimizing various infrastructures – ETL, Production and Managed Hosted environments
- ✓ Ensuring application of risk and clinical groupers from 3M, CMS and others TBD
- ✓ Development of a Master Provider Index
- ✓ Development of a Master Patient Index
- ✓ Development of a web tool for exhibiting reports from APCD data
- ✓ Development of price and quality transparency reports
- ✓ Development of various population & epidemiological reports
- ✓ Collection of dental data

Medicaid Data Usages – Examples from other States' APCDs

Interactive Web Reports – Colorado Medicaid

Colorado All Payer Claims Database

Home | Maps | Reports | Resources | About CIVHC

ADMINISTERED BY CIVHC

POWERED BY TREO SOLUTIONS

Filter the Claims Data:

Select criteria below to filter the data from the APCD.

Type of healthcare metric: Total Cost of Care (TCC)

- Total Cost of Care
  - Total Cost of Care (TCC)
  - TCC Compared to Expected (C2E)
- Utilization
  - ER Visits
  - Hospital Admissions
  - Professional Claims
  - Readmissions, Potentially Preventable (per population)
  - Readmissions, All Cause 30 Day (per population)
  - Percent Generic Scripts
- Access
  - PCP Density
- Population
  - Percent Covered Population
  - Illness Burden Score
  - Asthma Prevalence
  - Diabetes Prevalence
- Other
  - Data by Request

Type of payer data: Medicaid Only

Show data for: 2009 2010 2011 2012

View by: County

What's this?

Display Results:

Select how you would like the results displayed.

Show metric as: Actual value / % change from previous year

Export

Counties selected for reports:

No areas selected.

Create Report

Help

- Compared to Expected (C2E)
- Completeness Score (C-score)
- County
- Index
- Medicaid
- Total Cost of Care (TCC)

Legend

Total Cost of Care
Dollars Per Member Per Year

- Less than $2,400
- $2,400 to $2,600
- $2,600 to $2,800
- $2,800 to $3,000
- $3,000 to $3,500
- Greater than $3,500

access health CT

Interactive Web Reports - Colorado Medicaid

Colorado All Payer Claims Database

Home | Maps | Reports | Resources | About CIVHC

ADMINISTERED BY CIVHC

POWERED BY TREO SOLUTIONS

Filter the Claims Data:

Select criteria below to filter the data from the APCD.

Type of healthcare metric: ER Visits
What's this?

Type of payer data: Medicaid Only
What's this?

Show data for: 2009 2010 2011 2012

Display Results:

Select how you would like the results displayed.

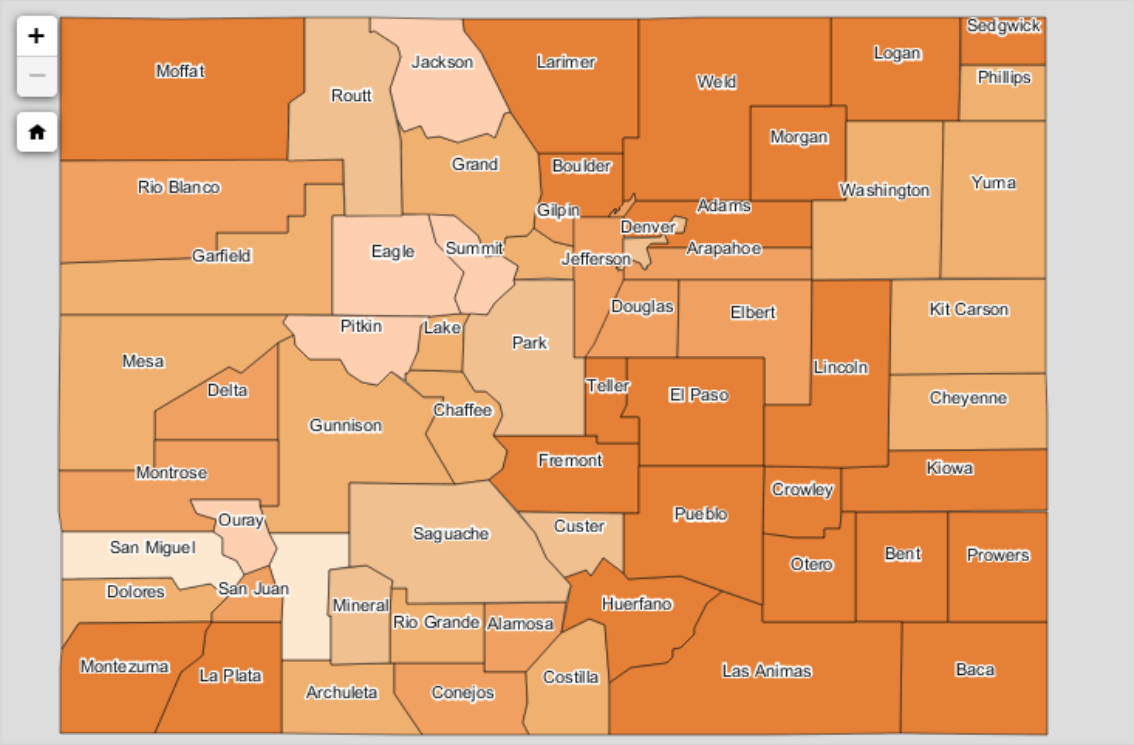
View by: County
What's this?

Show metric as:
- Actual value
- % change from previous year

Map | Data Sheet

Click on up to three counties on the Map below, for detailed reporting.

Export



Counties selected for reports:

No areas selected.

Create Report

Help

- Compared to Expected (C2E)
- Completeness Score (C-score)
- County
- ER Visits
- Index
- Medicaid

Legend

ER Visits
Per Thousand Members Per Year

- Less than 100
- 100 to 200
- 200 to 300
- 300 to 400
- 400 to 500
- Greater than 500

access health CT

Interactive Web Reports – Colorado Medicaid

Colorado All Payer Claims Database

Home | Maps | Reports | Resources | About CIVHC

ADMINISTERED BY CIVHC

POWERED BY TREO SOLUTIONS

Filter the Claims Data:

Select criteria below to filter the data from the APCD.

Type of healthcare metric: Asthma Prevalence (What's this?)

