All Payer Claims Database Advisory Group

NOTICE OF SPECIAL MEETING AND AGENDA

Date:	Thursday, June 12, 2014
Time:	9:00 a.m. to 11:00 a.m.
Location:	Legislative Office Building, Room IE 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, 2014 Meeting Minutes

IV. CEO / ED Updates

V. Update on DSS Data Collection

VI. Procurement Overview

VII. Update on Proposed Timeline for Data Collection

VIII. Update on Focus Group Findings

IX. Status of SIM Project and APCD Collaboration

X. Status of Subcommittees

XI. Next Steps

XII. Future Meetings

XIII. 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**.

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

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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.

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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.

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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

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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.

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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

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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.

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All-Payer Claims Database Advisory Group Meeting

June 12, 2014

Presentation Overview

- Approval of April 10, 2014 Meeting Minutes
- CEO/ED Update
- Update on DSS Data Collection
- Procurement Process
- Update on Proposed Timeline for Data Collection
- Update on Focus Group Findings
- Status of SIM Project and APCD Collaboration
- Status of Subcommittees
- Next Steps
- Future Meetings

CEO / ED Update

- Continuing to develop a detail contract document comprising of the following items:

  - *Contract items – Performance, Engagement of Contractor and Subcontractors, Operational, Duties of Exchange, Data Confidentiality & Security, Compensation & Payment, Terms & Termination, Intellectual Property & Ownership, Records Maintenance / Access to Records / Financial Statements, Insurance / indemnification, Compliance with Laws, Policies and Procedures*

  - *Scope of Services items - Project Management, Data Management Infrastructure, Data Collection, Data Management & Analytics, Managed Environment, Web Development & Deployment, Data Security, Consumer Research & Communications, Security, and Sustainability Planning*

CEO / ED Update

- Continuing to host/support various subcommittee meetings to address the following -
  - Addressing data privacy, security & legal issues
  - Amending (in progress) Data Submission Guide (DSG) to accommodate inclusion of dental data from 2015
  - Deliberating and developing use cases, identifying barriers and analyzing technical considerations in including denied claims

- Planning & developing framework to support SIM via APCD

- Working with an external security auditor to conduct comprehensive security audit of the data management vendor

- Customer research for price transparency, types and design of reports, structure of web based reporting tools

Update From DSS

Procurement Process

- Access Health Analytics (AHA) released a RFP to solicit proposals from Data Analytics vendors for implementation of an All-Payer Claims Database project on Jan. 27, 2014
- Prospective vendors were given one month period to respond (deadline of Feb. 28)
- Vendors were given an opportunity to ask questions by Feb. 9; 216 questions were received and answered by Feb. 14
- Vendor's Intent to Bid was set at Feb. 14 – 16 vendors expressed interest to submit bids
- By the deadline (Feb. 28), only 10 vendors submitted proposals
- Only 5 vendors met the criteria to be eligible for appraisal
- Top 3 were invited for Oral presentation; one could not come due to internal logistics
- Finalist was notified on March 31st, semi-finalist is on a holding pattern
- Contract work started immediately; current status is still on progress

Procurement Process – RFP Sections Overview

RFP Sections	Content Categories included within the RFP Section
Information	▪ Definitions ▪ Authorized Contact Person ▪ Questions Regarding this RFP ▪ Notice of Intention to Propose ▪ Proposal Due Date, Time and Location ▪ Oral Presentation/ Interviews and Discussion ▪ Confidentiality ▪ RFP Schedule of Events ▪ Responder Eligibility ▪ Contract Term ▪ Subcontractors
Background	▪ Introduction ▪ Project Overview and Scope of Solicitation ▪ Project Dependencies and Critical Success Factors ▪ Assumptions ▪ Project Organization
Scope of Work	▪ Project Timeline ▪ Approach to Design, Development and Implementation ▪ High Level Expectations ▪ Overview of Minimum Technical Requirements ▪ Deliverables ▪ Software and Hardware Requirements ▪ Service Level Specifications

Procurement Process – RFP Sections Overview (cont.)

