All-Payer Claims Database Data Release Committee
Meeting Minutes

Meeting Date	Meeting Time	Location
June 9, 2020	1:00 pm – 3:00 pm	Join Zoom Meeting https://zoom.us/j/176265523 Meeting ID: 176 265 523 Dial by your location +1 646 876 9923 US (New York) +1 669 900 6833 US (San Jose)

Committee Members					
Dr. Patricia Checko, Chair	X	Kristen McClain		Lisa Freeman	X
Michael Girlamo	X	Henry Jacobs		Michael Fields	X
Justin Peng	X	Anthony Dias	X		
Sheryl Turney	X	Kun Chen			
Supporting Leadership					
Olga Armah, OHS	X	Adrian Texidor, OHS	X	Tina Kumar, OHS	X
Vicki Veltri, OHS	X				

Agenda

	Topic	Responsible Party	Time
1.	Welcome & Call to Order	Dr. Patricia Checko	1:00 PM
	Pat Checko recognized a quorum and called the meeting to order at 1:09 pm.		
2.	Public Comment	Attendees	1:05 PM
	There was no public comment.		
3.	Review and Approval of the January 14 & 29 Minutes	Committee Members	1:10 PM
	Pat Checko asked for a motion to approve the January 14 meeting minutes. Lisa Freeman made a motion. Sheryl Turney seconded. There was no further discussion or abstentions. The minutes were approved. Pat Checko asked for a motion to approve the January 29 meeting minutes. Justin Peng made a motion. Lisa Freeman seconded. Pat Checko abstained. There was no further discussion. The minutes were approved.		

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4.	Application Review & Discussion: Archway (Executive Session, if applicable)	Victoria Yang, Archway Health Chief Analytics Officer Mah-Jabeen Soobader Jun Wang, Applicant Committee Members	1:15 PM
	Pat Checko introduced the Data Request Application being reviewed today. The applicant is Archway Health Advisors LLC. The objective of this research is to explore potential drivers attributed to the variation in the episode-of care cost and quality outcomes among the commercial population in Connecticut in order to quantify the cost reduction and quality improvement opportunities. She introduced Dr. Mah-Jabeen Soobader to provide a summary of the objectives of the data Archway, Health is requesting. Dr. Soobader introduced Victoria Yang, Senior Product Analyst to provide a brief background on their company Archway, Health. Victoria shared that Archway is a specialty care company around over six years. Their main focus is helping healthcare providers on value-based care, specifically on risk-based agreement care, primarily with Medicare, and CMS within a value-based program. They deal with providers to understand what the risk is and opportunity, and if they should move forward with those risks to help those providers understand what is happening to the patient in their entire episode of care. Dr. Soobader added they are a data focused company. Part of what they want to explore is to understand what is happening when they look at an episode of care. For example, what are all the things that drive the cost of treatment over the course of episode? What drives the complications during the episode (best level of care, variation in quality)? They found the complications and readmissions result in the cost drivers. What is a high performing specialist for a specific episode, requires them to understand the variation, clinical and cost drivers by physician, hospital level, and to identify what would be the appropriate way to benchmark specialists for a specific episode? The goal is to develop a methodology to identify high value specialists, benchmark them, by severity of condition, by case mixes, length of episodes, and mix of services. Pat Checko asked for clarification for how the data will be utilized for projects they are interested in and how it will be analyzed. Dr. Soobader answered that they have developed a mechanism to define episodes. Depending on the episode, they will use a combination of what is in		

	the market (VPCI=90 days episodes) (outpatient procedures at 30 days), and identify inclusion/exclusion, patient severity and risk adjustment, identify volume, and build an episode of care. They will then take the data, define the episodes, and mechanism to attribute the specialist to the episode. And identify who the specialist would be. In an example: oncology for chemo, etc. and then look at the universal episode, identify the variation in care, what are the complications, readmissions? Then if we rank specialists, can we develop a ranking methodology that incorporates the case mix s, volume, and type of episodes to determine what a high value specialist is and what that quality of care will be. They are still vetting their benchmark methodology to do this. Pat clarified what they are trying to do is explore the potential of the APCD database to develop a methodology that will allow Archway to rank the specialties and physicians. That can be used as a benchmark for quality. Sheryl Turney asked if this data will be combined with any other data? Dr. Soobader responded that they will not be combining the data itself but will combine and evaluate the ranking methodology. The goal is to try to create a methodology that will work for both Medicare and commercial data. They will not be combining the raw data. Sheryl asked for clarification if the data will be used to train the models or develop algorithms that they would use to build for the value-based program product? Dr. Soobader confirmed they will build, train and develop models. Sheryl commented that if there is an opportunity for further publishing, then they would come back to CT before they do that to discuss how and why they want to publish. Dr. Soobader agreed yes, when they have data it is best to share and validate that. Sheryl asked in terms of benchmarking, if that would that be something that they would want to use outside of the data itself. Dr. Soobader said yes, once it is created and built, they would use the model and validate it on other data sources as well. The methodology would be transferred to other data and use multiple data sources to develop it. Lisa Freeman asked if the risk adjusting will be based on the data provided, and what is being used to base the risk adjustments on? Dr. Soobader responded that depending on the data source (commercial/Medicare) they use HCCs, CSS, diagnostic codes, other indicators to do the risk adjustment, (no outside risk adjustment), and the ABC method for volume.		