Type of payer data: Medicaid Only (What's this?)

Show data for: 2009 2010 2011 2012

Display Results:

Select how you would like the results displayed.

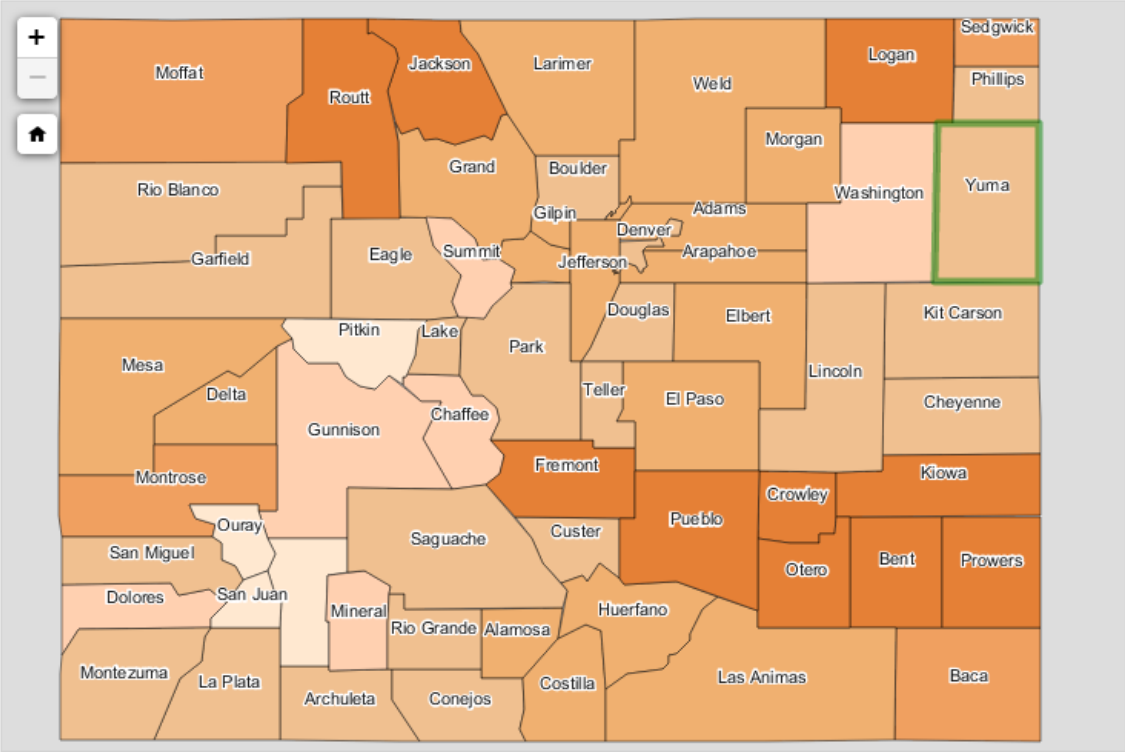
View by: County (What's this?)

Show metric as: Actual value / % change from previous year

Map | Data Sheet

Click on up to three counties on the Map below, for detailed reporting.

Export



Counties selected for reports:

Yuma

Create Report

Help

- Asthma Prevalence
- Compared to Expected (C2E)
- Completeness Score (C-score)
- County
- Index
- Medicaid

Legend

Asthma Prevalence

- Less than 1%
- 1% to 2%
- 2% to 3%
- 3% to 4%
- 4% to 5%
- Greater than 5%

access health CT

Interactive Web Reports – Colorado Medicaid

Colorado All Payer Claims Database

Home | Maps | Reports | Resources | About CIVHC

ADMINISTERED BY CIVHC

POWERED BY TREO SOLUTIONS

Filter the Claims Data:

Select criteria below to filter the data from the APCD.

Type of healthcare metric: *not applicable for reports*

Type of payer data: Medicaid Only ▾ What's this?

Show data for: 2009 2010 2011 2012

Display Results:

Select how you would like the results displayed.

View by: County ▾ What's this?

Selected Areas : Adams, Alamosa, Arapahoe — modify

Report

Download Data

Category: Utilization ▾

- Utilization
- Utilization Trend Graphs
- Inpatient Utilization
- Outpatient Utilization
- ER Utilization
- Readmissions, Potentially Preventable (per population)
- Readmissions, Potentially Preventable (per admission)
- Readmissions, All Cause 30 Day (per population)
- Readmissions, All Cause 30 Day (per admission)

Snapshot Reports

- Total Imaging Services
- High Cost Imaging Services

Report Filters

Comparative: Compared to Expected (C2E) ▾

Utilization

Export

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	1.23		1.30		1.26		1.21
	Rate Per Thousand	C2E Rate	Rate Per Thousand	C2E Rate	Rate Per Thousand	C2E Rate	Rate Per Thousand
Utilization Per Thousand Per Year							
Hospital Admissions	111	23%	102	17%	96	10%	90
Outpatient Visits	2,709	32%	3,658	91%	2,508	25%	2,661
ER Visits (subset of Outpatient Visits)	534	16%	492	1%	488	10%	444
Professional Claims	5,308	-15%	4,332	-34%	5,776	-6%	4,974
Ancillary Claims	974	24%	1,423	69%	926	16%	795
Rx Scripts	7,428	16%	11,755	32%	7,921	17%	8,422
% Generic	78%	1%	82%	3%	77%	1%	78%
Hospital Admissions by Gender/Age Per Thousand Per Year							
Female	146	22%	137	13%	125	9%	116
1 - Child (0-17)	33	-31%	34	7%	32	-28%	29
2 - Young adult (18 - 34)	341	16%	298	5%	301	11%	270
3 - Mature adult (35 - 64)	366	137%	208	49%	233	53%	214
Male	68	25%	59	30%	59	14%	57

access health CT

Oregon All Payer All Claims Database

What is included in APAC?

