Georgia All-Payer Claims Database (GAPCD) Advisory Committee

DRAFT Minutes

Quarterly Meeting

Thursday, November 10, 2022 | 10:30 am – 12:00 pm

Virtual Meeting | apcd@opb.georgia.gov

Attendees

Committee Members

p	Dr. Thomas Bat	p	Mr. Kelly Farr	a	Representative Butch Parrish
a	Senator Dean Burke	p	Mr. Matthew Hicks	p	Mr. Grant Thomas (Chair)
p	Mr. Gregg Conley	p	Ms. Crysty Odom	p	Commissioner Kathleen Toomey
p	Dr. Jon Duke	p	Mr. Chad Purcell		

(p)resent; (a)bsent

Supporting Leadership/ Facilitation Present

Office of Health Strategy and Coordination (OHSC): Elizabeth Holcomb, Anelia Moore, Colin Stauffer, Jake Star

Georgia Tech Research Institute Center for Health Analytics & Informatics (GTRI-CHAI): Megan Denham

CedarBridge Group (APCD Program Management Office): Carol Robinson, Donald Ross

Onpoint Health Data: Jim Harrison

Discussion Notes

Opening Remarks, Introductions, Approval of Meeting Minutes

Mr. Grant Thomas, Director of OHSC and Chairman of the All-Payer Claims Database Advisory Committee, welcomed the attendees and addressed some housekeeping items before moving to this quarter's agenda. Chairman Thomas indicated that there is much progress to share as we transition from planning to the implementation and countdown toward going live with data submissions.

Chairman Thomas informed participants that the meeting was open to the public and would be conducted in accordance with the state of Georgia Open Meetings Act, then let attendees know that the meeting would be recorded, and minutes would be posted to the website following approval by the committee at the next meeting. Minutes can also be obtained by writing to APCD@opb.georgia.gov. Participants were reminded that no public comment would be heard during the meeting, though comments may be sent to the same email address provided for obtaining meeting minutes.

Committee members were invited to speak up with questions throughout the meeting rather than wait until the end.

As Chairman Thomas moved to the agenda, he informed participants minutes from the previous meeting were emailed with the agenda the previous week, then asked if there were any questions or comments regarding the minutes. [Pause] There were no comments. Hearing no objection, the minutes from June were approved, and the committee roster was reviewed.

Closing the opening remarks, Chairman Thomas provided an update on changes to the APCD project team and introduced new team members. Chairman Thomas expressed gratitude to Deputy Director Melissa Barwick, who he informed committee members had taken a new position at the Georgia Department of Human Services. Ms. Elizabeth Holcomb, who joined OHSC last year as legal counsel, is now serving as the new Deputy Director and Legal Counsel. Ms. Anelia Moore has joined OHSC as Assistant Director and Senior Policy Advisor. Colin Stauffer from the data and analytics firm Resultant, recently joined the team as the dedicated project manager for the implementation phase. He also informed the Committee that there are new members on the team since the June committee meeting from the Georgia Technology Authority (GTA) who provide significant support for key projects at the direction of the Governor through the GTA Technology Empowerment Fund.

Project Plan Update

Mr. Jake Star provided an update on the project plan, sharing that the end date of the overall timeline has not changed, and commencement of data collection from payers has continued to be dependent on completion of the RFP process. Mr. Star announced that the RFP process has concluded, and a contract was awarded to Onpoint Health Data on October 21st. The timeline provides for six months between contract execution and go-live with a data collection portal. There are key dependencies and decisions for the team to make such as details about data that will be collected. Mr. Star pointed out that Ms. Megan Denham from GTRI, and the OHSC project manager, Mr. Colin Stauffer, would be ensuring project plan milestones are met. Engagement with key stakeholders, especially the payers, will be ramping up, and OHSC will be promulgating administrative rules requiring payers to submit data once the APCD goes live. The team will be working closely with DCH to prepare for Medicaid and SHBP data submissions to the APCD.