RFP Sections	Content Categories included within the RFP Section
Contractor Qualification Reference Requirements	▪ Relevant Vendor References
Proposal Content Requirements	▪ Proposal Format ▪ Proposal Organization ▪ Cover Page ▪ Table of Contents ▪ Glossary of Terms and Abbreviations ▪ Insurance and Indemnification Requirements ▪ Records/Intellectual Property Requirements ▪ Executive Summary ▪ Assumptions ▪ Narrative Response ▪ Partnership Opportunities for CT APCD Sustainability ▪ Technical Solution, Approach and Methodology ▪ Qualification – Relevant Experience and Expertise ▪ Project Team and Organization Capacity ▪ References ▪ Key Deliverables and Project Implementation Schedule ▪ Response to the Requirements Traceability Matrix ▪ Response to Service Level Specifications ▪ Price Proposal ▪ Appendices

Procurement Process – RFP Sections Overview (cont.)

RFP Sections	Content Categories included within the RFP Section
Appendix A	Evaluation and Selection Process ▪ General Information ▪ Scoring Criteria ▪ Rights of Access Health Analytics in Evaluating Proposals ▪ Disqualification ▪ Notification of Award
Appendix B	Intent to Propose Form
Appendix C	Proposal Cover Sheet
Appendix D	Minimum Standards for Proposal Consideration
Appendix E	Minimum Technical Requirements
Appendix F	Key Milestones
Appendix G	Price Proposal Template
Appendix H	Notice of Special Compliance Requirements
Appendix I	Data Submission Guide
Appendix J	High Level Technical Specifications for Managed Environment (SAS Based Data Hosting Environment)

Procurement Process – Written RFP Scoring

Category	Possible Points
Response to Minimum Technical Requirements	20
Approach, Methodology, Key Deliverables and Project Implementation Schedule	25
Organizational Capacity (company, staffing, effort)	10
Relevant Experience and References	15
Partnership Opportunities for Sustainability	10
Price Proposal	15
Compliance with Contractual Terms and Conditions	5
Total Possible Points	100

Procurement Process – List of Reviewers

#	Sections	Reviewer 1 (Business & Technical)	Reviewer 2 (Business & Technical)	Reviewer 3 (Finance)	Reviewer 4 (Legal)	Reviewer 5 (Technical)
1	Technical Requirements	√	√			
2	Approach, Methodology, Key Del. & Proj Implementation Schedule	√	√			√
3	Organizational Capacity	√	√			
4	Relevant Experience & References	√	√			√
5	Partnership Opportunities for Sustainability	√	√	√	√	
6	Price Proposal	√	√	√		
7	Compliance w/contractual terms & conditions			√	√	

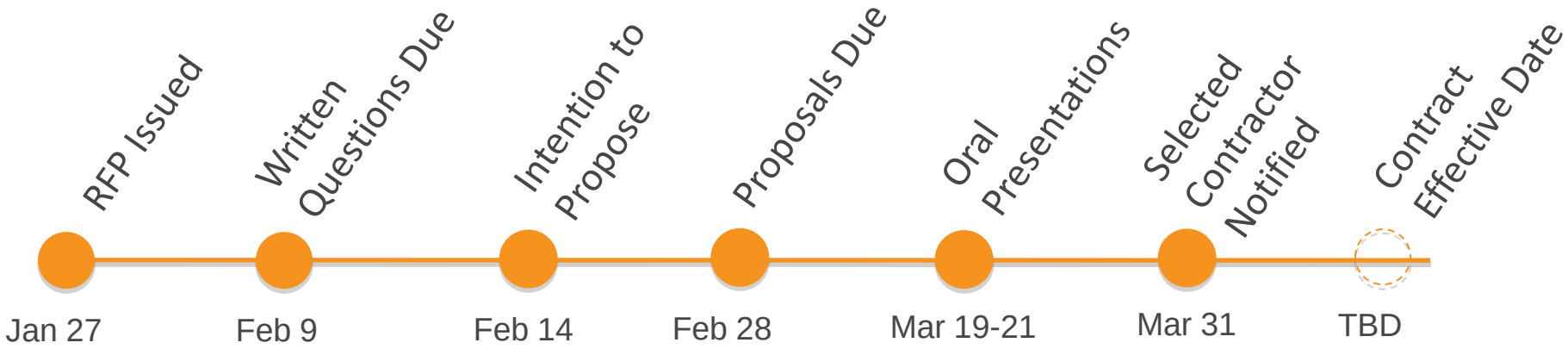
Procurement Process – Oral Presentation Agenda and Length