- All carriers and licensed third-party administrators with at least 5,000 covered lives are required to report to APAC

- In addition, all pharmacy benefit managers, managed care organizations (MCOs), coordinated care organizations (CCOs), and entities with Dual Eligible Special Needs Plans in Oregon are mandatory reporters

- In sum, APAC includes claims information from commercial health insurance carriers, licensed third party administrators, pharmacy benefit managers, Medicaid managed care organizations, Medicaid fee-for-service and Medicare parts C and D

A A A

an official NEW HAMPSHIRE government website

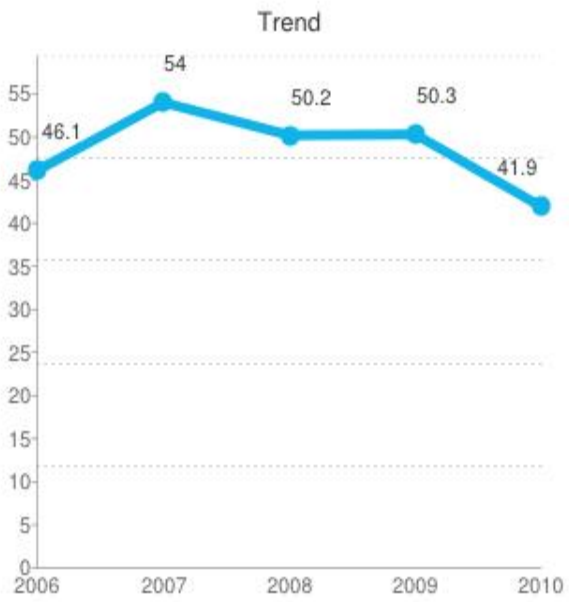
dhhs New Hampshire Department of HEALTH AND HUMAN SERVICES

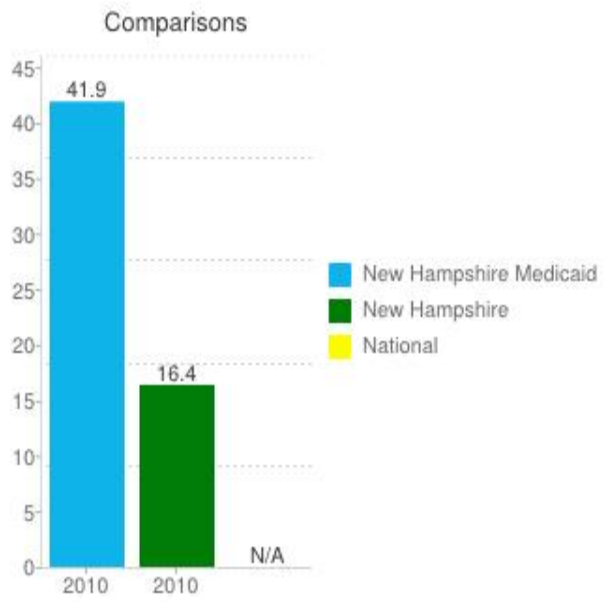
A-Z Index of Quality Indicators

- DHHS Home
- DHHS Medicaid Home
- Medicaid Quality Indicators Home
  - Quality Indicators
    - Health Care Services
      - Hospital Services
      - Preventive Services
      - Primary Care Services
    - Specific Health Topics
      - Health Behaviors
      - Respiratory Health
      - Behavioral Health
      - Cardiovascular Health
      - Diabetes Health
      - Maternal, Infant and Child Health
    - CMS Quality Indicators
      - Adult Quality

NH Medicaid Quality Indicators

Admission for Asthma per 1,000 Adult Medicaid Recipients Diagnosed with Asthma



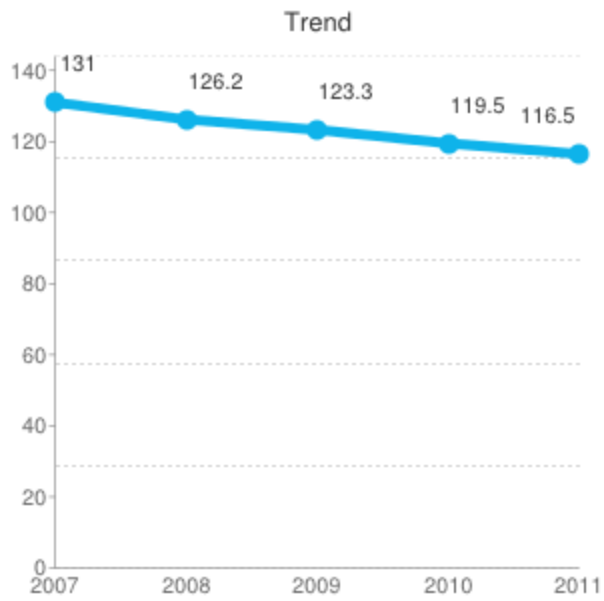


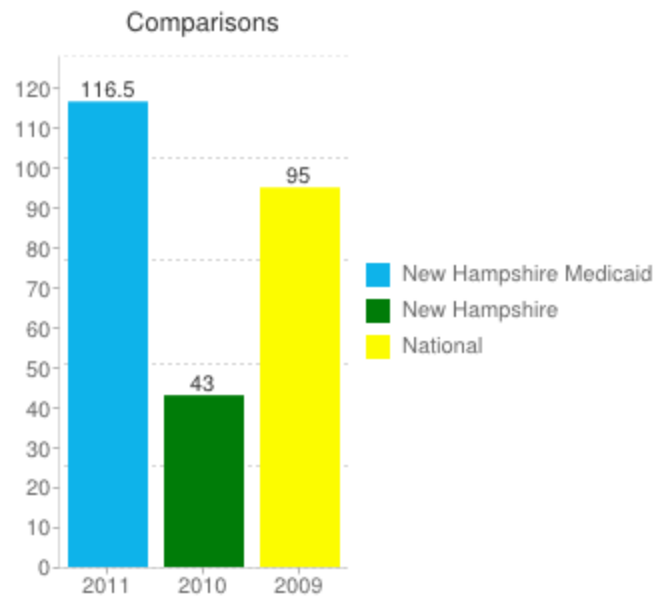
access health CT

- DHHS Home
- DHHS Medicaid Home
- Medicaid Quality Indicators Home
  - Quality Indicators
    - Health Care Services
      - Hospital Services
      - Preventive Services
      - Primary Care Services
    - Specific Health Topics
      - Health Behaviors
      - Respiratory Health
      - Behavioral Health
      - Cardiovascular Health
      - Diabetes Health
      - Maternal, Infant and Child Health
    - CMS Quality Indicators
      - Adult Quality Indicators
      - Pediatric Quality Indicators
    - Care Management Quality Indicators
      - MCO A