Mr. Star went on to explain that the transition to implementation also sets the stage for construction of the analytics module and progress has been made together with the Georgia Data Analytics Center (GDAC) on defining what the analytics environment will look like. A plan for the environment will be finalized in the next three months and it will be operational in the summer of 2023 with the first reports to be produced in September 2023.

Mr. Star closed this portion of the presentation by noting that the stakeholder workgroups have been relatively quiet since July, while the RFP and selection of a data collection supplier was concluded. Two of those groups will resume activity now and finish up in the next few months. Mr. Star asked if there were any questions from the Committee on the timeline. [Pause] There were no questions or comments.

APCD Budget Update

Mr. Colin Stauffer began the budget update by reminding all committee members that when the project began a year ago there were many unknowns, from the costs of the data collection supplier to the percentage of the federal match funding through Medicaid from the Centers for Medicare and Medicaid Services (CMS). However, Mr. Stauffer shared that the overall project budget has not significantly changed, though the timing of expenditures has shifted. OHSC does not anticipate making any changes to funding requests for the FY23 Amended Budget for the Department of Community Health (DCH) and expect to request only the currently budgeted base funding of $800,000 for FY24.

RFP Update

Mr. Star provided updated information about the RFP and contracting of the data collection supplier:

- Submissions were due from bidders on May 4th
- Proposal evaluation was completed June 20th
- Contract discussions were completed August 26th
- Final contract was submitted to CMS for approval on August 30th
- CMS approved the contract on October 5th; the state posted the Notice of Intent to Award (NOIA)
- The contract was awarded on October 21st.

OHSC received eight proposals with four of these meeting criteria for evaluation. There were seven evaluators on the team, which included representation from OHSC, GTRI, and GTA. No protests of the procurement or final selection were filed.

Mr. Star thanked Ms. Barbara Burns and Ms. Carrie Steele at the Department of Administrative Services (DOAS) for their assistance with the procurement, and GTA for their support. He asked if there were any questions or comments about the project and budget updates. [Pause] There were no questions or comments.

Mr. Star explained the RFP was drafted to place a heavy emphasis on finding a data collection supplier and partner with significant experience providing APCD data collection in other states and one who could deploy a system that would be up and running quickly. Mr. Star added the proposal evaluation process revealed a stand-out organization with an out-of-the-box solution and proven ability to deliver that solution cost-effectively. Mr. Star then announced the award of a contract to Onpoint Health Data as Georgia's data collection supplier. Mr. Star turned the presenting at this time over to Mr. Jim Harrison, CEO of Onpoint Health Data, to tell the committee about their company and their work.

Overview of Onpoint Health Data

Mr. Jim Harrison, CEO of Onpoint, shared information about the company. Onpoint is an independent, not-for-profit, based in Portland, Maine, led by and staffed with experienced, expert innovators in APCD development, claims, billing, reimbursement, and data exchange. Mr. Harrison shared some more details about the twelve states where Onpoint provides APCD support, and some characteristics of the APCD and analytics work they are involved with in those states. Onpoint supports more than half of all state APCDs and they are also a measurement contractor for the Centers for Medicare and Medicaid Services (CMS). The most recent APCD they supported was for Maryland where they met the projected timeline goals. They are currently supporting California and have met every milestone thus far. Mr. Harrison indicated Onpoint is comfortable with the timeline required by OHSC as described earlier in the meeting by Jake Star. Mr. Harrison also explained that Onpoint's APCD support of states and payers across the US includes more than 345 public and private payers and has managed more than 50 billion transaction records for more than 80 million lives.

Mr. Harrison closed his portion of the presentation by describing how Onpoint intends to help the state of Georgia, including seamless implementation of a proven platform with rapid processing of very large files. Onpoint continues to make investments in their platform to ensure that they can handle the increased volume of more state clients. Onpoint will provide support and technical assistance to payers and other data submitters. Mr. Harrison stated that while Onpoint is not contracted to be the analytics vendor for Georgia, they do provide consumable and reliable data as well as data enrichment. Onpoint will run master provider and master patient indexes and analytic use flags on conditions, emergency department visits, and inpatient services. Onpoint will also generate Tableau-based metadata reporting called the APCD snapshot early in implementation so that project stakeholders have a sense of the volume of data by payer and condition, as well as information about costs and quality of services being delivered.