Topic	Time Allotted
Introductions and Company Background	10 minutes
Solution Overview	15 minutes
Solution Demo	30 minutes
Approach	25 minutes
Data Security and Privacy Practices	10 minutes
Team	10 minutes
Pricing	15 minutes
Break	10 minutes
Q&A	30 minutes
Closing Comments	5 minutes
Total	**2 hours, 40 minutes**

Procurement Process – Oral Presentation Scoring

Agenda Topic	Max Points
Company Background	5
Solution Overview	25
Solution Demo	25
Approach	15
Data Security and Privacy Practices	10
Team	10
Pricing	10
Q&A	-
Total	**100**

Procurement Timeline



Activity	End Date
RFP Issued	January 27
Written Questions Due	February 9
Notice of Intention to Propose	February 14
Proposals Due	February 28
Oral Presentations	March 19-21
Selected Contractor Notified	March 31
Contract Effective Date	TBD

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Proposed Timeline for Data Collection

Newly Proposed Data Submission Timeline

First Kick-Off Meeting With Contractor and Reporting Entity (TBD Date)

Submission of Test Data (Within 100 days)

Submission of 36 Months of Historic Data (Within 60 Days & Contingent on AHA Approval of Test Data)

Submission of YTD Data (Within 45 Days)

Commence Monthly Data Submissions (Within 30 Days)

Submission Preparation (100 Days)

- Establish Communication Process
- Resolve Open Questions
- Establish Secured Delivery Protocol
- Share Data Variance Standards and Request Process

Update on Focus Group Findings

- Conducted a focus group discussion on the topic of cost transparency on May 20th
- We intend to engage 3 such groups in total
- The 1st group we had discussions with had the following characteristics:
  - 7 people - 5 males, 2 females
  - 5 Whites/Caucasians, 2 African Americans
  - 5 from suburbs, 2 from Hartford
  - 3 from Medicaid, 4 from Commercial plans
- We want to set up two more groups over the next 1 ½ months
- Focus of the questions were qualitative rather than quantitative on this topic

Update on Focus Group Findings (cont.)

Topics on Cost Transparency

- Willingness of focus group members to shop medical services on costs & quality attributes
- How is shopping influenced by:
  - Source of information
  - Distance of medical service from patient's home
  - Quality uncertainty of medical services
  - Types of medical services
  - Uncertainty about benefits – deductibles, network, out-of-pocket costs
  - Ease of use / understanding of information reported
  - Members' sensitivity to costs for medical services
  - Trusts in medical services' quality rating authorities
  - Trusts in State APCD

Update on Focus Group Findings (cont.)

Highlights of Responses

- Generally members, even in Medicaid, are willing to use shopping tools to understand variations in costs
- Willingness and intensity of shopping around for costs are influenced by the following:
  - Familiarity of searching for such information on the web or other sources have a positive effect on shopping
  - Richness of benefit plan has an opposite effect on search behavior
  - Quality uncertainty is also an important factor against shopping behavior
  - Serious and complicated surgery/condition has a negative impact on search behavior
  - Higher variations in costs have a positive impact on search behavior
  - Source(s) of quality rating, particularly consumer review, encourages shopping

Update on Focus Group Findings (cont.)