	Lisa asked as a follow up what factors are going into the risk adjustment, and if they are using an established standard for choosing what they are going to use to weigh the risk adjustment by? Dr Soobader answered that these are typical industry standards. The HCCs are basically a list of clinical categories that Medicare uses, as a standard methodology. Combination of what is accepted by industry standards. They found those methodologies to work well. Lisa asked how they define value of care, high value care and high value providers, are they consistent with CMS definitions or are they defining it yourself and will this be stated in the final product? Dr. Soobader answered that they will state their definition. It is not the same way CMS is defining it. She explained their methodology. First, they look at complications, complication rates, readmission rates, and post-acute care utilization, and mortality. Then they create a weighted composite score for the four factors. Each component is weighted differently, and they the use the score to rank all of the specialists. Pat Checko commented that this is a created variable of their own. Dr. Soobader agreed yes, they use what is in the data, and what typically is established. Lisa asked if the high value will be the better outcomes at a lower cost? Dr. Soobader answered that this is correct. She explained that after they rank them from a quality perspective, they look to see if it also means that you have the lowest cost specialist. So far, they found in the work they've been doing that generally the high quality is associated with lower costs. Because what's driving the quality (readmission and complication) actually drive up costs. Pat Checko added since we are only allowed to give deidentified data set, which does not allow for zip codes or towns, how are they going to look at geographic areas? Dr. Soobader answered that within the data set that is provided, the hospitals, physicians, and if there is an ID on that, they would use it in the model. Whatever level of geography is given; they will adjust. They plan to look at different hospitals in data sets, comparisons with Medicare payments information for those hospitals as well, and other hospital level identifiers. She added they will not be doing any geo-coding. Pat added that since so many of our hospitals are consolidated under a large hospital, will they be looking at them as individual hospital performance, or the larger umbrella? Dr. Soobader answered that they look at two right now; the specialist within the hospital and within the hospital. They will rank the specialist, then rank his		

	performance in each of the different facilities. They will also then look at the facility performance. Anthony Dias asked for clarification on the methodology. He asked if there is something in place that has been tested, or if they are leveraging the CT APCD data for building and testing a model with respect to the request. He added, relative to benchmark what does it mean, especially when they will not be co-mingling data? How does one get to benchmark at that level? Is it output level? Dr. Soobader answered yes, they are still validating but not starting from scratch in CT. They developed their model and existing methodology with the Medicare data. They have other APCD data that they have worked with that has been vetted and validated. The data they are requesting from CT's APCD data is additional independent data they plan to bring in to validate. She added, they continue to refine and tweak their methodology as they learn from each data source. Each data source brings value and challenges. In terms of benchmarking, the benchmark is identifying the high value specialist by specialty, it's the output of the result of the model. Each specialist by episode has a ranking. They look at specialist rank for different data sources. In CT they look at rankings in Medicare and rank in APCD, and since there are multiple payers they look at if it makes a difference by payer. Anthony asked if their study is triggered by an existing partnership with OHS, or are you making an offer to OHS? And how does this tie into other activities? Dr. Soobader answered no, this is purely an independent request. They do not have any existing relationships with OHS. Adrian Texidor added that this came in through the DRC application process and is independent from any of the OHS projects at this time. Dr. Soobader noted they are certified as QECP (requires releasing data on performance) qualified entity status with Medicare. This allows them to get 100% Medicare data for the state. Pat Checko responded there was an expectation that people who had access to the APCD database, could be able to ask for the Medicare and Medicaid data if it became available. The DRC does not have the ability to provide the Medicare and Medicaid data, we can only provide the commercial. However, since you have the QECP certification you can access the data. Adrian added for awareness, how we have Medicare data and Medicare DUA. In CT's APCD it is unique where it includes all three data sets within the APCD; commercial, Medicare, and Medicaid. Each are governed by separate data use agreements (DUAs). The commercial data has the broadest authority and disseminate for researchers when they go through the DRC process and receive an affirmative vote. However, the Medicare and Medicaid are limited. With Medicare, CT has a DUA with CMS that is serviced with RESDAQ. The		