Mr. Harris committed that the validation of data submitted to the APCD will be transparent to the submitters and the state along with a business rules document. These activities are intended to support the GDAC analytics effort.

Mr. Harris explained data refresh cycles are scheduled to be 30 days from submission to extracts from the APCD into the analytics environment, and data products will be built to Georgia's specifications.

Mr. Harris concluded the presentation and asked if there were any questions. [Pause] There were no questions from committee members.

Stakeholder Engagement

Mr. Stauffer explained engagement with various stakeholders of the APCD is a key aspect of its implementation and buy-in will be a critical driver of participation, use, and benefit. Planning is in place to conduct outreach to claims data submitters, the statewide healthcare ecosystem, and the public to solicit input, feedback, questions, and concerns so they can be addressed through communication,

processes, and action. The plan addresses two primary categories of stakeholders, 1) submitters, and 2) advocacy, and has the following high-level components:

- Identification of submitters and other relevant stakeholders
- Outreach and solicitation of feedback
- Public-facing facilitated meetings and town halls
- Publishing updates and other information on the existing website
- Incorporation of feedback and other inputs into evolving communications and APCD processes
- Ongoing engagement through submitter onboarding, delivery of use cases and analytics, and ongoing sustainability

Mr. Stauffer shared that some of the identified stakeholders have already been engaged and that collaboration with advocacy groups has been the most effective way to reach members of the healthcare and business communities. Mr. Stauffer asked that committee members let OHSC know if there are stakeholder groups that should be included so they can be added.

Insights revealed by stakeholder engagement thus far was noted to include:

- Employee Retirement Security Income Act (ERISA) employer payer groups desire easy opt-in for consumers and no cost to consumers
- Some payers do not pass the cost to participate on to insured or covered consumers while others indicate there may be some costs to consumers
- Claims with specially protected health information such as substance use disorder claims are redacted based on their understanding of federal regulations and will not be included in their data submissions to the APCD
- Stakeholders have also provided a variation of responses regarding historical data submissions with some indicating anything more than 2 years back would be challenging while others stated that 5 years of data is available for submission
- Most payers will likely be making multiple submissions to get all their data into the APCD because they have multiple benefit plans and coverage products managed on different systems within their organizations
- Finally, Mr. Stauffer highlighted a variation in responses from payers and submitters related to how soon after the data submission guide is finalized, they would be able to connect, conduct test submissions, and go live; approximately one-third are asking for a longer timeline than 6 months and another one-third need to do some internal planning before committing

Mr. Stauffer emphasized that, for the above reasons, finalizing the data submission guide and onboarding efforts must move as rapidly as possible. Mr. Stauffer wanted to be clear that payers have been supportive of APCD data use for the purposes of determining median pricing in compliance with the no surprise billing regulations.

On the advocacy side, OHSC has been pleased with the enthusiasm groups are expressing for the APCD and for their willingness to assist with communications, getting the word out, and facilitating community input. Mr. Stauffer shared that the questions and concerns from advocacy groups are typically related to ensuring privacy and security of persons' health care information, accuracy of data products such as

reports and analytics, questions about what kind of data goes into the APCD, and who will have access to APCD data.

Use Case Prioritization Update

Mr. Star explained that in meetings with the Use Case workgroup it was apparent that there are many valuable use cases for APCD data in Georgia. The consensus appears to be that many or all of them are important. It is also a reality that OHSC and GTRI need to begin somewhere, and a list of factors informing which use cases rise to the top of the list was outlined to the committee at the meeting:

- Is there a statutory mandate, federal funding or regulatory requirement, or other commitment for the use case?
- When will there be a sufficient volume of data in the APCD to support the use case?
- Does the use case provide insight that is useful to more than one stakeholder group, more than one policy decision, etc.
- It will take time to onboard payers, and they cannot all work through the submission testing process at the same time
- Getting historical data from previous years presents unique challenges but is essential for longitudinal studies and identifying trends, and use cases related to this aspect will become more insightful over time
- What is the volume of analytics effort for each use case?
- What use cases have provided the most valuable insights to other states where APCDs have been in place for a period of time?
- What kind of data, and how much data, will be needed to accomplish the intent of some use cases?