Highlights of Responses

- Generally positive responses received about the shopping intent if information is credible and easily available
- The respondents were very comfortable about interpreting numbers (reflecting various quality measures) of moderate size, say 3-4 rows and 3-4 columns
- Large tables with numbers are deemed too complex; symbols are more helpful to the respondents
- Most of the respondents have little knowledge about quality ratings and of the institutions reporting it. They feel more comfortable using patient reviews to rate providers
- They mentioned that they'll use APCD if the information is presented very easily, which means they need to get the information with minimal time on the web, say 5 minutes or less

Status of SIM Project and APCD Collaboration

- Background – project description, funding, etc.
- Operational requirement for SIM
- Data requirements – Medicaid, Commercial and Medicare
- Level of data analysis – enabling legislation may be required
- Edge serve technology to link Medicaid data with APCD data
- Funding opportunity to support SIM via APCD

Status of Subcommittees

Data Privacy & Security Subcommittee

- Dr. Robert Scalettar

Policy & Procedures Enhancement Subcommittee

- Matt Katz

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 TBD
September 11, 2014	9:00 – 11:00 AM	LOB, Room TBD
November 13, 2014	9:00 – 11:00 AM	LOB, Room TBD

SUMMARY OF STATE AND FEDERAL STATUTES AND REGULATIONS RELATING TO CONFIDENTIALITY OF CLIENT RECORDS AT THE DEPARTMENT OF SOCIAL SERVICES

State Law:

1. Section 17b-90(b) of the Connecticut General Statutes

   With specific exceptions set forth in the statute,

   > [n]o person shall, except for purposes directly connected with the administration of programs of the Department of Social Services and in accordance with the regulations of the commissioner, solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of, any list of the names of, or any information concerning, persons applying for or receiving assistance from the Department of Social Services or persons participating in a program administered by said department, directly or indirectly derived from the records, papers, files or communications of the state or its subdivisions or agencies, or acquired in the course of the performance of official duties.

2. Sections 1015.10, 1015.15, 1015.20, 1020, 1020.05, 1020.10, 1020.12, 1020.13, 1020.15and 1020.20 of the Uniform Policy Manual govern SNAP, Medicaid, TFA.

3. There are specific state statutory protections for client information the Department obtains from psychiatric providers and also for confidential HIV-related information. The Department may not re-disclose such information without specific consent from the clients and such re-disclosures must contain statutorily- mandated language when it is disclosed. *See* Conn. Gen. Stat. §§ 52-146e, 52-146i, 19a-583, 19a-585.

Federal Law

1. Medicaid statute - 42 U.S.C. 1396a(a)(7)

   A State plan for medical assistance must

   (7) provide--
   (A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with--
   (i) the administration of the plan; and
   (ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 [42 USCS §§ 1771 et seq.] and free or reduced price lunches under the Richard B. Russell National School Lunch Act [42 USCS §§ 1751 et seq.], in accordance with section 9(b) of that Act [42 USCS § 1758(b)], using data standards and formats

established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act [42 USCS §§ 1751 et seq.] under which the State shall establish procedures to ensure that--

(i) a child receiving medical assistance under the State plan under this title whose family income does not exceed 133 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act [42 USCS § 9902(2)], including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act [42 USCS §§ 1751 et seq.] and free breakfasts under the Child Nutrition Act of 1966 [42 USCS §§ 1771 et seq.] without further application; and

(ii) the State agencies responsible for administering the State plan under this title, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act [42 USCS § 1758(b)];

2. Medicaid regulations - 42 C.F.R. 431.300 to 431.307, inclusive.

These regulations specify that " purposes directly related to plan administration" include establishing eligibility; determining the amount of medical assistance; providing services for recipients; and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. They also specify the type of information that must be safeguarded. A copy of these regulations is attached. There are some changes related to the Health Insurance Exchange, which go into effect January 1, 2014.

3. HIPAA

Federal HIPAA regulations set forth under what circumstances protected health information ("PHI") may be used and disclosed by covered entities. PHI is information, including demographic information, which relates to (1) the individual's past, present or future physical or mental health condition; (2) the provision of health care to the individual; or (3) the past, present or future payment for the provision of health care to the individual and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

The Department of Social Services is a covered entity. In general, PHI may be disclosed without the individual's consent only for purposes of treatment, payment or health care operations. These terms are defined in the regulations. HIPAA provides a floor with regard to what a covered entity may share with others without an individual's consent . There are many exceptions in HIPAA, which allow protected health information to be disclosed without an individual's consent. But if there is a state statute or another federal

statute or regulation that is stricter than HIPAA, i.e., that is more protective of the individual's privacy than HIPAA, the covered entity must follow the stricter provision.

