All Payer Claims Database Advisory Group

Meeting Minutes

Meeting Date	Meeting Time	Location
Thursday, February 13, 2020	1:00 – 3:00 PM	**Center for Quantitative Medicine** Conference Room (3rd floor) 195 Farmington Avenue, Farmington, CT
	Web Conference:	Call-in: +1 646 876 9923 US (New York) or +1 669 900 6833 US (San Jose) Meeting ID: 706 192 603

Advisory Group Members					
Allan Hackney, OHS - Chair	X	François de Brantes		Easha Canada, DAS BEST	
Paul Lombardo	X	Sandra Czunas, OSC	X	Krista Cattanach	X
Dr. Robert Aseltine	X	Michael Girlamo, DHMAS	X		
Scott Gaul, OPM	X	Robert Scalettar, MD	X		
Ted Doolittle, OHA	X	James Iacobellis	X		
Kate McEvoy, DSS		Bernie Inskeep	X		
Patricia Checko	X	Victor Villagra	X		
Supporting Leadership					
Vicki Veltri, OHS	X	Olga Armah, OHS		Adrian Texidor, OHS	X
Tina Kumar, OHS	X				

Minutes			
	Topic	**Responsible Party**	**Time**
1.	**Welcome and Call to Order**	**Tina Kumar**	**1:00 PM**
	Tina Kumar recognized a quorum and called the meeting to order at 1:05 pm.		
2.	**Public Comment**	**Attendees**	**1:05 PM**
	There was no public comment.		
3.	**Review and Approval of November 14, 2019 Minutes**	**Council Members**	**1:10 PM**
	Allan Hackney asked for a motion to approve the November 14, 2019 meeting minutes. Dr. Robert Scalettar made a motion to amend the minutes (page 2 middle of page noted Dr. Aseltine-change to Dr. Scalettar). Bernie Inskeep made a motion, Pat Checko seconded. Sandra Czunas, and Dr. Robert Aseltine abstained. The minutes were approved.		
4.	**Updates: Status of CMS Data Use Agreement, cost estimator, carrier submission status, and denied claims**	**Adrian Texidor, Allan Hackney**	**1:15 PM**
	Update on Status of CMS Data Use Agreement: Adrian Texidor provided an update on the current Commercial, Medicaid and Medicare extract dates in the CT enclave. Currently, Medicare is on hold due to the processing of the Data Use Agreement (DUA) which will provide an update for the Fee for Service. The table for the updated Fee for Service dates can be found here: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/APCD-Advisory Group/Presentations/OHS_APCD_Advisory_Mtg_Presentation_021320.pdf#page=8.		

The current Memorandum of Agreement (MOA) for receiving Medicaid data expires on February 28, 2020. The Office of Health Strategy (OHS) and The Dept. of Social Services (DSS) are collaborating to renew the MOA, that will allow us to continue to receive Medicaid data in the CT APCD until February 28, 2022. The MOA renewal process simply requires the OHS Executive Director Vicki Veltri, and Commissioner Gifford of DSS to sign the MOA. Any Medicaid data use of OHS (and any other entity in the state) will need to be approved by Medicaid first. OHS can receive Medicaid data into the APCD but cannot be used until specific permission is given. Currently, the only approval for Medicaid data use is for Dr. Robert Aseltine of UConn Health Center for purposes of the State Innovation Model.

Medicare Data Use Agreement Status: OHS submitted an amendment to the DUA #51613. The amendment was approved by CMS which allows OHS to receive Medicare files in 2018-19 from CMS. Additionally, it allows OHS authority to use Medicare data for OHS initiative driven research projects including: The Cost Growth benchmark, Quality Benchmark and the Cost Estimator.

The DUA allows OHS to use the Medicare data until September 2020. OHS has been granted extended use of the data through April 2020. There are ongoing conversations with CMS to confirm the costs associated with the continued use of the Medicare data.