Mr. Star provided an example of a specific use case – compliance with federal legislation provided in the 2022 No Surprises Act (NSA) and Georgia legislation provided in the 2021 Surprise Billing and Consumer Protection Act, that protects consumers from surprise billing practices. The Office of Commissioner of Insurance and Safety Fire (OCI) has accountabilities related to this requirement and this use case is supported by the payers. In addition, seeking CMS federal match funding presumes there will be a demonstrated savings in Medicaid expenditures as one benefit of APCD data. Therefore, any analyses provided for DCH will also be helpful to the rest of the healthcare environment in the state.

The factors presented above, among others, were considered in prioritizing the first use cases that will be pursued in development of APCD data products, so that value can be demonstrated as quickly as possible.

At this time, Dr. Jon Duke from GTRI took over the presentation of initial use cases.

Dr. Duke reiterated that there is a long period of activity that the APCD will support and offered to the committee that the materials provided in advance of the meeting contain additional detail and context for the use cases being presented during the meeting.

Dr. Duke directed the committee members' attention to the first category of use cases being displayed, those related to cost and utilization. Examples Dr. Duke provided included total cost of care, chronic

disease costs of care, avoidable costs, behavioral health costs of care, surprise billing regulatory compliance, and pharmaceutical costs. Each of these use cases were described in detail by Dr. Duke.

The second category Dr. Duke described to the committee were those use cases related to population health. These included trends in chronic diseases, cancer, behavioral health, and maternal health. Dr. Duke explained that there are other sources of data available for analysis of these trends such as chronic disease and cancer registries and Department of Public Health data, but it is important to understand how the APCD, which has useful data concerning conditions and comorbidities, can augment and complement those other sources. Dr. Duke characterized this category as illuminating trends such as the incidence of these conditions by demographic or geographic sub-categories, and disparities as opposed to focusing on costs as in the first category.

The third category described by Dr. Duke was healthcare quality, an area that APCD data can be very useful. Use cases including low value care that can be defined many ways such as not wanted, not needed, low efficacy services, and others. Dr. Duke shared recent CDC changes in interpretations of low value care and one of those is the low value of opioids for back pain and the limited relief they provide along with increased morbidity and increased dependence or addiction they can result in. Another use case in the area of health care quality presented by Dr. Duke included preventive screening and the volume or rates of screening that occurs, aligned with the U.S. Preventive Services Taskforce recommendations. As with the previous two categories, these analyses can be segmented by population demographics and geographical location, or by the delivery system where they are accessed, to gain insights to health care in Georgia.

Dr. Duke stressed that these use cases are just a small portion of what is ultimately possible, and that they do not address all the areas of interest that can be explored with APCD data, but strike a good balance of the factors considered, as described by Mr. Star earlier in the meeting. They will also inform the next wave of teams that will use the ACPD data, by understanding how the APCD can support study of different kinds of questions that the data can help researchers answer. At this time, Dr. Duke asked if there were any questions. [Pause] There were no comments or questions.

Mr. Star covered some additional information about timelines related to the use cases that had been shared. Mr. Star indicated that the project team will be building out the analytics environment during the first few months of 2023 prior to receiving data submissions and there would not likely be production data collected from submitters until June of 2023 with first validated outputs for analysis in September of 2023. Mr. Star explained that once those milestones are reached, lower complexity reports could be published by January 2024, and over the course of 2024 analyses can be completed for the initial priority use cases. Work will continue with the Use Case workgroup and the Advisory Committee to define the next phase of studies and use case priorities, and work on the data release process for releasing data products to non-state government parties for their analyses and study.

Mr. Star said the project team will work with other state agencies and approved research organizations via the data request, approval, and release process, to get the right hands on building out the analyses.