4. 42 C.F.R. Part 2 – Alcohol and Substance Abuse Treatment Programs

While the Department is not an alcohol or substance abuse treatment program, if the Department has information about an individual that was obtained from an alcohol or substance abuse treatment program, with very limited exceptions, we must obtain the client's specific consent in order to re-disclose this information. 42 C.F.R. § 2.32.

ELECTRONIC CODE OF FEDERAL REGULATIONS

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Title 42: Public Health
PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

Subpart F—Safeguarding Information on Applicants and Beneficiaries

Contents

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SOURCE: 44 FR 17934, Mar. 29, 1979, unless otherwise noted.

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§431.300 Basis and purpose.

(a) Section 1902(a)(7) of the Act requires that a State plan must provide safeguards that restric the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

(b) For purposes of this subpart, information concerning an applicant or beneficiary includes information on a non-applicant, as defined in §435.4 of this subchapter.

(c) Section 1137 of the Act, which requires agencies to exchange information to verify the inco and eligibility of applicants and beneficiaries (see §435.940 through §435.965 of this subchapter), requires State agencies to have adequate safeguards to assure that—

(1) Information exchanged by the State agencies is made available only to the extent necessar to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l)(7) of the Internal Revenue Code is exchanged only with agencies authorized to receive that information under that section of the Code; and

(2) The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

(d) Section 1943 of the Act and section 1413 of the Affordable Care Act.

[51 FR 7210, Feb. 28, 1986, as amended at 77 FR 17203, Mar. 23, 2012]

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§431.301 State plan requirements.

A State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concernin applicants and beneficiaries to purposes directly connected with the administration of the plan.

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§431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include—

(a) Establishing eligibility;

(b) Determining the amount of medical assistance;

(c) Providing services for beneficiaries; and

(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related the administration of the plan.

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§431.303 State authority for safeguarding information.

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and beneficiaries.

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§431.304 Publicizing safeguarding requirements.

(a) The agency must publicize provisions governing the confidential nature of information abou applicants and beneficiaries, including the legal sanctions imposed for improper disclosure and use

(b) The agency must provide copies of these provisions to applicants and beneficiaries and to other persons and agencies to whom information is disclosed.

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§431.305 Types of information to be safeguarded.

(a) The agency must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded.

(b) This information must include at least—

(1) Names and addresses;

(2) Medical services provided;

(3) Social and economic conditions or circumstances;

(4) Agency evaluation of personal information;

(5) Medical data, including diagnosis and past history of disease or disability; and

(6) Any information received for verifying income eligibility and amount of medical assistance payments (see §435.940 through §435.965 of this subchapter). Income information received from S or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable.

(7) Any information received in connection with the identification of legally liable third party resources under §433.138 of this chapter.

(8) Social Security Numbers.

[44 FR 17934, Mar. 29, 1979, as amended at 51 FR 7210, Feb. 28, 1986; 52 FR 5975, Feb. 27, 1987; 77 FR 17203, Mar. 23, 2012]

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§431.306 Release of information.

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and beneficiaries.

(b) Access to information concerning applicants or beneficiaries must be restricted to persons (agency representatives who are subject to standards of confidentiality that are comparable to those the agency.

(c) The agency must not publish names of applicants or beneficiaries.

(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be usec verify income, eligibility and the amount of medical assistance payment under section 1137 of this A and §§435.940 through 435.965 of this chapter.

If, because of an emergency situation, time does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.

(e) The agency's policies must apply to all requests for information from outside sources, inclu governmental bodies, the courts, or law enforcement officials.

(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or beneficiary, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under §435.940 through §435.965 of this subchapt the agency must execute data exchange agreements with those agencies, as specified in §435.945 of this subchapter.

(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under §433.138(d) of this chapter, the agency must execute data exchanges agreements, as specified in §433.138(h)(2) of this chapter.