NH Medicaid Quality Indicators

Inpatient Utilization - Total Hospital Admissions for Any Condition (Children and Adult) per 1000 Medicaid Recipient





Last updated: 09/06/2012

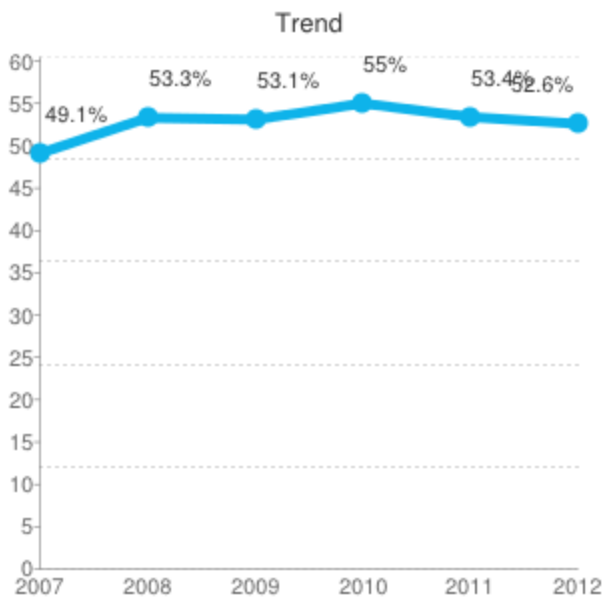
Data

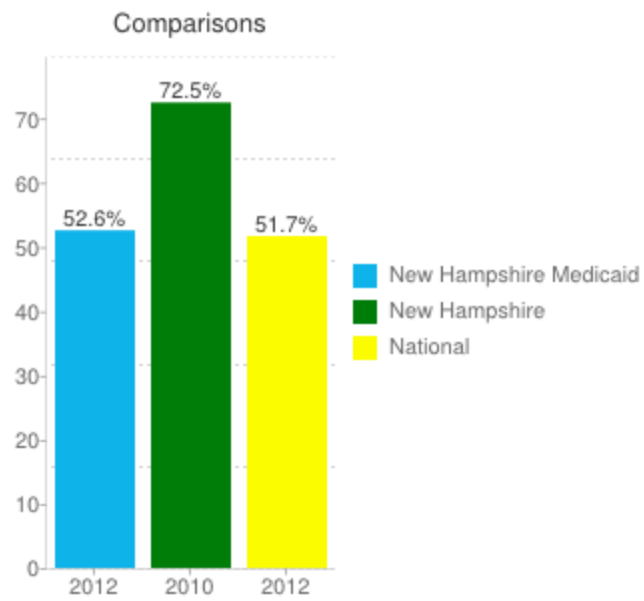
Year	Measure Numerator	Measure Denominator	NH Medicaid Rate	NH Rate	National Rate
2011	11,732	100,680	116.5	N/A	N/A
2010	11,871	99,303	119.5	43.0	N/A

- DHHS Home
- DHHS Medicaid Home
- Medicaid Quality Indicators Home
  - Quality Indicators
    - Health Care Services
      - Hospital Services
      - Preventive Services
      - Primary Care Services
    - Specific Health Topics
      - Health Behaviors
      - Respiratory Health
      - Behavioral Health
      - Cardiovascular Health
      - Diabetes Health
      - Maternal, Infant and Child Health
    - CMS Quality Indicators
      - Adult Quality Indicators
      - Pediatric Quality Indicators
    - Care Management Quality Indicators
      - MCO A

NH Medicaid Quality Indicators

Percent of Women Receiving Breast Cancer Screening





Last updated: 04/09/2014

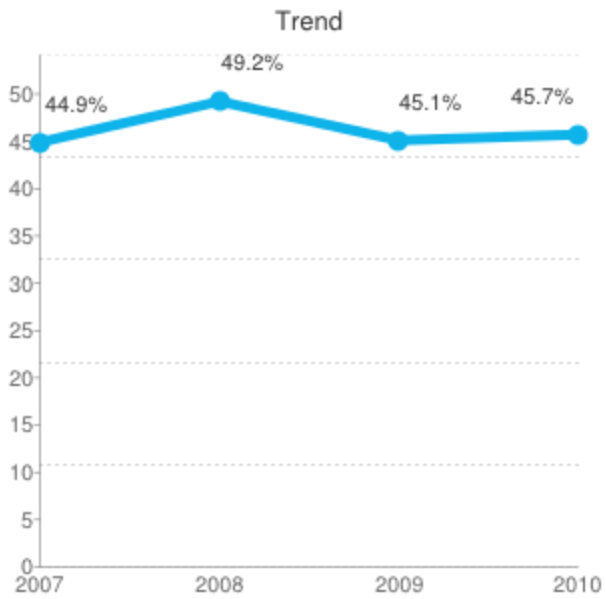
Data

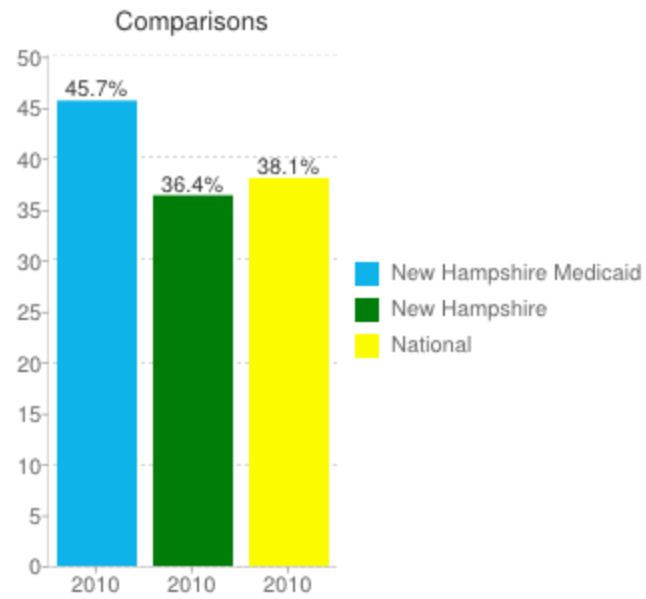
Year	Measure Numerator	Measure Denominator	NH Medicaid Rate	NH Rate	National Rate
2012	1,583	3,009	52.6%		51.7%
2011	1,638	3,069	53.4%		50.4%
2010	1,694	3,081	55.0%	72.5%	51.4%