Mr. Star concluded the Use Case Priorities portion of the presentation by asking if committee members had any questions. [Pause] There were no questions, and Mr. Star turned the presentation over again to Dr. Duke.

Transparency in Coverage: Overview and Impact on APCD

Dr. Jon Duke began by sharing the Transparency in Coverage Final Rule from the Federal Register, where the code of federal regulations and proposed rulemaking are published. Dr. Duke explained that he wanted to share the new regulations in the context of the price and cost transparency objectives of the APCD and their occurrence concurrent to APCD work across the US. New Federal regulations promulgated by the U.S. Department of Health and Human Services (HHS) governing transparency in coverage data are intended to promote cost transparency from insurers in a similar fashion to the hospital transparency regulation.

Dr. Duke showed a chronology beginning with the Hospital Price Transparency Rule from 2021 requiring machine readable files containing provider rates and consumer-friendly display of shoppable services, through to the Transparency in Coverage Rule in 2022 requiring machine readable files with payer rates, and additional phases with more requirements coming in 2023 and 2024. Dr. Duke explained the intent is to make available to the public the "sticker prices" for certain procedures and other charges from health systems. He went on to say that there were opportunities and challenges associated with implementation of the Hospital Price Transparency Rule, and these were applied to payers, and a similar transparency in the payer negotiated rates to providers, which went into effect this past July of 2022.

The payer-generated machine-readable files must contain in-network rates, out of network rates, allowed amounts, and prescription drug pricing, as of January 2022. Coming up this January 2023, payers must offer internet-based consumer self-service tools providing personalized out-of-picket cost estimates data for 500 specific items and services. In January of 2024, provisions take effect expanding the internet-based self-service tools to include cost estimates for *all covered items, services, and prescription drugs.* The requirements come with penalties for non-compliance of $100, per covered health plan enrolled member, per day, effective as of July 2022.

Dr. Duke outlined the exceptions regarding benefit plan types that do not need to comply, including:

- Grandfathered plans
- Excepted Benefits
- Short-term limited duration plans
- Retiree-only plans
- Medicare & Medicare Advantage plans
- Medicaid & Medicaid Managed Care Organizations
- Flexible Spending Account administrators (FSAs)
- Health Reimbursement Arrangements (HRAs), including ICHRAs and QSHRAs
- Health Savings Accounts

The first data that was available in the machine-readable files (MRFs) once the rule went into effect were in-network rates for all covered items and services furnished by contracted, in-network providers, and out-of-network billed and allowed charges for covered items and services furnished by out-of-network providers. CMS prescribed the file formats and included regulations prohibiting logins and

needs for authentication for members of the public to view the information, and to ensure current data by requiring monthly updates to the MRFs.

Dr. Duke provided some visual examples showing file fields for each type of information, the names of the fields, the type of data (strings, arrays) definitions for the fields in plain language, and whether the field is required or not.

Dr. Duke underscored that these types of information had previously been closely guarded proprietary business information for health plans and insurers. Negotiated rates with providers were previously only known to those who were parties to the contractual agreement (the payer, and the provider), so this has been a profound shift from no transparency to a high-level of public transparency easily accessible by all consumers, and with a substantial financial penalty for non-compliance.

Dr. Duke added that the peculiarity, or "catch" to these requirements is size of the files and provided an example from United Healthcare's website with a message to consumers cautioning them that the estimated size of JSON formatted machine-readable files posted there may be millions of lines of data up to a terabyte, and consumers should consider the capacity of the system they will view these files on before downloading them. United has 70,000 such files posted on their website. The entire quantity of data for all US payers is estimated to be greater than 250 petabytes (1 PB = 1 million gigabytes), or roughly twenty times the size of the Library of Congress.

Dr. Duke explained to the committee that GTRI has their own big data environment with servers enabling them to perform analysis on and with these enormous files and amounts of data. Also, Dr. Duke shared that there are other problems with the files that make them difficult for consumers to understand because of the complexity of provider and pharmacy payment methodologies and a small percentage of these files contain values such as $0.01 pricing for a hip replacement procedure, or $88888.88 for cardiac stress test. There are also provider and procedure code pairings for scenarios that would never actually occur in reality, such as the negotiated rate for a psychiatrist to perform a cardiac bypass procedure, something that is not in the scope of practice for a licensed psychiatrist.