[44 FR 17934, Mar. 29, 1979, as amended at 51 FR 7210, Feb. 28, 1986; 52 FR 5975, Feb. 27, 1987; 77 FR 17203, Mar. 23, 2012]

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§431.307 Distribution of information materials.

(a) All materials distributed to applicants, beneficiaries, or medical providers must—

(1) Directly relate to the administration of the Medicaid program;

(2) Have no political implications except to the extent required to implement the National Voter Registration Act of 1993 (NVRA) Pub. L. 103-931; for States that are exempt from the requirements NVRA, voter registration may be a voluntary activity so long as the provisions of section 7(a)(5) of NVRA are observed;

(3) Contain the names only of individuals directly connected with the administration of the plan; and

(4) Identify those individuals only in their official capacity with the State or local agency.

(b) The agency must not distribute materials such as "holiday" greetings, general public announcements, partisan voting information and alien registration notices.

(c) The agency may distribute materials directly related to the health and welfare of applicants beneficiaries, such as announcements of free medical examinations, availability of surplus food, an consumer protection information.

(d) Under NVRA, the agency must distribute voter information and registration materials as specified in NVRA.

[44 FR 17934, Mar. 29, 1979, as amended at 61 FR 58143, Nov. 13, 1996]

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2014 FUNDING OPPORTUNITY ANNOUNCEMENT FOR STATE INNOVATION MODEL TEST GRANT

Agenda

- Purpose of SIM
- Funding Opportunity Highlights
- Application Package
- Project Narrative: 9 major requirements
- Scoring criteria
- Process for completing application
- Timetable

WHAT IS THE STATE INNOVATION MODEL INITIATIVE?

- The State Innovation Model Initiative (SIM) is an initiative of the Center for Medicare and Medicaid Innovation (CMMI)
- CMMI created under the ACA to improve quality and contain costs
- *SIM Design* grants enable states to develop a State Healthcare Innovation Plan to improve health and healthcare
- Align providers, consumers, employers, payers, and state leaders around health and health care reforms
- Reach 80% of Connecticut's citizens in 3-5 years
- Connecticut's Healthcare Innovation Plan was submitted December 30, 2013

CONNECTICUT'S VISION

Establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

HIGHLIGHTS

Triple Aim

1. Strengthen population health
2. Transform health care delivery system
3. Decrease per capita health care spending

HIGHLIGHTS

- Twelve states will be awarded **$20-$100 million** each over a **4-year period**. Funding will be proportionate to the state's population & scope of reform.
- The 4-year timeframe is longer than the previous 3 1/2-year timeframe. Allows **up to one year (rather than six months) for pre-implementation**.
- In-person or virtual **presentation to HHS is required** (state cost).
- **Financial Analysis is required**; must estimate proposal's return on investment and specifically for Medicare, Medicaid, and/or CHIP populations, over test grant performance period. New requirement for external actuarial certification.

PRIMARY AIMS

1. Strengthen population health
2. Transform health care delivery system
3. Decrease per capita health care spending

PROJECT NARRATIVE (29 pages)
FOCUS ON NINE REQUIREMENTS

1. Plan for improving population health
   - The state must develop a state-wide population health plan during the test period.
   - Plans should address at minimum tobacco use, obesity, and diabetes.
2. Healthcare delivery system transformation plan
   - Describe how plan will engage providers in health care delivery transformation.
   - Over 80% of payments to providers from all payers are in FFS alternatives that link payment to value.
   - Every resident of the state has a primary care provider who is accountable both for the quality and the total cost of their health care.
   - Performance in quality and cost measures is consistently high.
3. Payment and/or Service Delivery Model
   - Payment and/or delivery model that includes but is not limited to Medicaid population, state employee population, and/or commercial payers' populations
   - Identify target populations, numbers served, services delivered, etc.
   - Encourages models that directly align with one or more existing Medicare programs such as ACOs, primary care medical homes, and bundled payment programs

NINE REQUIREMENTS CONT.

4. Leveraging regulatory authority
   - Such as for aligning requirements for health insurers, integrating value-based principles, and to improve the health care workforce.