- DHHS Home
- DHHS Medicaid Home
- Medicaid Quality Indicators Home
  - Quality Indicators
    - Health Care Services
      - Hospital Services
      - Preventive Services
      - Primary Care Services
    - Specific Health Topics
      - Health Behaviors
      - Respiratory Health
      - Behavioral Health
      - Cardiovascular Health
      - Diabetes Health
      - Maternal, Infant and Child Health
    - CMS Quality Indicators
      - Adult Quality Indicators
      - Pediatric Quality Indicators
    - Care Management Quality Indicators
      - MCO A

NH Medicaid Quality Indicators

Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase





Last updated: 08/01/2013

Data

Year	Measure Numerator	Measure Denominator	NH Medicaid Rate	NH Rate	National Rate
2010	598	1,309	45.7%	36.4%	38.1%
2009	518	1,149	45.1%	32.3%	36.6%
2008	566	1,150	49.2%	29.5%	

Update From DSS

Status of Subcommittees

Policy & Procedures Enhancement Subcommittee

- Mattew Katz

Data Privacy & Security Subcommittee

- Dr. Robert Scalettar

Data Privacy and Security Subcommittee Meeting – 6/26

- **Security Related RFP and RTM Requirements For The Data Management Vendor**
  - Data Collection
  - Data Management
  - Managed Environment
  - Reporting Software and Services
- **Update and Overview of Preferred Vendor Security Audit**

Auditor Tasks:

1. Cyber Security Evaluation of Proposed APCD Data Management Vendor
2. Proposal and Proposed Methodology Review
3. Provision of Technical Assistance in Contract Language
4. Software Code Review (Future Service)

Data Privacy and Security Subcommittee Meeting – 6/26

- **Proposed Outline of Data Governance Process**
  - Data Release Protocol Overview for Internal/External Users
  - Data Release & Governance Tools for External Release:
    - Data Disclosure Rules
    - Data Release Process and Criteria
    - Data Review Committee Construct and Policies
    - Data Use Agreement Components
  - AHCT to propose a Straw Man Model to the subcommittee:
    - Leverage processes from other APCDs/IRBs
    - Communicate strategy for DRC composition
    - Incorporate vendor technical capabilities

Next Steps

Future Meetings

Access Health Analytics
All Payer Claims Database – 2014 Meetings Schedule
All meetings are held on the second Thursday of each month from 9:00 – 11:00 a.m. EST.
(unless otherwise indicated)
*Session - indicates that the meeting will not be held at the LOB due to Legislative Session.

Date	Venue	Venue
January 9, 2014	9:00 – 11:00 AM	LOB, Room 1A
~~March 13~~ April 10, 2014	9:00 – 11:00 AM	*Session
~~May 8~~ June 12, 2014	9:00 – 11:00 AM	LOB, Room IE
July 10, 2014	9:00 – 11:00 AM	LOB, Room 1D
September 11, 2014	9:00 – 11:00 AM	LOB, Room TBD
November 13, 2014	9:00 – 11:00 AM	LOB, Room TBD