Dr. Duke explained what price transparency data could offer constituents. Some possibilities include payer's ability to determine if they are paying more for the same services than other payers are to the same providers, health care systems determining if some other provider is getting paid better than they are for the same services by the same health plan, or an employer wanting to identify if they are paying more than similar companies to cover their employees for the same services in a benefit package.

Dr. Duke asserted that since there are many types of questions this transparency data cannot answer, the value of the APCD in answering these questions is highlighted. APCD data is superior for studying:

- Total healthcare costs for a given population
- What kinds of care are being accessed in various communities
- How the rate of incidence of a given condition in a population might change over time
- What outcomes are associated with a given treatment for a specific condition
- How geographic, demographic, or other factors impact outcomes

The claims level data is the best source to study many aspects of the performance of Georgia's healthcare systems and newly available data on pricing transparency is useful for different kinds of comparisons.

Dr. Duke asked if the committee had any questions or comments.

One committee member thanked Dr. Duke and said big provider groups face constant daily attacks. They noticed that one of the advocacy groups asked about data security, and they asked if it is OHSC, GTRI, or Onpoint that is responsible for data security.

Dr. Duke responded that a lot of different stakeholders, submitters, Onpoint, and others are contributing to security. Mr. Star added that it is all of the above. Mr. Star indicated that this is one of the reasons why the state is separating data collection from analytics. Onpoint will be responsible for the security of the data that they are receiving and OHSC and GTRI, as the administrator of the APCD and in their oversight and management roles, are responsible for holding Onpoint accountable and ensuring the Onpoint controls are adequate to protect the data. Mr. Star reiterated that the data coming in will be deidentified, but the data still needs to be protected. The intention with GDAC is to have an environment that is eventually HITRUST certified, meaning there will be HIPAA and extended controls in place to protect that environment, and the statute names the administrator as having an oversight role in managing the security of the environment. Mr. Star added that GTA has an oversight role as well, and they are watching the security controls and ensuring the APCD delivers what it is supposed to. Dr. Duke stated that all the agencies and offices have collaborated: OHSC, GTRI, GDAC, GTA, DCH. Everyone involved has helped to think this through which bodes well for the level of complimentary work happening to achieve functional objectives with adequate security to protect the data.

A committee member asked about the protection in the cloud environment and asked if they have security and monitoring as the host. Dr. Duke indicated that there is no personally identifiable information in transparency in coverage data, which is in fact available to anyone in the public, but there is a higher level of security over the APCD data. Mr. Star added that Onpoint's environment is in Amazon Web Services' (AWS) cloud environment, and the analytics environment the state is building will also be in AWS.

One last question from a committee member was regarding stakeholders who will see transparency with pricing during negotiations with payers. Specifically, the committee member asked what does the project team think is going to happen to negotiations between provider groups, health systems, and payers with providers trying to get the highest rates they can, and payers negotiating for lower rates; what will the ultimate outcome be, especially with large health systems? Has the project team engaged them? Dr. Duke indicated he believed that to be one of the most exciting questions around this work and is happy to talk to committee members offline about how transparency data can be used by stakeholders across the board, on all sides. They are tricky to use without the technical infrastructure to do so. A provider may ask what a given insurer is paying every other provider in the state, or other cities that look like my city. Dr. Duke pointed out that question can be answered precisely and that could not be done previously, but it is unknown to the state how much of that is being done this early on because of the challenges of handling the very large data sets. Dr. Duke finished his response by saying it should increase consumer understanding as well as a more optimized set of relationships, but it is too early to tell whether prices will go up or down.

A committee member thanked the panel once again for putting together a great team.

Chairman Thomas thanked the committee for the questions and comments and added that the workgroups have done a lot of work looking at security and privacy, even a group dedicated to privacy, security, and access, and that group had stakeholders from state government agencies and externally to look at those issues collaboratively. Related to providers and the transparency data, Chairman Thomas added that in this year's state budget the legislature appropriated funding for OHSC to look at data from hospitals and aggregate it and post it in a public domain where it will be easy for consumers to compare and obtain financial information on hospitals all in one place.