	stipulations are for internal state driven purposes only. We received that data because of the CT State Innovation Model. Any release of Medicaid data must satisfy CFR44.125 it says any release of Medicaid data must benefit the administration of Medicaid program. We have to ask our state's Medicaid Data Director (DSS) for permission to release Medicaid data on a case by case basis. Additionally, we have to ask for use of Medicaid data for any OHS internal state driven projects. We are working on a parallel process to have someone sit on the DRC. Currently, we will take your application and ask DSS to release the data. Dr Soobader added that once they have the commercial data approved, they can use the Medicare data for that state, they just need the DRC approval to tell QEC. Pat asked Demian Fontanella (OHS Legal Counsel) to weigh in on this. Demian agrees with Adrian's comments. He added that the use of the other data sets is dependent upon the agreement that gave you the data sets. It is a distinct process and authority through this application process. Pat clarified that they are asking for the use of the CT APCD commercial data for this project to test their methodology, they would also like to take the Medicare data to apply the same methodology and be in a position to compare on quality outcome and cost between payers. The data will not be combined at all. Tthey will have the ability to use the Medicare data because of their existing QECP certification. Demian added that based on this understanding, since there is not an intention to combine the data for any analysis, but reiterated that they are using their developed methodology and applying it to the commercial data that the DRC would approve. It may go in the DUA, but we would want more detail. We would not put anything in our DUA that tries to dictate Archway's ability to use other data sets that we have no authority over. Michael Fields added that in the application it indicates they are not looking to charge a fee for the results preliminary analysis, but is there a point where they would be charging fees for either the ranking or the information associated outcomes from the methodology? Dr. Soobader answered that there would be some commercialization for the methodology and ranking. There is no intent to commercialize the ranking and the physician data for the rankings. The methodology can be commercialized at some time during the process. Michael commented that if the process methodology rates providers, and if those rankings impact the ability of providers volume of members that they see as a result, is there an opportunity, or are providers made aware of their rankings, or is there an appeal process?		

	Dr. Soobader answered that they help specialists, providers, hospitals improve the quality of care. If they identify areas of improvement, their analytics today that they give providers all identify and provide a benchmark and where they need to improve, what the improvement levels are, etc. Michael Fields added that, in addition to provider and claimant information, are you looking to get payer specific information as part of request, and help to understand what the objective of the request is? Dr. Soobader answered that when they look at variation in quality and cost, sometimes the cost is driven by payment. So, they want to see within a payer what the variation is, and then across payers. They do not necessarily need to know who the payer is, but they don't want the results to get mixed up because different payment rates may be driving the results. Michael clarified that if the payer were deidentified but present in the data set that would serve the purpose because you maintained the integrity of which a specific payer was involved, but not necessarily who that payer was in the data. Dr. Soobader answered yes, sometimes we get the payer information, but it is not released, and we are not looking at this but can be deidentified. Lisa Freeman asked regarding the validity of the data, since you are looking at providers themselves. With COVID-19, there was a shift in delivery of healthcare in terms of in person/telehealth, and the different way referrals are being handles, and treatment being slowed down. Is this factored in, or is the data not that current? Dr. Soobader answered that the data is not factored in, but in Medicare data they see variations. In regard to the COVID-19 data, they will be working to figure out if they start using recent data what the implications will be on the benchmark methodology. They are doing work in looking at COVID patients. Health systems has been completely disrupted, there is doubt they can use this year's data and validity to use it. Pat suggested to keep the data clean, to stop at 2019. Dr. Soobader added that it would be helpful to have the most recent data to compare and contrast, but they wouldn't use it to be build a robust methodology. Adrian Texidor shared that we release the first 3 digits of zip code, when a particular geographic area has less than 20,000 individuals. Vicki Veltri clarified that the first 3 digits of CT vary 060, 061. 062. It isn't just 060. Olga Armah added that the zip codes range from "060-069". Pat asked if Chris Wyvill had any security questions for the data itself and security.		