Payer Differences in Hospital Admissions for Ambulatory Sensitive Conditions

An Analysis of Connecticut Hospital Discharge Data

Robert H. Aseltine, Jr., PhD
July 10, 2014

UCONN HEALTH
Center for Public Health and Health Policy

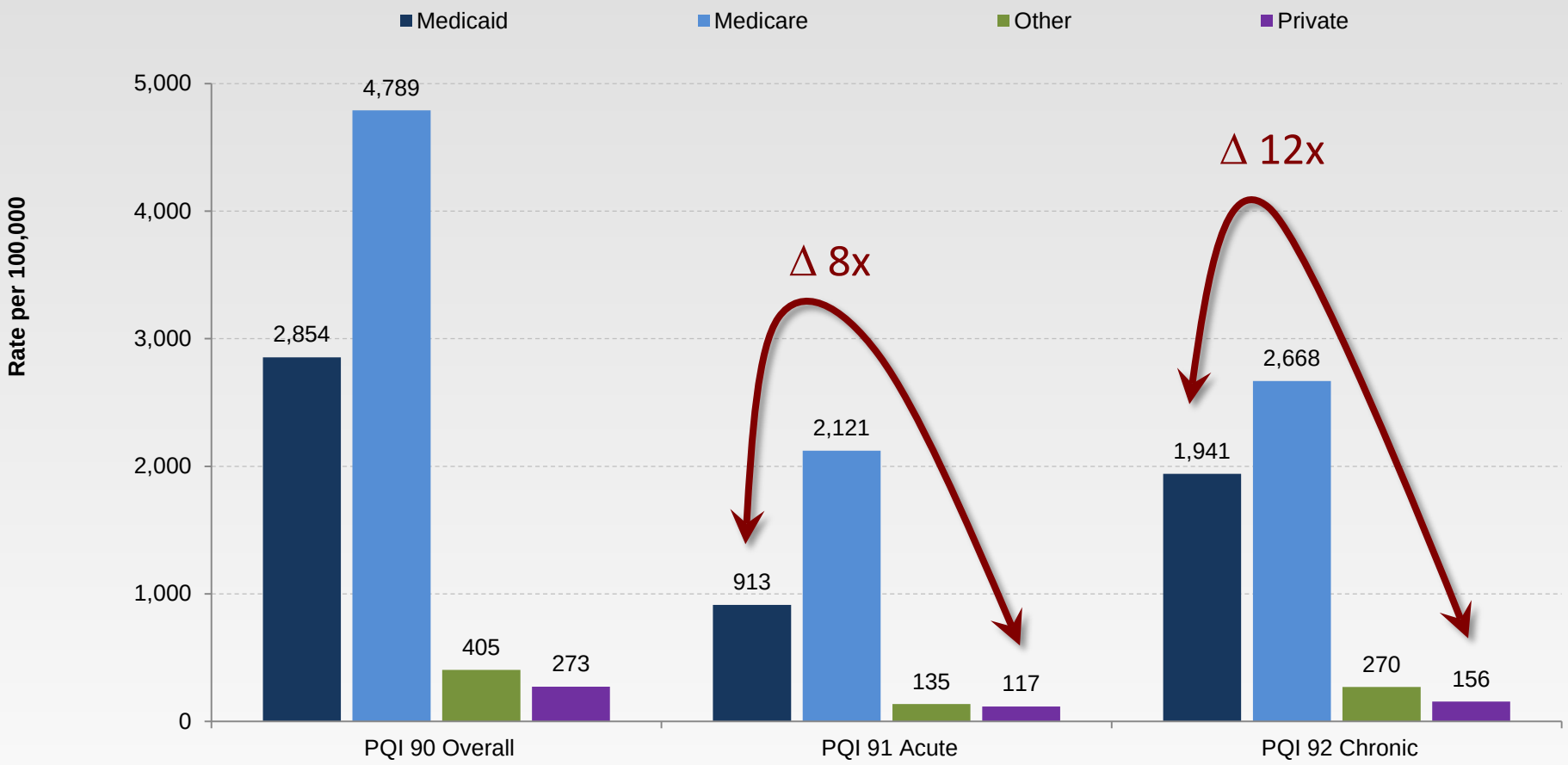
Objective

- Establish baseline rates and reduction targets for the State Innovation Model Initiative
- Rates of hospital admissions, 30 day readmissions, and ER admissions for conditions that can be managed in outpatient settings
  - Impact on both cost and quality
- Data: 2010-2012 Hospital Inpatient Discharge Database (HIDD) maintained by DPH

Measures

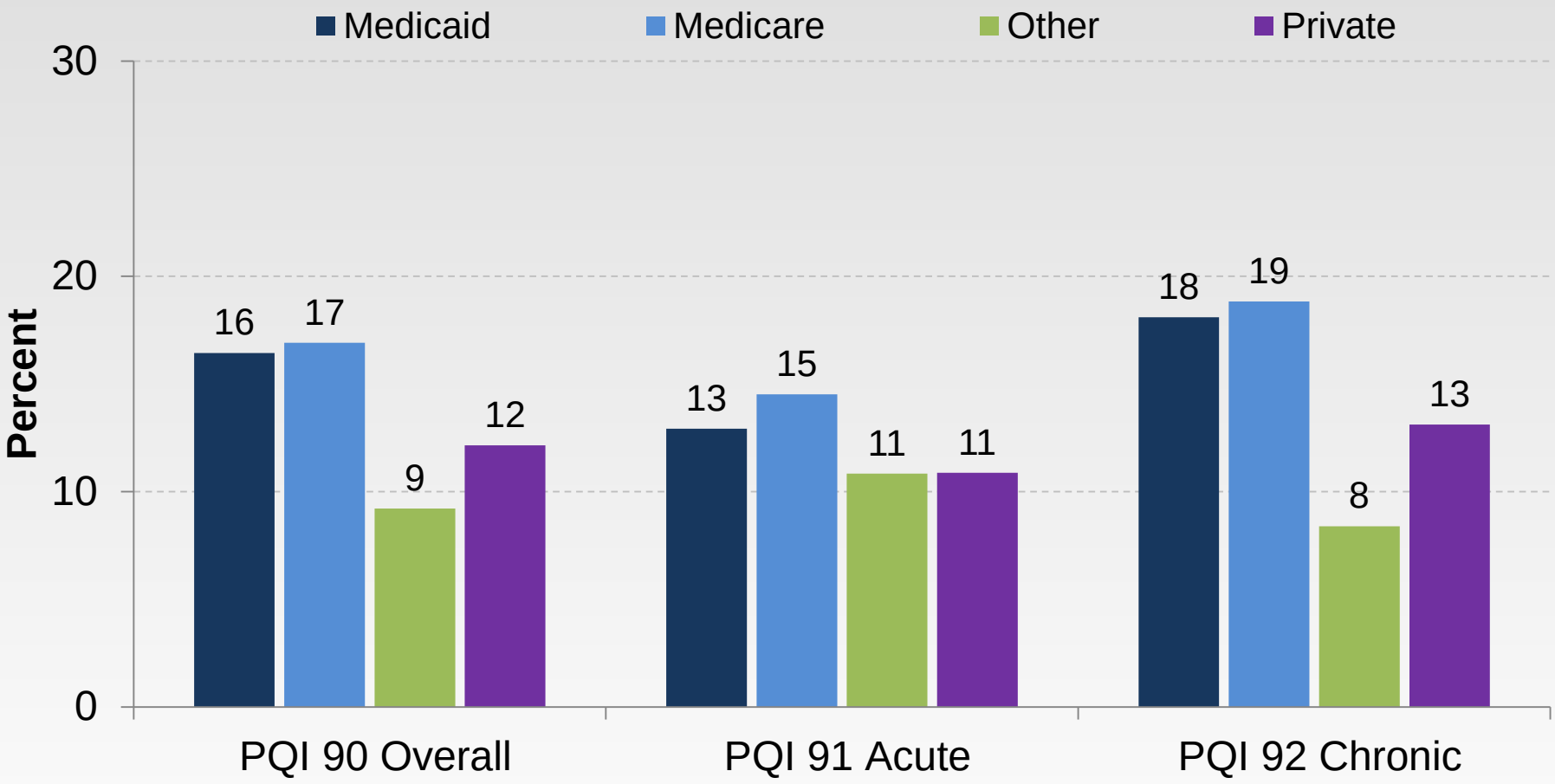
- AHRQ Prevention Quality Indicators
  - PQI 91 Prevention Quality **Acute Composite** includes admissions with a principal diagnosis of one of the following conditions: *dehydration, bacterial pneumonia, or urinary tract infection*
  - PQI 92 Prevention Quality **Chronic Composite** includes admissions for one of the following conditions: *diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure*
  - PQI 90 Prevention Quality **Overall Composite**
- Rates per 100,000