Dr. Scalettar asked if the Medicaid MOA to expire on February 28, 2020, has been rewritten and signed. Adrian indicated that the this is a standard MOA between the two agencies, which does not need to be revised. The only revisions will be the dates that will allow access to the data until February 28, 2022. Currently, the OHS Legal Counsel, Demian Fontanella has revised this, and it is currently at DSS.
Dr. Scalettar expressed the importance of getting the Medicaid MOA signed, as the OHS executive order relies on this data. Additionally, during the APCD meeting in November 2019, there was an action item to explore how other states are using the Medicaid data.

Adrian shared that the other states using Medicaid data also share the same legal hurdle CT faces, which requires the Medicaid Director to approve all uses of the data. However, in some of those states the Health and Human Services function as a Medicaid Dept, which enables them to allow the use.

Pat commented that in a perfect world, we would be able to assign someone from Medicaid to the APCD Data Release Committee, and that person would be able to make a ruling regarding release and use of Medicaid data for a particular project., Most Data Release applicants seek all of the data, including Medicaid. This will be challenging for external applicants to receive Medicaid data.

Regarding the Medicare data, Victor Villagra asked what would happen with the historical data after the DUA expires in September 2020, used for in house OHS project, such as the Cost Growth Benchmark, Quality Benchmark, and the Cost Estimator.

Adrian answered that OHS will retain the results of analyses such as reports etc. But we will be required to destroy the Medicare data housed in CT's APCD. Adrian projected that OHS will continue to access Medicare data and pay for continued use for the projects.

Update on Uses of the APCD Data:

Adrian shared that currently there are a few OHS projects that utilize the APCD data, including:

- In collaboration with The Office of the State Comptroller, The Healthcare Affordability Standard is being developed (to be featured on www.HealthscoreCT.com).
- The Cost Estimator tool on HealthscoreCT.com, recent updates were made to the interface design, and some of the data elements and components.

- Dr. Robert Aseltine & his team from *The Division of Behavioral Sciences and Community Hea*lth at UConn Health Center used the data to develop the State Innovation Model (SIM) scorecard and SIM evaluation.
  Dr. Robert Aseltine commented APCD data was used to create the Scorecard featured on Healthscore CT, which is the commercial quality measures for the advanced networks in the state. Currently, his team is working through the limited list of Medicaid and Medicare scores. One of the big limitations with this data, is that the Medicare pharmacy data is two years behind, consequently many of the quality measurements that Dr. Aseltine's team does, require pharmacy data for exclusions, diagnosis, or measurements (medication management).
  Dr. Aseltine's team are the first and only recipients of the Medicaid data (Dec. 16, 2019). They are working through the data to provide quality measures for the state's advanced networks, but also FQHCs. They believe they have sufficient data to rate 2/3 of the FQHCs for the Medicaid patients.
- Dr. Aseltine added that his research group will also use the APCD data for suicide risk modeling. They only have commercial data, this has gone well and provided avenues to explore how the APCD data informs other data without co-mingling datasets.
- Dr. Aseltine explained the Fusion technique his research team will be using. They are working to develop methodology to borrow information from an external database (i.e. The APCD), to use for any health care setting. They submitted a grant proposal to the NIH, where they are trying to apply this to the work in suicide risk modeling, and identify patients at risk and apply it to every hospital in CT.
- Adrian shared that CT's commercial APCD data will be included in the RAND hospital study. RAND is in version 3.0 of the study. This is a price transparency study, more information to follow during spring regarding where CT falls in hospital pricing, and of certain procedures.

Victor asked that in looking at the quality score for a particular hospital, do the definitions align with other work harmonizing other quality metrics? Is this identical to what we would get when searching the NCQA commercial quantity scores? Dr. Aseltine answered that all NCQA scores are endorsed measures, the only limitations in terms of comparability that some of these measures have clinical components is that they do not have access to clinical data and are exclusively using the administrative components. This is being replicated identically.

Allan introduced and welcomed Scott Gaul who joined the APCD from the Office of Policy and Management. Scott shared that he is hopeful to understand and translate to people the potential uses of the APCD. He believes that some of the APCD projects discussed should be highlighted in CT.