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	Chris Wyvill commented that based on the application, there were no questions regarding security, transitions and storage of the data, the security policies they have place look good. In terms of date ranges of data and when they'll get delivery, the only question is to confirm that after one year from delivery, they intend to destroy the data. Pat Checko added that this is a requirement. Dr. Soobader commented yes, they will reapply if they need it for longer.		
5.	Final Vote Archway Application	Committee Members	2:00 PM
	Pat Checko asked for a motion to approve the Archway Health application. Lisa Freeman made a motion. Justin Peng seconded. Vote was unanimous. No abstentions or further discussion. The application was approved. There is an agreement that we are cognizant that they will be using Medicare data to which they have separate approval and access and the two data sets will not be combined.		
6.	Discuss APCD Data Requestor Survey	Dr. Patricia Checko, Adrian Texidor, Committee Members	2:15 PM
	Pat Checko discussed the APCD Data Requestor survey. Pat acknowledged we did spend time on this and a version of this was approved. Since that time, Adrian and Pat have been reviewing it. They decided it would be a good opportunity to ask applicants about their experience working with the first line individual and working with the DRC itself in the process. These are both key interactions the applicants have. Adrian added that a data release application task force was created and convened and met from January-March and develop the survey. He reviewed the survey as a result of the conversation and feedback received from the committee. The survey will be distributed to members so they will be able to review and provide feedback. Lisa Freeman asked for the question in the survey, when asking for time period ("how long did it take"), she suggested to provide multiple choice answers so it may be easier to compare, as opposed to leaving it open ended. Justin Peng asked in regard to question 11, if that information is available from their application, or are we asking for more information? Adrian answered that some people who receive these surveys we don't have an application. The reason being we don't have a window for how Access Health stores their applications, we thought it would be important to get more information from others.		

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	Pat Checko commented that if members of the committee have any comments or would like to provide feedback to please provide them right away and allow one week from today to respond. Adrian will send the survey out to the members for their review and feedback.		
7.	Update on APCD Application Task Force	Dr. Patricia Checko, Adrian Texidor, Committee Members	2:30 PM
	Pat Checko commented that the DRC has been working with this process for approximately three years. She explained they are using a process and application that was created previously that no longer is directly related to the request. While we have no control over the policies and procedures, we can look at the application and see how we can improve the processes we are directly involved in. The first step is the development of the survey to get input from people who have tried to use the data. This will give us a baseline and experience information that will serve us as we move forward. Pat thanked Sheryl Turney, Lisa Freeman, Justin Peng, Michael Girlamo who have all volunteered to be apart of the Application Task Force. The goal is for the Task Force to meet once a month over the next four months and have a report ready by September. They will be responsible for evaluating a process that starts with getting an application and instructions to move it along. We will review what other APCDs do, what they release, how they release, what the processes are. Pat added she will share the application process Vermont uses. The group should look at what data elements the users want/get, their security policies, follow up during the DUA process. Pat commented that we hope we can find something to send forward to the APCD Advisory Group as they move forward on new regulations. Pat added that she plans to bring up issue with deidentified, limited data sets and issues with security. Tina Kumar will help research other state APCD applications to use as examples.		
8.	Update on APCD Projects & OnPoint Services	Adrian Texidor, OHS	2:40 PM
	Adrian Texidor provided a few updates. Recent OnPoint Contract Extension: Adrian recalled that OHS did a six-month contract with OnPoint to evaluate the services offered. During that time, we		

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	were learning in the APCD database what services are provided, evaluating our needs and the DRC and external researchers. OHS decided to engage in OnPoint services for an additional three years until May 2021. The contract amount awarded at $2.2 million. In the contract, OHS made some changes to upgrade the enclave environment, explore adding 3M groupers into the APCD directly, APRDRG and clinical risk factors (CRFs). OHS has the Cost Growth Benchmark in flight and can hopefully engage the DRC. Additionally, OHS is working on six applications requests that came in from February-June. They are all in various stages, and not ready for preview. Lastly, Olga Armah has oversight of the CT APCD originally, Allan Hackney's role.		
9.	Wrap up and Meeting Adjournment	Dr. Patricia Checko	3:00 PM
	Pat Checko asked for a motion to adjourn the meeting. Lisa Freeman made a motion. Pat Checko seconded. The meeting adjourned at 3:00 pm.		

Upcoming Meeting: July 14, 2020
Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/APCD-Data-Release-Committee