Workgroup and Subgroup Update

Don Ross, from CedarBridge Group Consulting, expressed thanks to the workgroup and subgroup members who participated in several meetings over the last year. Mr. Ross shared the types of stakeholders represented by the members of these groups, the volumes of input they provided and the work they have accomplished.

Mr. Ross added that some of these groups have a little work left to do to complete that phase of the project, including the ongoing role of the Use Case workgroup beyond the initial prioritized use cases.

The Data Submission Standards subgroup will be working with the data collection supplier, Onpoint Health Data, OHSC, and GTRI to finalize the data submission standards and the Data Submission Guide for publication.

Finally, Mr. Ross shared the Data Use Agreement subgroup has input coming up on a final draft of the agreement that will be executed between the Administrator and recipients of data products, with requirements related to the uses of the data, persons who may access the data, security, privacy, and other aspects.

Upcoming Activities and Next Steps

Chairman Thomas communicated the focus of the program management will shift from the high-level planning to the detailed execution required for success. Chairman Thomas reiterated that there is a great team in place now for that phase of the work, and thanked the CedarBridge Group team for their work, guidance, and support during the planning efforts over the past year.

Chairman Thomas pointed out that the intensity of the activity will be increased now, and the team is making great progress during the transition from planning and procurement to implementation. The data submission guide will be finalized soon, and test submissions with pilot submitters will occur, as well as workgroup and subgroup activity to prepare for data release. Also, the payer and advocacy engagement will continue to provide input to the agency for promulgation of the rules needed related to data collection. Finally, the analytics strategy and building that environment will continue.

Chairman Thomas said the aggressive timeline will continue, and he expressed his gratitude to partners at DCH, DOAS, GTA, who have and are supporting the work, and the stakeholders on all the groups and this committee. All the collaboration and engagement will continue. In addition, Chairman Thomas took

the opportunity to thank the Governor's office, the House, and the Senate for the support, direction, and funding for FY22 and FY23 state budgets for this project. Chairman Thomas provided a reminder that OHSC will monitor and respond to any questions sent to the APCD email address provided at the beginning of the meeting and also available on the website, and the slides for this meeting and all meeting minutes will be posted on the website, also.

Chairman Thomas opened the floor for committee members to provide any input or ask questions. [Pause]

Chairman Thomas asked Dr. Jon Duke a question about the opportunity to pair information collected via pricing transparency requirements with the APCD data and how those would come together and what the potential is.

Dr. Duke responded that those data sets fit in a complementary way because the APCD data adds not only the volume of utilization flowing through the system to the pricing data from price transparency MRFs, but also what is the relative volume of different services in different communities. To summarize, the state will have the pricing, and with the APCD data, also the statewide volume of services utilized, but also the condition diagnoses, the rendering provider detail, and all the data at the community level and more granular levels, as well as some other demographic segmentation of populations. Dr. Duke is confident they will be able to merge those data sets to answer questions about the cost of care as it was, as it is, and how it might be in various scenarios.

A committee member asked as we look at quality measures and population health measures that will be collected, as well as pricing, in our state we have a number of private and health system accountable care organizations (ACOs) who are moving to next generation ACOs and risk-bearing agreements. Do we have a workgroup that will look at how the APCD can help the transition of ACOs to assist them in reaching quality metrics, close gaps in care, maximize value-based care and payment? The committee member noted that Mr. Harrison from Onpoint had shared their organization has helped CMS with measurement work for systems moving toward value-based payment.

Dr. Duke responded that the project team has not begun that work yet, but the question is relevant because the quality measures are calculated using the APCD data and will complement what is being done already. Best practices will be shared to support quality improvement work across the system and to improve the measurement of quality programs already in existence.

Adjournment

Chairman Thomas thanked everyone for participation and for the great work and contributions to the discussion from committee members. He announced that the next meeting will be held in February 2023.