Allan asked for feedback on denied claims:

-extract data more efficiently out of the APCD
-data sitting at UConn Aims who is able to process the data and producing into the cost estimator.
-allowed them to understand what we have, what we don't have any opportunities that are starting to arise that people explore the data.
Secondly, we've had a chance to talk to other states about their uses of APCD data. One conference in Baltimore around healthcare IT issues, another is an organization, NESCO that brings the New England states together for periodic discussions. APCD'S are in different states of operations, or disarray. We are learning what is working and isn't.
Finally, OHS is looking at agenda for the legislative session and view how we may be able to move forward with the APCD for expansive directions.
Some ideas require direct legislative action, one that we heard from routinely from other states is ensuring to capture denied claims to the paid claims in the APCD. Most states are asking for denied claims, mainly

	because of the services that are performed to patients represent a body of work that pertains to the care of the patients. We looked at the current statute, and we believe there is an opportunity to request for denied claims. Allan asked the group for feedback to then determine what the steps are. Paul Lombardo asked what the use would be for denied claims, if we are trying to establish the cost structure in the state, and if denied claims get covered in the future. Allan answered it's not cost, but episodes of care. If you do risk groups, then you would want to know the activity. Ted Doolittle shared from his perspective that denied claims are critical information because it shows how people are using their health insurance coverage. One of the main impacts on everyone's life is when you do have denied claims. Pat Checko thinks some of it relates to services, there are costs related to denied claims, usually coming out of the pocket of the consumers. By looking at denied claims, it gives us an idea for what needed services are not being addressed by insurance companies or legislative. Dr. Aseltine shared that with the rationale provided for why a claim is denied is important to understand whether the underlying service is relevant to analysis. Allan doesn't know if we will get a reason code but will take the question back. Dr. Aseltine said one thing that would be concerning for the reason code is that we rarely get unstructured data. agrees that it is important, but this was discussed in 2013-2014. Denied claims are important aspects for a provider/patient relationship, and we need to be sensitive of what this would do. Bernie Inskeep asked that we define denied claims. She commented that there is an enormous amount of noise in the healthcare business from incorrect billing. It will be extremely expensive to store; it will not inform, and it will be very difficult to weave through. If there is a claim, then all of the claim lines are submitted. Victor Villagra thinks that capturing this data is extremely important, that this is a blind spot that is happening all over state. One of the most common objections is the noise, Vermont unanimously passed the bill in 2012 to collect this information. Claims are not administrative error; these are denials that impact the member directly. Important factors that are important: is particular claim denied because of a benefit limit that has been met? Also, important because we do not have true denominator upon which appeals are examined. doesn't think there is much variation in the standards. Dr. Scalettar commented that he supports Victor's comments on this issue. It is critically important and suggests that there has been a lot of progress made on this. Allan concludes that there is a great deal of interest in this topic, but as Bernie indicated it is important to make sure we know what to ask for. OHS will work on defining this better and will come back to the APCD Advisory Group in May for additional input. Allan asked if any of the members would be interested in participating in these on-going discussions. Victor Villagra, Robert Scalettar, Paul Lombardo, Ted Doolittle, Bernie Inskeep volunteered to be a part of these discussions.		
5.	**Update on Data Release Committee**	**Patricia Checko**	**1:55 PM**
	Pat Checko, chair of the Data Release Committee (DRC) shared that the DRC finally approved Dr. Robert Aseltine's' proposal to utilize the factor analysis approach on opioid data. This will be done using the de identified data set and ensures that there is no co-mingling of the data.		

	Currently, Pat and Adrian are reviewing a pending data release application. The Data Release User Survey is targeted to be distributed by the end of February, (using Survey Monkey) to anyone who has gone through the data release application process. The survey will also be shared to applicants who withdrew their applications to understand some of their issues. This survey is aimed to look at the process itself, and to determine applicants were able to utilize the deidentified data with the blinded dates to address the hypothesis they were looking at. The survey ultimately will also be used to collect information as it will become valuable to us as we move forward and how our statute needs to be modified to make it accessible for people to use. Additionally, the DRC is in process of creating an Application Workgroup, set forth to revise the existing Data Release Application, and will be shared with the APCD advisor to review and finalize. Vicki Veltri added that since the APCD is under a state agency, subject to regulation. Any policies and procedures that are developed, will have to go through the regulatory process.