5. Health information technology
   - Current HIT adoption
   - Detailed description concerning HIT Governance, Policy, Infrastructure, and Technical Assistance Domains

6. Stakeholder engagement
   - Significant number of stakeholders across entire state engaged and committed
   - Providers, payers, state hospital and medical associations, community-based and long terms support providers, consumer advocates, tribal communities

NINE REQUIREMENTS CONT.

7. Quality measure alignment
   - Develop a state-wide plan to align quality measures across all payers in the state

8. Monitoring and evaluation plan
   - Quantifiable measures for regularly monitoring the impact under the Test, on the three outcomes of the Triple Aim
   - All quality and cost measures must use the state's entire population in the denominator

9. Alignment with State and Federal Innovation
   - Must coordinate and build upon existing initiatives
   - Must ensure funding does not duplicate activities or supplant current federal or state funding

PROCESS

Different initiative owners will prepare sections of the application

Initiative owners will submit first draft materials to the PMO for questions/comments

Initiative owners will submit second draft to the PMO and present it to the Steering Committee

Steering Committee will approve drafts and submit any changes that the PMO will make to the final version

TIME TABLE

May June

May 22
- FOA released

June 6
- Letter of intent filed

June 12
- Steering Committee Meeting with Briefings by initiative owners

June 16-24
- Program narrative drafts completed and distributed to Steer Co

TIME TABLE

June July

June 26

- Steering Committee meeting: Program Narrative Presentations

June 30-July 8

- Budget & Operational Plan draft completed and distributed to Steer Co

July 10

- Steering Committee Meeting: Budget & Operational Plan presentations

July 16

- SIM PMO submits Test Grant

APCD – OPERATIONAL REQUIREMENTS

1. Evaluate statewide impact of reforms
   - Population health
   - Delivery system - % of residents with PCP
   - Quality
   - Cost – per capita spending
   - All quality and cost measures must use the state's entire population in the denominator

2. Monitoring and reporting to CMS
   - Production of extracts for federal reporting

3. Rapid cycle evaluation
   - Integrated data is used to inform and improve the model throughout the period of the award. The state must include a clear feedback loop and strategies for continuous monitoring and improvement of the model through collection and analysis of data across payers and partners
   - Comparative evaluation of provider performance and model comparisons (e.g., ACO vs FQHC vs geo-community)

APCD – OPERATIONAL REQUIREMENTS

1. Production of claims extracts to support provider analytics (?)
   - Large system providers are seeking efficient, standardized method of securing claims data to support advanced analytics (health risk stratification, utilization and quality analysis, cost analysis)
2. Production of cross-payer quality reports
   - Cross-payer quality reports in accordance with common quality score card
   - Analytic and data visualization tools(?)
3. Source of data to support claims/clinical data integration and enhanced analytics
   - consumer attribution, risk stratification, risk adjusted cost comparison, quality and utilization metrics; care gaps analyses, alert generation that identify high-priority consumers who need targeted intervention, implement analytics that identify health disparities

APCD – DATA REQUIREMENTS

1. Commercial (fully insured and self-insured)
2. Medicare
3. Access to Medicaid (via edge server)
   - Bond funds authorized in 2014 session to use edge server technology to link Medicaid and other data sources including APCD
   - Bond funds will cover initial set up, configuration, and the production of basic cross-payer reports
   - Additional development costs to support advanced analytics and data visualization tools will be required in future years, subject to the availability of SIM test grant funds

APCD – LEVEL OF DATA ANALYSIS

1. Some analyses may require person-level analysis using PHI data and communicating to providers
2. Grant requires that we identify future legislative changes to enable using APCD PHI data, such as for treatment and coordination purposes

APCD – FUNDING OPPORTUNITY

1. SIM Funding available for HIT
2. Test grant funds may be used, for example, to
   - procure Medicare files
   - apply edge serve technology to access APCD data
   - hire an analyst to support SIM by working in APCD's managed hosting environment
3. Preference for infrastructure investments
4. Require plan for sustainability, as appropriate