2012 Hospitalizations
Prevention Quality Composite



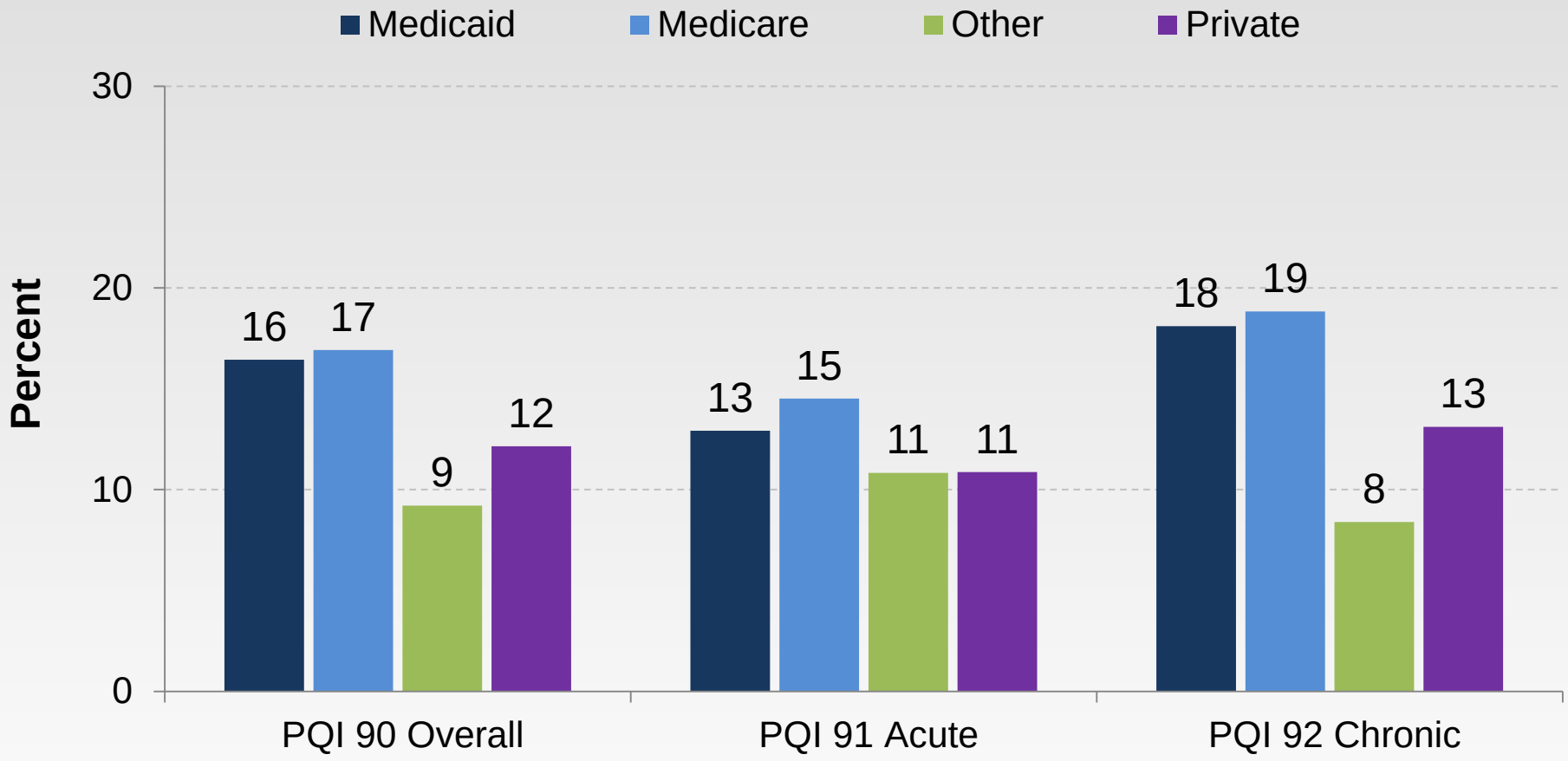
UCONN HEALTH
Center for Public Health and Health Policy

Percent 30-day Readmission Prevention Quality Composite



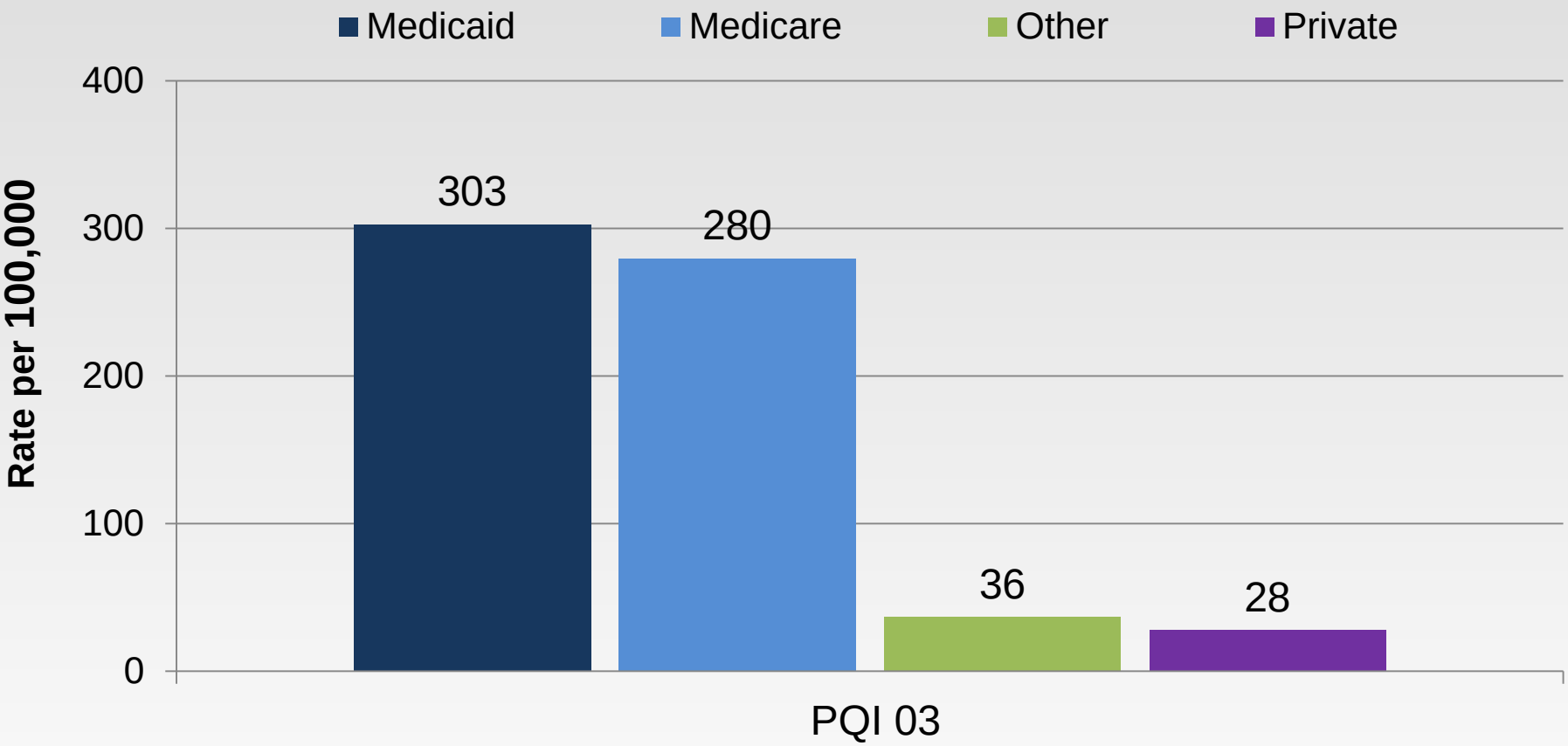
UCONN HEALTH
Center for Public Health and Health Policy