6.	**Overview on Governor Lamont's Executive Order No. 5**	**Vicki Veltri**	**2:00 PM**
	Vicki Veltri shared an update on the Executive Order No. 5 & No. 6 that Governor Lamont issued. Executive order No. 5 requires OHS to: -develop an annual health care cost growth benchmark by Dec. 2020, for calendar years 2021-2025. -set targets for increased primary care spending as a percentage of total health care spending, so that we reach 10% by 2025. -develop quality benchmarks across all public and private payers beginning in 2022. This would include clinical quality measures, over/under utilization measures. -monitor and report annually on health care spending growth across public and private payers. -convene a cost growth benchmark advisory team -monitor accountable care organizations and development of alternative payment models progressing in CT. House Bill 5018: *An Act Concerning Health Care Cost Growth in CT,* codifies the executive order and includes additional items such as data likely to collect, adding definitions to the bill, provisions around protecting data, and the quality benchmark and primary care target. If state exceeds the benchmark for year, OHS is to consult with the entities to try to come up with ways to bring the cost growth under the benchmark. Vicki added that that they have just begun to embark on this work, and the advisory team will be named on Friday 2/21. There is much more work to come and there will be multiple opportunities for engagement in this work, via the existing the councils/bodies. Executive order No. 6 is a companion to Exec. Order No. 5. This was directed under Dept. of Social Services and requires the agency to be more transparent about its cost and quality reporting. They are set forth to develop and deliver a report by the end of 2020 to the Governor about measures DSS would report on publicly and how it can align its work and plan strategically for the future. Commissioner Gifford has been working hand in hand with OHS. Robert Scalettar asked for a high-level overview for the challenges that may be faced in succeeded Executive Orders No. 5 & 6 to be a reality and impactful. Vicki commented there has been positive discussion with individuals in the health care industry regarding this work and the need to move forward. Heath care affordability is the number one issue that people issue identified when asked about challenges they are facing. As it continues to roll out, some of the challenges we		

	may see is around data, i.e. do we have a complete data set? What kind of data we have, what is missing, what is easily available? Other issues would be around decision making, what's in a denominator/numerator for spending both for the cost growth and primary care targets. Where to target initiatives? Victor Villagra asked in regard to cost growth benchmark if there is early thinking of how those benchmarks be thought about? Will there be a correlation with the healthcare affordability standard? Vicki believes it's too early to say but based on discussions with other states who have targeted their benchmark to the rate to the growth of economy of their state. The CPI growth, the affordability standard may be measures to consider. The technical team will be advising us on this.		
7.	**Announcements and General Discussion**	**Allan Hackney**	**2:30 PM**
	Vicki shared an update on OHS resources. Allan Hackney will be devoting time to the Health Information Alliance, and Olga Armah from OHS will be transitioning to APCD day to day management. Olga will also be appointed Chair of the APCD Advisory committee at the next meeting. Allan commented that the work will be moving rapidly with the HIA, and believes Olga is a good fit to lead the APCD. Allan acknowledged Chris Wyvill who handles the infrastructure needs for OHS, and also as a Security Administrator for the APCD project. Allan said it has been his pleasure to work with the APCD team and will continue to work with some of the members on the HIT Advisory Council. Rob Aseltine asked if there were any updates on negotiations with DPH on integrating vital statistics in the APCD. Allan answered that we are in initial discussions with DPH. Two things may help move along: Also, the HIE will help there as well, the ability for DPH to get more data is going to be amplified. There is progress.		
8.	**Wrap up and Meeting Adjournment**	**Allan Hackney**	**2:25 PM**
	Allan Hackney asked for a motion to adjourn. Dr. Robert Aseltine made a motion to adjourn, Bernie Inskeep seconded. None opposed. The meeting adjourned at 2:25 pm.		