Admissions through Emergency Room Prevention Quality Composite



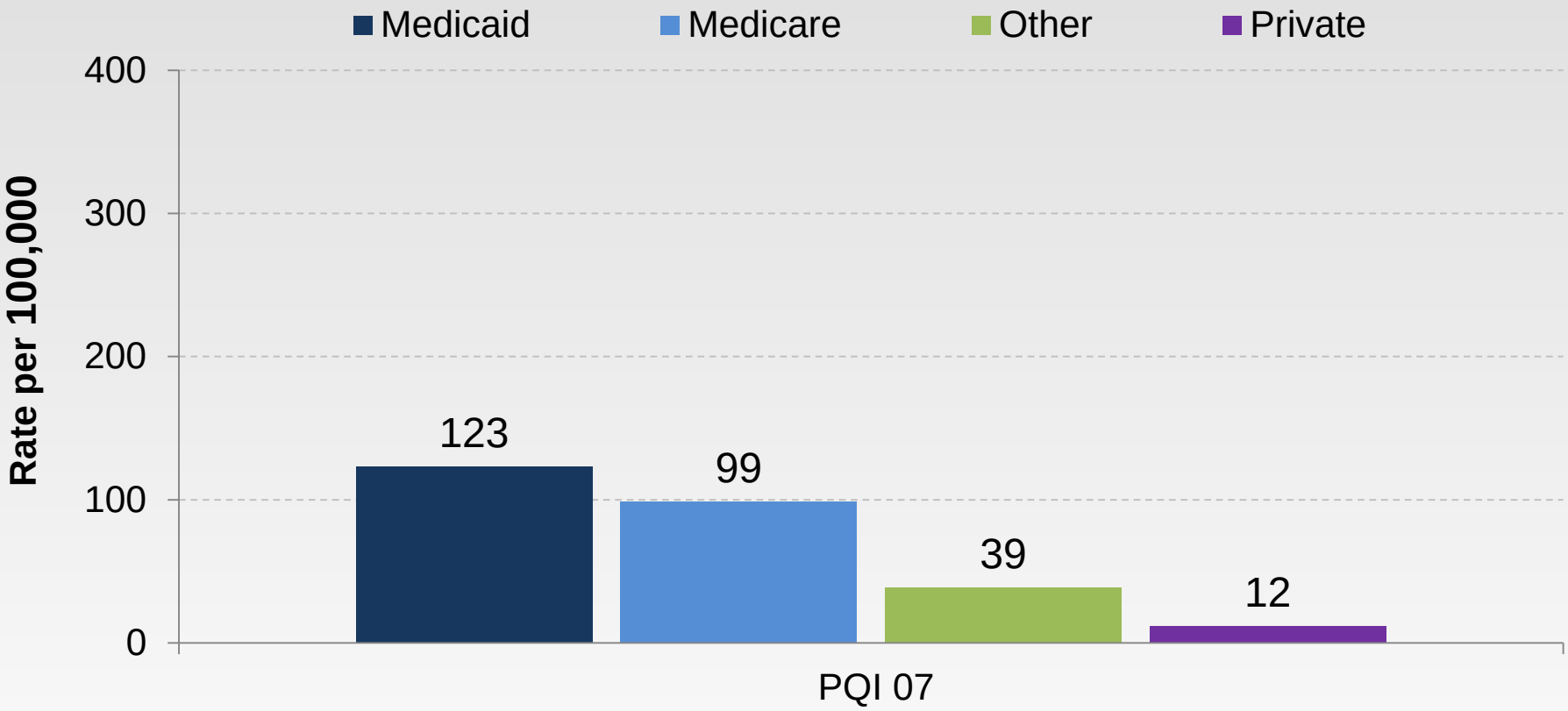
UCONN HEALTH
Center for Public Health and Health Policy

2012 Hospitalizations
Diabetes Long-term Complications Admission Rate



UCONN HEALTH
Center for Public Health and Health Policy

2012 Hospitalizations
Hypertension Admission Rate



UCONN HEALTH
Center for Public Health and Health Policy

Conclusions

- **Enormous variability** in rates of hospital admission and readmission for ambulatory sensitive conditions across payers
  - Rates much higher among Medicaid recipients compared to privately insured
- **Limitation**: Analyzing ambulatory sensitive conditions without data from ambulatory settings
  - APCD would address this limitation